

Chapter 2

The Role of Premarital Agency in Delaying Marriage and Reproductive Decision Making in Urban India

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Introduction

This chapter focuses on young women's transitions to adulthood, marriage, and reproduction within a globalizing society in a low-income area of 700,000 people in Mumbai, India. Statistics at the national level reinforce the standard image of an India of early marriage, high fertility, low contraceptive use, low education, and widespread poverty. Nearly 50% of women in India, mostly from low-income families, marry below the legal age of 18. National-level data suggests that adolescent marriage is typically followed by early childbearing and limited birth spacing (International Institute for Population Sciences & International, 2007). Although the total fertility rate (TFR) has declined over the past two decades, the decline has been slower than predicted (International Institute for Population Sciences & International, 2007). Reversible contraceptive use remains limited by government programs that almost exclusively emphasize female sterilization (Brault, Schensul, Singh, Verma, & Jadhav, 2015; Connelly, 2009; Matthews, Padmadas, Hutter, McEachran, & Brown, 2009; Murthy, Ramachandar, Pelto, & Vasan, 2002; Srinivasan, 1995). Only 56% of all married women in India use any contraceptive method, and only 10% of women use a reversible method (IIPS NFHS, 2007). For those women who use sterilization, most undergo the operation before the age of 30.

The literature on young women in India frequently focuses on a stereotypical life course trajectory in which gender inequity and lack of agency are the dominant

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narratives. In this portrayal, young women in India experience gender inequity in the form of son preference and a low female-to-male ratio (Patel, 2007; Sen, 2003). The onset of menarche is often a surprise for adolescent girls as there is limited education and information prior to menstruation. The mobility restrictions that follow the onset of menstruation frequently include leaving school at an early age to remain in the home to support the natal family and learn to be a wife (Khanna, Goyal, & Bhawsar, 2005; Nair et al., 2012). Female adolescents must adapt to a family context in which there is high pressure to preserve virginity and the family's *izzat* (honor or reputation), and tension as the family seeks to arrange an appropriate marriage quickly (Bennett, 1983; Dharmalingam, 1994; Garg, Sharma, & Sahay, 2001; Jeffery & Jeffery, 2002; Khanna et al., 2005; Mishra & Mukhopadhyay, 2012). After marriage, many young women describe "first-night" stories of an inexperienced husband demanding sex from a naïve girl (Bloom, Tsui, Plotkin, & Bassett, 2000; Khan, Barge, Sadhwani, & Kale, 2005). The early years of marriage involve adaptation to a low-ranking role in the husband's family, building a relationship with a husband they barely know, dealing with overbearing in-laws, and the pressure to have sons (George, 2002; Kapadia-Kundu, Khale, Upadhye, & Chavan, 2007).

This stereotypical picture does not account for new opportunities for women in a globalized Indian economy in the realms of education, employment, and societal roles. High levels of inflation and an increasing cost of living in India, combined with national and international support for gender equity and female education, have placed greater emphasis on female literacy allowing women to take advantage of new employment opportunities (Ghosh, 2011; Luke, Munshi, & Rosenzweig, 2004; Nayar, Bhide, Drotner, & Livingstone, 2008). Economic constraints are also associated with changing living arrangements that are driving down fertility rates, as it is no longer feasible or practical to have large families living in the same household in India's increasingly expensive and cramped cities (Gupta, 2005; Niranjana, Nair, & Roy, 2005).

Globalization in India has also been characterized by increased access to technology and media. For young women, expanded access to media provides exposure to a variety of images of "modern" women from both Western and Bollywood films (Ghosh, 2011; V. Mishra, 2011). While Bollywood has long been popular, young women have increasing opportunities to fulfill desires to emulate these images with "skinny jeans" and cosmetics through a growing consumer culture and the spread of shopping malls (Ghosh, 2011; Mankekar, 2004). Young women are increasingly exposed to soap operas, television shows, and media messages that encourage gender equity, reduced family size, and contraceptive use (Brown, 1991; S. Kumar, 2010; Nema & Sharma, 2009). Expanded access to cell phones and Internet also provides adolescent girls with new ways to access information outside parental control (Chakraborty, 2010, 2012).

