CONTEXTUALISING HEALTH AGENCY -

EXPLORATION OF NARRATIVES FROM MARGINALISED WOMEN IN VARANASI, INDIA

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Abstract:

Gender equality and women's empowerment are critical development goals which are highlighted by global agendas such as the Beijing Declaration and Platform for Action and the Sustainable Development Goals. A key facet of these attempts is understanding and expanding women's agency, particularly to advance their health. However, traditional metrics often impose ideals of agency from a western standpoint and struggle to define and measure agency within women's contexts.

This qualitative study conducted in Varanasi, India, interviewed 17 ever-married marginalised women, aged 30-49, to explore their perceptions of health and agency. Participants were selected via snowball sampling, and semi-structured face-to-face interviews were employed for data collection. Data was analysed using saliency analysis, a thematic analysis approach that ensures themes that may not necessarily repeat but hold substantial importance for the study's objectives are retained.

The findings reveal that despite economic constraints, marginalised women demonstrate health agency. Interestingly, increased agency did not consistently improve health outcomes, with women instead prioritising family well-being, especially their children's. Moreover, gender interests were intertwined with family well-being, shaping agency towards communal alignment. Women exercised agency collaboratively via engaging in collective decision-making, cultural practices, and power negotiations. However, physically demanding, low-paying jobs drastically affected their health, highlighting the significance of structural constraints and suggesting a strong linkage between health outcomes and economic resources.

The study emphasises the importance of considering women's values, goals and strategic gender interests in improving well-being, warning against detached Western notions of autonomy. It stresses the need for contextualisation and genuine acknowledgment of women's narratives in interventions to increase their overall well-being and health.

Keywords: Health Agency, Women's Health, Health Empowerment, Women's Autonomy, Women's Decision Making, India

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LIST OF ABBREVIATIONS

AHS	Annual Health Survey
ASHA	Accredited Social Health Activist
BHU	Banaras Hindu University
BPL	Below the Poverty Line
CT Scan	Computerised Tomography Scan
HDI	Human Development Index
IDI	In Depth Interview
MMR	Maternal Mortality Ratio
NGO	Non-Governmental Organisation
OBC	Other Backward Castes
SC	Scheduled Castes
SDGs	Sustainable Development Goals
SHGs	Self-Help Groups
ST	Schedule Tribes
TB	Tuberculosis
The UN	The United Nations
UP	Uttar Pradesh
WHO	World Health Organisation

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1 INTRODUCTION

The introduction chapter provides the foundation for the research, explaining its context, objectives, and the problems and questions it addresses.

1.1 Research background and context

Empowerment of women is commonly recognised as a vital development goal. It is now more than 25 years since the Beijing Declaration and Platform for Action came into existence that made a commitment to improve the human rights of women and girls worldwide (Raj, 2020).

However, women from low- and middle-income countries continue to face immense health challenges today (Sharma et al, 2021). Despite progress, women's health issues remain multidimensional and complex, influenced by a range of factors including biological, cultural, and social aspects (Thresia & Mohindra, 2011). Unlike the conventional biomedical perspective, the social model of health views it as a holistic concept shaped by social, individual, and physical elements (Bhagwati, 2020). Thus, alongside biology, physiology, and healthcare, various factors like social, cultural, political, economic, environmental, and psycho/social conditions have been found to impact an individual's health (ibid).

India, characterised by its cultural and geographical diversity, is experiencing rapid industrialisation and urbanisation, which is accompanied by a growing population (Sorenson et al, 2018). While technological and economic advancements since 2000 have led to numerous development returns in India, widespread gender-based health disparities can still be observed in the country, particularly among marginalised women (ibid). For instance, according to the World Economic Forum's Gender Gap Index 2023, India ranked 142 out of 146 countries in the Health and Survival subindex (2023). It is no surprise that United Nations (2023) identifies Indian women as one of the most marginalised segments of society. They have been found to face numerous health risks such as maternal health issues, violence, and malnutrition (Gorski

et al., 2017). Within Indian women, marginalised communities like *Dalits* (untouchables), *Adivasis* (ancient indigenous inhabitants), indigenous minorities, and women with disabilities face additional discrimination and inequalities (United Nations, 2023).

Furthermore, poverty has been found to exacerbate women's health susceptibilities, particularly in low- and middle-income countries like India. For instance, according to UN Women (2022) projections, up to 446 million women worldwide could be living in acute poverty, with 20.9% of the world's extremely poor women living in Central and Southern Asia alone. Moreover, caste and socioeconomic status have also been found to interlink with women's health outcomes. Lower caste Indian women have been found to suffer from increased health risks due to their socioeconomic position (Mohindra et al., 2006; Bhan et al, 2016).

Regardless of these challenges having been well-established, gender biases persist in health research, leading to neglect and disregard of the numerous dimensions of women's health (Mohindra et al., 2006). Some of the key identified biases are lack of research on issues specific to women, incomplete health approaches, and inadequate consideration of intersections between gender and other social factors like class, ethnicity, and caste (ibid). Therefore, understanding health issues among women, both globally and specifically among Indian women, is essential (Bhan et al, 2016). It is particularly crucial to contextualise these issues within the societal and cultural framework that shapes women's lives (ibid).

Moreover, women's health serves as a key measurement of women's empowerment, and it is incorporated into various indices to assess women's status (Thresia & Mohindra, 2011). Kabeer (1999) describes the process of women empowerment as a means for women to gain facilitating resources like education, material wealth, and social networks outside their family that help develop their agency, especially in situations where they were previously denied this capacity. According to Kabeer (1999), agency is the capability to recognise goals and act upon them, thus it is the key element of women's empowerment. The empowerment process hence involves acquiring new resources that aid in the progression of women from a less agentic status to a more agentic one, helping them achieve their self-defined goals (Qutteina et. al, 2019). Their self-defined goals can be related to their health and well-being and economic, educational, and political participation (ibid). However, agency extending over economic, social and political actions differ according to the context (Sen 1999).

Therefore, when engaging in promoting women's rights and well-being, it is important to consider the crucial element of ensuring and expanding their agency (Richardson et al., 2019). It is also critical to recognise the gender-based power imbalances and social inequalities inherent in gender, and to acknowledge that programs addressing gender dynamics can significantly impact women's agency, either positively or negatively (Chang et al., 2020). Thus, policymakers, researchers, and experts should

be mindful that even programs not explicitly focused on gender may expend substantial influence on women's agency (ibid).

However, caution must also be taken while imposing ideals of agency from a western standpoint which via exclusively focusing on women's autonomy and independence can ignore the interplay between women's agency and their contexts (Wray, 2004). Today, development theorists and policymakers are rejecting well-being approaches that continue considering people in the developing world as beneficiaries and passive recipients (Campbell et al., 2009). Instead, they favour approaches that use agency by considering people as active participants capable of shaping and controlling their lives (ibid).

The Sustainable Development Goals (SDGs) of the United Nations (UN), describe SDG 5 as achieving gender equality and empowering all women and girls (Raj, 2020). Though several advancements on SDG 5 have been made, particularly in the reduction of child marriage and female genital mutilation, progress in the health indicators related to women and girls' empowerment has been meagre (ibid). Furthermore, Gammage et al. (2016) assert that augmenting women's agency is recognised as a key approach to reducing gender gaps, especially in enhancing women's health.

Hence, the importance of improvements in measuring women and girls' health agency is of paramount importance (Raj, 2020). Without it, the public health system can neither work towards achieving SDG 5 nor dislodge the power dynamic which external experts alone exercise over communities and individuals by prescribing suitable goals that eventually undermine women's health and cement social inequalities in health (ibid).

However, despite recent research showcasing the link between women's agency and health improvements, accurately measuring women's agency remains a challenge (Gammage et al., 2016). It is widely accepted that there is a vast difference between the local realities of women's lives and the international programmes and policy goals that make several unrealistic assumptions regarding women's potential for action (Campbell and Mennell, 2016). Thus, the health indicators have not expanded to adequately echo the empowerment process, and all the frameworks of measuring agency that exists today are unable to offer a complete picture of all the constraints women face in exercising their agency (Raj, 2020; Donald et al., 2020).

Such a backsliding approach has undoubtedly influenced the designing and implementation of interventions that are valid and reliable, and whose success and failure can be detected (Campbell and Mennell, 2016). Therefore, a lack of and poor understanding and measurement of agency has proved troublesome for the monitoring of progress and research into the health and social consequences of low empowerment that is required to achieve SDG 5 (Richardson et al., 2019).

Moreover, as Campbell and Mannell (2016) point out, a key question when analysing women's agency is not how agency is constrained but also how are the constraints negotiated. There are contextual, culturally diverse, intersubjective, and perceptual aspects of agency, whose disregard halts further investigation into the differences that are posed by context (Wray, 2004). Gammage et al. (2016) highlight that women demonstrate strategic agency, as they gather knowledge on those who have authority over them, not only within their personal spheres but also to navigate wide-ranging structural constraints. The strategies adopted by women to negotiate and reposition themselves are complex and cannot be placed within either 'resistance' or 'reproduction' of the oppressive gender norms (Raisborough and Bhatti, 2007).

Moreover, apart from inadequate problematisation of the concept, there is also a lack of utilising theory to justify the selection of indicators as well as incorporating them into measurement approaches (Campbell and Mennell, 2016). Exploring the processes that encourage favourable outcomes for women in their context and integrating these insights into program design is therefore essential. Hence, the priority to improve understanding and measurement on women's agency, especially those that integrate theory and consider local context and local inputs are widely valued in academia (Richardson et al., 2019). For this, Mannell et al. (2016) propose methodological processes that assess women's agency from their own vantage points and prioritise women's individual understandings of their actions and experiences.

1.2 Objective of the thesis

This study carries out a contextualised investigation focusing on bringing forth the experiences of a distinct cohort of women residing in the Global South that represent marginalised segments of society. These women navigate a cultural milieu rooted in traditional gender roles yet undergoing rapid transformation in specific dimensions marked by factors like low-paid informal employment. The study aims to, through utilising a bottom-up inductive approach, examine how marginalised urban married women in Varanasi, India, facing economic challenges discern and place their agency in matters of health.

This research seeks to contribute to the dynamics, experiences and articulations of health ideals and health agency of women from the Global South. By capturing women's viewpoints and insights on health agency within their daily lives, and through illustrating their own words and stories, the study makes a methodological contribution to the subject area. Consequently, it intends to supplement the overall canopy of research that is being conducted to enhance understandings on women's

health agency and the development of context-specific indicators, particularly tailored to the context of women from the Global South.

1.3 Research question

This thesis addresses the following central research question alongside three subsidiary-questions:

1. In what ways can the notion of health agency be contextualised amidst working-class marginalised women in Varanasi, India?

    1.1 What are the health ideals (conceptualisation) and goals of women?
    1.2 How do women (try to) achieve their health goals and interests?
    1.3 What factors facilitate or hinder women in achieving their health goals and interests?

These questions are answered through an analysis of 17 semi-structured interviews with ever-married reproductive aged women, between the ages of 30-49 in Varanasi, India. Through the inductive identification of codes and themes in the interviews, conclusions are drawn, bypassing constraints that could arise from analysing the interviews solely based on the theory of women's agency and empowerment. Additionally, examining the findings with relevant research allows for comprehensive assessment, revealing both existing gaps and confirming progress in the right direction.

1.4 Structure of the thesis

The thesis is structured into six main chapters. Chapter 1, the introduction, as can be seen lays out the objectives and research question that guide the study. It provides an overview of the research context, rationale, and significance. Chapter 2, the literature review explores existing and relevant literature on women's agency and agency related to their health and offers a synthesis of the key concepts and nuances in academia on the topic to help aid the investigation of the research question. Specifically, it does so in a way to expand upon both the concept and manner of contextualising women's health agency and helping connect it to their well-being. Chapter 3 outlines the methodology applied in the research, providing details on the approach, data collection methods, and analytical techniques used to reveal women's voices and explore women's health agency in Varanasi, India. Chapter 4 presents the findings from the empirical analysis in women's own words thus, offers insights into women's health

attitudes, values and goals, and agency manifestations. Chapter 5 engages in a critical discussion of the results by contextualising them within the literature on the subject while also exploring implications for interventions that can improve women's health outcomes and their overall wellbeing. Finally, Chapter 6 presents the conclusions that are drawn from the study. It summarises key findings and suggests avenues for future research. The appendices that contain supplementary materials and a list of references follow.

2 LITERATURE REVIEW

This chapter expands upon the concepts of women's empowerment and agency, exploring their interconnectedness. It highlights the significant role of agency in improving women's overall well-being, including their health outcomes while also ascertaining how improved health can impact their agency and overall wellbeing. Additionally, it examines the existing literature and expert perspectives on the factors that influence agency, with a special focus on the health agency of women in interconnected societies such as South Asia. Furthermore, the chapter discusses literature that addresses the challenges associated with measuring women's agency accurately and try to establish its connection to their well-being.

Exploring this literature helps portray the importance of agency in women's wellbeing and it also helps enrich the understanding of the complex, even contradictory discussions surrounding women's agency. This aids in identifying the key areas and viewpoints that require further exploration and expansion within academia. Therefore, the literature review not only provides an apt foundation to scrutinise the empirical findings, but also helps inform methodological approaches, allowing us to determine the accuracy and gaps within existing literature, particularly in relation to contextualising women's health agency. Finally, this approach to literature review can help expose the repercussions of misinterpreting and/or incorrectly contextualising women's health agency and help establish connections between women's health agency and their overall wellbeing.

2.1 Navigating women's empowerment and agency

Women's empowerment, according to several experts in the field is defined as the process by which women enhance their capacities to make strategic life choices thus, it is very necessary to the promotion of women's rights and well-being (Richardson et

al., 2019). Empowerment, according to Donald et al. (2020) is a broad concept associated with well-being improvements across health, education, security, public life and economic opportunities, while agency is closely related to it. The ill effects of low empowerment have been extensively investigated and proved in the last few decades. For example, low empowerment in women is linked to a higher risk of intimate partner violence, reduced consumption of antenatal care and the possibility to employ capable healthcare professionals during delivery, increased risk of stress and anxiety, and reduced use of contraceptives (ibid).

However, research has battled to decisively define empowerment, select accurate and appropriate measurement indicators, measure empowerment in a manner that includes the context of women's lives, and discuss the relations of power that deeply impact women (Richardson et al., 2019; Drydyk, 2013).

It is crucial to briefly capture the concept's evolution for a better understanding on the discussions that prevail in the academic field. Several feminist scholars built on Indian economist and philosopher Amartya Sen's work to produce substantial literature on women's agency and empowerment (Richardson et al., 2019). Agency, a vital component in Sen's 'capability approach', which he articulated in the 1980's, centres on the possibility for people to live the kind of life that they desire (ibid). Sen (1999) defines agency as a person's freedom to do and accomplish whatever they deem important to pursue their goals and values. The 'capability approach' has two components – functionings, which correspond to a person being and doing things they value (realised capabilities), and capabilities which indicate the functionings that the person can viably attain (Richardson et al., 2019). Thus, a person must have certain capability to turn resources and public goods into a functioning to achieve well-being for themselves (Sen, 1999).

According to Sen (1999), though they intersect, there is a difference between well-being and agency; he distinguishes between them by clarifying that women's practical needs are well-being related, while the strategic gender interests go under agency. For Sen, agency is concerned with the ability and power to remove barriers, use opportunities, have the freedom to take part in, discuss and voice opinions on economic, social and political institutions, and most importantly, it does not look at the involvement of women as beneficiaries (Campbell et al., 2009; Sen, 1999). Therefore, Sen (1999) establishes that when women can identify goals, make choices and act upon them, i.e., exercise agency, their well-being is positively affected, as it also brings several benefits to the society, such as reducing child mortality and fertility rates, along with making improvements in the economic, political, social and environmental aspects (Campbell et al., 2009). Moreover, other academics, such as Davis et al. (2014), also ascertain that enabling a woman to make decisions about and have control over her body can enhance her quality of life and result in improved health outcomes.

Focusing specifically on health, Tengland (2007), echoing Sen (1999), frames empowerment as a multifaceted goal that integrates factors from primarily three central concepts of welfare, health, and quality of life. This holistic view comprises various elements, including autonomy, freedom, knowledge, self-esteem, self-confidence, and the ability to exert control over one's health and life. This perspective suggests that empowerment is a justifiable goal of health promotion, therefore, health empowerment can be seen as both a goal and an approach or process (ibid). Naturally, looking at it as a process accordingly requires experts to partly forgo authority and control, as the components of problem forming, decision making and action taking by the persons instead becomes integral to the process (ibid).

In Kabeer's (1999) women's empowerment process, which is influenced by Sen's work, three dimensions that affect the ability to exercise choice, namely resources, agency, and achievements are specified. The resources and agency of Kabeer correspond to Sen's capabilities (Richardson et al., 2019). By resources, Kabeer refers to material (money), human (education), social (social capital) and environmental (violence-free environment) resources that play a facilitating role in the empowerment process by offering supportive conditions to increase women's agency (ibid). The ability to identify and act upon personal goals and values, i.e., agency, comprises internal and external qualities- critical thinking skills are an example of internal quality while the ability to perform decisions are external quality (Kabeer, 1999). According to Kabeer (1999), achievement is defined as the obtained results of an exercised agency such as an increase in good health.

Based partly on Marhta Roger's Science of Unitary Human Beings, which is grounded in the arts, the theory of Health Empowerment is influenced by her principle of integrality, which suggests human beings as integral to their daily living environment and their health experience (Phillips, 2016; Shearer, 2009). This consequently is exemplified by the patterns, self-organisation behaviour, diversity and changes reflective of an individual's views and values on health (Shearer, 2009). Thus, the theory, in line with Kabeer's (1999) view, recognises the occurrence of health empowerment resulting from a combination of personal and social-contextual resources (Shearer, 2009). Personal resources relate to characteristics such as self-capacity while social-contextual resources are support gained from social networks and social services (ibid).

Furthermore, Kabeer (2008), as discussed in Gammage et al. (2016), distinguishes between various forms of agency. Kabeer categorises agency into two types: everyday actions and more significant life decisions (ibid). Kabeer (1999) (as cited in Raman et al., 2016) offers a useful distinction between 'passive' forms of agency, where actions are taken when options are limited, and 'active' agency, involving purposeful behav-

iour. Additionally, she differentiates between actions that perpetuate the current situation and those that aim to question or change it (Gammage et al., 2016). According to her, agency encompasses consciousness, voice, and action, whether exercised individually or collectively (ibid).

2.2 Exploring key factors and impacts

In Sen's (1999) view, agency of women is influenced by education and their ability to earn money. Sen (1999) demonstrates this by analysing cooperative conflict, a general feature in group relations, since people bear both harmonious and conflicting interests, which take place between men and women to reveal what influences in women obtaining a specific 'deal' in family divisions. In cooperative conflicts, both parties get gains, however, many alternatives lean toward one party, and usually it is the women that catch the shorter end of the stick (ibid). Sen (1999) informs that such conflicts are typically resolved via unfair patterns of behaviour that are implicitly settled, thus, many times, women are unable to even grasp how deprived they are.

Such disadvantages that women face, Sen (1999) deduces are influenced by the perceptions of entitlement based on who is doing 'productive' work and who is 'contributing' more to the family's prosperity, which impacts the intrafamily distribution of food, health care and other provisions, too. This antifemale bias, he says, is influenced by the social standing and economic power of women (ibid). An apt example, that Batura et al. (2022) bring forth is from their study which found women with higher education levels having more opportunities to learn and engage with new information. The study discovered that the women also tended to contribute more to their household income, which resulted in increasing their decision-making power compared to men (ibid). The ability to contribute financially appeared to give women a sense of independence, especially if they worked outside the home (ibid). Though how contributions and productivity are measured are seldom openly discussed, Sen (1999) emphasises that the impact of women's greater empowerment and agency will help correct these inequalities.

However, it is important to note that the means of empowerment, such as literacy are not always found to empower women, as other factors like culture or family structure may be disempowering for some women instead (Drydyk, 2013). Under feminist discourse, the constraints and oppressions imposed on women through gender roles and the interpretations of femininity in different societies has been widely discussed (Day et al, 2010). These constraints include, for instance, social norms and rules that place women at a certain level or position in the social hierarchy, which further depend on and differ by their various intersecting group identities (Davis et

al, 2014). For example, Kabeer (as cited in Drydyk, 2013) observed that long-standing customs and beliefs can sometimes limit empowerment, even when women's agency expanded.

While many studies associate increased empowerment with enhanced health and social outcomes, critical researchers are beginning to challenge this widely accepted belief (Davis et al., 2014). Mitroi et al. (2016) propose a model focused on empowering women through their involvement in healthcare instead. Although efforts to empower women span various domains such as politics, finance, and education, Mitroi et al. (2016) argue that healthcare appears as the most impactful avenue for women's empowerment. Additionally, scholars like Kabeer (1999) introduce nuance, suggesting that empowerment is a gradual process. A woman's level of empowerment may evolve as she gets older, achieves financial independence, or confronts different life challenges (Davis et al., 2014). Critics also caution against overlooking the concept of agency in analysing the central social dimension which is inherent in feminist perspectives (Drydyk, 2013).

Therefore, understanding women's circumstances becomes important in contributing to their well-being, revealing the factors that facilitate or impede their health agency and how they navigate it within their contexts. The subsequent sections expand upon the key aspects to explore the complex relationship between women's health and their agency.

2.2.1 Recognising women's negotiation strategies

Day et al (2010) infer that Foucauldian-influenced poststructuralism galvanised feminists to expand their horizon and study women's agency from numerous angles, such as recognising women's ability to ponder over their position and available choices to determine their course of action. In particular, several feminist economists advocate for including the implicit and elusive approaches that are used by women to negotiate and contest power while bargaining to comprehend agency (Donald et al., 2020). This leads to the formation of the construct of women's ability to reposition themselves to secure a more powerful position and attain characteristics to their liking.

Similarly, from the viewpoint of the theory of health empowerment, empowerment refers to the dynamic health progression that accentuates a decisive partaking in the process of changing oneself and one's environment, identifying patterns, as well as actively utilising inner resources for one's well-being (Shearer, 2009). In other words, health empowerment from this standpoint is the enabling of the cognizance/awareness of the capability to decisively partake in one's health and decisions regarding healthcare (ibid). The promotion of health empowerment via promoting personal and social-contextual resources, therefore, are said to enhance individual well-being and aid in attaining health goals (ibid).

As vast literature on agency exists, Donald et al.'s (2020) simplification becomes helpful. They state that in the literature on psychology, agency commonly links to having autonomy, and in the literature on economics, it corresponds to the bargaining power (ibid). In the literature on autonomy, however, that focuses on an individual being able to act on their goals and values, their capability to generate a transformative shift in their environment, via, for example, shaping the social hierarchies or norms that exist in that environment is not discussed (ibid). On the other hand, bargaining power which relates to being able to negotiate and exert influence to yield a certain leverage concerning the partner's utility in the household welfare function overlaps with agency, since it corresponds to an individual being able to act on their choices and goals and influence decisions, in association between two or more individuals (ibid).