With an expanded range of options for life choices, young women have new opportunities to make decisions about their lives. An increasing number of relatively economically marginalized young women make decisions regarding their education or employment opportunities and take a more active role in the

arrangement of marriage (Fuller & Narasimhan, 2008; Jensen, 2012; Netting, 2010). Once married, many young women have positive sexual experiences, negotiate contraception, and have husbands and in-laws sensitive to their needs (Allendorf, 2013b; Barua, Pande, MacQuarrie, & Walia, 2004; Bojko et al., 2010; Char, Saavala, & Kulmala, 2010).

Although globalization has created a number of new opportunities for young women, the impact of globalization has been unevenly distributed, across both socioeconomic statuses and between urban and rural areas, contributing to variation in marital practices and reproductive health. In light of the rapid social change occurring in India, this chapter employs the life course approach and feminist perspectives to explore variation in young women's agency in their transitions from natal to marital families, and the impact of agency on the timing of marriage and reproductive health.

Feminist anthropological and sociological understandings of agency are central to understanding women not just as passive products of structural and cultural factors, but active participants in practices and decisions that affect their lives (Bourdieu, 1977; Frank, 2006; Ortner, 2001). Agency can be defined as a young woman's ability to make life choices, either through subverting or embracing norms, in a context where independent decision making is not always supported (Abu-Lughod, 1990, 2008; Kabeer, 1999). Understanding variable practices of agency can help in understanding those young women who follow traditional trajectories, as well as young women who do not.

The life course approach provides a framework to explore how precursors such as community and social norms, socialization, education, and familial and peer relationships can shape young adults' trajectories and outcomes (Clausen, 1991; LeVine, 2011; Weisner, 1997; Worthman, 2011). Within life course approaches, adolescence is viewed as a particularly critical stage in which adolescents develop agency and transition from the roles and responsibilities of childhood to those of adulthood (Shanahan, 2000). Of importance for this study, researchers have focused on cultural models of transitions to adulthood, which set culturally constructed paths to become an adult and obtain a "good life." However, researchers also note that periods of social change necessarily alter these cultural models. This study employs a life course perspective by attempting to understand young women's trajectories in the context of power differentials imposed by changing social contexts in which young women differentially gain or lose agency in their transitions from their natal to marital families. In this way, we explore how premarital factors as well as factors external to the marital dyad contribute to reproductive decision making for newly married young women.

Study Area and Methodology

Study Area

The research was conducted in an urban “slum” area in Mumbai, India, of approximately 700,000 people, consisting of Muslims (54%), Hindus (43%), and a small percentage of Buddhists and Christians. The majority of residents of the study area are long-term migrants with a mean time in Mumbai of 15 years (Schensul et al., 2009). Residents from the study area are primarily from Bihar, Uttar Pradesh, rural Maharashtra, Karnataka, and Tamil Nadu. The average household income in the area is 4500 INR per month (approximately \$75 USD per month). The study area contains small-scale factories (*zari* industry) that assemble piece goods into garments, bags, shoes, toys, and packaging. There are also scrap, steel polishing, and construction companies. Many men in the study area also work as truck, taxi, or auto-rickshaw (three-wheeled taxi) drivers. Rag-picking, or collecting scraps for resale from the garbage dumping ground, is also a common occupation, particularly for women in the study area.

Healthcare is provided in multiple locations in the study area. Government healthcare is provided through an urban health center (UHC) and three health posts distributed in different parts of the study area. This healthcare is free although there are out-of-pocket costs, such as transportation associated with it. The UHC has a variety of outpatient departments (OPDs) such as general male and female health, pediatric growth and development, antenatal care, immunizations, geriatrics, and sexual health (primarily STI/HIV testing and counseling), as well as a small laboratory and pharmacy. The health posts are satellite clinics that provide immunizations, basic infant and child growth monitoring, Direct Observable Treatment Service (DOTS) for tuberculosis, antimalarial medication, birth control pills and condoms, antenatal vitamins and care for pregnant women, and referrals as needed. Community health volunteers (CHVs) work out of the health posts and make door-to-door rounds to provide education and distribute many of the services available at the health posts.