Furthermore, Bina Agarwal's groundbreaking work in 1995 sheds light on household bargaining dynamics, as highlighted by Gammage et al. (2016). She demonstrates how social norms act as both constraints and facilitators in this context. Raj (2020) too emphasises the role of women in navigating power structures while exercising health agency, whether through vocal expression, negotiation, or strategic adaptation to power structures. Similarly, Raisborough and Bhatti (2007) reveal how women negotiate and redefine gender norms, thus, they infer that these strategies cannot be categorised into frameworks of 'reproduction' or 'resistance' (ibid). Day et al. (2010) also suggest that the distinction between 'resistance' and 'reproduction' in certain forms of agency, despite the feminist poststructuralist deliberations, can be complex to distinguish thus, cannot be perceived as being opposite in nature.

Agarwal's work, as cited by Gammage et al. (2016), further demonstrates how social norms determine the division of roles, resources, and responsibilities based on gender, age, and marital status. She also highlights that the strategic silence and absence of dissent among subordinate household members is due to their recognition of the potential risks of protesting (ibid). Moreover, she suggests that changes in intra-household power dynamics reflect evolving norms. Thus, this emphasises the interconnectedness of negotiation with women's agency and potential empowerment, as the power relations within the social context and over one's life's course remain in a flux (Raisborough and Bhatti, 2007). However, Gammage et al. (2016) warn against viewing negotiation and bargaining as exclusive manifestations of agency, as is highlighted in the newer approaches, and advise to explore their underlying processes too.

2.2.2 Placing agency within interconnected societies

Mumtaz and Salway (as cited in Raman et al, 2016), from their ethnographic study conducted in rural Pakistan caution against applying Western perceptions of women's autonomy and mobility. They argue that the idea of individual autonomy, although

central in Western moral and political philosophy, is not practical or beneficial in many other contexts (ibid). Another example is by Mannell et al. (2016) who draw inspiration from Mahmood's (2012) pioneering research on women's involvement in the piety movement in Egypt. Mahmood's argument challenges conventional notions of agency, as she argues that actions like publicly wearing a veil, often seen as restrictive by some neoliberal feminists, actually reflect women's profound agency by enabling them to construct meaningful religious identities.

Davis et al. (2014) and Mitroi et al. (2016) suggest that a culturally specific measure of women's empowerment may be more pragmatic than a one applied universally across different regions. For instance, experts advocate for a deeper comprehension of women's roles within the interconnected society of South Asia (Raman et al., 2016). Bloom et al. (2001), in their research in Varanasi, found that women's autonomy considerably influenced the use of maternal health care, challenging the impact of established autonomy determinants such as education (ibid). They further observed that women with stronger bonds to their birth family had greater autonomy (ibid).

Similarly, in their study conducted in Urban India, Raman et al. (2016) observe that women primarily engage in decision-making within the family, often jointly with their husbands. Beyond ensuring their children's basic needs, women make most decisions collectively, regardless of its size (ibid). This aligns with previous criticisms from scholars in South Asia, who have remarked that an excessive focus on women's independent actions, overlooks the strong emotional and structural ties that bind household members together (ibid). In Raman et al.'s (2016) study, the necessity for negotiation to involve all family members, as evident in urban India, demonstrates the value of collective decision-making. Furthermore, women readily acknowledged the influential role of their in-laws in family decision-making processes, as well (ibid).

Moreover, recent studies conducted in South Asia and Africa indicate that women's participatory engagement has a beneficial effect on their health. Insights from professionals working with women in South Asia support women's preference for companionship and social interaction in various activities (Raman et al., 2016). Likewise, Mitroi et al. (2016) emphasise the importance of establishing communication networks for women, integrating local cultural practices into training programs, and enhancing women's abilities to care not only for their own children but also for other women. Arun and Prabhu's (2023) study on the social determinants of health for rural Indian women also find that a lack of spousal support followed by familial support, and time, is the strongest determinant of health that prevents Indian rural women from maximising their health outcomes. For further exploration on this topic, the works of Prost et al. (2013) and Tripathy et al. (2010) can also be viewed.

Furthermore, Raman et al. (2016) find that unravelling the various factors affecting women's agency and autonomy in urban South Asia can be complex. However,

they discover a common theme highlighting collective action, such as group decision-making, group mobility, and involvement in women's organisations (ibid). They observe that several factors intersect to influence women's agency, including religion, socioeconomic status, and whether they come from rural or urban areas (ibid). Their previous findings also indicate that women in urban India derive their identity and resilience from their hometown, maternal family, and female relatives (ibid).

Thus, as can be noted, while the social sciences consider agency within structural constraints, mainstream economics traditionally has viewed it as individual utility maximization within personal circumstances and budget constraints (Gammage et al., 2016). However, economists now recognize that decision-making involves interactions between individuals as well as by them, and that people are positioned differently in their ability to succeed in this process (ibid). For instance, the Indian government has strongly supported Self-Help Groups primarily to tackle poverty and empower women. However, it is only in recent times that their likelihood to improve women's health outcomes has been examined (Chakravarty & Jha, 2012, as cited in Raman et al., 2016). Therefore, participating in these groups could be a culturally suitable way for improving the overall well-being of Indian women, a critical aspect that is often forgotten and overlooked in Western concepts of agency (Raman et al., 2016).

2.2.3 Challenging neoliberal notions of agency

When centring in on women's agency, it becomes evident that on the one hand, empowerment encompasses the pre-conditions as resources and the outcomes as achievements, while agency relates to the process of linking them (Donald et al., 2020). However, as stated in section 3.1 above, both well-being outcomes and resources can also affect agency. Women's agency regarding their capacity to define and act upon their healthcare choices, for example, depends on the resources they have, such as, education, employment, healthcare infrastructure, and various structural constraints (ibid).

When examining women's agency, it is hence crucial to recognise that women don't have unlimited possibilities accessible to them, and they are undeniably constrained by restrictions set in place, within and regardless of their contexts. Wrenn (2014) expands on this, alerting particularly against neoliberal agency that is shrouded in inauthentic exercising of power. Through this statement, Wrenn (2014) is referring to how with the adamant of capitalism, which necessitates the complimentary and reinforcing mechanism between institutions and people's mental models, exercising agency is only permissible towards bearings that sustain the system.

For example, the Global Women's Health Index exposes significant deficits in women's health. Their study shows that women who sought medical care had a two-

year longer life expectancy in comparison to those who did not, emphasising the importance of regular healthcare visits on women's life expectancy (Hologic, 2023). This, hence, shows the importance of preventive measures in protecting women's health. However, interventions have always prioritised addressing women's health issues instead (World Economic Forum, 2023). Gender biases in the healthcare system have also impeded progress. According to Harvard Health Publishing (2017), inequalities are a result of medical science's continuous focus on male-centric biology which constantly overlook the distinct symptoms women display in various health conditions.

Experts are of the opinion that these inequalities are imbedded in structural inequalities that are reproduced within society (Fergusson, 2015; Riggirozzi, 2021). Most importantly, economic forces and interests significantly influence healthcare agendas, and they often prioritise profit-driven undertakings over addressing women's pressing health concerns (Siristatidis et al., 2021). Cohen and Rodgers (2021) emphasise that capitalism's core lies in capital accumulation and economic growth, which is often reached through exploitive processes. For instance, Bedford and Rai (2010) discuss how consumption patterns in the North that are driven by accumulating debt reshape the international division of labour, and lead to a reinforcement of the gendered division of labour. This was, for example, observed during the Covid-19 pandemic, which exacerbated the colossal unpaid care (or care economy) performed by women due to disruptions in schooling and other services (Smith et al., 2022). Thus, women deal with the double burden of work, as their work inside and outside their homes remains invisible (WHO, n.d.; Syed, 2021).

Poverty too has been found to worsen health discrepancies as women who are often engaged in caregiving roles end up bearing an uneven burden of poor health (World Economic Forum, 2023). The pandemic was able to expose these systemic inequalities in global healthcare frameworks and systems, as it portrayed how they particularly disproportionately impact women from marginalised communities who face intersecting factors of gender, race, socio-economic status, and geographical inequalities (Lokat and Bhatia, 2020; Schubert et al., 2022; Cohen and Rodgers, 2021). Due to women being paid lower wages than men, their well-being is directly impacted by the determinants of health such as income and social status, which in turn influence their access to essential resources like food and healthcare, and also influence their health-related behaviours, thus, preserving the vicious cycle of inequality (Syed, 2021; Riggirozzi, 2021).

Hence, the global systems of production, exchange, consumption, and social reproduction impact women's health and their behaviour (Bedford and Rai, 2010). However, without transparent and accurate data on women's health, such disparities cannot be corrected. As the research landscape is fraught with pitfalls, including biases,

ethical concerns, and operational limitations, gender-responsive healthcare policies and interventions efforts get hindered (Siristatidis et al., 2021).

2.3 Measuring women's agency

The global health community underlines the necessity to enable women to take charge of their health, with women's agency shown to significantly impact various health-related outcomes, such as family planning, healthcare utilisation, and child nutrition status (Campbell & Mannell, 2016; Donald et al., 2020). Thus, measuring women's health agency holds vital importance in public health, as it plays a crucial role in achieving Sustainable Development Goal 5 on Gender Equality and addressing prevailing power imbalances in healthcare (Raj, 2020; n.d.).

Consequently, extensive methodological deliberation has focused on measuring women's agency and empowerment due to its profound impact on interpreting research findings (Chang et al., 2020). Ussher (2010) highlights that women's health issues have typically been defined by expert opinions, prompting feminist scholars to raise objections regarding the lack of input from women themselves. Without a clear understanding of women's agency, external experts risk exerting power over communities and individuals by prescribing public health goals that may inadvertently perpetuate social inequalities in health (Chang et al., 2020).

Therefore, discussing the literature on measurement is essential to expand the discourse on understanding and conceptualising women's health agency and its linkage to women's overall wellbeing.

2.3.1 Challenges in agency measurement

The mixed conceptualisations of agency and measurement approaches have masked the understanding on how health agency impacts women's well-being. While recognising the importance of the local context, it is clear that isolated indicators do not offer an accurate representation of women's roles as agents (Chang et al., 2020). Existing literature largely focuses on quantifiable aspects, like women's decision-making authority within their households, their mobility beyond their homes, women's education, and media exposure to measure agency (Hanmer & Klugman, 2016; Donald et al., 2020). Such quantitative research, where measuring agency often serves as and relies on assets like physical, financial, human, and social capital, may not fully seize the nuanced role of agency in women's empowerment (ibid).

It is important to avoid presuming a direct link between changes in these assets and changes in women's agency too (Hanmer & Klugman, 2016). As individuals op-

erate within unique structures and constraints, increased access to assets doesn't uniformly influence their agency (ibid). Therefore, it's vital to acknowledge that women's augmented agency cannot solely be attributed to increased asset access as it could also lead to changes in their assets (ibid). Measuring this interplay needs a more direct approach, detached from asset-based indicators like the mere change in assets (ibid).

Furthermore, Raj (2020) clarifies, that in public health, the consensus is that all measured health behaviours reveal agency. However, given the existing power structure, the deduction of those behaviours as acts of agency would be inaccurate (ibid). Under SDG5, the only indicator measuring women and girls' agency concerning health behaviour is contraceptive decision-making, its accuracy too as an indicator of agency remains rather ambiguous (ibid). As per Drydyk's (2013), the reason for this is the strong focus on measurement, which has led to a distortion in the term's meaning.

Measuring women's agency presents other challenges too, particularly in the context of its multidimensionality and hight context-specificity (Hanmer & Klugman, 2016). In non-western contexts, measurements are often applied without proper testing and understanding of the underlying elements which lead to imprecise interpretations (Qutteina et al., 2019). For instance, it is worth noting that certain questions may not accurately reflect women's agency when separated from their specific local context (Chang et al., 2020). This also implores focusing on certain other elements such as whether women are more empowered if they make decisions alone or jointly with others, whether they welcome control over their decision-making, and if they don't, then whether having it indeed tallies as empowerment or not (Raj, 2020). It is important thus, to delve into such questions and consider them while assessing women and girls' health agency and their wellbeing.

Additionally, agency and empowerment are sometimes used interchangeably, leading to a failure to capture the psychological and sociological dimensions that shape decision-making processes and the changes that occur over time and across different contexts and constraints (Donald et al., 2020).

Raj (2020) also states that the reason for the little insight into women and girls' agency is due to the lack of information on choice and context about the powerful players that exist in a particular environment. She proves this with the example of measuring the age at marriage in early/child marriages that imposes several proven social and health risks for girls and their offspring (ibid). Age at marriage, she mentions, does not provide any understanding regarding the conditions of the marriage-whether it was pursued, complied, or forced (ibid).

Furthermore, women's opportunities for agency are found to evolve across their life cycle. Factors such as marital status, ethnicity, age, religion, educational level, economic status, and social class play critical roles in shaping the contours of women's agency (Chang et al., 2020). For example, in their research on examining Indian slum

women's health seeking behaviour for themselves and their children during and after pregnancy, Batura et al., (2022) found that women's health agency increased with age.

The diverse contextual dimensions, along with constraints such as poverty and access to services, impact the range of choices available to women, intertwined with societal norms, societal positions, and cultural expectations that explain their possibilities and desires (Hanmer & Klugman, 2016). These multifaceted factors make the interpretation of agency indicators a complex and context-dependent task (ibid).

Consequently, there's also growing advocacy for depending on the reliability of revealed preferences, behaviour observations, and tangible data, as opposed to self-reported outcomes or proxy measures like socio-economic status in decision-making assessments (Chang et al., 2020). This also points towards the unreliability of self-reported data especially when measurements are around sensitive topics (ibid). Thus, clarity on choice and the context would permit a higher ability to gauge agency, something that remains missing in the SDG5 indicators (Hanmer & Klugman, 2016; Raj, 2020).

While several scholars suggest that what individuals value (and exercise agency towards) is socially beneficial, it is not necessarily so. There is the possibility for the acts of health agency resulting in both positive and negative health results (Drydyk, 2013). Campbell and Mannell (2016) too state that feminist literature usually assumes all agency to be in a women's interest, however, assuming, for example that women having agency and doing paid work is a sole solution to violence is problematic. Studies have shown that in certain cultures, intimate partner violence increased when women exercised agency as it led to the men feeling undermined (ibid).

Drydyk (2013) clarifies that although empowerment involves expanded agency, empowerment is conceptually linked to well-being, something that agency cannot capture. In truth, not everything a person does is dedicated towards their wellbeing, and it is not only their wellbeing that people always value (ibid). This, Raj (2020) suggests is the reason for the lack of agency measurement, since other components of the empowerment process - social norms, resources, and assets - can generally be agreed upon as being an aid or threat. While agency carries the element of accepting the choices and decisions of the persons, even if they do not support the desired health results or long-term empowerment and agency of women and girls (ibid).

2.3.2 Considerations for agency measurement

The absence of a consensus on the most effective methods for measuring women's decision-making highlights the need for further validation and measurement research, especially to cater to various distinct contexts (Chang et al., 2020). Hanmer & Klugman

(2016) state that it is acknowledged that individual attributes, local contexts, and intrinsic factors such as consciousness and aspirations have considerable significance when conceptualising and measuring women's agency.

Furthermore, agency expansion alone, without being linked to well-being freedom, and without the dissolution of structural constrains will not bring the desired outcome of women's empowerment (Drydyk, 2013). low agency is only one-way women are disempowered (ibid). It is nevertheless crucial to note that any opposition to women and girls' health and life choices, decisions, and agency acts results in silencing women and making them invisible, while preserving the numerous elements of disempowerment (Raj, 2020).

To address these challenges, Donald et al. (2020) propose a multidisciplinary framework that encompasses various dimensions, namely goal setting, perceived control, the ability to initiate actions towards goals (referred to as 'sense of agency') and acting on goals to study women's agency. In principle, their recommendation centres on enhancing the quality of measurements by incorporating a variety of local contexts, diverse population segments, various age groups, and multiple facets of decision-making.

Raj's (2020) methodology is congruent with the approach advocated by Donald et al (2020). Raj (2020) proposes a comprehensive model for measuring women's health agency, incorporating the elements of 'can-act-resist,' 'choice', and 'consequences. This model involves questioning women about their desire to engage in health behaviour (choice), their ability to engage in health behaviour, act on this desire, and resist external pressures (can-act-resist), and the consequences of their actions, including both backlash and goal achievement (consequences). This holistic approach to measurement aligns with the findings of Chang et al. (2020), which suggests exploring three key types of questions: women's health goals and interests, the decision-making process that lead to outcomes, and women's perceptions of any changes.

Similarly, Mannell et al. (2016) suggest methodological approaches that prioritise women's personal interpretations of their actions and lives and recognise the influence of patriarchal social structures as fundamental considerations for potential interventions. In doing so, they emphasise the need to understand and assess women's agency from their own vantage point, acknowledging the intrinsic complexity of women's experiences within diverse cultural and societal contexts rather than relying solely on the interpretations of Western feminist scholars.

Thus, based on the reviewed literature, it is clear that there exists a significant need to probe deeper into understanding women's views and values regarding health, particularly within the context of their environment. Raj (2020) emphasises the importance of exploring the entire process through which women achieve their self-defined health goals, highlighting the nuanced nature of health agency. Rather than

oversimplifying empowerment or agency into a singular measure, Gammage et al. (2016) advocate for a multifaceted approach that considers the various manifestations of agency in real-life situations. Additionally, Mannell et al. (2016) stress the importance of prioritising women's own interpretations of their actions and experiences, recognising the complex interplay of cultural and societal factors. Moreover, Drydyk, (2013) expresses the significance of connecting women's agency to their wellbeing.

Hence, this thesis aims to address these gaps by thoroughly examining women's health agency within the specific cultural and societal contexts of Varanasi, India, shedding light on the complexities and nuances inherent in marginalised women's experiences and perspectives.

3 METHODOLOGY

Expanding upon the definition of health, its perceptions, and agency manifestations of women from marginalised urban communities is critical as it sheds light on their distinct challenges and opportunities within the subject of women's health and agency. This qualitative research investigates the perspectives of ever-married reproductive age women from marginalised communities in Varanasi, Uttar Pradesh, India, to discover how they perceive their health and exercise agency over it. The approach taken in this study focuses on uncovering the dimensions and manifestations of their health agency within the specific cultural, social, and economic context of North India.

This chapter provides a summary of the research methodology applied in the study. Section 3.1 discusses the methodological approach. As discussed in the literature, since women's health agency is especially dependent and shaped by the local context, the study attempts to utilise the flexibility of qualitative research which allows for an in-depth exploration of the research questions. In the case of this study, an approach that helped capture respondent's perspectives and uncovered dimensions that may have been obscured in a more structured approach took precedence. Section 3.2 covers the study setting, and section 3.3 pertains to the data collection, featuring the detailed process behind conducting semi-structured interviews with 17 participants. Section 3.4 elaborates on the data analysis method of saliency analysis, while section 3.5 presents the ethical considerations and privacy. Section 3.6 addresses the influence of the researcher's positionality, and Section 3.7 deals with the limitations and the steps taken to validate the research. These sections collectively contribute to a rigorous and ethical exploration of women's health agency within their context.

Through this methodological framework, the researcher has aimed to contribute to a broader understanding of women's health agency while also accounting for the distinctive local context it operates in.

3.1 Methodological approach

Qualitative research methods are an invaluable choice when investigating the complexities of human experiences and perspectives as they allow us to uncover the intricacies of personal narratives and cultural contexts (Hammarberg et al., 2016). As they aim to unravel these complexities by engaging participants through inquiries into the 'what', 'how', and 'why' of the phenomenon, they become particularly effective in examining individualised programs and when cultural diversity plays a significant role (Isaacs, 2014; Hammarberg et al., 2016). In the field of public health, qualitative research is increasingly recognised as essential as it provides insights into the socio-cultural, economic, and political factors that impact health and disease, and they can provide interpretations of health by various groups and demographics (Isaacs, 2014). Moreover, qualitative research is adept at revealing the processes behind cause-and-effect relationships, identifying novel research areas, and addressing the limitations of quantitative studies (Yoshikawa et al., 2008).

As this study explores women's health agency within marginalised communities, a flexible, yet structured approach to the study's undertaking becomes necessary. The shortage of research on women's health agency, along with the varied, and at times, conflicting views on women's empowerment, autonomy, and agency, emphasise the significance of this study. Moreover, to comprehensively analyse the link between women's enhanced well-being as a result of increase in agency, we must record women's goals, interests, decision-making processes, and personal perspectives on the changes (Chang et al., 2020). Miles and Huberman (1994), as cited in Sechelski and Onwuegbuzie (2019), underline that the strengths of qualitative data lie on the proficiency with which their analysis is executed. The complex questions, such as whether a woman's choice to rely on home remedies over hospital visits signifies health agency, or whether the impact of familial pressure on healthcare decisions should be recorded in observing their health agency, require a nuanced and flexible approach. Thus, a qualitative approach can ensure that women's agency is not viewed myopically.

3.2 Study setting

The interviews for this study were conducted in the city of Varanasi. Varanasi city is located within the district of Varanasi, which is located in the Indian state of Uttar Pradesh (UP). This section provides a brief overview of both the state and the city in sub-sections 3.2.1 and 3.2.2 to help place the interviewed women within their environment. This is followed by sub-section 3.2.3 on the specific study setting.

3.2.1 Uttar Pradesh

Varanasi also known as Kashi or Banaras is a historic city located on the banks of River *Ganga* (The Ganges) in the Eastern part of the State of Uttar Pradesh (UP), in Northern India. UP shares its borders with a number of Indian states including New Delhi, the capital of India. It also shares an international border with Nepal towards the East.

UP is one of the most densely populated states in India, and the largest in the country in terms of its population size (Tiwari et al., 2022). The 2011 population census, the most recent in the country, shows that the population of UP is 240 million, accounting for approximately 20% of the overall population, and 18.6% of the rural population of India (Ministry of Rural Development, 2011; Aurora & Singh, 2017).

On the Human Development Index (HDI), that measures the key dimensions of human development such as healthy life and decent standard of living achieved by a state or country, UP is positioned on the 18th rank out of the 23 ranked Indian States (India has 28 States and 8 Union Territories in total) (Government of UP, 2019). UP, unfortunately, is also one of the most economically disadvantaged states in India. The 2016-2017 data from the UP Government shows that 39.8% of the total population, 45.7% of the urban population, and 38.1% of the rural population in the state live below the poverty line, which makes UP the state with the highest number of poor residents in the country (Aurora & Singh, 2017; Government of UP, 2019; Tiwari et al., 2022). The state's per capita income is also less than half of the national average (Tiwari et al., 2022).

Furthermore, UP has one of the highest proportions of Scheduled Caste (SC) individuals, who constitute 21.1% of the total population of the state (the national proportion is 16.7%) with data further indicating that approximately 80% of SC households earn less than 5000 rupees (approximately 60 EUR) per month (Ministry of Rural Development, 2011; Tiwari et al., 2022).

Gender disparities are also found to be extensive in UP. The sex ratio of 912 women for every 1,000 men has consistently been lower than the national average of 943 women every 1,000 men (World Bank, 2016). Although the maternal and infant mortality rates in UP have been declining, the mortality and morbidity is higher in comparison to national and global averages (Department of Health & Family Welfare, 2015; Government of UP, 2019). The Annual Health Survey (AHS) in UP in 2012-13 found that the maternal mortality ratio (MMR) had declined from 440 per 100,000 live births in 2004-06 to 258 in 2012-13 (World Bank, 2016). Although, when compared to the national average of 167, this figure is significantly higher (Government of UP, 2019).

The average age at marriage for females in the state was 19 years while being 21 years for males, and approximately 13% of females and 19% of males were married

before reaching the legal age of marriage (18 for females and 21 for males in India) (Government of UP, 2019).

Moreover, the participation of women in the labour force in UP is among one of the lowest in the country as they have very limited access to non-farm jobs, particularly rural women (World Bank, 2016). According to the 2011 census, compared to the national average work participation rates of 53.26% for men and 25.51% for women, in UP, men's work participation rate was 47.7% and it was a meagre 16.7% for women (Government of UP, 2019).

Although more women in UP complete secondary education compared to other low-income states in the country, around half of them are still illiterate (Government of UP, 2019). The percentage of adults having completed secondary school was found to be lesser than one-third, with less than 70% of the population being literate (World Bank, 2016; Government of UP 2019). The adult literacy rate in the state, 77.3% for males and 57.2% for females is also slightly below the national average of 80.9% for males and 64.6% for females (Tiwari at al., 2022; Government of UP 2019).

3.2.2 Varanasi

Varanasi is situated in the Hindi-speaking belt of India, also falling under the cultural and ethnolinguistic region of Bhojpur where a large percentage of people speak in either Hindi and/or one of its dialect, Bhojpuri. The Ministry of Urban Development (2015) approximates that 80% of the city's population speak Hindi (and/or Bhojpuri) while the remaining 20% speak Urdu. Figure 1 sourced from CIA (n.d.) shows the location of Varanasi on the Indian Map.

The residents of Varanasi can be classified into three categories, the first being those who have been residing in the historic old city for generations, the second being the newcomers, mostly migrants, who have settled in the newly developed areas mainly on the city's periphery, and the third category comprising the high number of daily temporary tourist population (Ministry of Urban Development, 2015).

As Varanasi holds religious significance for several religions of Indian origin such as Hinduism, Jainism, and Buddhism, it has been a major pilgrimage hub. Additionally, as Varanasi is one of the world's oldest continuously inhabited cities, and the oldest in India, it also attracts a large number of domestic and international tourists (Varanasi District, 2023). The city's healthcare facilities also draw people from across Eastern UP and Western Bihar, as they seek better medical services in the city (Ministry of Urban Development, 2015). Prominent medical institutions such as the government hospital at the School of Medical Sciences, Banaras Hindu University, and the School of Tibetan Ayurveda at the Tibetan University attract thousands of people to the city daily (ibid). Varanasi hence receives a high floating population of approximately 25,000- 30,000 persons per day (ibid).

FIGURE 1 Varanasi on the Indian map

The region of Eastern UP has consistently faced issues of inequality and poverty since India's independence (Tiwari & Sharma, 2019). Although the city is renowned for its handloom and power loom silk production, and it employs hundreds of thousands in the sector, the city faces issues like industrial sickness, poor infrastructure, and recurrent natural disasters such as floods (ibid). 14.5% of the city's population was found to be living below the poverty line (BPL) in 2014 (ibid). The district also receives a high number of migrants from various parts of UP, with 85% of migrants coming from within the state, and 69% coming from nearby rural areas (Ministry of Urban Development, 2015). The rural migrants often move to the city due to distress migration (ibid).

Varanasi district has a 43% level of urbanisation, which makes it the 7th most urbanised district in the state (Ministry of Urban Development, 2015). According to the 2011 government census, the city's population was 1.2 million, and while it was continuing to grow at a rate of 10%, it was lower than the 20% growth rate of 1991 (Directorate of Census Operations, 2021). The 2011 census also stated that the average household size in Varanasi was 6.6 members which remains higher than both the state and national averages of 6 and 4.9 respectively (ibid).

Varanasi has approximately 227 slums which are distributed throughout the city, and they are located on both government and private land (Jha & Tripathi, 2015). 13% of the slums are located in the core old city, 50% in the middle zone, while 37% are

found in the outer or peripheral zones of the city (ibid). According to the 2011 census, the slum population in the city was 0.4 million, with 44% of the slum population found to be living below the poverty line and 79% belonging to various marginalised communities (Directorate of Census Operations, 2021; Jha et al, 2016). Moreover, the population of the urban poor and slum residents collectively is believed to form approximately 38% of the total population of Varanasi (Jha & Tripathi, 2015).

According to the 2011 government census, the sex ratio in Varanasi city had increased from 876 females per 1,000 males in 2001 to 887 females per 1,000 males in 2011 (Directorate of Census Operations, 2021).

In terms of education, the 2011 census showed that a significant gain was made in the literacy rate as it increased from 66% in 2001 to 76% in 2011 (ibid).

3.2.3 Sample area

The sample area for this research is situated within the city of Varanasi and comprises specific zones that have unique demographic and socio-economic characteristics that offer critical insights into the lives of its residents (Jha et al., 2019). Figure 2 sourced from Jha et al. (2019) illustrates the 3 zones of the city with the indicated sample areas circled in yellow.

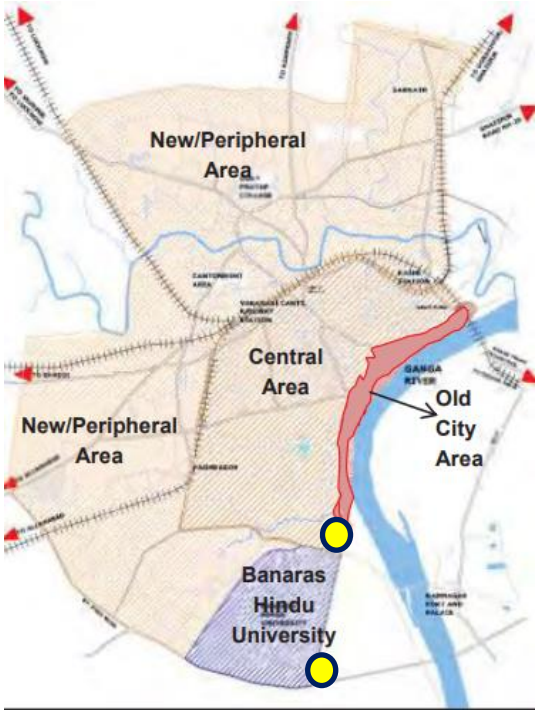

FIGURE 2 Sample area

The innermost zone in Varanasi, situated along the banks of the Ganga, spanning from Rajghat to Assi, is the ancient old city which represents the Hindu core of Varanasi (Jha at al., 2019). This area has some of the city's most important Hindu temples.

The few Muslim settlements in the area are all identified as slums that face issues of poor housing and lack basic facilities such as proper sanitation and clean drinking water (Jha et al., 2019; Jha et al., 2016). The increasing number of slums in the area can be attributed to the rapid non-inclusive urbanisation which is mainly driven by rural-to-urban distress migration (Jha et al., 2016).

The middle or central zone encircles the ancient city, and it is characterised by its medieval growth (Jha at al., 2019). The area has experienced significant residential growth since the 1950s and has also seen an emergence of roadside commercial centres and office spaces. This is the region where migrants who arrived in the city post-India's independence in 1947 settled along with middle-class families who moved to the city for educational and employment opportunities (ibid). Additionally, the middle zone accommodates several migrant slum settlements on government-encroached land and unauthorised colonies (ibid).

The outer zone, which envelops the middle zone, indicates discontinuous expansion towards the northern and southern parts of the city (Jha et al., 2019). This area underwent development primarily after the 1990s, with agricultural land being converted into residential colonies. This zone is characterised by numerous unauthorised colonies, including slums, and it also functions as a bridge between rural and urban life, with Asia's largest residential university, Banaras Hindu University (BHU), situated in its southern part (ibid).

For this research, the sample area was strategically chosen from the southern ends of the middle and outer zones of the city. The study particularly focused on marginalised women residing in the vicinity of the Lanka and BHU areas. This area includes a busy market, a large residential university, various residential apartment complexes, and a mix of legal and illegal settlements, comprising of both concrete and temporary structures. The settlements in the area are home to hundreds of marginalised families, including those from Varanasi and its neighbouring regions, as well as workers from nearby states such as West Bengal, who seek employment opportunities within the city. The population in this area includes informal daily wage labourers, domestic helpers, and contractual labourers, many working at the university's agricultural farms and plant nurseries. The informal daily wage workers are employed as plumbers, auto-rickshaw drivers, construction workers and street vendors (Jha & Tripathi, 2015).

This particular area was selected for its accessibility to the researcher and the convenience it offered in reaching and engaging with the hundreds of marginalised women living and working here.

3.3 Data collection

This section describes the process of gathering and managing the primary data collected through 17 in-depth interviews. Scientific methodologies guided the decisions pertaining to the designing of the interview questionnaire, sample selection, sample size determination, interview procedures, and data management.

3.3.1 Semi-structured interview guide development

The formulation of the open-ended interview questionnaire was a detailed process which was based upon the foundational concepts defined by experts such as Donald et al. (2020) and Raj (2020) outlined in section 2.3.2.

The interview questionnaire was created in June 2023, and it underwent multiple revisions and translations. Valuable input from the thesis supervisor helped improve the questionnaire. The revisions were aimed at refining the questions and making them more focused and easily comprehensible, especially in the Hindi language. To ensure effectiveness, two preliminary trials were conducted, during which the perspectives of potential respondents were sought. These trials exposed crucial insights, such as the benefit of adopting a flexible approach in the interviews rather than employing a rigid set of predetermined questions that stifle the natural flow of interviews.

This resulted in the formulation of five primary interview questions which were each supplemented by sub-questions. The sub-questions were designed to be asked as needed, to facilitate participants in diving deeper into aspects they might not have spontaneously shared.

3.3.2 Sample selection

The sample for this study consisted of 17 ever-married women of reproductive age (30-49) in Varanasi, and the selection process primarily utilised the snowball sampling method. To qualify as a participant, women had to be ever- married, of reproductive age, reside in the city and be from a marginalised background in terms of economic status and/or belonging to a backward caste. Single women were not excluded if they had been married at some point.

Sampling in research aims to choose a subset of the population that can effectively represent the entire population (Nederifar et al., 2017). Due to the perceived sensitivities around local social norms and the topic of women's health, snowball sampling was employed to access potential participants. Snowball sampling is a type of nonprobability convenience sampling that is conducted on a sample that is either available to the researcher or selected by them, and it is particularly useful when researching sensitive subjects or hard-to-reach populations (Nederifar et al., 2017;

Browne, 2005). This method begins with a small group of individuals meeting the research criteria (seeds) who then recommend other potential participants, usually their acquaintances, thus, creating a chain of referrals until the chosen sample size or data saturation is reached (Parker et al., 2019).

However, since it relies on social networks, snowball sampling can also be perceived as a biased sampling technique (Browne, 2005). Nevertheless, as the focus for sampling is on representativeness which is defined as representing an aspect of the general phenomena, it can be argued that when exploring sensitive subjects, snowballing allows for 'hidden' views to emerge (ibid). Furthermore, the snowball sampling technique that keeps interpersonal relations as a central notion can also help form research accounts, as commonalities between the study topic and the methodology may be recognised (ibid). As this research explores women's health agency within a society characterised by strong gender roles, the scope of social networks was found to be crucial.

Even so, to mitigate potential bias, the researcher also approached women on the streets based on her judgment, considering the type of work they seemed to be engaged in, the locality they lived in, and their attire. While some women agreed to participate, out of which two were later interviewed, others did not show up for their scheduled interviews, possibly due to time constraints or discomfort discussing health-related matters with a stranger. This reinforced the validity and practicality of the snowball sampling method for the study.

3.3.3 Sample size determination and data saturation

Saturation is an important concept which is critical in determining the number of interviews to conduct in a study (Sebele-Mpofu, 2020). The concept of theoretical saturation was introduced by Glaser and Strauss in 1967 for developing grounded theory to signify the point at which main ideas and essential variations required to formulate a theory are identified, and where little or no new information is obtained by conducting additional interviews (Weller et al., 2018; Saunders et al, 2018).

Different researchers employ varying approaches to determine when saturation is reached. Some researchers, like Guest et al. (as cited in Weller et al., 2018) suggest that thematic saturation can be reached with 12 to 16 interviews. It has also been found that as some responses are more likely to be repeated than others, saturation might never be 'fully' reached (Weller et al., 2018).

Thus, given the researcher's limited resources and the inductive nature of data analysis, complete theoretical saturation was considered unattainable. As the research approach was not grounded theory; hence, neither the sampling, nor saturation would be theoretical, and as the sampling, data collection, and analysis would not be an iterative process, sample adequacy would be difficult to achieve (Hennink et al., 2017).

Braun and Clarke (2021) emphasise that in interpretive qualitative research, the interpretative judgment of the researcher regarding the purpose and goal of the analysis is more important for defining what saturation entails. Sanders et al. (2018) recommend Legard et al.'s (2003) suggestion of focusing on data saturation instead of thematic saturation, particularly from each individual interview. According to Weller et al. (2018) this also holds more cultural significance. Data saturation emphasises probing as a tool to gather maximum information and the most salient concepts per respondent to gain a comprehensive understanding of their perspective (Saunders et al., 2018). This also aligns with the concept of meaning saturation specified by Hennink et al. (2017) which focuses on acquiring a deep understanding of the issues and the point at which they are fully comprehended with no further dimensions, nuances or insights left to obtain. To achieve saturation in meaning, where in-depth understanding is the focus rather than code saturation where the researcher has heard everything, conducting 16-24 interviews is recommended (ibid).

Given the researcher's intent to conduct interviews to maximise the diversity of data from the respondent group and ensure valuable insights from respondents are not overlooked to facilitate the development of more reflective themes and concepts, achieving data or saliency saturation per interview was found to be the most suitable approach to enhance sample efficiency. Consequently, for this research, 17 in-depth interviews were conducted, with an emphasis on saliency saturation at the data collection level.

3.3.4 Conducting semi-structured in-depth interviews

For a comprehensive exploration into the research topic, which focused on both causal relationships and corelations, open-ended face-to-face in-depth interviews (IDIs) were chosen. They were found to be the best method considering the research topic, the environment's sensitivity and the researcher's resource availability. IDIs are an ideal tool for acquiring and interpreting the thoughts, feelings, and experiences of participants, which can help provide a, in-depth understanding of the topic within the local context (Fylan, 2005; Yilmaz, 2013). In a setting such as the traditional society of India, where discussing agency may touch upon sensitive or challenging themes, semi-structured interviews can be a suitable choice (Fylan, 2005).

A total of 17 interviews were conducted between July and September 2023. To accommodate the participant's busy schedules, the date, time, and location of the interview was decided during the first meeting. Interviews occurred in the following days and, in some cases, on the same day of the first meeting to maintain momentum. Most of the interviews took place at the participants' workplace, which mainly included farms and apartment buildings, while one interview was conducted at the participant's home. Interviews took place in private settings to ensure the confidentiality

of responses and to minimise outside interruptions. The interviews were conducted in Hindi, with notes taken in both English and Hindi by the researcher. Participants responded in Hindi, Bhojpuri, or a combination of both, based on their preference.

Each interview began with an introduction which was followed by declaring the interview's purpose and an explanation of the participant's rights. After this, the participants' verbal consent was obtained (see Appendix 1). Section I, the beginning of the interview questionnaire focused on collecting demographic information of the participants, such as their name, age, marital status, and household income. Section II, the interview guide, comprised of five open-ended questions revolving around several themes, such as, meaning of health, importance of health, health aspirations and goals, actions to achieve health goals, enablers and hinderances in achieving health goals, and consequences of decisions and actions (see Appendix 2).

In accordance with Sechelski and Onwuegbuzie's (2019) view, given that interviews are particularly valuable for obtaining in-depth insights into the participant's perspective, including their beliefs, some flexibility should be granted to diverge from the standardised interview procedure. Thus, to enable a participant-centred approach, the order of questions in Section II was flexible, adapted to the particular context and the participant's response to help maintain the flow of their thoughts. This is also in line with Roulston's (2010) (as cited in Sechelski and Onwuegbuzie, 2019) constructionist view, where the dialogue between the interviewer and interviewee is said to collaboratively shape and construct the data.

Additional probing questions for clarification were also incorporated as subquestions under the primary five questions in Section II. These probing inquiries were aimed at prompting more in-depth responses, exploring the 'why' behind the participants' beliefs and actions.

By the end of each interview, as the researcher clarified and confirmed ideas, probed for clarification, and delved deeper into the participant's experiences and decision-making processes, saliency saturation per interview was achieved. Therefore, there did not seem to be a need for conducting follow-up interviews.

3.3.5 Data management

Data gathered from interviews was documented into two forms: written notes taken on the computer, and audio recordings using the researcher's mobile phone.

To ascertain an accurate and authentic translation of the interviews, the researcher first translated the content into English by going over the interview audios in detail, and afterwards reviewed the interview translations and made further notes for clarifications by going over the audios a second time, if necessary. Special attention was paid to protect the nuanced meaning of the words. Field notes taken by the researcher during or immediately after the interviews were also incorporated into the

dataset in parenthesis. These notes included factual information and also captured the emotional expressions of the participants. This was aimed to provide a more sincere understanding of the interviews, to recognise the feelings and emotions that surfaced during discussions of specific experiences or topics.

Translations of the interviews were aimed to be done shortly after the interviews, with 12 of them being translated into English within two weeks of the initial interview. Due to the researcher's travel commitments, 5 interviews were translated within six weeks of the interview.

3.3.6 Description of data

This section provides a brief summary of the acquired data from the interviews to set stage for the subsequent section on data analysis.

17 interviews were conducted by the researcher in total, with 16 taking place in July 2023, and one additional interview taking place in September 2023. These interviews collectively generated 429 minutes of audio data. The duration of each interview varied, with the shortest lasting 16 minutes and the longest 45 minutes. On average, each interview was approximately 25 minutes long.

The translation of the 17 interviews from the original Hindi into English generated 55 pages of translated text, formatted with 12-point font and 1.15 line spacing. This page count does not include Section I of the interviews, the participant's demographic information. When incorporating this content, the total volume of generated text increases to 72 pages.

3.4 Methods of data analysis

This section describes the methodology utilised to analyse the collected data, which was critical in ensuring the validity and reliability of the findings. This includes the comprehensive step-by-step approach taken to examine the interviews, identify codes and themes, and draw conclusions.

3.4.1 Data analysis strategy

The data analysis process applied to in this study signifies an important stage in revealing the multifaceted narratives of women's health agency. Thematic analysis which stands out for its adaptability as it is unburdened by a prior theoretical constraint aligned well with the objectives of this study. Saliency analysis, the chosen method of analysis, as defined by Buetow (2010) presented a distinctive approach to thematic analysis by guaranteeing that codes that may be important to the study don't

go undetected, even if they do not occur frequently. Saliency analysis shares principles with the reflexive thematic analysis described by Braun and Clarke (2021). While studying women's agency, as Campbell and Mannell, (2016) point out, especially in the Global South, it is vital to observe the detailed accounts of women and the complexities of their lives to explore new perspectives on power and agency.

As already discussed in section 3.3.3 above, to strive for conceptual depth, there is a need to extract the richness and insights embedded within the data (Saunders et al., 2018). Thus, in thematic analysis, the true focus should be on reaching saturation of dimensions, nuances, or insights pertaining to the codes, rather than simply spotlighting the most prevalent codes (Hennink et al., 2017).

Raj (2020) emphasises the need to explore women's health agency through an in-depth lens that captures their perceptions of health, health goals, decision-making processes, choices, actions, and the subsequent consequences—both positive and negative that also include their perceptions on change. Thus, a bottom-up inductive data analysis approach was adopted for the analysis.

The below sections first discuss thematic analyses, which provided the necessary foundation for conducting saliency analysis, the particular method adopted to analyse the data collected in this study. Specifically, the techniques described by Buetow (2010), which have numerous similarities with Braun and Clarke (2006, 2021) were utilised to help guide the systematic analysis of data.

3.4.2 Thematic analysis

Thematic analysis, as described by Braun and Clarke (2006) is as a qualitative descriptive approach which constitutes a method for detecting, interpreting, and presenting patterns or themes within collected data. Beyond data organisation and description, this method is particularly helpful in revealing and describing various facets within the data (Saeidzadeh, 2023; Braun and Clarke, 2006). The essence of thematic analysis lies in identifying and establishing themes through comprehensive data analysis to search for patterns, which leads to the creation of analytical categories, helping inform the phenomenon under investigation (Gale et al., 2013; Saeidzadeh, 2023).

Thematic analysis can be performed in several ways, as it is compatible with numerous research approaches (Percy et al., 2015). A key principle of this method is to explore both the manifest (explicit) and latent (implicit) content during analysis, thus, capturing both surface-level meanings and the underlying, implicit significance (Braun and Clarke, 2021).

The inductive approach is a process of theme generation that is done via identifying open (unrestricted) codes that emerges directly from the data thus, allowing for the unexpected to be captured (Gale et al., 2013). This provides the possibility to gather

socially situated responses, such as drawing from cultural beliefs, the lived experiences of participants, how they assign meaning to phenomena or other significant facets of the interviewees' lives, that cannot be predicted by the researcher in advance (ibid).

This was especially evident during the analysis of the interviews, where the flexibility of thematic analysis and inductive coding helped to ascertain the nuanced underlying themes. Therefore, the approach helped explore both indirect and explanatory themes, helping provide a more thorough understanding of the participants' experiences and perspectives.

Like many other qualitative methodologies, thematic analysis adopts a non-linear process, where iterative movement between different analytical phases is applied (Saeidzadeh, 2023). During the data analysis process in this study, the six-phase analytical process by terry et al. (2017) (as cited in Saeidzadeh, 2023) of data familiarisation, code generation, theme construction, potential theme review, theme definition and naming, and report production was followed.

Initially, the interview text was thoroughly read to gain familiarity with the data. Subsequently, the codes were generated that typically ranged between 30-60 in the initial coding phase of each interview. To simplify the data and reduce redundancy, similar codes were combined. Simultaneously, during the coding process, any identified potential themes were noted in parentheses. This iterative process, according to Isaacs (2014), operates as a verification towards the research questions, assuring that the data's organisation supports the objectives of the study. After the coding was completed, a table was created where codes were categorised under each corresponding theme, which served as a cross-check to ensure that codes and themes were accurately assigned. At this stage, themes were identified and labelled descriptively.