Nongovernmental organizations (NGOs) also play a role in healthcare in the study area. NGOs provide targeted medical services, similar to the health posts, as well as education on a variety of health problems and reproductive health. NGOs also often refer women and children to more specialized healthcare services.

In terms of the household composition, most households are nuclear (47%), followed by joint households (37.1%), and households consisting of men only (15.8%). In the study area a nuclear household is one which consists of a married couple and their children. A joint family is one which consists of a married couple, their children, and the husband or wife’s family members. The average size of a home in the study area is one room, and the average number of people per household is 6.4, although there is evidence to suggest that average family size is decreasing concurrently with a decrease in fertility required by the limitations of space and income (Allendorf, 2013a; Niranjana et al., 2005; Schensul et al., 2009).

The Overall Study

The data presented here come from a larger study examining factors related to sexual and reproductive health outcomes of young women in low-income communities in Mumbai, India. Fieldwork was conducted over the course of 13 months between 2012 and 2015. The study employed a sequential explanatory research design (Creswell, 2013; Ivankova, Creswell, & Stick, 2006). In this design, the first study phase utilized qualitative methods for identification and discovery and to enhance the validity of quantitative instruments. The second, quantitative stage was used to test hypotheses concerning the relationships between key variables of interest.

Sampling

Married women in the age range of 15–25 were selected for both qualitative ($N = 68$) and quantitative ($N = 150$) samples. Separate samples were used for the qualitative and quantitative portions of the study, but the same sampling criteria were used for both phases of the research. A purposeful sampling approach was used. The parameters of the sampling frames for both interviews and the survey were age at marriage (over and under 18, the legal age at marriage) and religion (Hindu and Muslim). Subareas within the two communities were chosen based on relative socioeconomic status (i.e., equal numbers of more impoverished and less stable areas and less impoverished and more stable areas); however the variable of socioeconomic status was not a significant correlate of the variables examined for this chapter. Within subareas, CHVs, NGO workers, and community mobilizers were enlisted to discuss the study on their door-to-door rounds, and to refer interested and eligible participants. Such partnerships with community “gatekeepers” and community-based organizations are a common method of recruitment in low-income settings (Benoit, Jansson, Millar, & Phillips, 2005; Rashid, 2007, 2011). Women who participated in the study would often tell neighbors, female relatives, or friends about the study and refer them to us as well. In this way, samples for both the qualitative and quantitative portions of the study were obtained.

Data Collection

The first stage consisted of qualitative data collection including key informant interviews ($N = 25$) and in-depth interviews with married young women ($N = 68$). Interviews were conducted in Hindi and Marathi with the aid of a research assistant. The second stage consisted of quantitative data collection with a structured survey instrument administered to married young women ($N = 150$).

In this chapter, we focus on relationships between the following variables: premarital agency, age at marriage, marital communication, amount of time between marriage and first pregnancy, and postmarital gender equity norms. *Premarital agency* is a scale measuring a woman's decision-making power in their natal families before marriage. This scale was adapted from a female agency scale developed for married women in the study area (Kostick et al., 2010). Additional items specific to adolescents were added based on the in-depth qualitative interviews collected in the first stage of the research. The scale has 16 items and a Cronbach's alpha of .730. *Marital communication* is a scale developed for married women in the study area (Stephen L Schensul et al., 2009). The marital communication scale consists of 16 items and had a Cronbach's alpha of .805. The scale included items related to ease of marital communication on different topics such as household matters and feelings, and the extent to which the woman's husband helps with different household chores and work (cleaning, cooking, childcare, taking family members to the doctor). *Postmarital agency and gender norms* is a scale measuring a woman's beliefs concerning gender equity and postmarital decision making. Although neither this scale nor the study includes men's perspectives on gender equity, during the original development of the scale, men's opinions were elicited and used to develop specific items (Kostick et al., 2010; Kostick, Schensul, Singh, Pelto, & Saggurti, 2011). The scale combined items previously developed for women in the study area (Kostick et al., 2010; Kostick et al., 2011), and has 38 items and a Cronbach's alpha of .857. The other variables consisted of single questions. The survey was translated into Hindi and Marathi and administered with the aid of a research assistant.