In the initial interviews, the generation of codes resulted in a relatively higher number of themes, ranging between 10-12. However, with progressing interviews, as refinement occurred, the complexity of codes were simplified, resulting in the emergence of 6-8 themes in each subsequent interview. The early transition between coding and theme generation was more frequent, and it became less frequent after analysing 4-5 interviews. As the themes become clearer and more robust, although some overlap persisted, the shift between code generation and theme development became more focused on examining the placement of codes under correct themes and ensuring uniformity amongst interviews.

After coding and theme generation for the first 12 interviews, a thorough review of the themes was conducted which led to the relocation of codes between three themes, namely, the 'health - attitudes from women's perspectives', 'self-directed health management', and 'gender roles and marital relationship' for accuracy. This

resulted in the formation of the 7 themes and their sub-themes. The final five interviews were subsequently analysed, and a check ensured that all aspects of the themes were accurately represented across the 17 interviews.

3.4.3 Saliency analysis

Saliency analysis, as described by Buetow (2010), provides a structured approach to analyse qualitative data with a specific focus on both the recurrence and significance of codes. This approach is crucial in exposing themes that may not necessarily repeat but hold substantial value for the study's objectives (ibid). Codes that are important are the ones that help advance understanding or are useful in addressing real world problems, or both (ibid). Saliency analysis supports the principles of reflexive thematic analysis described by Braun and Clarke (2021). Braun and Clarke (2021) stress that meaning is not naturally embedded within the data but that it emerges through the interplay of the data and the researcher's contextual and theoretically informed interpretive practices. This indicates that the research process involves not only discovery but also knowledge generation and construction, thus having the potential to offer new understandings or insights on the subject (ibid).

Under qualitative research, where subjective accounts are observed and constructed thus, where multiple valid interpretations can coexist, saliency analysis becomes a valuable tool. It allows for the identification of codes that hold not only contextual relevance but also transferability to numerous settings (Buetow, 2010). In this regard, Braun and Clarke (2021) state that the concept of 'no new' is not relevant, and the decision that saturation or saliency is reached, instead dependents on the interpretative judgment of the researcher based on the purpose and objectives of the analysis. For instance, during the data analysis for this study, several crucial elements revealing insights into how women define their health and navigate their health and the distinctive ways their families contribute to their well-being emerged. Some of these significant aspects were non-repetitive, thus, they might have been overlooked without the application of saliency analysis principles.

Buetow (2010) states that saliency analysis distinguishes between primary saliency, which in concerned with the units of meaning that are obvious at the data surface, and secondary saliency, which instead seize the latent messages situated deep within the data. These nuanced layers of analysis, Buetow (2010) believes allow for salient conclusions as they capture both the explicit and hidden components of the data. For example, in examining the empirical data, a crucial observation emerged – the husbands of the participants were playing a key role in managing their health issues. However, a deeper exploration made it evident that most participants desired and sought their husband's support in health matters. Furthermore, participants ex-

pressed their health concerns and wishes to their spouses, who via actively participating in joint health-related decision making facilitated the realisation of the participant's wishes. This insight is in complete opposition to a scenario where the participant's husbands are seen to make the majority of decisions on behalf of the participant.

Most importantly, in saliency analysis, the significance of codes which relates to their alignment with the research question is more important than their mere presence in the analysis (Buetow, 2010). Buetow (2010) states that the importance is established on the novelty and depth of understanding the finding offers, its usefulness in addressing real-world problems, or a combination of both. Furthermore, it is also highlighted that the importance also extends to the observed absence of codes or themes in relation to the study question (ibid).

In this study, to undertake saliency analysis effectively, a structured matrix according to Buetow (2010) was used to categorise codes for each of the 17 interviews into four cells on distinct categories: 1. highly important and recurrent, 2. highly important and not recurrent, 3. not highly important but recurrent, and 4. not highly important and not recurrent. The first 3 cells in this matrix highlighted the salient codes, that manifest both at the data surface level or lie beneath it (Buetow, 2010).

This process conceptually aligns with reflexive thematic analysis described by Braun and Clarke (2021), which stresses that codes are not fixed but that they rather evolve, expand, contract, merge, or split as the analytical process advances. In reflexive thematic analysis, codes operate as analytic observations that spot individual ideas or facets, while themes surface from the union of these codes (ibid).

Buetow (2010) states that codes from cells 1 and 3 may unite to produce themes within the cells (Buetow, 2010). This helps categorise themes from the cells as being highly important or not (ibid). Here, distinction between dominant and minor or non-important themes can also surface, but the core focus should remain on ascertaining the importance of themes (ibid). As previously discussed, the analysis process in this study involved consolidating codes and simplifying their complexity. Additionally, codes from cells 1 and 3 were merged to form themes where it was deemed appropriate. It is also worth noting that in a limited number of interview analyses, codes in cell 3 were found to be redundant in relation to the research questions. This occurred when participants provided detailed information on their financial hardships or health issues that do not directly align with the research focus yet are captured in the codes and themes as a result of their frequent occurrence.

Moreover, as Buetow (2010) stresses, it was evident that saliency analysis protects highly important but non-recurrent codes (in cell 2) from getting lost or stretched to fit into themes. This discerning approach also exposes vital information that may remain unspoken by most interviewees, thus, technically doesn't constitute an explicit theme but holds key significance for the study (ibid). For instance, the critical theme

'navigating knowledge gaps, cultural beliefs, and adapting actions' was a result of identifying and protecting codes that were neither recurrent nor observed in a majority of interviews.

Also, it was evident that the comprehensive nature of data collection to achieve saliency saturation in each interview resulted in making saliency analysis the most apt method for data analysis. For the analysis of each interview, a summary table was created that helped review each analysis and ensure uniformity amongst the 17 interviews. This approach allowed for recurrent but non-essential codes (cell 3) to be denoted as minor themes that help clarify and accentuate major themes. This also highlights the selected content's interconnectedness, stressing the need to understand it in the context of the whole, as part of a cohesive narrative that reference and complement each other.

3.4.4 Presentation of key themes and sub themes

The saliency analysis resulted in the identification of 7 key themes and several sub-themes that are presented in Table 1 below. Chapter 4, the results, describe the themes and sub-themes in detail.

TABLE 1 Themes across 17 participants

Theme	Title	Sub Themes
1	Health-attitudes from women's perspectives	1. Definition of health, 2. Prioritising health and its challenges 3. Curing rather than preventing health issues
2	Self-directed health management	1. Medication choices, traditional practices, & trust in doctors 2. Women's approach to health through eating practices 3. Reliance on home remedies 4. Navigating health autonomy: defying expectations 5. Health-conscious adjustments in daily life
3	Gender roles and marital relationship	1. Women's dependence on husbands for healthcare 2. Couples making joint health decisions 3. Women facing mental stress due to husband's lack of support 4. Managing household health & prioritising family well-being
4	Family support in health	1. Maternal support and sharing health concerns 2. Alternate family support in absence of husband's support 3. Financial assistance 4. Everyday health matters

		5. Encouragement for independent decision making 6. Cultural appropriateness in healthcare support
5	Communal support and solidarity	1. Health support from other females 2. Leveraging long-terms connections and building trust
6	Maternal aspirations and sacrifices	1. Financial prioritisation for children's needs 2. Workload and its impact on health 3. Linking personal health to family well-being 4. Mental stress concerning daughter's marriage 5. Supporting adult children and financial stress
7	Navigating knowledge gaps, cultural beliefs, and adapting actions	1. Impact of child marriage 2. Sheltering women 3. Culturally sensitive adaptive strategies 4. Knowledge about healthcare industry

3.5 Ethical considerations and privacy

The research design and practices implemented in this study adhered rigorously to ethical principles throughout the stages of data collection, analysis, and reporting, and a constant commitment was made to minimise potential harm to the participants. The below two sections provide an account of the practical measures taken to maintain consent, privacy, and rights of the participants.

3.5.1 Informed consent and voluntary participation

Ensuring informed consent from the participants was a very important part of the data collection process. The procedure for obtaining consent was thoughtfully structured to respect the participants' rights and preferences, especially since most of the participants were illiterate and very busy thus, many a time not interested in hearing much about the purpose of the study or their rights.

Prior to the interviews, in several cases during the first meeting, participants were provided with a brief understanding of the study's purpose. This meeting with potential participants served as an introduction where they were also told about the study's objectives, and the commitment to preserving the confidentiality of their data. Additionally, they were briefed on the broad topics that would be covered during the interview, which helped in setting clear expectations. Some women opted to do the interview on the first meeting itself while some chose another day, time and location for the interview.

Since the snowball sampling method was employed, some of the women had received preliminary information about the interview process through the 'seeds', although there was a common misconception that the interviews exclusively revolved around their medical histories. Therefore, the introduction phase was necessary to inform participants regarding the purpose of the study. Participants were also informed about their right to opt out of the interview at any time upon their wish or to decline to respond to specific questions if they felt uneasy.

Consent also included the use of participants' names, and the use of audio recording devices during the interview. Given that a large number of women were illiterate, oral consent was obtained from all the participants. This process was also recorded.

3.5.2 Data collection in marginalised urban communities

Conducting interviews with women from marginalised urban communities involved several key considerations to make sure that the data collection process was both comfortable and effective. The researcher, being a native of the city, had a deeper understanding of the local context, including the language, mannerisms, and cultural nuances. This familiarity greatly facilitated the interview process and helped establish a sense of respect, connection and trust with the participants.

Creating a comfortable and non-intimidating environment for the participants was a priority for the researcher. For example, based on their preference, participants had the choice to either sit on the floor or on a chair. The researcher took cue and seated herself after. Recognising that a few participants were uncomfortable eating or drinking during the interviews, a light snack, juice, and yoghurt boxes were offered after the interviews. Though this was initially meant to serve as a refreshment for them, all participants saw it as provisions they could take home for their children.

As several participants asked the researcher for job prospects, to manage expectations, they were all informed that the interviews were solely for educational research purpose and not connected to any government or Non-Governmental Organisation (NGO) that could provide assistance or employment opportunities.

Participants were also assured that there were no right or wrong answers to the questions. They were made aware that the researcher sought to obtain a personal and accurate account of their lives, specifically related to health, its management and related decision-making. This helped put the participants at ease and helped them view the interview as a candid conversation between two women.

Speaking on the topic of health and their decision-making around health also brought up various painful memories and the hard everyday realities for the women, causing many of them to become emotional during the interview. To make sure that participants did not feel ridiculed or mocked when sharing personal information, the

researcher did not interrupt them, and tried to provide a safe space where participants could express their feelings freely.

Despite the effort to create a comfortable atmosphere, a few participants initially showed scepticism as they hesitated to answer questions or provided very brief responses. In such cases, the researcher revisited the questions later in the interview once more trust was established. Participants who initially refrained from sharing health-related concerns, financial hardships, or their dependence on family members gradually became more open as the interview progressed.

3.6 Researcher's positionality

This section on the researcher's positionality discusses the researcher's background and perspective that play a critical role in shaping the entire research process, right from choosing the thesis topic to the analysis and discussion of the findings. Including this section is essential for transparency and comprehending the potential biases that may have influenced the research.

I am a 34-year-old Indian woman, born and raised in India but exposed to international settings from an early age. I have dedicated around 7 years to working in the development sector in India. As I embark on my master's journey in Finland and author this thesis, I acknowledge the profound influence of both my cultural heritage and professional background, which inevitably shape my perspectives and biases.

Hailing from a privileged class in India and having closely interacted with women from underprivileged backgrounds, I have keenly observed the challenges and vulnerabilities faced by women, intensified by their low economic and social status and the pervasive gender roles and norms that shape their lives from birth. Amidst these adversities, I have witnessed women exhibit agency and decision-making power too.

Consequently, my effort in this thesis has been to discover insights that explain how women's agency is moulded and exercised within their identifiable restrictive realities. To remain true to this objective, I have committed to presenting the collected data without distortion, as best to my knowledge. During data collection, I have encouraged participants to express themselves freely, without nudging them towards narratives that align with my preconceived notions. Actively listening to those with vastly different lived experiences has been a priority to ensure open dialogue.

However, it is important to note that despite making such efforts, both the women I interviewed, and I were aware of the inherent socio-economic differences in our lives. For instance, most of them were from low caste backgrounds, a reality they confront daily, as it is evident from the address of their home and their surname that

reveals their caste. Thus, efforts were made from my side to be sensitive and inclusive during the interview process, such as by taking cue and adopting their seating arrangement, using colloquial language during the interview, and finding common ground during emotional moments. However, due to the social stigma, there is a possibility that the women withheld information, or did not openly share their stories and thought processes with me. There is also a chance that I had limitations in interviewing them, for instance by missing the right cues to help them open-up further.

While stating this, however, I must also mention that I found most participants to quickly open up during the interviews, perhaps due to the relevance of the subject matter or their amusement of being interviewed. Additionally, I assumed the interviews to inherently imply a power dynamic which could influence the participants to disclose particular strengths and weaknesses. Although, this could hold true to a certain extent, it was rarely observed, and I had to only on a few occasions ask (extra) additional questions to ensure comprehensive understanding. This could be due to my ease in language, demeanour, and communication since I am familiar with and have worked with marginalised women in the city. Additionally, given that most of the interviewed women were domestic helpers and farm labourers, they regularly interact with individuals from diverse social and economic backgrounds thus this could also have resulted in them being outspoken and seemingly genuine during the interview. Moreover, only one interview was conducted at the woman's home, while the others took place at or around their work locations. This setting possibly provided them a safe space to discuss the topic without, for instance, fearing scrutiny from their family members.

It is also essential to highlight that working with national and international NGOs in India and interacting with Western 'experts' has exposed me to divergent views many a time detached from ground realities. As the Western or White perspective quietly assumes the status quo, all other viewpoints, even when acknowledged, are routinely marginalised to conform to the prevailing Western notion of gender roles and the ultimate ideals of freedom, dignity, and rights. This can, in my opinion, suppress the authentic desires and rights of individuals, leaving them voiceless in the purported process of empowerment. While in recent years I have witnessed a more open-minded engagement with individuals from the West, there are discernible gaps in their perceptions, particularly on women from the Global South.

Furthermore, Women from the Global South are often generalised and confined to the same category, while nuances western experts invariably apply to themselves and their Western counterparts are simultaneously overlooked. This understanding, for me, stems from my subjective experiences amid extreme dichotomies in gender

roles in and within society and across different classes. It has instilled in me a commitment to understanding the intricacies of the marginalised women's lives without judgment in this thesis, aiming to untangle their realities from dimensions accessible to me.

This commitment involves trying to avoid the imposition of any agenda or narrative, and instead portray facets of women's lives in relation to their genuine complexities and humanity—a privilege many, with presumed 'freedom,' 'happiness,' and 'choices,' only grant themselves. While striving to achieve this goal, it is essential to acknowledge the possibility of me overlooking the extent of the various constraining factors and their impact that continue to affect women's realities in the Global South.

3.7 Limitations and validity

This section addresses the limitations of this study and summarises the steps that were taken to validate the findings, that paid emphasis on recognising and addressing constraints to maintain the overall credibility of the research.

As highlighted in the literature review, contextualising and expanding upon women's health agency involves considering numerous factors such as how agency may manifest, what influences it, and which measurement indicators may be relevant. Given the diversity of the variables at play, a one-size-fits-all definition or set of indicators for women's agency is unlikely to be useful. Therefore, this study contextualises women's health agency specifically for a cohort of marginalised women in Varanasi, India, aiming to amplify their narratives and extract findings from that.

However, it is important to note that even within this demographic, most participants were working women hailing from a Hindu religious background, limiting insights into the health agency of, for instance, housewives or Muslim women, as only one participant represented each of these two groups (however, the study did not look at how belonging to the Hindu faith impacted women's health agency).

Furthermore, literature is clear on the evolving nature of women's agency over their life cycle, influenced by aspects like marital status, ethnicity, age, religion, education level, economic status, and social class, highlighting for the need of a focused approach which incorporates numerous factors and intersectionalities. Although this study addresses a specific cohort with similarities in social and economic class, caste, marital status, ethnicity, and age, it does not study the particulars of the several factors in isolation and how each influences women's health agency.

Additionally, the study does not include looking at each nuanced circumstance and study the differentiations within the agency, such as Kabeer's distinction between

passive and active agency, or how the agency manifested in those varying contexts evolves and what its detailed underlying processes are.

Nonetheless, the study offers valuable insights and explores women's agency, health values and goals, and the linkage between health agency and improved health outcomes. This not only provides a foundation for the expansion and contextualisation of women's health agency, but also provides further avenues for investigations and advancements in various fields such as psychology and public health.

Additionally, the use of one-time interviews without follow-up or focus group discussions with family and community members may have limited the depth of the insights. Although, as expanded upon in the methodology, steps were taken to corroborate women's views.

Moreover, while various definitions and approaches can be taken to explore women's agency, autonomy, and decision-making in healthcare, this study adopts an inductive approach, which prioritises bringing out insights from the voices and perspectives of the participants themselves. These findings can assist future research of varied nature, such as those utilising a deductive approach or focus group discussions or even quantitative studies.

It is also crucial to recognise that to minimise the potential influence of the researcher's views, biases, and limited experience in data collection, efforts, as described in the methodology section, were made to ensure reliability during data collection and analysis.

It is also finally important to note that due to the study's scope being limited to 17 women within a specific cohort, the findings of the study cannot be generalised to other South Asian or Indian contexts. The findings can instead provide nuance and depth, and insights for methodological approaches to help contextualise women's health agency in other locations.

4 RESULTS

The Results chapter explicitly focuses on presenting the outcomes of the saliency analysis by providing a voice to the 17 interviewed women thus, minimising the analytical voice of the researcher. This section is structured in this manner to offer a comprehensive depiction of the findings from the women's point of view, with the initial part briefly outlining the participants' profile to enhance comprehension of the interviewed women. Subsequently, the 7 major and numerous minor themes undergo a detailed exploration. This approach has been undertaken to ensure that this thesis, which is focused on women's health agency, does justice to the voice of the women. Additionally, this also allows to provide a clear and organised presentation of the research outcomes to help with the discussion chapter, which is a separate chapter that discusses the results in the context of the literature.

4.1 Participant profile

A total of 17 ever-married women participated in the research, with ages ranging from 30 to 49. Their educational levels varied from uneducated to completing their schooling. Seven women identified as literate, while the others were illiterate.

Of the participants, 14 were currently married, 2 were widowed, and 1 was technically married but separated without a divorce (due to her husband leaving her). The age at marriage spanned between 12 to 21 years.

Except for one woman, all participants were engaged in informal work, in mainly two occupations. Ten women worked as domestic helpers in others' homes (including one currently between jobs), one served as a security guard at a residential apartment, five were involved in contractual farm labour, and one identified as a housewife. The contractual workers received employment for only 3 to 6 months annually. While domestic workers and the security guard received a monthly salary,

contractual workers were paid on a daily basis, with their monthly salary determined by the number of days worked.

In contrast, their husband's ages ranged from 30 to 65. Their educational backgrounds varied from being uneducated to having studied at the college level. Similar to the participants, all husbands were employed in the informal sector, lacking written contracts, paid leave, and other benefits. Six earned a monthly salary, while others were paid based on the work obtained or the number of days worked in a month.

The participants had varying numbers of children, ranging from 0 to 7 per woman (counting all children birthed, including deceased ones). Among these children, 25 were girls and 29 were boys. The youngest child's age ranged from 5 to 27 years.

The households of the participants varied in size, ranging from 1 member (the participant) to 15 members (when including the joint family).

The average number of household earners was 2.9, excluding members who lived in the household but did not contribute to the expenses of the participant's nuclear families. This figure includes members who usually work but may not be working at the moment due to being in between jobs or having seasonal jobs.

The average household income ranged from 4,500 to 60,000 INR (approximately 50-650 EUR). Considering the higher end of participant's estimate (several participants presented a range) when all members are working, the average monthly income per household reached 21,382 INR (approximately 235 EUR).

Religiously, out of the 17 participants, 16 identified as Hindu, and 1 as Muslim. Among them, 3 participants belonged to higher castes—1 *Brahmin* and 2 *Kshatriya*—while the remaining 14 belonged to lower caste[i]. Within the lower castes, 3 participants were from the OBC (Other Backward Castes) category, and 11 from the SC (Scheduled Castes) category[ii]. Among the SC participants, 8 identified themselves as belonging to the sub-community of '*Chamar*,' the most prominent caste amongst the SC. It's important to note that the term '*Chamar*,' considered a pejorative term by the Supreme Court of India and described as a casteist slur, is prohibited for use due to its derogatory connotation.

Out of the 17 participants, 8 reside in the central area of the city, while 9 live in peripheral areas. Among those in the central area, 2 are confirmed to live in slum areas and 2 in illegal settlements. Notably, all 4 participants residing in these areas belong to the SC category, and 3 out of 4 identify with the '*Chamar*' sub-caste.

4.2 Health attitudes from women's perspective

The narratives of the 17 participants, all hailing from marginalised backgrounds marked by factors such as gender and social class, offer profound insights into their unique perspectives on personal health. This exploration examines their intricate thoughts, shedding light on their health goals, decision-making processes, and the factors influencing their health behaviours. As we traverse their stories, we gain an understanding of what health signifies to them, the workings of their health priorities, and the considerations that shape their health-related actions.

Beyond these initial insights, subsequent sections examine the specific themes, offering a wide-ranging view of the broad landscape that defines women's health from these marginalised perspectives.

4.2.1 Definition of health

The participants' definitions of health are deeply rooted in their ability to work and contribute to family welfare. Their collective perspective highlights the relationship between health, work, and family well-being. Polly emphasises this connection, stating, "when everything is okay, then I can do my daily work comfortably in peace." Savita echoes a similar sentiment, viewing good health as essential for effective work performance: "health should be good so that I can do work. If I am not healthy then how will I be able to do anything?".

Several participants such as Usha and Rekha also define being healthy as being disease free. Usha says, "I think I am healthy as I have no issues and I am able to work". Nutan also sees a healthy body as one without any disease, stating she would like to stay healthy- "that I don't face any issues and diseases. That my body is able to function, and I die with a functioning body." Nutan attaches high importance to health in relation to her ability to work: "as long as my health is okay, then I can work. I would like to live my life like this before I die."

Sushma on the other hand defines her health holistically as being disease-free, being able to work and also seeing work to have larger benefits: "it (work) will be good for my physical, mental, as well as economic health.". Similarly, Soni B. sees work as a means to improve mental and physical well-being, expressing, "when I work, I feel better. If I just stay home all day, then my health deteriorates as I don't feel good." For her, health is having vitality and the ability to work. She adds, "if I don't work, then I feel lethargy and sleepy. Then I sleep all day and don't do any work. I don't feel like it.".

Likewise, Dharamsheela places importance on her state of health to include bodily strength and vitality, so that she can carry out tasks without feeling fatigued. She

says, “now, I do something and feel tired. I am weak. I go home from work, and I have to sleep for some hours because I am so tired. If I were healthy then I would go home and be able to quickly finish all the housework.”. Sunita too places importance on similar attributes. She explains she is in a healthy state when, “the body feels energetic, without feeling lethargy. If the body is not healthy then you wouldn’t feel like doing anything. Then you wouldn’t be able to do anything.”

Like several other participants, for Soni D., her health is crucial to ensure her children are taken care of.

Kausalya also sees work as a means to improve her mental and physical well-being, stating, “I like doing cleaning work as it’s good for my health. My body gets a workout. This way, I get some exercise.” She defines her health as being disease-free and remaining physically strong and slim. Though adding that she doesn’t prioritise her health, she states “the physical work I do keeps me fit…as long as my body is functional, I will be okay, and when I cannot work, then I will be in God’s hands.”. Rajkumari feels healthy when “there is no disease or feeling of illness.” She ties her health to her ability to work like other participants, noting, “if I can sleep well then, I can feel at peace. I will know that the next morning I can wake up and manage to go to work.”.

Several other participants also divulge how their mental peace impacts their health. Rajia says, “when a human being lives in peace then it also reflects on their health, and they get healthy. If someone doesn’t live in peace, then will their health improve or deteriorate? Tell me?”. Though she says her health is okay as she does not have any diseases, she explains, “if I take any tension, then my eyes get red, and I become nervous. I am also losing hair from this side of my head. If there is no tension, then I can say that I am healthy. If there is tension, then my health deteriorates”. For Mala as well, stress is a vital component that determines her health: “I usually feel weak and am always anxious. I don’t feel hungry. If I take any tension (overthink), then I start feeling anxious.”

4.2.2 Prioritising health and its challenges

While participants recognise the importance of their health, economic hardships often push personal well-being to a low priority. Despite the financial challenges, some participants assign high importance to their health, understanding its intrinsic value. Sushma, acknowledging the higher healthcare costs, emphasises, “I don’t think too much about money though. If I am healthy then I have everything.” Soni B. confirms this sentiment, stating that despite expensive doctor’s visits, she believes in seeking medical help due to the effectiveness of the prescribed medicines. Likewise, Mala, Rekha and Savita value and prioritise their health issues over financial savings. Savita

notes "we listen to the doctor, so, we recover quickly," while also recognising the impact of poverty on healthcare quality. She says, "we don't go to large clinics and well-known doctors. We don't have the capability to go to such doctors". Regarding her financial concerns, she adds, "I sometimes think that since we don't have money and there is no health aid, what will we do if we get sick?". Though she quickly adds, "but still, I am not negligent. If I get sick, then I go to get checked".

Nutan, however, cites financial reasons for not prioritising medical support, expressing concern over the excessive costs of health tests. Kausalya, living alone and facing financial constraints, refrains from seeking medical care, emphasising, "I don't have enough money to eat well and take care of my health." She has concerns about affording prescribed medicines and acknowledges the broader impact of poverty on her well-being, stating, "my health would have been better if I had more money. I would eat better and take care of myself. I would have less tension." Rajia avoids contemplating health matters to prevent additional stress. She elaborates, "I don't even think about my health or care for myself. If I pay attention to my health, then I will become worried." Dharamsheela, confronted with eye complications and advised by medical professionals to undergo eye removal, vividly expresses her emotional turmoil, stating, "we (Dharamsheela and her husband) both started crying… we both were scared… we were also thinking that we don't have the money for the surgery".

Rupa, a widow, avoids medical treatment due to fear of high costs associated with a serious illness. She has allowed her health issues to worsen, noting, "I tell him (doctor) that it's okay. If the problem will become serious, then I'll die from it." Divya highlights the impact of poverty on her health, stating, "we have to make do with the basics. If we had more money, then we would eat better." Similarly, Rajia and Dharamsheela candidly acknowledge their lower priority given to personal health. Rajia acknowledges, "I don't eat properly. So how will I be healthy?" echoing the challenges she faces in maintaining a healthy lifestyle. In a parallel sentiment Dharamsheela reflects on her health, stating, "I am not healthy. If I were healthy then I would take care of myself." Usha too reflects on the universal desire for health, stating, "who doesn't think they should be healthy…eat things that improve their health. Occasionally, I think about these things, but we lose out due to not having money."

Several participants also describe how the adverse effects of poverty extend to healthcare experiences at mainly government but also private hospitals. Rupa suggests that connections play a crucial role in receiving proper treatment, saying, "only people who have connections at the hospital get proper treatment. It depends on the reach people have. Nobody helps poor people. They just make us run around." Kausalya, lacking such connections, faces challenges accessing government hospitals, forcing her to visit private clinics that are expensive. Savita, who is sceptical about government doctors, also prefers private healthcare. She shares, "I am unsure whether

government doctors will give us the right medicines or not. We have heard that they give small doses of medicines to save medicines. They may be negligent and not listen to us…Other people go, those who have trust in the government go. I don't."

Sunita avoids seeking healthcare at government facilities due to mismanagement and overcrowding. She articulates, "If I have to go to a doctor, then I go to a private clinic. I pray to God that I never have to go to a government hospital again... I fear BHU (government hospital) ... there are so many patients there, I get nervous seeing them. You have to stand in long queues. We go to BHU only as a last resort." Dharma and Divya also express a preference for private hospitals due to the inefficiencies in government facilities. Divya shares her views, stating, "we think that if we have to spend money on healthcare then it is better to go to a private hospital/clinic." This deliberate choice highlights the impact of perceived inadequacies in government healthcare facilities on participants healthcare-seeking behaviour.

4.2.3 Curing rather than preventing health issues

For numerous participants, the focus on healthcare leans more towards curing issues rather than taking preventive measures. Polly, reflecting a common sentiment, shares, "I go to the doctor when my issues become worse...and I don't feel relief from the medicine; otherwise, I somehow make it work... The doctor asks me to exercise and lose weight and take appropriate rest. But I am unable to do all this...if I sit at home, then I won't be able to take care of the household expenses." The reactive stance of several participants reflects a pattern of seeking healthcare primarily in response to acute health issues. Usha, sharing a similar perspective, acknowledges seeking health support only when her pain becomes unbearable. She states, "I would just endure the pain. I told someone when the pain increased." Sunita's approach to health is also characterised by a lack of proactive measures. She asserts, "I don't do anything for my health. Once my situation worsened and my health worsened, I had to go to the doctors." Similarly, Mala shares her experience of enduring stomach aches while attributing them to her extensive workload or general weakness, disclosing, "I had terrible stomach aches. It used to hurt a lot when I worked. My situation was like that for some time."

4.3 Self-directed health management

Women navigate and take charge of their health independently in myriad ways. This section explores the diverse and practical measures participants undertake, demonstrating their agency in addressing minor everyday health concerns. Within this theme, a spotlight is presented on the personal actions the participants have taken to improve

their health, be it through the utilisation of home remedies or asserting their choice to avail or avoid medical consultations and support. Through these narratives, we gain insights into the nuanced ways women exercise autonomy and resilience in managing their health.

4.3.1 Medication choices, traditional practices, & trust in doctors

The participants showcased a holistic engagement with self-directed health management, combining over the counter medicines with traditional and non-conventional systems of health care, and cost-effective strategies to manage their health issues independently. This approach was taken to independently address minor issues, such as pain, fever, and headaches, without immediate reliance on healthcare professionals. Polly, emphasising the significance of maintaining a home pharmacy, shares her strategy, stating, "I always keep medicines at home, I keep painkillers...when I have issues, I take the medicine at night so that I am able to go to work the next morning." Several participants, including Rajia, Rajkumari, Usha, and Divya, exhibited a proactive attitude by visiting nearby pharmacy stores for medications on their own. Usha explains her approach, saying, "If I get sick, have a fever or headache, then I get medicines from the store." Divya echoes this sentiment, asserting her autonomy in health decisions, stating, "I don't have to ask anyone before buying or consuming medication for minor issues."

Nutan, displaying a nuanced knowledge of medications, details her approach, "I know which medicines to take…if I have a cold or a fever, I take Sinarest medicine. If I have body pain, then I take Combiflam…You will always find Combiflam at my house." She stresses a cautious use of medicines based on necessity, stating, "I take these if I really need to, otherwise I don't take medicines." Similarly, Dharamsheela, also adopts a more judicious and informed approach to medication stating, "When it pains a lot, then I buy painkillers from the store …the pain subsides as long as I keep having the medicines, but for how long can I keep having the medicines?" She chooses to apply pain balm and prioritise rest, demonstrating a conscious effort to manage pain without prolonged dependence on medications.

Savita, highlighting the importance of timely medication, asserts, "We are not negligent about our health. Therefore, we have never faced any problem." Her diligence in adhering to medication schedules portrays her commitment to preventive health measures. Furthermore, she also embraces diverse healing practices, incorporating homeopathic medicine and seeking remedies from witch doctors through spells, incantations, and plant medicine. Similarly, Rajkumari prefers Ayurvedic medicine while Soni D expresses a preference for homeopathic medicine over allopathic alternatives, citing concerns about the potential side effects of strong doses. She attests to the positive impact of homeopathic medicine on her well-being, stating, "Whenever I

take homeopathic medicine, I feel okay. In my family, only I take homeopathic medicine." This multifaceted approach highlights the participants' openness to alternative healthcare methods, including those that suit their personal preferences.

Kausalya, while acknowledging the use of conventional fever, cold, and cough medications, strategically navigates the financial aspect of healthcare. She shares, "At times, when the medicines they (doctors) prescribe are expensive, then we exchange a few of them for cheaper medicines and sometimes ask the pharmacist to keep the medicines until we arrange the money to afford it." This resourceful approach showcases participants' adaptive strategies in accessing necessary medications of their choice that is within their budget and reach.

The participants also demonstrated their reliance on and trust in doctors, emphasising their willingness to seek medical advice, allocate time for doctor's visits, and adhere to prescribed treatments. Soni B., a domestic worker without any off days, reflects this commitment by stating, "I usually go in the evenings (to the doctor) when I have time...I can't take any transportation (due to money), so I go walking." Similarly, Kausalya prioritises doctor visits, asserting, "If I have problems, then there are doctors that sit near my place, so I go to them to get medicines. If the problem is uncontrollable, then I go to the hospital by myself." Savita follows doctor's recommendations diligently, stating, "If the doctor suggests that we should eat certain foods, then we try and do that. That way, we get well." Usha, a widow, actively engages in conversations with doctors about her health condition, expressing, "I told them (doctors) that if it can get better with medicine, then that would be good. And they said that the medicine would improve the situation, but I would have to get an operation down the line…So, I told them that I would like to get the operation."

4.3.2 Women's approach to health through eating practices

Participants highlight the significance of their health by showcasing their commitment to maintaining their health through consuming nutritious and regular meals tailored to their individual capacities. Sunita incorporates vegetables and fruits into her diet, Rupa focuses on maintaining eating twice daily, and both Nutan and Savita prioritise wholesome meals for overall well-being. Soni B. describes her diverse daily diet, saying "I eat everything. I eat vegetables and fruits like banana, apple, guava, and mangoes. These days I eat mangoes every day."

However, Dharamsheela, constrained by financial considerations, adopts a pragmatic approach to her diet, stating, "I eat when I feel hungry. I don't eat fruits. How will we afford that? I eat rice, lentils, and vegetables…I eat, but I am unable to do more (for health)". Similarly, Rekha, who adheres to routinely eating three daily meals states, "I eat 3 times a day. I don't do anything for my health. I eat whatever food is cooked at home. Rice, lentils, vegetables, eggs etc.". Divya aligns her dietary

choices with budget considerations. She states, “I think about my diet according to the money we have. I eat bread, rice, lentils, and vegetables…I buy milk from the market for my children. If there is any left, then I have some too.”.

On the other hand, Dharma recognises the impact of her early work hours on her health and makes conscious choices, stating, “I eat on time to ensure my body isn’t negatively affected.” She further elaborates on her dietary considerations and adjusting her eating schedule to accommodate her work hours. She explains, “If I don’t eat since the morning and have the lunch break at noon, then I wouldn’t feel good, so I have realised that I should instead eat around 10 am. So, I pay attention to when I should eat and how much I should work”. Similarly, Mala who developed digestive issues after her surgery recognises that her eating habits make her weak, but she explains her decision “That’s why I don’t eat anything out of fear. I only have tea in the evening and have lunch. I don’t eat any snack items. If I eat anything for taste, then after 10-15 minutes I will start having problems. So, I sleep on an empty stomach at night.”

4.3.3 Reliance on home remedies

Participants displayed resourcefulness in integrating traditional, accessible remedies into their health management strategies. They turned to home remedies, especially in the initial stages of health concerns or as a primary intervention before seeking medicines or medical support. Nutan, a proponent of relying on home remedies instead of medical treatments, employs simple yet effective remedies like lemon water, coffee, or glucose to address health issues such as headaches and low blood pressure. She says, “I feel that if I can control my issues at home then why should I get checked by a doctor?... I feel that I will manage and live the way things are going. This is my thinking”.

Soni D., after a road accident, initially applied onion and turmeric to her wound, emphasising an initial reliance on home remedies before seeking professional assistance. She explains, “Initially, I had applied onion and turmeric thinking that since it didn’t seem like a major issue, my leg would be able to heal.”. Kausalya incorporates warm water into her routine to alleviate stomach issues, showcasing the diverse array of home-based solutions participants employ.

Sunita, in dealing with tuberculosis symptoms before diagnosis, highlights the customary practice of relying on herbal decoctions and home remedies to alleviate coughs and related issues. She says, “If you get a cough or something like that then you think that you will get better using home remedies such as drinking herbal decoctions to feel better. So, this is what I was doing”.

4.3.4 Navigating health autonomy: defying expectations

Participants demonstrated autonomy in health decision-making by resisting pressures from spouses, family members, and even medical professionals. Nutan, facing family insistence to consult a doctor during health issues, persistently makes excuses and avoids it, stating, "I don't ask anyone for suggestions… When I have issues and my family asks me to go to the doctor and I refuse, they scream and shout, but once I become better then they also don't say anything and relax…Once my situation was bad, and the doctor told me to get IV fluids. But I refused. I don't understand all this… I only get my blood pressure checked there. That's all…My family doesn't think the same." Soni D., contrasting Nutan, insisted on additional medical tests despite the hospital's assessment of a minor sprain. She says, "At the hospital they told us that it was a minor sprain, but I insisted on getting an x-ray done".

In instances like Kausalya's and Rajkumari's, where health concerns are shared with husbands, the final decisions rest with the women. Kausalya, who most of the time lives separately from her husband, asserts, "I tell him about my issues but do things as I see fit." Rajkumari follows a similar pattern, sometimes considering her husband's suggestions but ultimately deciding independently. Even with her husband's support, Divya emphasises her determination to seek medical attention, stating, "If he told me that I couldn't go to the doctor, then I would still go."

Contrastingly, Rupa, fearing a potentially serious health diagnosis, avoids medical tests against her doctor's recommendations. She expresses anxiety about the implications, stating, "If I find out that I have a disease, my whole life will be consumed by getting treatments done. I don't get the ultrasound as I am always tensed that I will die if I find out I have a disease. How will I get money for the medicines? I am sure it a big disease."

4.3.5 Health-conscious adjustments in daily life

The participants make display intentional adjustments in their daily routines and work practices, recognising personal health risks and taking adaptive measures to safeguard their well-being. Polly, for instance, decided to halt strenuous cleaning jobs, citing concerns about dizziness associated with excessive bending and stress. She says, "I stopped doing cleaning work for my health. I only cook now." Furthermore, Polly incorporates health considerations into her future plans, intending to reduce work after five years for improved well-being. She explains, "After that I will still work but not so much."

Dharma highlights the significance of self-care through a mindful balance between work and rest. She articulates, "I also do some things for myself like eating on time and working only as much as my body allows, so that my body isn't negatively

impacted. If I work too much, then I can get issues. So, one should only work to the extent that one's body remains healthy." In a similar vein, Kausalya reveals her healthcare strategy of occasionally taking leave from work to attend to medical necessities. She explains, "I adjust doing everything this way…This is a body. It cannot work nonstop 30 days a month…If I don't take leave from work, then how will I take care of necessary things? We don't get any day off. It's not like an office where you get Sundays off. This is not the system in such domestic work.".

Some participants also engage in modest yet impactful actions to enhance their well-being. Sushma, grappling with leg pain induced by her demanding workload, prioritises a comfortable journey home, expressing, "I go home in an auto, so it takes 10-15 minutes to reach home after work." Both Soni B. and Soni D. integrate daily practices into their routines for health improvement. Soni B. emphasises, "I walk in the mornings to keep healthy. It doesn't matter whether I find work or not; I go for morning walks." Soni D. outlines her morning routine, stating, "After waking up in the morning, depending on the amount of time I have, even if for only 10-15 minutes, I do some Yoga."

Kausalya incorporates light stretching post-meals to feel lightness in her body. Recognising her tobacco use, Rupa acknowledges the unhealthy habit and moderates her consumption. She reveals, "She (mother-in-law) used to have *paan* (beetle nut leaf with tobacco) that she would keep in her mouth even while sleeping. So, she got mouth cancer. I also eat it…I leave it at times too. Sometimes I go without it for 1-2 months…That's why I only have 2 pieces of betelnut at once. I don't eat too much."

Furthermore, while sick, Rupa also adapted ways to gain her abusive mother-in-law's support. She says, "I asked my mother-in-law to get medicines for me…but she scolded me and refused. I got really worried…So, I became adamant on not cooking or doing anything...I told her that I was unwell and would cook food once I recovered… She (mother-in-law) used to send food to my room every day, but I wouldn't eat it. Although, she abused me more as a result". These insights portray the participants' need of maintaining health-conscious practices within the demanding domestic and job responsibilities.

4.4 Gender roles and marital relationship

In exploring the theme of gender roles and marital relationships among the participants, a nuanced narrative unwraps which sheds light on the profound impact of these dynamics on their health experiences, actions and decision-making processes. The participants openly share insights into how specific gender roles within their marital relationships influence their overall well-being. Notably, a widespread sentiment

among most participants is the desire for their husbands to actively manage and support their health interests. For these women, the demonstration of care from their spouses is crucial, and it extends beyond mere emotional support to practical actions such as accompanying them to medical appointments and ascertaining their health-related wishes are fulfilled.

On the contrary, the experiences of women without spousal support are a stark contrast, as they are expressed by high levels of mental stress. In the absence of a partner's involvement, these women find themselves navigating health decisions and practical considerations alone, often struggling with financial strain and a sense of isolation. Thus, the intricacies of these narratives reflect a complex relationship between marital dynamics and the participants' health journeys.

Moreover, a large number of participants emerge as primary caretakers for their family members, including their husbands, displaying a tendency to prioritise the well-being of their loved ones over their own. This self-sacrificial attitude to health stresses the multifaceted roles women undertake within the family structure.

4.4.1 Women's dependence on husbands for healthcare

Many participants revealed a significant dependence on their spouses for support in addressing health issues. Polly, whose husband works at a medical store, leans on his medical knowledge. She articulates, "I speak with my husband about my health issues, and he is the one who gives me the medicines…He knows which medicines to give me when I have leg pain or when I feel dizzy. If it wasn't for his knowledge, I would have to wander from doctor to doctor." Beyond giving medications, Polly's husband has been a pillar of support during illnesses and pregnancies by taking on household responsibilities. She explains, "he washed clothes, cooked, and helped the kids bathe, etc…My husband is my support. He helps me in everything."

Likewise, Soni D., who acknowledges her husband's leadership role, entrusts him with her health needs. Describing her reliance on his support, she states, "I speak to my husband about all my health issues… I tell my husband and ask him to take me to get checked. So, he takes me." Soni D. further explains her preference for not going to places alone, stating, "Though I can go by myself, I don't usually go alone walking or take an auto or rickshaw by myself, so I think if he has the time then he can take me to get checked… He also thinks I should go with him. He comprehends things better. I may not grasp everything fully, so he helps." Sharing a similar sentiment, Sunita reveals, "If the pain increases, then I ask someone to get me painkillers from a pharmacy. My children or husband get the medicines for me. I go out of the house if there is some work I am required to do." Dharamsheela's husband and children also play a crucial role in facilitating her hospital visits. She clarifies, "If my husband is busy, then my children take me to the doctors. I don't go by myself. I ask them to take me, and

they will take me to the hospital, get me checked, and get the medicines." Dharamsheela also relies on her family to obtain her medications, expressing, "Where will I go to buy medicines? They take me or get me medicines… They take care of me."

Similarly, Divya highlights her husband's integral role in her health care, especially for visits to larger clinics or hospitals further away. She states, "If I have issues and we have to visit a larger clinic or hospital, then my husband will have to take me for getting checked. I don't go by myself." Emphasising the importance of her husband's presence for major or serious health issues, Divya affirms that she shares all her health concerns with him, trusting him to procure the necessary medicines. She believes that her husband takes care of her and looks after her health diligently.

In a parallel line, several other participants, including Savita, Rekha, Dharma, and Rajkumari, echo the trend of sharing health concerns with their husbands and counting on them to facilitate visits to the doctor during illness. Rekha's husband, who prioritised her eye issues over his own work, highlights the critical role of a supportive spouse, emphasising, "I know some women who don't have their family's support, and therefore their health suffers. A husband helps a lot." Dharma acknowledges that her recovery from paralysis can be easily attributed to her husband's unshakable commitment to her treatment. She says, "If it wasn't for my husband, then I wouldn't have gotten better. Who else would have taken me for all the checkups and to the different doctors and run around like that?" Dharma perceives her husband as a caring figure who ensures the well-being of both her and their children, taking them for medical checkups and obtaining necessary medications. These accounts collectively highlight the substantial reliance women place on their husbands for practical support in addressing health needs.

Usha's reliance on her deceased husband to take her to the doctor and Rajkumari's dependence on her husband for longer commutes further emphasise the prevalent reliance on spousal support for medical care. This pattern suggests that most participants refrain from undertaking long journeys to visit the doctor independently and prefer seeking their partner's assistance. The women express a mutual understanding with their husbands regarding this practice. Sunita emphasises the crucial role of a husband's support in a woman's health, noting, "Women who don't get help from their husbands usually start doing outside work to earn money so that they can do things for themselves, their kids, and also their health. Most of the issues are faced by those women whose husbands have an alcohol or drug problem as they become irresponsible. I know women like that. They sell vegetables or do sewing work. So, the kind of family you are married into and the kind of husband you get matters a lot (in these communities)." This stresses the participants' strong adherence to traditional gender roles, wherein they expect and rely on their husband for comprehensive care, including managing their health and attentively addressing their concerns.

4.4.2 Couples making joint health decisions

A prominent sub-theme emerges as participants consistently highlight a collaborative approach to making health decisions within their marital relationships. Rather than one-sided choices, many couples actively engage in joint decision-making regarding health-related matters. Polly, for instance, underlines the mutual involvement in managing health and illness issues, reserving solo doctor visits for instances when her husband is unavailable. Similarly, Savita, emphasising the harmony in her marriage, independently seeks medical care when her husband is occupied. Describing their relationship, she states, "He listens to whatever I have to say. We get along. Whatever I say he does, and whatever he says I do… Even regarding having children, my husband never said that he doesn't want less or more children, daughter or sons. After I had my 2 sons and then my older daughter, I decided to not have any more children. Without any planning I got pregnant with my 2nd daughter. Even though I didn't want any more kids I got pregnant and had her…my husband also didn't ask me to terminate the pregnancy."