Data Analysis

Interviews were audio recorded, translated, and transcribed in English. Codes and transcribed text were entered into Atlas.tiV6.2, a qualitative data analysis software (Murh, 2004). Codes were developed in this research utilizing a tree diagram method in which factors were embedded in domains, allowing analysis to occur at the domain and the factor level (S. L. Schensul, 1993). The coding scheme was deductively developed based on the domains in the research model and modified by the content of the key informant and in-depth interviews. Coding was conducted in multiple iterations to enable the emergence of novel themes. Text were coded and reviewed for patterns related to consistency, variation, and exemplary cases related to reproductive decision making.

Quantitative data were entered into SPSS 22.0 (SPSS, 2001). Descriptive statistics were obtained for continuous and categorical variables. To develop scales, we conducted factor and reliability analyses. To calculate each scale, means were taken of all items to be included. Cronbach's alpha was calculated to assess the reliability of the scale. Scale variables were all normally distributed, and did not require transformation. For the variables of interest in this study, simple univariate correlations and regressions were conducted.

The parent study from which the data for this chapter is drawn was funded by the National Science Foundation and received IRB approval (protocol H13-138) from the University of Connecticut. Written informed consent was obtained from all participants. For illiterate participants (17% of the sample who attended little or no school), the consent form was read to them and they provided a signature or marking indicating their comprehension and consent to participate.

Results

Demographics of the Sample

Table 2.1 provides key demographic characteristics of the sample and the descriptive statistics for the variables of interest. The average educational attainment is relatively low, with most girls receiving no secondary education, and leaving school early in adolescence. The majority of marriages continue to be arranged, although the number of love marriages has increased in recent years. Over half of the women in the sample lived in extended families with their husband and in-laws, but in keeping with trends towards smaller families in urban settings, many women in the sample lived in nuclear families. In terms of reproductive histories, pregnancy within the first year of marriage is the norm. The average number of pregnancies and living children is lower than national trends, but not all women in the sample had been pregnant or completed their families. The frequency of medically terminated

Table 2.1 Characteristics of the study sample ($N = 150$)

Variable	Frequency
Average age of participant (range)	21.7 (16–25)
Average educational attainment (range)	6.4 years (0–17)
Average premarital agency (range)	1.468 (1.000–1.938)
Average age at marriage (range)	17.85 years old (13–24)
Type of marriage	66% ($N = 99$) arranged 34% ($N = 51$) “love”
Average age at marriage (range)	17.85 years old (12–24)
Family type	53% ($N = 80$) extended 47% ($N = 70$) nuclear
Average marital communication score (range)	1.934 (1.19–2.75)
Average postmarital agency and gender norms (range)	1.428 (1.05–1.89)
Average age at first pregnancy (range)	18.6 years old (14–24)
Average amount of time between marriage and first pregnancy (range)	10.8 months (1–4 years)
Average number of pregnancies (range)	1.83 (0–6)
Average number of living children (range)	1.32 (0–4)
MTPs	13.3% ($N = 20$)
Miscarriages	13.3% ($N = 20$)

Table 2.2 Type of contraceptives used by women at the time of the study (*N* = 50)

Type of contraceptive	Percentage (%)
Sterilization	34
Condoms	26
Copper-T	16
Birth control pills	14
Hormonal contraceptive injections	8
Safe period	2
Total	100

pregnancies (MTPs or abortions) and miscarriages was relatively low among women in the sample. The low frequency of MTPs and miscarriages prevented us from conducting further analyses on the role of MTPs or miscarriages on fertility patterns.

Overall, contraceptive use in the sample was relatively low, with 39% (*N* = 59) of the participants having ever used contraceptives and 33% (*N* = 50) using contraceptives at the time of the study. Details on contraceptive use are provided in Table 2.2. Sterilization was the most prevalent form of contraceptive used, and the average age at sterilization was 21.7 years old. Condoms were commonly used, but other forms of reversible contraceptives were used less often.

Relationships between Premarital Agency and the Timing of Marriage

Qualitative and quantitative analyses revealed relationships between women’s experiences in their natal families and the timing of marriage. Premarital agency was significantly associated with age at marriage ($B = 3.177, R^2 = .122, p < .001$), indicating that as premarital agency increases, so does the age at marriage. Women who married as adolescents tended to have limited opportunities to make decisions for themselves before marriage, leaving decisions related to education, employment, mobility, socialization, and timing of their marriage to their parents or other family members. As one young Muslim woman stated, “In our religion, they don’t ask us if we want to get married. My mother and father were talking about my marriage, and so that’s how I knew about it.”

Women with more agency described how their natal families supported them to make decisions for themselves, particularly with respect to education, employment, and timing of marriage, and many women who delayed their marriage did so to pursue educational or employment opportunities. One young woman typical of this pattern was allowed to delay her marriage to complete her high school education, and was then allowed by her in-laws and husband to pursue a college degree. She explained,

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

Relationships between Timing of Marriage and Postmarital Factors

Age at marriage is associated with several postmarital factors. Age at marriage is positively and significantly associated with both marital communication ($B = .031$, $R^2 = .031$, $p < .05$) and postmarital gender equity ($B = .164$, $R^2 = .027$, $p > .05$). These positive relationships suggest that the older a woman is when she gets married, the more positive her marital communication is (suggesting more communication with her husband), and the more equitable her postmarital gender norms are.

An unexpected finding was that women who marry earlier delay their first pregnancy for longer periods than women who delay marriage. We found a negative correlation between age at marriage and amount of time between marriage and first pregnancy ($R = -.301$, $p < .001$). This suggests that although women who marry young tend to have limited agency before marriage they may not follow the traditional trajectory of early childbearing and limited reproductive decision making. At the same time, women who marry later tend to have greater natal family agency, but also to have their first pregnancy closer to the time of marriage.

Relationships Between the Timing of Marriage and Reproductive Decision Making

Early Marriage and Support to Delay the First Pregnancy

Several young women stated that they and their husband wanted some time to settle into their marital relationship before having a child. As a result, these couples would use condoms or birth control pills to avoid conceiving soon after marriage. Support from the husband and in-laws is a key factor for married adolescents delaying pregnancy. A number of participants stated that when they got married, their in-laws and husband viewed them as "too small" to take on the roles of a wife, including housework, cooking, and childbearing. These young women appreciated that their in-laws and husband took the responsibility of decision making out of their hands. As one woman stated, "I have my mother-in-law to take decisions, so it's not my headache to make any decisions." Women in this subgroup also had more family support for contraceptive use for spacing pregnancies and maintaining a smaller family size. One young woman stated, "I didn't know anything about contraceptives before marriage. After I delivered my first child, my in-laws told me to take some pills, so there

would be space before my next child. They said it wouldn't be good to have the next child so soon."

Due to their age at marriage, young women in this subgroup were not always expected to begin having intercourse with their husband immediately after marriage. These young women were allowed to ease into their new roles and did not have the traumatic forced sex experiences described by many women in their "first-night" stories. Other young women had husbands working outside of Mumbai or India, and did not immediately move in with their husband, instead remaining with their natal families after marriage.

Women also received support from their in-laws and husbands to access contraceptives. Many married adolescents stated that they knew little or nothing about contraceptives before marriage, but learned about them from their in-laws and/or husband. As a result of this support young women felt that they were more likely to use contraceptives to delay their first pregnancy. Many couples made the joint decision to use contraceptives (either birth control pills or condoms) to delay pregnancy until they and their families were more financially stable, reflecting increasing financial pressures in the urban setting. Women, husbands, and in-laws in this subgroup tended to have internalized media and national health campaigns supporting a smaller ideal family size (generally two to three children). They also did not express very strong gender preferences for their children, feeling that they could be happy with daughters or only one son. A sentiment expressed by one woman and shared by many others was, "Nowadays who expects more than two or three children? Because, you have to look after them, you have to educate them, you have to give them everything that they need. Nowadays, it's not possible to look after so many children."