Even in instances where husbands are no longer present, the echo of shared decision-making persists. Usha, reflecting on her past, acknowledges, "My husband and I made joint decisions." Dharamsheela, facing the likelihood of eye removal, recalls a collaborative decision with her husband: "My husband and I decided that I wouldn't get my eye removed. He wasn't forcing me. He said that let's try and get some medicines and see whether it recovers. He listens to me. We decide on things together." For Dharma, whose husband continued her treatment despite financial concerns, the collaborative dynamic is unmistakable: "Between me and him, we were discussing things. It was not that I was refusing to go to the hospital, and he was forcefully taking me to get the treatment… I listened to my husband. He also listens to what I have to say. We listen to each other. He does what I say, and I do what he says." Dharma further notes, "We don't argue. We listen to each other and decide on the best course of action."

Participants participate in health-related decisions within their marital dynamics by also sharing concerns and desires with their spouses. For instance, Dharamsheela says, "I tell my family what I feel will help me. For instance, I tell them to bring me medicines from a specific doctor and they do that. I ask them to take me to a specific doctor, I tell them that he is good." Soni D., whose husband takes charge of all health decisions, sheds light on a specific case where she took an active role in her own healthcare. Despite the doctor's assurance that her leg sprain was minor, Soni D. expressed her concerns to her husband and insisted on getting an X-ray. Recounting the situation, she shares, "So, my husband said that if I am feeling a lot of discomfort, then I should get the X-ray." The participants showcase that, in their marital unions, health decisions are often a shared journey, adopting understanding and unity.

Furthermore, for some participants, the encouragement for independence and self-care also extends from their spouses. Sushma's husband actively supports and facilitates her transition from traditional roles to independence. Despite restrictions on her movement in her in-laws' village, her husband in the city encourages her freedom of mobility. Sushma notes, "My husband doesn't have any issues... Here in the city, I can visit the doctor or buy medicines on my own." Similarly, Savita's husband supports her health decisions and motivates her to prioritise self-care. She explains, "He has never put any restrictions on me or told me that I shouldn't have a certain medicine or do a certain thing. He actually tells me to take better care of my health and eat better. He scolds me regarding my diet and says that I don't eat well and don't do so and so and will fall ill as a result." This dynamic showcases instances where spousal support contributes to achieving women's autonomy in health management.

4.4.3 Women facing mental stress due to husband's lack of support

The descriptions of participants highlight the overwhelming mental stress faced by those lacking their husband's support. Rajia, a single mother, expresses the challenges she encounters while raising her children alone that have led to disruptions in her daughter's education. Kausalya, grappling with the absence of spousal support due to her husband being an addict and living away from her, experiences heightened tension that affects her overall well-being. She shares, "I feel that my heartbeat increases…The major issue is tension. I am always tensed about being alone. What will happen to me? There is nobody whom I can ask for any support…If I suddenly fall, then who would help me? ... My husband runs away. If I get sick, I am not sure if he will come."

The absence of Kausalya's husband not only contributes to her mental stress but also necessitates self-reliance, as she lacks the support of children. She elaborates, "I have had the energy to walk and visit the doctor, so I have been able to visit the doctor and care for myself, but if I get any disease and don't have strength then I will have to seek someone's support. I do everything myself and make decisions on my own. I don't have anyone to support me… So even if I am sick, I have to take care of myself…What can I do? Whom can I ask for help? … As long as my body is functional, things are okay." Expressing a desire for her husband's care, Kausalya envisions a situation where she can quit her job as a domestic helper and prioritise her health.

Similarly, Rajkumari struggles having an unsupportive husband. Feeling unheard and lacking assistance in health matters since her early days of marriage, she has to make independent decisions about her well-being. She discloses, "If my husband's mood is alright, then I tell him, otherwise I go by myself to the doctor and get medicines. If he is not angry and I tell him that I am not feeling well, then he tells me to get checked. He doesn't go with me. I get the medicines, etc., myself." Moreover,

Rajkumari's husband disapproves of her choice to use over-the-counter medication instead of seeking professional medical advice, adding strain to their relationship. She explains, "If I get sick, then he may say 'are you ill? Well, get the medicines and kill yourself.' He gets angry about me not visiting the doctor and getting medicines from the pharmacy… He says that I should go to the doctor for checkups so that I can get proper medicines."

Much like Rajkumari, Mala navigates the challenges of making independent health decisions due to her husband's disapproval of her and their daughters working as domestic helpers. The strained communication within their relationship leads Mala to withhold information about her health issues from her husband. She shares, "I don't tell my husband. I don't feel like telling him. I have a lot of tension with him. He gets angry… I am disheartened with him. If a person doesn't understand my concerns, then what is the point in talking to them?... He thinks that since we earn money now, we will take care of our needs ourselves. He thinks we don't need him anymore. So, he says that since we make our own money, we should take care of our issues ourselves. He says our concerns are not his problem anymore. He used to care for us before. Since we started earning, he has stopped caring for us. He has deserted us in anger. He asks us to leave our jobs…I think I will have to live my life by myself. I will have to take care of all things by myself. If my husband doesn't help, then what can I do?" Both Mala's and Rajkumari's situations exemplify how a husband's disapproval strains marriages and influences their decision not to share their health concerns with them, ultimately leaving the participants feeling deserted and unsupported.

In parallel, Rupa recounts a history of an abusive husband who dismissed her health concerns, subjected her to accusations of pretending to be ill, and physical abused her. Despite sustaining wounds and cuts, she received no support or medicines from her husband, who was, however, caring when sober. Though Rupa finds peace in her home now since her husband's passing, the lack of support and financial cushion poses constant challenges to her well-being.

Recounting the societal norms that discourage divorce, Rupa explains, "In our community, we don't divorce. Whatever he is like, he is the husband. Our parents have married us off and given us to them. We don't remarry. Whether he is good or bad, he is your husband…My parents wouldn't help me…Instead, they would say that living at the in-law's is like chewing chickpeas made of steel. That's how a girl can live at her in law's place. These are the things our parents teach us. That's why, if you are happy, you can visit your parents, but if you are sad since your husband beat you then you cannot visit your parents."

These narratives stress the participants' not only physical but also emotional reliance on their husbands. The absence of this support creates mental torment and concern for the participants, reflecting a deep-seated structure and desire for spousal care

in the communities they live in. Furthermore, they desire spousal support in their autonomous health related decision-making, without which the participants contend with strained marital relationships impacting their health and well-being.

4.4.4 Managing household health & prioritising family well-being

Within the sphere of gender roles and marital relationships, a distinct sub-theme emerges as participants take charge of managing household health and prioritise the well-being of their families. While Soni D. explicitly notes her husband's role in overseeing the health issues of the entire household, many other participants actively engage in the health management of their families. Sushma, despite her own time constraints and inability to get her leg checked, serves as the primary health support for her husband, ensuring his well-being. She shares, "If he has any health issues, then he tells me about it, and we call the doctor and get him checked…somehow I get him checked by the doctor." Rekha collaboratively takes care of her children's health issues with her husband, emphasising their shared responsibility. She explains, "First, I take them to any doctor that's in the locality. If I am not home, then my husband will take the children, and if he is not available, then I take them. I am their security. If the problem is big then my husband and I take them together to the hospital." Savita, who independently makes health decisions for herself, extends her capability to her family's health needs. She confidently chooses doctors for her family members and actively engages in conversations with medical professionals. Recounting her husband's bout with jaundice, she says, "I would help him do everything while I was also continuing to work. For 10 days he was bedridden, and I gave him medicines and took care of his food, etc."

Soni B., prioritising her husband's needs, takes charge of her family's health concerns. She states, "If my children or husband get sick, it is me who takes them to get checked by the doctor…my husband has a leg infection these days. I have taken him to get checked." Managing household finances is also part of her responsibilities, reflecting on her multifaceted role, she adds, "I have to take care of all the things. I have to manage the money. My husband also hands me the money that he earns. I have to manage all the household expenses". Likewise, Nutan, a decision-maker in her household, manages expenses, decides on medical checkups, and offers guidance to her husband, son and daughter-in-law. She articulates, "I make decisions in my house. I decide that my husband should go for a checkup… I manage all the household expenses and decide how to spend the money and on what...If I see that they are not doing too well, then I take them to the doctor straightaway." Despite her proactive approach to her family's health, Nutan reveals a selfless tendency by admitting, "If my children or husband get sick, then I promptly take them to the doctor. But I don't think this regarding my health. This is the truth." Furthermore, she also believes in

self-reliance and adds that she doesn't want to be bedridden when she gets older and have others serve her.

The experiences of Rupa, a widow, and Sunita, also exemplify the profound sacrifices and responsibilities shouldered by married women when it comes to family health concerns. Rupa, confronted with her husband's severe health issues, assumed the role of the sole caretaker. Reflecting on this challenging period, she shares, "We were getting him treated at a private hospital… he himself got extremely ill, and we had to put so much money into that. I forgot about my troubles and was constantly concerned about him." In the face of adversity, Rupa's dedication to her husband's health took precedence over her own well-being, highlighting the deep commitment many married women feel towards their spouses, children and other family members.

Similarly, Sunita's narrative echoes a familiar sentiment of prioritising family duties over personal health. She articulates, "I am, after all, a woman. Even if you have issues or if you have minor issues, you continue doing the housework. You somehow manage as you think you'll get better." Sunita's steady dedication extends beyond immediate family members. In describing her husband's response to her own sickness, she emphasises, "When I had gotten sick, my husband knew, but the main thing was that my mother-in-law was also sick. She was his mother. A man thinks that his mother's health is a priority instead of his wife. She was also getting sick a lot, so we had to run to the doctors. My husband would have to do the same for me. Now, how much can a person do alone?" The complexity of Sunita's situation increases as she describes the challenges she faced while undergoing TB treatments at her parent's place when her children were young thus, having to visit her husband's home often to care for them. These testimonies collectively highlight the profound care married women extend towards their family's health concerns, often at the expense of their own well-being.

4.5 Family support in health

Family support emerges as a crucial and pervasive theme in the participants' narratives, depicting the versatile role of family members in shaping the health experiences of the participants. This theme not only highlights the assistance provided during health-related situations but also points out the profound impact on mental well-being, especially when absent. From emotional, financial and practical assistance, family shapes and supports the participant's health journeys and well-being.

In this context, family encompasses a broad spectrum, including parents, siblings, extended family, adult children, and both the participant's and their husband's

family and relatives. As gender roles and marital relationship is another prominent theme, that has been discussed separately above.

4.5.1 Maternal support and sharing health concerns

Participants consistently turn to their families, especially their mothers, for advice and support in various health-related circumstances. For instance, Polly, facing financial constraints during childbirth, sought help from her mother and sister, emphasising the significance of familial assistance during critical moments in a woman's life. She emphasises, "I called my mother and sisters who came and took me to a large nursing home. My mother also stayed back for around 10 days and helped me after the delivery." Soni B and Sushma, like Polly, rely on maternal guidance for health issues that exceed their husband's and in-law's support. Sushma expresses, "I told my mother about this. I first told my mother-in-law who said it's (eyesight issues) probably due to weakness. Rupa, whose late abusive husband and mother-in-law provided no health support to her, relied on her parent's support for medical aid and after suffering a miscarriage, she asked her husband to drop her to her mother's house. Like several other participants, Rajkumari also echoes this reliance, she recalls, "if I had a lot of issues, then my parents took care of me. My maternal grandmother would call me and take care of me too". Then I called my mother, and she got me checked and treated". Thus, the influence of a mother in a married woman's well-being, particularly concerning reproductive matters, appears significant.

Similarly, Dharamsheela, facing eye issues, turned to her parents for support when seeking treatment in the city, finding it challenging while residing with her husband and in-laws. Explaining her decision to stay at her parents' house, she notes, "Here I would have to manage everything by myself, but at my parents' home, there would be some help. My children were also young. So, we decided that I will take them and stay at my parents' home for a bit." Sunita, who received support from her parents for health treatment and recovered at their home, highlights the contrast between a parents' and in-laws' home for a woman. She articulates, "I went there as my mother is there, and my sister-in-law is there. The in-laws' house is, after all, is the in-law's house. You cannot get as much rest and care as you can at your parents' home. If you don't do something at your parents' house, then it will do, but at your in-laws' house, you have to do it under any cost. This is the truth for everyone."

For Rekha, her family collectively addresses her health issues. Collective decisions regarding her eye operations were made by her parents, brother, and husband. Similarly, Sunita's significant health concerns are managed by her parents, brother, and husband. Reflecting on her family's support, she notes, "I don't think that if we

had more money, then my health would be better taken care of...For my TB (Tuberculosis) treatment, my husband paid, and my brother and father also helped out. I think my family takes care of me. They are there if I get ill."

4.5.2 Alternate family support in absence of husband's support

Participants facing a lack of spousal support in health matters, turn to other family members to manage their health concerns. Rajkumari, unsupported by her husband, found solace in her mother-in-law's care and support. She says, "my mother-in-law used to take care of everything. When I told her I am not well, then she took me to get checked." With her in-laws and parents deceased, she says, "who will I tell about my situation now?". Highlighting the significance of family in a woman's health, Rajia, a single mother facing stress due to lack of family support, expresses, "Who else will I talk to? My parents are dead, and I have brothers, but they all have money, so they don't want to have any relationship with me…nobody helps."

Moreover, Rupa, in an abusive marriage, leaned on her cousin and aunt for health-related aid, especially when her husband and his family were non supportive, exhibiting the crucial role played by extended family in times of distress. Regarding her abuse she expresses, "his mother also used to hit me. Both the mother and son used to beat me together". She adds, "nobody in the family helped with even a penny…That's why I don't even ask". Rupa instead relied on her cousin and aunt's support in instances her husband did not provide support and dismissed her health concerns. She explains, "My cousin sister took care of me day and night and took me to the doctors… She used her own money for my treatments… She helped me. I called for her." Recalling an instance when she was sick and her husband refused to help her, she describes the crucial role her aunt provided in getting her to a doctor by arguing and fighting with her husband. She explains, "My aunt used to fight and say, 'you think she is faking her illness?' She used to cuss at him. Then I would be able to go to the doctors. Otherwise, he wouldn't let me go".

Mala, who avoids seeking support from her husband amid marital issues arising from his disapproval of her working, chooses to share her health concerns with her adult children, particularly her young daughters. She explains, "I don't tell my husband about any health issues. My children are there, so I instead tell them." Soni B., despite having a supportive family regarding her health conditions, recognises the challenges faced by other women. She notes, "if someone's family doesn't support them, they probably don't go to the doctor, or maybe they figure out a way without their family knowing…some people also don't have money. These are the key issues women face when it comes to not getting proper medical care."

4.5.3 Financial assistance

Financial assistance from family members is a recurrent theme, with Soni B. highlighting her brother's immediate support in times of need. She says, "I call him if I need help, and he comes to give me the cash himself". Dharma also received financial support from her nephews, who couldn't be there physically to help her during her eye treatments. Rekha actively seeks financial aid for health from her parents, emphasising, "They help, and I don't have to pay them back; it's not a loan but help." Additionally, Sunita relies on relatives for financial support in health concerns, stating, "Now if we have any financial issues, we ask someone for money. Someone would lend us money. I have a lot of relatives in Banaras."

While participants acknowledge familial support through finances, some, like Usha, refrain from seeking financial aid due to awareness of family members' financial struggles who are all informal labourers. Usha, a widow instead receives support from her daughter and son-in-law. She says, "my daughter who is married helps. Her husband has a business…so they help out. …My daughter and son-in-law call and ask if I need anything." Such examples portray the delicate balance participants navigate in seeking support.

4.5.4 Everyday health matters

Participants share instances where family members actively contribute to managing daily health challenges. Dharma's nephews play a vital role in suggesting healthcare options to her. She says, "once people (family members) know that I am not improving then they suggest another doctor/hospital to us, and we go there". Furthermore, when ill, her husband and children support her by doing household chores. For everyday health matters, Sushma relies on her mother, and sister-in- law's advice. She says, "my sister is law is like a friend to me". The interconnectedness of family is evident in Nutan, Rekha, and Soni D.'s experiences who receive support from their children and/or extended family members to manage daily health challenges. Nutan speaks of her close-knit family, saying, "when I am in pain, all the family members that are home stay around me". She also receives health care support from her daughter-in-law during migraine attacks. Regarding her family's support for everyday health matters, Rekha notes, "Whatever I say, they listen to me. If I say that I am sick, then they all pay attention to my problem. My daughters will say, 'Let's go to get checked,' and my husband also says that he will come along. Additionally, Soni D., who lives in a joint family and suffers from leg pain due to heavy workload, says, "my sister-in law does all the housework. When she is not around then I have to wake up even earlier to work". Apart from her sister-in-law supporting daily household tasks,

her daughter and husband also help with chores so that Soni's leg pain doesn't aggravate.

4.5.5 Encouragement for independent decision making

Family members also serve as motivators for independent health related decision-making and taking proactive actions. Polly and Dharma recall instances where family members encouraged seeking medical help during pregnancies and eye-related issues, respectively. Recalling the time when she was pregnant with her first child and unaware, Polly says, "I told my sister-in-law, who didn't live with us but told me to go to the doctor over a phone call". Dharma also emphasises the role of her mother-in law in encouraging her to get treatment when she was feeling dejected due to the cost of the ineffective eye treatments she was undergoing. She remarks, "she (mother-in-law) said that I am young and have my whole life in front of me, so I should get better…she said that I must continue with the treatment." Sunita discusses her health concerns with her sisters and sister-in-law, and the women encourage each other to get checked if anyone is feeling ill. Soni B.'s family also prompts her to prioritise her health, emphasising the familial role in promoting individual well-being. Sharing their stance, she says, "when my children or husband figure out that I am sick, they ask me to get checked by the doctor and get medicines." Similarly, Dharamsheela mentions, "I tell them (family) that I am not feeling well, and they ask me if it's a big problem, and if so, then I should get checked and get some medicines. They say that if I am not well, then who will do all the work?"

4.5.6 Cultural appropriateness in healthcare support

A few participants also emphasised the importance of culturally appropriate healthcare support, as exemplified by Sushma's experience. After her accident, Sushma's in-laws arranged for a doctor to visit their home in the village. She explains, "we (women) are not allowed to go outside the house, so my family took me home, and the doctor came to our house to treat me." This aligns with cultural norms that restrict women's movement, ensuring the provision of care within the familial space.

Similarly, Mala, who relies on her children for healthcare assistance, emphasises that her children insist on accompanying her to the doctor's office. She states, "Any one of my sons accompanies me; whoever is free comes with me. All my children care for me in that way. I don't go anywhere alone... Everyone at home becomes upset if I go anywhere alone. My sons get angry. They say either take one of us or go with Rani or Kajal (the daughters), but don't go anywhere alone. They care for me, thinking that if I am alone and face some issues, then what will I do by myself?" This

dynamic reflects the family's commitment to safeguarding Mala's well-being, resonating with the cultural norms that prioritise sheltering women and limiting women's autonomy in independent movement to safekeep them.

4.6 Communal support and solidarity in health

Extending beyond immediate family or relatives, communal support and solidarity are shown to play a crucial role in shaping the participants' health experiences.

4.6.1 Health support from other females

Firstly, the larger community serves as a financial safety net during health crises, especially female employers. For instance, Polly seeks financial assistance from the community during significant expenses, such as health-related costs. Reflecting on the time when she was delivering her child, she mentions, "we didn't have enough money even though we had borrowed a little money from family and friends." Rupa, engaged in domestic work, recalls receiving aid from her employers during illness, stating, "if I got pains, then the aunties (employers) used to help by giving me medicines."

In times of affliction, community members also contribute to household tasks, fostering a sense of shared responsibility. Rupa describes that when she was suffering from Chikungunya, she couldn't do any housework and "if someone came to visit me then they cooked something for us before leaving".

On the other hand, reflecting on the lack of support from her community, Rajia, who had previously received medical assistance from her female employer, laments the current state of affairs. She shares, "these days Muslims are under a lot of scrutiny … we don't even get work. See, I have resorted to wearing *Bichiya* (toe rings Hindu married women wear), and I also colour my feet (symbol of marriage for Hindu women) … the people we work for usually don't help as they think we are lying to them…She (employer) is from my caste. She is rich. What is the use of those who cannot even help when someone is in need?". Faced with limited assistance, Rajia expresses her reluctance to seek help from neighbours, fearing ridicule.

4.6.2 Leveraging long-term connections and building trust

More importantly, participants leverage their social environments to build enduring relationships and trust within the community, especially with doctors to ensure ongoing support for their health needs. Polly, for instance, actively cultivates relationships with both doctors and community members. Polly emphasises reciprocity, providing assistance and expecting support when needed. She describes her approach

with a female doctor, "She lives alone, and I have done a lot for her. That's why she treats me as her own family. She calls me when she needs any help. She has back pain, so I give her massages. This way both her and I stay happy. Even if I need help at night, she comes over." Furthermore, she practices the "pay it forward" principle by keeping a stock of medicines at home, available for anyone in the community. She explains her approach by saying, "that's why in my house, we keep all medicines. If anyone needs medicine, we give it to them. I'll also get better and so will they." Similarly, Rekha's health management strategy is linked to her community. Seeking financial assistance from her neighbours, she participates in a network where members lend each other money for immediate health needs. Describing the communal exchange, she expresses, "we lend each other money. If I have money, then I lend it immediately if anyone needs it so that they can get checked asap. People usually ask for money due to medical reasons. …We think that it's good to help other people. There is nothing greater than helping people". This cooperative approach to health expenses highlights the role of community bonds in navigating healthcare challenges.

Similarly, Soni B and Kausalya establish rapport with doctors, enabling flexible payment arrangements for health services in times of need. Soni B explains her relationship with a long-known doctor, "sometimes, even when I don't have money, I go to the doctor. Since he has known me a long time, he allows me to pay him later. If I go to a new doctor, then they wouldn't treat me without me paying first." Kausalya, relying on her established connections, echoes the same statement, highlighting, "If I don't have money, then the doctors that have known us for some time, allow us to pay them later sometimes too." Rupa emphasises the special treatment she receives from a certain doctor who provides medicines to her without immediate payment as she only visits his mother, a doctor, and him for any health support. Regarding her relationship with the doctor she says, "if he comes to know that I am sick and haven't received treatment then he scolds me like a family member, saying, "do I ever ask you for money? Come and get checked. What will happen if you die? Who will look after the children? You can pay me later". Dharamsheela, financially strained after spending on her family's health issues recounts, "at the BHU hospital a doctor told us to go to a specific place for effective treatment…we had already spent so much money. But when we went to the new place, we received medicines for free". These doctors express a deep understanding of the participants' financial constraints, depicting a community-based healthcare support system that prioritises long-term relationships over immediate financial transactions.

4.7 Maternal aspirations and sacrifices

The thematic analysis reveals a crucial and touching exploration of maternal aspirations and sacrifices, a theme which was evident across all participants with children. This overarching theme comprises of several interconnected sub-themes, each underlined by the participants' profound commitment to prioritising their children's well-being over their own personal health.