The support women receive from family also makes them less susceptible to community gossip. Women stated that neighborhood speculation about their fertility or contraceptive use was less of a problem because they felt well supported by their husband and in-laws. One woman described feeling stress over neighborhood gossip about her lack of children, but that her husband had told her to disregard their neighbors. Although some women are marrying early, suggesting lack of agency and poor outcomes, the support provided by family enables them to delay pregnancies and access contraceptives.

Early Marriage and Early Childbearing

However, there is a subgroup of women who marry early and begin conceiving early, as evidenced by quantitative data suggesting that married adolescents have more pregnancies than those women who delay marriage (comparison of mean number of pregnancies between early and delayed marriage is significant, $p < .01$). After marriage, women in this subgroup typically receive less support from their husbands and have poorer intra-marital communication. Poor marital communication and support often limits women's ability to communicate with their husbands about family planning or their fertility preferences. For this subset, it is the

pronatalist husbands and in-laws who take control of fertility decisions, encouraging the young wife to conceive as soon as possible after marriage. These traditional views and limited agency, compounded by poor communication, contribute to these women having fewer options for delaying pregnancy. One 18-year-old participant stated that she wanted to wait 3 years before conceiving her first child, but her husband did not and she explained, "Whatever my husband says, that is what will happen. No one will listen to me. My husband is the one who will take the decision." Other young women described how their mothers-in-law would ask about their menstrual cycle, and scold them when they had not yet conceived.

For some Muslim couples, religious beliefs played a significant role in the choice to not use contraceptives. Many Muslims in the study area feel that contraceptive use is forbidden in Islam. Several women stated that they and/or their husband refused contraceptive use, because the timing and number of children were "up to God."

Community gossip is also a factor for women who are unable to use contraceptives or delay their first pregnancy. Several women reported that their neighbors would begin judging the young woman and/or her husband if they did not conceive immediately. One woman described feeling frustrated, as she knew little about contraceptives, but was accused by neighbors of "taking something" to prevent pregnancy. As she explained, "He [her husband] was working in Pune, and I am staying here. But, my neighbors and family members were saying all kinds of rubbish things, like I am taking contraceptives, and that's why I am not conceiving a child. So, when my husband came here, I got pregnant."

For the women who preferred to delay conception, an additional challenge is lack of knowledge about contraceptives. When asked if they would like to delay pregnancies, many women stated that they would, but did not know how to other than abstaining from sex. The lack of knowledge or support for contraceptive use leads many women in this subgroup to exceed their ideal family size and have multiple unwanted pregnancies. As a result, the qualitative data suggest that abortions and sterilization were more common among women in this subgroup. A few women had exceeded their ideal family size, and were unable to negotiate condom use with their husbands. The inability to prevent further pregnancies led these young women to seek sterilization or injectable hormonal contraceptives in secret, with the aid of a sympathetic female relative or NGO worker. These long-term contraceptives can be obtained without the knowledge of others, have relatively few side effects, and do not require follow-up visits. Thus, married adolescents who conceive soon after marriage are less likely to use contraceptives to delay or space pregnancies, and may only obtain long-term contraceptives after multiple unwanted pregnancies.

Delayed Marriage and Childbearing Soon After Marriage

For women who married at an older age, marriage often signaled the beginning of their family. As a result, many women did not plan or discuss the timing of the first pregnancy, and left it to chance. These women stated that they were not concerned

about the timing of the first pregnancy, which was why they did not actively seek contraceptives to delay their first pregnancy.