4.7.1 Financial prioritisation for children's needs

The participants consistently navigate the delicate balance of financial constraints while prioritising their children's needs. Dharma, grappling with eyesight issues, constantly worried about the money they were having to spend on her treatments, articulates the financial dilemma, stating, "We have 4 children. Their educational expenses could become an issue. I was also not earning, so where would the money come from?" Rupa, currently unemployed has avoided getting medical tests to diagnose her condition for years, mostly due to fear around the treatment of costs echoes similar sentiments, revealing the difficult choices mothers face concerning medical expenses and providing for their children, "What will a poor person do? Should I get treatment or feed my children?" Nutan further emphasises the financial considerations, explaining her mindset for refusing medical treatment, "If I save it (money), then it can be used for something else. I tell my children that even if I get really sick and cannot speak, don't sell anything of ours to cover my medical bills." In alignment with this prevailing sentiment, Soni B mentions her unwavering commitment to prioritising her children's well-being over her health. She says, "With the money, I take care of my children... I think about my children. I don't think about myself."

Dharamsheela, having invested 3-4 lakh rupees (approximately 3300-4400 EUR) in her son's health and still repaying the loan from her family, articulates, "I don't think about my health. What can I do? Should I think about myself or my children first? Things will continue like this. If my children are healthy and well, then I will be well." This sentiment resonates across participants, with Polly highlighting the daily contemplation of raising and educating her daughter, candidly expressing, "how to raise my children, educate my daughter... these are the things I think about every day. I think truly little about my health—nothing about my own health. I think about giving a better life to my children and wish them to have a happy life." Similarly, Sunita places her children as her top priority, expressing, "I think about my children, that they grow up well, study and become independent. These are my aspirations. What will we think about us? I worry about my children. What will I think about myself? I have children, so I think about them; they should be able to lead a good life." Rajia,

who faces high stress, similarly mentions, “I have been looking for a job for the last 1 year…My children had to endure hunger…Where will I take my 3 children and go?” These reflections capture the selfless dedication of mothers who navigate life’s hardships with a resolute commitment to their children’s happiness and prosperity, even sacrificing their health in the process.

4.7.2 Workload and its impact on health

The participants, predominantly working women, grapple with the dual challenge of managing heavy workloads to meet households needs and their health. Their dedication reflects the intertwining of personal aspirations and responsibilities to provide for their children and secure a better future for them. Divya, suffering from leg pain due to weakness, emphasises the necessity of work, stating, “How will we take care of all the expenses if I don’t work? We have three children, and we are educating them too. So, we have to manage everything... how can I leave work?”. Soni D. stresses the unavoidable nature of work, even when it exacerbates her health issues, “Whenever my workload is heavy, the leg pain increases... but I am obligated to work. We have to raise our children, take care of them and educate them. So, it’s necessary to work.”. She also adds, “I want to go for walks, but I don’t get enough time”. Dharamsheela, employed as a farm labourer, shoulders a strenuous workload both in the fields and at home, where she caters to her children and in-laws. Since she engages in tasks that involve frequent bending, she faces constant backaches. Addressing the necessity to work, she laments, “but I am a poor person, and if I don't work, then how will I eat?” Expressing the inevitability of her labour-induced back pain, she contends, “I have to do work, and I know it will end up in back pain, so what will I do thinking about what I could do to avoid the pain? I have to do this work. If I don’t do this work, then my children will not be taken care of. I do this work out of necessity. Otherwise, I would have taken care of myself.”

Similarly, Sushma, who moved to the city to provide better opportunities to her children, suffering from leg pain due to heavy work duties states, “I only think about my children, I don’t do anything to take care of my health on a daily basis…in front of the children, who thinks about their own health?”. In the context of shouldering a demanding workload, Polly asserts, “Until I get a house built and my daughter married, I’ll keep working. I’ll work until my body works. The day my body gives, they will have to bring money.”

Additionally, a few participants convey the challenge posed by their demanding work routines that hinder their ability to prioritise personal health. Sushma’s recognition of her busy schedule exemplifies this struggle. She states, “I have no time to get my legs checked... but if my children have any health issues, then I take a holi-

day for them." This highlights the delicate balance navigated by the participants between professional commitments and familial obligations, often at the expense of their own well-being.

4.7.3 Linking personal health to family well-being

Some participants recognise the symbiotic relationship between their personal health and the well-being of their families. Dharma clarifies this perspective, stating, "If I am healthy, then my children will be healthy, as I will be able to take care of them." Savita, too, emphasising the role of personal health in fulfilling familial obligations, states, "If I am not well, then I will not be able to care for my children and other family members... so it's important that I am healthy.". Soni D. echoes this sentiment as well, stating, "I think that if I am healthy, then my children will be taken care of, and my whole family will be better off."

4.7.4 Mental stress concerning daughter's marriage

The mental stress surrounding daughters' marriage arises as a significant aspect of the participants' health experiences, particularly their mental health. Rupa articulates her concerns, stating, "Somehow, I am saving a little money so that I can get my daughter married... I am hoping that I don't have to ask anyone for money… these are the issues I am tensed about." Rajkumari expresses the weight of financial responsibilities tied to her daughter's marriage, "I would borrow and loan money from others and somehow get her married. My mind remains occupied with such thoughts. What can I do?". Polly, who grapples with physical health issues amidst the strain of mental stress, speaks of her anxieties around her daughter's future. She reveals, "I have dreams about my daughter... I'll get her married when she is 20. So, for the next 5-6 years, I'll invest in her education. Once she is married off, then she won't be my responsibility anymore. If she is able to earn money... she wouldn't have to ask her husband for money. These are the things I think about."

Mala grapples with mental stress as she attempts to arrange marriages for her two daughters. Working as domestic helpers alongside her daughters to save funds for their marriages, Mala frets over the uncertainty of the future. She reflects, "for how much longer we will earn?... How long will I be alive? No one knows how much time anyone has...They need to be married. So, I am tensed about how I will get them married. I need to save money for that, but if all the money gets used up in household expenses, then how will I be able to save? It costs a lot to get a daughter married...everything is so expensive these days." Despite the financial challenges, she finds solace in the belief that "They will get married. If God has given them life, then they will get married sometime." Similarly, Rajia faces high stress levels arising from the burden of

repaying a high-interest loan taken for her daughter's marriage. Expressing her tension, she reveals, "I have tension since I have taken a loan to get my daughter married. These are the reasons for why we are very tensed and disturbed." She adds, "I think that if I were able to return the loan, then my tension would go away."

4.7.5 Supporting adult children and financial stress

Participants supporting adult children further navigate continued financial stress while prioritising their family's well-being. Rajkumari, who is overworked and doesn't have anyone to share her health concerns with supports her widowed daughters and grandson. She expresses, "What can I do? I have to think about the children and take them along too. So, I am always tensed." Nutan, focused on providing a better life for her children and grandchildren, emphasises her dedication, "I was able to get both my children married by managing household expenses…We now live in our own house. I saved every penny due to which I was able to achieve all this. So, I am always thinking of saving money. We want better things for our children. I have worked hard to educate my children."

4.8 Navigating knowledge gaps, cultural beliefs, and adapting actions

Several participants highlight the challenges they face due to cultural practices and gaps in health-related knowledge that stem from them. Simultaneously, women also adapt their actions by drawing on cultural and traditional resources to address their health issues. Thus, an interplay between cultural norms, knowledge gaps and adaptive actions that shape the participants' health experience emerges.

4.8.1 Impact of child marriage

Though the legal age of marriage for women in India is 18, the average marriage age of 16 for the participants shows to have had significant impacts on their health. Early marriages, with participants marrying as young as 12, contribute to health complications. Polly, who became a mother at 14, tells her experience, "I was 14 when I had my older son. And when my older son was 2, I got pregnant with my younger son. And soon after my younger son was born, I became pregnant with my daughter. I was married young and became a mother at an early age, due to which I had many complications. I had my menses for the first time and then I got married. I had my menses once more and became pregnant. So how would I understand what was happening?" Rajkumari, married at 12, links her lack of knowledge to the early onset of childbirth,

resulting in health issues and the loss of an infant child. She says, "when I was married, I didn't know anything. I had children when I was a child myself, so I got ill due to that. My oldest child died due to stomach-ache as an infant. I was so young myself; I didn't have much knowledge about things". Describing the toll of her demanding workload on her health, Dharamsheela reveals, "my back aches a lot. I have had the issues for the past 10-12 years. I had children at an early age. Somehow, I had to make do.".

The pressure for bearing sons, deeply rooted in tradition, adds another layer to the health challenges. Rajkumari, emphasising the cultural emphasis on sons, reveals, "several daughters were born while we were trying for a son. People in those days wanted heirs, and you need to have sons for that."

Poverty also exacerbates the issues, with Rupa highlighting how economic constraints drive child marriages in her community. She notes, "poor parents started looking for a groom for their daughters as soon as they get their menses. They think that she has become a woman, and they want to get rid of the daughter as soon as possible." Reflecting on the financial hardships resulting from her early marriage, Rajia, whose 23-year-elder husband left her without a divorce, shares, "my in-laws had their own house but later on they sold everything and used up the money. When I asked them for money, they said they don't have anything. They didn't even give me my rightful portion of the property. I was a child when I got married".

4.8.2 Sheltering women

Traditional practices of sheltering women also contribute to women's limited awareness, even in daily activities like walking and, result in, at times, accidents. Sushma's injury due to a falling roof tile she believes is linked to the traditional confinement of women indoors. She notes, "in the village, we (women) are not usually allowed to go outside the house. So, when I was walking, I didn't take notice of the loose roof tile." Rupa, sharing similar sentiments pointing towards the importance of independence in women's movement "whoever stays inside the house is hesitant, they don't become confident. When they go out, they forget the route." Rupa who sought assistance from her parents during health concerns also adds that as she has been accompanying her mother around town since a young age, she can visit her parent's place without anyone's assistance.

4.8.3 Culturally sensitive adaptive strategies

Participants also highlight the lack of community wide knowledge and taboo surrounding sexual and reproductive health issues. Polly recounts her experience, "my mother-in-law didn't understand what was happening with me (when she was sick

while pregnant). My parents also didn't tell me anything. we didn't know anything about sanitary napkins, so we used cotton rags instead." Cultural hesitancy to discuss reproductive health with parents is evident, as Polly explains, "when I got my first period, I didn't tell my mother. We are shy. We don't share such information with our parents."

However, the participants demonstrate adaptive strategies within their cultural context. Polly seeks advice from friends to compensate for the lack of SRH knowledge and communication with her parents. She says "I told my friend about it (her menses). She told me that I wasn't hurt and what I had to do". She further exemplifies the use of cultural communication patters around SRH issues. By informing her friend about her menses, she says, her parents also became aware of it. She explains, "my friend told her mother about it who then told my mother". Another example is of Dharma, who actively involves her supportive mother-in-law in healthcare decisions, emphasising, "we have to tell everything to my mother-in-law and seek her approval. She is our elder… our guardian." Additionally, Polly opts for more economically friendly traditional health facilities during childbirth, relying on midwives for home deliveries.

4.8.4 Knowledge about healthcare industry

Several participants shared insights into their knowledge about the healthcare industry, such as on subsidised healthcare support, and government healthcare programs influencing their decisions in managing their health effectively.

Polly, for instance, actively seeks out doctors who offer discounted services and free medications to individuals from economically weaker sections. Emphasising the financial relief provided by such practitioners, she notes, "the CT scan is also expensive. It costs 5000 (approximately 55 EUR), but the doctor said he would only charge 1500 (approximately 16.5 EUR) from us." Highlighting the kindness of these healthcare providers, she adds, "they have never taken even a rupee from us. Not just us, they don't take money from any patient. They also give us 1-2 medicines for free."

Similarly, Soni D. opts for clinics over hospitals, leveraging the discounted checkups and medications available there for minor health issues. Explaining her choice, she states, "if we have any little problem, like headache or fever, or a cold or cough, then they give us medicines for just 50-60 rupees (50 Cents)." Usha, on the other hand, relies on the local ASHA (Accredited Social Health Activist) worker for healthcare support, stating, "once the pain increased then I told Sushma Aunty. She is an ASHA *didi* (sister), so she took me to get checked, and I got an ultrasound done."

Moreover, participants like Kausalya and Polly demonstrate awareness of government healthcare schemes, strategically availing available resources. Polly describes her attitude, saying, "if there are all these government facilities available, then why shouldn't I avail them? I will save money that way." Kausalya too seeks information

about the government's smart health cards and acknowledges the lack of information dissemination in her community.

Notably, both Polly and Kausalya display caution against potential healthcare industry exploitation. Polly explicitly states her aversion to quacks, emphasising the financial burden they impose on vulnerable poor individuals: "I don't go to quacks. You know, poor people make 5 rupees, and the quacks will give medicines worth 500. People don't get better with the medicine, and the quacks keep asking them to return. In 1-2 days, people end up paying 2000-3000 (approximately 20-30 EUR)." Kausalya, while expressing her desire to obtain a government smart health card, voices her scepticism due to potential scams: "these days there are lots of scams going on too. If someone tells us about it over the phone, then where will we go to get it made?"

5 DISCUSSION

The discussion chapter explores the existing academic literature, collating it with the findings from this study to offer a nuanced understanding of health agency among working-class marginalised women in Varanasi, India. By doing so, it aims to expand the conventional notion of women's health agency to better reflect the realities of women in the Global South. Through this analysis, it becomes evident that the conventional, often Western-centric perspectives on agency fall short in capturing the complexities of how women from the Global South, particularly those belonging to lower socio-economic strata navigate their health agency. Additionally, the chapter investigates possibilities for broadening the definition of health agency by connecting it to women's well-being, providing valuable insights for future research in the area.

5.1 Unravelling the link: health agency and women's health outcomes

Sen (1999), Kabeer (1999), and other experts argue that women's increased agency leads to improved well-being and societal advancements. Davis et al. (2014) also suggest that increased agency enhances women's quality of life and generates better health outcomes. However, contrary to these premises, the findings of this research do not support such direct correlations. While women's agency is undoubtedly crucial, it is apparent from this study that other determinants, in particularly economic distress, play a significant role in shaping women's health outcomes. This partly aligns with the view of Donald et al. (2020), who highlight how women's ability to define and act on their healthcare choices is contingent upon the resources that are available to them.

In this study, a nuance was noted here too. Although women were able to articulate their health goals, their ability to act on them was largely constrained by having

limited economic resources. While having more resources certainly may afford them greater healthcare choices, it does not negate or replace the health agency that they exercise in other manners within their existing constraints.

In the first theme explored in this study, namely 'Health Attitudes from Women's Perspective,' participants clearly indicated a close link between their Definition of Health (first sub-theme) and their ability to work and contribute to family welfare. Moreover, as can be seen in the second sub-theme, 'Prioritising Health and its Challenges', while some participants demonstrated proactive behaviour in seeking medical care and adhering to medical treatments, others faced significant challenges due to economic constraints, especially those with chronic or serious health issues requiring prolonged and costly treatments. Thus, as participants disclosed in the third sub-theme, this financial strain often led them to 'Curing Rather than Preventing Health Issues'.

It is therefore important to note that the majority of participants, who were predominantly low-income informal workers, emphasised the necessity of working to support their families financially. Consequently, the study's findings revealed a disconnection between women's desire for improved health and their actual health outcomes, despite having higher levels of agency (if applying the commonly utilised indicators for agency such as increased mobility and earning an income). On the contrary, participants intentionally prioritised work while ignoring their health concerns, even against the wishes of family members, such as spouses, who recognised the detrimental effects of excessive work on their well-being.

This also then prompts us to question whether the current conversation on women's agency, particularly regarding their health, is failing to fully comprehend their agency. By predominantly emphasising 'increasing' empowerment and agency through lone avenues like income generation, rather than considering other factors that might have a more significant impact on women's agency and well-being, it may inadvertently be damaging their overall welfare, including their health agency. Therefore, it is essential to engage in a discussion that explores both whether participants were exercising health agency, and what forms that agency took or how were they manifested. This nuanced approach is necessary to bolster these finding and contribute to the scholarly literature on the subject.

In terms of their health, it was evident that participants in this study tended to prioritise it lower on their list of priorities. Nonetheless, as detailed in the subsequent sections, women demonstrated various forms of health agency. It is crucial to highlight a significant point mentioned earlier, which expands upon this perspective. The study's findings reveal that women's definition of their health was intricately linked to their family's well-being. When women perceive their health in relation to their family welfare, their health values and objectives accordingly differ. Therefore, in line

with the definition of women's agency proposed by Sen (1999), which involves their ability to identify goals, make choices, and act on them, their health agency would inherently manifest differently, often being along a family-centric trajectory.

5.2 Factors shaping women's health agency

Sen (1999) proposes that women's agency is influenced by factors such as education and economic independence. However, Drydyk (2013) challenges this view and states that literacy alone may not empower women, as family dynamics and cultural norms can offset its effect. Similarly, Bloom et al. (2001) discover in their research that women's autonomy significantly affects their utilisation of maternal health care, sometimes more so than their educational levels and other determinants. This suggests a complex, two-way relationship between these variables. Hanmer and Klugman (2016) further stress the importance of not presuming a direct correlation between changes in assets and changes in women's agency, as is commonly assumed in agency measurement models.

For the participants in this study, as observed in theme one, their 'Definition of Health' was closely linked to their capacity to work, which enabled them to earn income, maintain mobility, engage in physical activity, and socialise. However, the findings neither confirm nor suggest that their agency was low because of their limited education levels. In reality, their definition of health differed (as mentioned earlier), and their expressions of agency varied (as will be elaborated upon below), indicating that their health agency was subject to a distinct set of factors, such as their difference in values.

In Kabeer's (1999) empowerment process, she outlines three dimensions influencing women's decision-making: resources, agency, and achievement. Among these, resources like social capital are identified by her as providing helpful conditions for women to enhance their agency. Furthermore, inspired by Martha Rogers, the theory of health empowerment, (as cited in Shearer, 2009), also explores the interconnectedness of human beings with their environment and how it shapes their health experiences.

In Bloom et al.'s (2001) study conducted in Varanasi, women who had stronger ties with their families, particularly with their birth families were found to display greater autonomy. Additionally, women often participated in decision-making processes jointly with their families, particularly their husbands. These findings strongly confirm the outcomes of the current study. For instance, theme four 'Family Support in Health' highlights the significant reliance participants have on their families, particularly female members such as mothers, sisters, and sisters-in-law, for various

health-related support, such as sharing health concerns, obtaining financial assistance, discussing everyday health matters, and seeking support in the absence of spousal support. Furthermore, sub-theme six 'Encouragement for Independent Decision-Making' illustrates how family members actively encourage women to prioritise their health, make independent health-related decisions, and take better care of themselves. Moreover, it was also revealed that family members offer healthcare support in culturally appropriate ways.

These findings not only align with Kabeer's (1999) empowerment process and Bloom et al.'s (2001) findings but also reveal the existing gaps in understanding the lives and experiences of women in the Global South, including how they exercise their agency and the factors that influence it. Raj (2020) further emphasises the lack of information on choice and context, which is responsible for the limited insight into women's agency. It can be argued, and added therefore, for example, that disregarding or dismissing cultural and communal approaches to healthcare seeking and support as backward, and instead focusing on eliminating such practices, may have adverse effects on women's health and their ability to exercise agency in matters of health.

These findings are consistent with various other studies focusing on South Asia, such as Raman et al.'s (2016) research in India and Mumtaz and Salway's work in Pakistan. As emphasised by them, understanding women's roles within the interconnected society of South Asia is crucial. The third theme in this study, 'Gender Roles and Marital Relationships,' illustrates how women engage in joint decision-making with their husbands regarding their health. Participants revealed the assistance and support they received from their spouses, highlighting how gender roles within marital relationships influence their overall health and well-being. For instance, participants expressed a strong desire for their husbands to actively manage and support their health concerns. It is however important to note that participants did not relinquish control of their health to their husbands but rather expressed their health-related preferences and sought emotional and practical support to achieve their health goals jointly.

Another crucial point to consider is that participants who lacked spousal support, as described in sub-theme three, 'Women Facing Mental Stress Due to Husband's Lack of Support' under theme three 'Gender Roles and Marital Relationship,' experienced significant mental strain and difficulty in pursuing their health goals independently. While in conventional Western terms, the measures they undertook to manage their health might be viewed as exercising a higher level of health agency, the reality for these participants was one of extensive difficulty and mental stress. This portrays the significance of considering the overall lives of women instead of focusing on their individual acts in isolation.

Similarly, research from South Asia and Africa, as highlighted by Raman et al. (2016), indicates that participatory involvement positively affects women's health, with women generally preferring collective decision-making and activities over individual acts. Mitroi et al. (2016) stress the significance of contextualising empowerment appropriately within cultural frameworks, advocating for the establishment of women's communication networks and the integration of local cultural practices. The findings of this study, as illustrated in theme five, 'Communal Support and Solidarity in Health,' also demonstrate the significant role of communal support in women's pursuit of health goals and values through the formation of connections and trust. It is important to note that the community not only serves as a facilitator or resource for achieving health goals but also nurtures a deep sense of shared responsibility and co-operation, particularly among women. Participants lacking such networks expressed feelings of suffering and isolation, especially those without spouses and family support.

Therefore, merely emphasising women's 'independence' and 'autonomy,' as emphasised by contemporary agency researchers, without acknowledging the significant familial and societal ties and roles women willingly embrace and utilise for their well-being, may have inadvertent consequences. Additionally, the findings of this research indicate the strong bonds among women that they leverage to achieve their health goals. This area also ought to be investigated further to advance women's health agency in the context of the Global South. As observed in the findings of this study, particularly in theme six, 'Maternal Aspiration and Sacrifices, under sub-theme three, 'Linking Personal Health to Family Well-Being,' theme three, 'Gender Roles and Marital Relationship,' and theme four, 'Family Support in Health,' participants derive satisfaction and fulfilment in life through activities such as ensuring their children's education and marriage, taking charge of their family's health concerns and wellbeing, and making collective decisions with their spouses and families.

5.3 Advancing upon women's gender interests and health agency

Similarly, to probe deeper into the gender interests of women, let's undertake another exploration to further expand upon the concept of women's health agency within the framework of this study. Sen (1999) suggests that women's practical needs and strategic gender interests differ; while practical needs relate to well-being, strategic gender interests fall under agency. Although this study does not delve into this distinction extensively, it was observed among the participants that their family's well-being which they link to their health, as discussed earlier, aligns with their gender interests.

In other words, in this study's findings, it is evident that the participants' strategic gender interests were not primarily focused on their health agency in a manner that distinguishes between their health goals and the well-being of their families, especially their children. As outlined in theme 6, 'Maternal Aspirations and Sacrifices', and sub-theme 4, 'Managing Household Health & Prioritising Family Well-Being' under theme 4 on 'Gender Roles and Marital Relationship', women's strategic gender interests were deeply intertwined with their roles as mothers and family caretakers, and although not discussed here, this stretched beyond their health concerns to encompass their life's purpose overall. Participants with children noted their willingness to prioritise their children's future over their own health, viewing their children's well-being as inseparable from their own.