Having already dealt with the pressures surrounding delayed marriage, these women saw less need to further confront the issues associated with delaying pregnancy. However, pressure from family and community members also contributed to women in this subgroup conceiving sooner. Some young women who delay marriage marry into families with more traditional beliefs, and women who have already acted outside expected norms may feel additional pressure to conform to the wishes of their husband and in-laws. One participant who wanted to delay her first pregnancy so she could finish her coursework felt pressure from her mother-in-law to become pregnant. As a result, the woman discontinued birth control and attempted to conceive. As these women have already delayed marriage, they often feel that they cannot also delay childbearing.

Some women also deliberately timed their pregnancy to alleviate household tensions. As has been documented elsewhere (Moonzwe Davis et al., 2014), when a woman becomes pregnant her status typically increases. Several young women who moved in with their husband's family outside of Mumbai wanted to have a child soon after marriage, so they would have fewer disagreements with their in-laws. One woman stated that, "... my in-laws only accepted me after I became pregnant ... They thought because I am from Mumbai, I am too fashionable, and won't be able to adjust to them." A woman's first pregnancy/birth is also typically a time when she can return to her natal family and be relieved from regular household responsibilities, thus providing further incentive to become pregnant sooner rather than later.

The women in this subgroup had strong family size preferences. They commonly reported that having more than two children was financially impossible and irresponsible, and generally felt that their husband and in-laws were supportive of a small family. Although women who marry later are less likely to delay the first pregnancy or use contraceptives initially, qualitative findings suggest that they are able to make more fully informed decisions about their fertility and contraceptive use, and ultimately have better reproductive outcomes in terms of fewer overall and unplanned pregnancies.

Delayed Marriage and Delayed Childbearing

There are also a small number of women who marry later and also choose to delay their first pregnancy to pursue opportunities for work or school after marriage. Women who marry later have high levels of premarital agency, which persist as they tend to marry into families with equitable gender norms and continue to feel encouraged to make decisions for themselves. As one woman explained, "My husband has no problem at all, my mother-in-law has no problem at all. I am free to take my own decisions ... With my husband and my in-laws, I can communicate very freely." The higher levels of agency and support translate into more marital support to use contraceptives, with many husbands leaving the decision to their wives.

The women in this subgroup also have knowledge of contraceptives and desire to use them both to delay first pregnancy and to space pregnancies. As one woman explained:

"In the beginning, we [participant and husband] decided that we shouldn't have any children for at least 2 to 3 years. Because, if I conceive a child right away, it will be a problem for me to look after myself, my baby, the house, and my studies. So, I didn't want to have a child right away. Then, for 5 or 6 months, I thought about it and I took some pills in the beginning, so I wouldn't conceive a child."

Some young women take advantage of their positive marital relationships and confidence in decision making to obtain contraceptives and delay pregnancy after marriage to continue pursuing their academic or employment goals or to enable themselves time to adjust to marriage. The young women in this subgroup are relatively free of many of the social and familial expectations to prove fertility placed on the young women in other subgroups. These young women have the individual and social resources to firmly maintain their postmarital agency.

Discussion and Conclusions

India is undergoing a period of rapid economic and social change, especially with respect to roles and norms for women. These changes are impacting young women from economically marginal communities as they transition into adulthood. The data presented in this chapter describe the complex trajectories of young women transitioning to marriage and adulthood in low-income communities in Mumbai, India. Young women with the agency and support to make their decisions are increasingly choosing to delay marriage, but many girls continue to marry as adolescents. Women with greater agency who marry later make independent decisions regarding the timing of their first pregnancy and contraceptive use. Women with little premarital agency leave much of their reproductive decision making to their husband and in-laws.

The spectrum of choices made by women and their families argues against the overly simplistic stereotypes in which women with little agency have no voice in their fertility translating into poor outcomes, and women with more agency choose to actively plan their families through immediate contraceptive adoption. Rather, there is a need to explore intragroup variation to fully understand women's experiences and elaborate on their variable practices of agency (Abu-Lughod, 1990, 2008; Kabeer, 1999). The trajectories described here also suggest that characteristics of the marital relationship and reproductive decision making are shaped before marriage and by factors outside the marital dyad, requiring a life course perspective that is attentive to the impacts of social change (Clausen, 1991; Edmeades, Lee-Rife, & Malhotra, 2010; LeVine, 2011; Weisner, 1997).

Women with higher levels of premarital agency often come from families in which female decision making, education, and employment are valued and

encouraged. These young women are experiencing the benefits of international and national discourses on the rights of girls and women, which are providing a more supportive social environment for these girls and women to gain and exercise agency. Women with higher levels of agency can delay marriage until they are ready, and tend to marry husbands who have similar gender-equitable norms, as evidenced by their improved marital communication and support. These women draw on their individual and social resources to take advantage of national policies and programs that have promoted female literacy and education, a career orientation, and smaller family norms.

Girls who marry as adolescents have little agency, as their natal families constrain opportunities for independent decision making, leaving reproductive decisions in the hands of husbands and in-laws. However, life after marriage offers a variety of possibilities and adaptations for women entering marriage with little agency. Although these women may have little knowledge or desire to delay their first pregnancy or to have small families, some marry into families in which norms about small family size have been accepted. The acceptance of smaller families is largely an adaptation to rising costs and space limitations associated with life in Mumbai. In this way, low-income adolescents who would stereotypically have less access to contraceptives and less support for smaller families are nonetheless able to delay their first pregnancy by negotiating sex and using contraceptives due to the changing socioeconomic constraints placed on their families and communities.

Concurrently, many adolescents continue to marry into families with patriarchal norms dictating that women prove themselves to be “good” daughters-in-law and wives by producing children soon after marriage. Due to lack of knowledge of contraceptives and lack of support to delay pregnancy, these women become pregnant early in marriage and have higher fertility. These women also represent the uneven nature of globalization’s impacts. Their families neither support pro-gender equality development agendas nor attempt to adapt to the economic realities of “new India” which dictate smaller families. Often families constrain agency and education due to lack of resources. Early marriage is desired as a way to unburden the family of another mouth to feed as well as the stress associated with protecting a woman’s *izzat* (honor). For these young women with limited agency, international and national human rights policies and programs have not addressed the underlying social and economic inequities perpetuating early marriage and gender inequity (Rashid, 2011).

Although contraceptive use and fertility have often been tied directly to education and economic development, researchers are now arguing for a more nuanced understanding of the factors contributing to fertility decline in India as well as other South Asian countries (Bates, Maselko, & Schuler, 2007; Caldwell, 2000; Chaurasia, 2014; Edmeades et al., 2010; A. Kumar & Mohanty, 2011; Reed et al., 2016). Consistent with previous work, this study documents the uneven impacts of globalization on gender equity and female agency (Arora, 2012; Desai & Andrist, 2010), as well as the marital factors commonly associated with reproductive decision making (Chaurasia, 2014; Edmeades et al., 2010; Khanna, Sudha, & Rajan, 2009; Stephenson & Tsui, 2003). However, by incorporating both qualitative and quantitative data as well as a life course approach, this study provides new insights into how

premarital factors are being shaped by social change and impacting the timing of the first pregnancy. Given the dynamic marital and reproductive patterns described here, it will be important for healthcare providers and policy makers to adapt current family planning policies and programs to meet the changing needs and desires of women and their families in India.

Discussion Questions

1. How does this chapter conceptualize female agency? Do you agree or disagree with the authors' understanding of agency? Please explain your answer.
2. Globalization has been conceptualized in many different ways, but is largely seen as a process by which goods, people, and ideas move across national boundaries in a way that is both accelerated and unprecedented. Considering the data presented in this chapter, as well as in other readings, what are the ways in which globalization particularly impacts adolescent girls' socialization and health?
3. This study employs a mixed methods approach by integrating both qualitative and quantitative data. What are the benefits and challenges of this approach to understanding issues related to adolescent sexual and reproductive health?
4. Imagine that you have been asked to design new reproductive health programming for girls and women in urban India. What would your programming consist of? What would be your program goals and policy recommendations?

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