As Sen (1999) states, women's strategic gender interests are closely tied to agency, it is essential to examine how South Asian women perceive themselves and what they value to truly ascertain their gender interests. This is crucial because, as many experts have pointed out, neglecting to listen to women's voices allows Western perspectives to dominate the discourse, shaping the perceptions of what women desire. Building on this, as mentioned earlier, if women align their gender interests with their family, their methods of exercising agency would naturally involve those familial aspects. As detailed in previous sections, this pattern was strongly evident in the study's findings.

While discussing cooperative conflict Sen (1999) argues that women often fail to recognise the extent of their deprivation, due to unfair patterns of behaviour, resulting in unfair divisions within families that disadvantage them compared to men. Bina Aggrawal (1995) (as cited in Gammage et al., 2016) provides a nuance here shedding light on how social norms can simultaneously constrain and enable women. In terms of women's agency, the decision not to dissent can often be an adaptive strategy, as the consequences of rebellion may outweigh the benefits. This perspective is supported by the work of Raisborough and Bhatti (2007), who highlight women's strategic negotiation and repositioning of gender norms as a means to achieve their goals. Similarly, Donald et al. (2020) emphasise the importance of observing women's negotiations and power contestations during bargaining to fully grasp their agency. Consequently, as Day et al. (2010) assert, it is faulty to view women's strategies and exercising of agency as mere 'reproductions' or 'resistance' to oppressive gender norms.

As demonstrated in this study's findings, while participants did not overtly express numerous experiences of conflicts at home regarding achieving their health goals, negotiations were apparent in various themes that reflect the shifting power dynamics within which women's negotiations and agency could be observed. For example, in theme 2, 'Self-Directed Health Management', sub-theme 4, 'Navigating Health Autonomy: Defying Expectations,' women demonstrate negotiation strategies within their contexts, such as via making excuses, ignoring arguments, or standing

adamant on their decisions. Similarly, in theme 7, 'Navigating Knowledge Gaps, Cultural Beliefs, and Adapting Actions,' participants highlight several cultural practices that are detrimental to their health, while under sub-theme 3, 'Culturally Sensitive Adaptive Strategies,' they explicitly disclose how they adapt their actions to align with cultural practices while addressing health issues. Moreover, the reliance on spouses and family members for health support is evident throughout the study, for instance illustrated in sub-theme 2, 'Couples Making Joint Health Decisions,' of theme 3, 'Gender Roles and Marital Relationship,' where various means via which participants engage with their spouses to pursue their health objectives are described.

Hence, there remains an opportunity to dwell deeper into two aspects. Firstly, exploring how women's strategic gender interests are intricately linked to their family's well-being, which they view in lieu of and often prioritise over their own health and overall well-being. Secondly, by further divulging into discussions on the negotiation and bargaining tactics employed by South Asian women to attain their health objectives, while repositioning gender norms, we can capture the nuances of their health agency instead of omitting or viewing women as not having any agency. Such an approach ensures that supportive social norms and cultural elements within women's societies are not weakened in the quest for 'empowerment.'

5.4 Exploring women's agency beyond neoliberalism

While not explored within the confines of this thesis due to space limitations, it is important to note, as is already extensively discussed in academia, that regressive social norms aid in shaping women's psyche which result in potentially perpetuating their low health along with other disempowering issues. However, as highlighted earlier, it is crucial to recognise that not all social norms hinder women's agency. On the contrary, one might argue, as briefly mentioned in section 5.1 above that the predominant neoliberal Western emphasis on 'empowering' women to integrate into the economy could inadvertently coerce women to alter their mindset, potentially leading to their exploitation as cheap labour resources, which in turn could have detrimental effects on their health.

As Wrenn (2014) argues, neoliberal agency may involve a superficial exercise of power aimed at sustaining the profit-driven capitalist global system. The findings of this study, particularly under theme one 'Health Attitudes from Women's Perspective', clearly indicate the plight of participants, many of whom engage in physically demanding labour for low income. Their heavy workloads, both within and outside their homes, take a toll on their health, yet they continue to meet the needs of their families (prioritising their family's well-being which is intricately linked to their

health agency). It could be argued that by exceeding the threshold of 'healthy' work, as suggested by the findings, that help them acquire benefits such as income, physical activity, social interaction, and mobility—all positive factors that contribute to expanding their agency, they instead enter a negative space where their health is compromised due to their heavy workload and responsibilities.

Although not investigated in this thesis, social, economic, demographic, and geographic pain disparities have been widely examined in literature. These disparities often outweigh other determinants of health, such as the availability and quality of healthcare services, in terms of their significance.

On the other hand, Kabeer (2008) conceptualises women's agency as encompassing consciousness, voice, and action, whether exercised individually or collectively. As previously discussed in section 5.2, the roles and values of women differ within the interconnected society of South Asia. Additionally, Raman et al. (2016) highlight the emerging viewpoint on the significance of utilising Self-Help Groups (SHGs) in India to improve women's health outcomes, presenting a culturally apt approach. As observed in the findings of this study across themes three (Gender Roles and Marital Relationships), four (Family Support in Health), and five (Communal Support and Solidarity), women heavily rely on engaging with their spouses, families, and communal networks to make health-related decisions and attain their health goals.

Moreover, within their primarily economically constrained environments, participants in this study were observed to express their health agency through various other avenues. In theme two,' Self-Directed Health Management', it was observed how women assume responsibility for their day-to-day health independently through traditional practices, home remedies, dietary habits, and lifestyle adjustments.

This stresses the importance of comprehending and broadening women's agency within their contexts, which includes the structural limitations and available choices. Moreover, an untoward Western weight on inculcating 'independence' solely through income generation, particularly through physically demanding low paying jobs can pose significant risks to women's well-being. Ultimately, it is crucial to outline women's gender interests within their unique contexts and correlate these interests with their agency and well-being to ensure that women are not disproportionally burdened in the pursuit of 'empowerment.'

5.5 Connecting women's health agency to well-being

As discussed thus far, the issue doesn't seem to lie with the definition of agency itself, but rather with the Western emphasis on independence, which often overlooks the diverse health goals and values of women across different contexts. Drydyk (2013)

suggests the importance of distinguishing between women's agency and their well-being, as empowerment is conceptually linked to the latter, while agency alone cannot capture it. As already discussed above in section 5.1, the findings of this study uphold this view, revealing that women's agency does not necessarily correlate with improved health outcomes. For instance, in sub-theme four 'Navigating Health Autonomy: Defying Expectations' under theme two on 'Self-Directed Health Management', participants demonstrated a tendency to neglect their health, even resisting medical advice and familial recommendations, pleas and anger, despite potential consequences on their health.

As discussed earlier, the participants in this study display a strong connection between their health agency and the well-being of their families, in association to which they place their own well-being. This linkage, (among other possible factors not covered in this study), contributes to why their health agency cannot be exclusively tied to their personal health outcomes. Drydyk (2013) highlights that not all actions individuals take are solely directed towards their own well-being. While it's crucial to differentiate between agency and well-being, as experts point out, it's equally important to recognise the interplay between them, as the results of this study point towards. This understanding can help explain the underpinnings behind why women exercise their health agency in certain ways, even if it may not directly benefit their individual health outcomes.

Hanmer and Klugman (2016) emphasise that women's agency is influenced by their individual attributes, local contexts, and intrinsic factors, which should be prioritised in conceptualising and measuring it. Mannell et al. (2016) advocate for considering women's personal interpretations of their actions and lives, as well as their constraints, in potential interventions aimed at enhancing agency and improving well-being, aligning with the inductive approach adopted in this study's methodology. Moreover, Tengland (2007) emphasises the importance of viewing women's health empowerment as both a process and a goal. Approaching it as a process necessitates experts to forgo authority and control, as women's decision-making and action-taking become central to the process instead.

Raj (2020) furthermore highlights the challenge in measuring agency, ascribing it to the complexity of factors involved in the empowerment process, including the social norms, resources, and assets that are merely counted as a threat or aid to women. Unlike these factors, agency actually requires accepting women's choices and decisions, even when they may not align with desired health outcomes, making it difficult to fully grasp (ibid).

Campbell and Mannell (2016) furthermore raise concerns about the assumption that all agency leads to women's well-being, highlighting cases where agency can worsen issues such as intimate partner violence, as observed in some cultures. This

resonates with narratives from a few women interviewed in this study, demonstrated in theme two on 'Self-Directed Health Management', sub-theme five on 'Health-Conscious Adjustments in Daily Life'. For instance, one participant's exercise of health agency within an abusive context resulted in further mental and physical abuse by her husband and mother-in-law.

Therefore, if the objective of measuring and enhancing women's health agency is to improve their wellbeing, it becomes essential to define their health goals, values, and gender interests, which vary across contexts and may be interlinked. Furthermore, it is important to address the structural constraints that hinder women from prioritising their health. In this context, elements of the theory of health empowerment, influenced by Martha Roger, become relevant, as it emphasises the promotion of personal and social-contextual resources to enhance overall well-being and achieve health-related goals (Shearer, 2009)

In such a manner, it becomes feasible not only to discern how women exercise health agency and improve measurement, but also to progress further and establish connections between women's health agency and their well-being in interventions using culturally and contextually appropriate approaches. If agency is deemed and proved to be significant and regarded as a means for women to increase their well-being, disregarding women's voices, values, and contexts while imposing ideals of agency clearly constitutes a flawed approach.

6 CONCLUSION

The women in this study, navigating lives that are rife with socio-economic challenges, particularly economic difficulties, demonstrate various ways and strategies in which they exercise their health agency within their familial and societal structures. The participants displayed strategic decision-making to acquire their health goals and they often employed negotiation tactics and culturally appropriate methods, and leveraged their familial, spousal, and social networks too. Their health agency to achieve their health goals reflected a collective, communal form of autonomy, with consciousness, actions, and voices rooted in collective family well-being rather than Western individual interests.

Furthermore, these women's practical well-being related interests and gender interests were both inherently found to be intertwined with that of their families, shaping their health-related values and goals. While the manners in which they exercised their health agency were found to be placed within their individual circumstance and available resources. This finding contributes to Sen's (1999) 'capability approach' and Kabeer's (1999) empowerment process by illustrating that while women's practical needs regarding their well-being may differ from their agency, which is linked to their gender interests, there appears to be a stronger correlation between them in certain cultures, such as within interconnected South Asian society. This broader perspective allows for an investigation of the numerous influences on women's agency that are shaped by the various elements that women prioritise and value, which are moulded by their culture and circumstances.

As a result, this study discovered non-conventional, rather non-western-centric, manifestations of women's health agency. Identification of these manifestations are necessary for understanding women's lives and informing interventions in the Global South. Importantly, women's health agency was significantly dependent (both as an enabler and constraint in the absence of) upon their family and social networks, particularly spouses and female relatives. This conclusion supports the theory of health

empowerment and extends the literature on household bargaining by Aggrawal (1995) and Raisborough and Bhatti (2007) by expanding upon the many ways in which women in interconnected societies with entrenched gender roles engage in their health decisions. Thus, this study adds to the literature on the various manifestations of women's health agency while also exposing facets that may have gone unnoticed.

Moreover, the study found that increased health agency did not consistently lead to improved health outcomes in the women, since their values, goals and gender interests were different. This finding aligns with and confirms Tengland's (2007) perspective that women's well-being and empowerment should be regarded as a primary goal of health promotion. Empowerment including aspects of welfare, health, and quality of life, makes health empowerment both an objective and a process, necessitating experts to forgo their control (Drydyk, 2013). Therefore, there is a need for addressing the issues that are detrimental to women's health, such as inadequate healthcare services, alongside increasing efforts to link women's health agency with overall well-being via methods they themselves deem as supportive and empowering. This study revealed several of those methods, thus enriching the literature on the topic of improving women's well-being via their health agency.

Furthermore, the findings of this study also contribute to the literature on agency indicators, as discussed by experts such as Drydyk (2013), as it ascertains that a narrow focus on conventional agency indicators like income generation and education may inadvertently suppress agency enablers within certain societies, especially in closely-knit and interdependent communities. It is crucial to recognise that numerous other factors, such as their unique values, influence women's health agency in the Global South, that may have a greater impact on women's health outcomes and overall well-being. Neglecting those factors in measurement, policy and interventions could prove detrimental to women. Instead, recognizing and addressing diverse enabling and constraining factors to women's health agency in the Global South is essential for designing effective policies and interventions. Otherwise, there remains a major risk of further isolating women and worsening the negative impact on their health.

However, it is important to note, that the findings do not challenge or undermine the importance of income generation programs or education. While they indeed contribute to enhancing women's agency and well-being, as income generation was found to in this study, the findings besides that also stress the significance of the relationship between context and resources in shaping women's agency. It is thus important to note that health agency, while significant, is just one component with the potential to enhance women's well-being. Furthermore, dismissing women's agency from certain cultures, communities and societal strata based on Western notions would therefore be both false and detrimental to their health, preserving neoliberal agendas that exploit women's labour. Most importantly, by demonstrating the detrimental effects of

heavy workloads on women's health, this study's findings support the literature regarding the influence of neoliberalism on women's health, as demonstrated by Wrenn (2014), and its potential impact on shaping women's health agency.

Some of the potential research ideas that particularly arise from the findings of this thesis are also important to note. Kabeer (1999) for instance provides insights into diverse forms of agency, suggesting the need for further research to better understand women's health agency, its determinants, manifestations, and how it can be measured and fostered. Exploring these aspects within different contexts and intersecting groups can clarify the nuanced dynamic of women's health agency. Such investigations can also help recognise additional culturally appropriate approaches to improve women's health agency that are considerate of their context, priorities, choices, and circumstances. Else, the imposed models may actually undermine their supportive family and social structures that are necessary for their well-being and health agency.

Further research which examines the negotiation and bargaining tactics used by women across different contexts to achieve their health goals is also needed, as this can help detect the nuances of agency manifestation. Understanding the underlying processes of these manifestations is also vital, not only for strengthening agency measurement but also for guaranteeing its sustainability over time. As social norms and power dynamics continuously evolve, consideration of the power structures and women's negotiation processes can inform policy and interventions. Therefore, longitudinal studies that are able to track changes and variations in women's health agency over time and their subsequent impact on their health outcomes can offer helpful insights into the dynamic nature of agency within different contexts. This can ultimately help improve the alignment between women's health agency and their overall well-being.

As contextual factors are found to play a key role in shaping women's health agency, research is also needed to investigate specific contextual factors within various demographics, such as cultural norms and access to particular resources. For instance, collective decision-making with spouse and seeking support from other women arose as significant aspects in this study, stressing the importance of identifying and strengthening such aspects to enhance women's agency and wellbeing.

Intersectionality too remains crucial in understanding women's health agency, as factors such as gender, age, class, caste, and ethnicity intersect to influence agency manifestations due to the distinct availability of choices women have under different circumstances. Further qualitative research that captures women's lived experiences and narratives from diverse backgrounds can provide crucial insights into the enabling and constraining factors of health agency. For instance, although not discussed but noted in this study, understanding the unique circumstances of single mothers and widows can provide key insights into adapting interventions to meet their needs.

A nuanced approach to identifying challenges and constraints on women's agency is also critical. Therefore, future research has to also move beyond mere identification to contextualising these constraints within women's realities in manners that connect it to their wellbeing. For instance, recognising the sacrifices mothers make for their children's well-being stresses the interconnected nature of a mother's agency and the well-being of her children. This fact can be help inform interventions to improve women's health agency and outcomes in apt ways, for example, via incorporating the wellbeing of their children in policies and interventions.

Furthermore, as community-based approaches show promise for supporting women's health agency, particularly in interconnected communities like India, future research on the topic is necessary. Moreover, research should focus on developing and evaluating culturally and gender-sensitive policies and programs that are meant to empower women and improve their health outcomes as it can help design effective strategies tailored to local contexts. For instance, exploring the role of mothers and mothers-in-law in affecting married women's health agency can be a critical area for further study.

By reanalysing interventions and tailoring them to align with cultural values, contextual circumstances and available choices, for different demographics, we can enable women in the Global South and promote their health and well-being. Ultimately, studying women's health agency in varied contexts and exploring the intricacies of its manifestations is crucial for supporting women and promoting positive health outcomes for them.

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APPENDICES

APPENDIX 1: INFORMATION AND CONSENT FORM

Information for participants in research

JYVÄSKYLÄN YLIOPISTO

Dear Participant,

This study is conducted by Shalvi Sinha, a student pursuing a master's degree in social sciences from the University of Jyväskylä, Finland.

The purpose of my study is to conduct research for my master's thesis which is on exploring women's health agency in Varanasi, U.P. I would like to ask you to participate in my study because this study aims to gain insights into the perspectives of women, such as yourself, regarding your health, as well as your experiences, circumstances, needs, and challenges in relation to your health agency. I intend to interview approximately 15 to 20 women as part of my research.

Voluntariness and the rights of research subjects

Participating in this study is completely voluntary. You can refuse to participate in interviews, withdraw your consent or cancel your participation in this study. You do not have to tell me why you do not want to participate. This will have no negative consequences to you.

Information about the study

I will interview you at your place of work at am/pm on xx.xx.xx.
I would like to know about your perspectives regarding your health, as well as your experiences, circumstances, needs, and challenges in relation to your health agency. The interview will take between 30 to 45 mins. I will record our interview if you give me your permission to do so.

Protection of personal data

- I will ask data regarding your name, age, marital status, education level, work, health, husband, no. of children, household income, ethnicity, religion,

Research results

The content of this study will be released in scientific publications to share new information. This research topic will also be discussed in presentations and during lectures.

Data archiving

Your responses may be archived anonymously and permanently in the Finnish Social Science Data Archive for later research if you give me your permission to do so. As a result, your responses could be used by other researchers, and for learning and teaching purposes.

Rights of research subjects

You can ask me anything about this study before, during or after the interview. You have the right to access any data you have given me and have it rectified. In addition, you can tell me if you do not want your data to be processed.

I will ask you to sign a consent form before our interview or you can give me verbal consent that I will record.

The form is on the last page of this file.

Consent form

I have been asked to take part in a study [Women's Health Agency in Varanasi, Uttar Pradesh.

I have understood the information given above as Shalvi has read aloud the information to me. I have received sufficient information about the study. Shalvi has also talked to me about the study and responded to all my questions about it.

I understand that participating in this study is voluntary. I have the right, at any time during the study, to cancel my participation in the study. I do not need to give any reasons for cancelling my participation. Cancelling my participation will not result in any negative consequences for me.

☑ Yes, I will participate in the study.

Date

Verbal Consent Given

Signature of the research subject

Name in print

Signature of the researcher

Name in print

APPENDIX 2: QUESTIONNAIRE AND INTERVIEW GUIDE

Section 1: English Questionnaire (translated from Hindi)

a. Name
b. Age
c. Are you able to read and write?
d. How many years of education have you received?
e. Do you work outside of your home? If yes, what type of work do you do?
f. What is your marital status?
g. At what age were you married?
h. Does your husband work? If yes, what is his occupation?
i. How old is your husband?
j. How many years of education did your husband receive?
k. How many children do you have?
l. What is the age of your youngest child?
m. Aside from your husband and children, how many people live in your household? Can you tell me who they are?
n. How many individuals earn in your household?
o. What is the total household income?
p. What is your caste?
q. What is your religion?
r. Location/area of residence

Section II: Interview Guide (translated from Hindi)

Conceptualisation of health and health goals:

1. What does 'health' mean to you? What is a healthy state for you?
2. How important is your health to you? What do you do to stay healthy in your daily life?

Aspiration-Can-Act:

3. Have you had any health issues in the past or do you currently experience any health concerns? If yes, could you please provide details about those health issues?
4. Could you share more about the steps you took and how you managed your health during that period of illness? Questions to help inquire further (use as/if required):

a. Do you share your health issues, consult or seek advice from anyone when making decisions related to your health?
b. What actions did you take to address your health concerns? Tell me in detail.

c. Who or what resources (people/organisation/mindset) assisted you during that time, and in what ways?
d. Did you encounter any challenges or obstacles while trying to manage your health issue? If yes, could you tell me more about those challenges?
e. Regarding their health-related action- Do you have to ask someone or seek anyone's approval to do this? What do you do when you cannot do as you wanted due to so and so/such and such thing?

Tip: Take note of the actions and challenges they faced to ask follow-up questions.

Consequence-Resist:

5. What happened when you took that action/step/decision regarding your health? (negative or positive consequences) (What did you do next? How did you solve it? Why did you take that step/make that decision?)

Additional questions to assess potential backlash in the form of punishment (such as violence and alienation) or control (such as hinderance in mobility to prevent future action) (use as/if required):

a. Did you face any negative consequences when you did that/made that decision? If yes, could you provide more details on what you did to manage that (how you managed or coped with those consequences)?
b. Were there any attempts to restrict or control your mobility or actions to prevent you from taking similar actions in the future? If so, how did you handle that?
c. In cases where your opinions or preferences differed from those of the household head or others, what did you do? How did you express your views? Did you engage in discussions, arguments, or negotiations? How did you reconcile the differing opinions and decide on a course of action?

6. Is there any additional information or experiences you would like to share that may be relevant to our discussion or research topic?

Tip: Repeat vital information and take note of any changes in their definition/importance of health, etc.

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[i] The Indian caste system comprises of more than 3000 castes and sub-castes, and it is rooted in the concept of lineage or kinship, with each caste traditionally associated with a specific occupation, although not all members necessarily practice it (Johnson & Johnson, n.d.). There is no nationwide ranking system for the approximately 3000 castes, and the class system exhibits a certain degree of mobility, allowing for economic advancement and movement within the hierarchy, albeit within traditional constraints (ibid). The caste system has traditionally established a hierarchy of social roles which are identified as inherent traits that remain steady throughout an individual's life (Sankaran et al., 2017). Within the broad categorisation of the caste system, the Brahmin caste which traditionally comprises of priests or scholars dominates the top position. Next in line come the Kshatriya caste or the warriors and kings, followed by the Vaishya caste which is associated with merchants, and 4th in line is the Shudra caste which comprises of labourers (ibid). In addition, at the bottom of the societal ladder sit

the outcastes who are known as '*Dalits*' or the 'untouchables,' engaged in occupations like rag picking, street sweeping, and latrine and manual sewage cleaning (ibid). Although they fall outside the formal caste system, they occupy the lowest societal tier (ibid).

[ii] The Indian Constitution, through affirmative action, includes provisions to address the socio-economic challenges faced by communities that experience acute backwardness due to historical practices like untouchability and issues such as ancient agricultural practices, lack of infrastructure, and geographical isolation (The National Commission of Scheduled Tribes, 2023). For this, the government of India has officially categorised the backward classes - 'untouchables' as Scheduled Castes (SC), indigenous tribes as Scheduled Tribes (ST), and other disadvantaged castes as Other Backward Castes (OBC) (Sankaran et al., 2017).