"Examining the Reproductive Autonomy of Women in Exercising Control over their Sexual and Reproductive Health (SRH) and Rights in Intimate Partner Relationships: A Study Conducted in the Thiruvananthapuram District of Kerala"

By

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Under the guidance of

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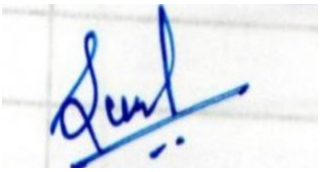
DECLARATION

I, Sai Devi S, hereby declare that this dissertation titled **"Examining the Reproductive Autonomy of Women in Exercising Control over their Sexual and Reproductive Health (SRH) and Rights in Intimate Partner Relationships: A Study Conducted in the Thiruvananthapuram District of Kerala"** is the outcome of my own study undertaken under the guidance of Dr. Sunayana Swain, Professor of Women's Studies, School of Gender Studies at Tata Institute of Social Sciences, Hyderabad. This dissertation has not previously formed the basis for the award of any degree, diploma or certificate of this Institute or any other Institute or any other Institutes or Universities. I have duly acknowledged all the sources used by me in the preparation of this dissertation.

May 11, 2021

Sai Devi S

B.A. in Social Sciences



CERTIFICATE

This is to certify the dissertation titled **"Examining the Reproductive Autonomy of Women in Exercising Control over their Sexual and Reproductive Health (SRH) and Rights in Intimate Partner Relationships: A Study Conducted in the Thiruvananthapuram District of Kerala"** is the record for original work done by Sai Devi S under my guidance and supervision. The results of this research presented in this dissertation have not been previously formed the basis for the award of any degree, diploma or certificate of this Institute or any other Institute and University.

May 11, 2021

Dr. Sunayana Swain,

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ABSTRACT

Women from across the globe encounter a multitude of barriers in autonomously defining and achieving their reproductive intentions. The lack of reproductive autonomy and agency is predominantly determined by gendered roles and relationships and then subsequently by other intersecting factors that directly and indirectly impact women's health, well-being, and quality of life. Such a compromised sense of reproductive autonomy in women also serves as a significant impediment in achieving larger development goals such as fertility reduction, gender equality, and comprehensive social inclusion. Despite the presence of a relevant body of literature that looks into these issues and the functioning of the reproductive rights of women across different regions of South Asia and in various other international settings, there remains a limited and selective sense of understanding on how precisely women's RA can be an extremely crucial factor in determining their control and freedom to exercise choices in intimate partner relationships. Therefore, this study understands and recognizes the lack of reproductive autonomy and integrity historically associated with female bodies and contextualizes it further against the current patriarchal setting of Indian Society. High levels of reproductive autonomy, according to this study, enable a woman to choose contraception, pregnancy, abortion, and childbirth without any external pressure from spouses, health care providers, the government, or any other religious doctrines and will also allow for active spousal communication in topics related to reproductive and sexual health. The study's findings reveal a nuanced picture of women's reproductive autonomy in exercising control over their sexual and reproductive health in intimate partner relationships. It had captured the extensive presence of reproductive coercion in married and unmarried women belonging to the reproductive cohort and how it violates women's autonomy and reduces them to mere objects of patriarchal power.

LIST OF TABLES

LIST OF ABBREVATIONS

DHS	Demographic Health Survey
IPV	Intimate Partner Violence
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
RA	Reproductive Autonomy
SRH	Sexual and Reproductive Health

CHAPTER 1

INTRODUCTION

"Reproductive Autonomy is cardinal to a whole range of issues. If we can't take charge of this most personal aspect of our lives, we can't take care of anything. It should not be seen as a privilege or as a benefit, but a fundamental human right."

- Faye Wattleton
(First African American President of Parenthood Federation of America, 1978)

1.1 Statement of Problem

Women from across the globe encounter a multitude of barriers in autonomously defining and achieving their reproductive intentions. The lack of reproductive autonomy and agency is predominantly determined by gendered roles and relationships and then subsequently by other intersecting factors that directly and indirectly impact women's health, well-being, and quality of their lives. Such a compromised sense of reproductive autonomy in women also serves as a significant impediment in achieving larger development goals such as fertility reduction, gender equality, and comprehensive social inclusion. Pregnancy, childbearing, and abortion are all processes that are incredibly intrinsic to the female bodies, the physical, emotional and mental consequences and implications of which are expected to be solely born by women and women alone by Society. This is precisely the reason why women should have an unhindered autonomy not only to take their sexual and reproductive health (SRH) decisions but also to carry them out without encountering any socio-cultural or economic barriers.

However, through the bio-essentialist paradigm, females were for the longest time seen as nothing beyond the total of their physiological construction. They were always perceived as the more biological beings, the more corporeal and the more natural ones, far more than men will ever be (Grosz 1994). The functions of women were restricted to being a mother and an incubator which were all defined entirely using her ability to procreate. Such a crude understanding of female bodies, devoid of the ideas of bodily integrity and autonomy, continues to dominate across the world, manifesting itself in various forms. Women are still not entirely in control of their

reproduction and continue to struggle to make informed, independent, and active choices related to their SRH. Recent medicalization of women's bodies, have made them the sites for regulation and control. The technology-driven bio-medical field has only further deprived women of their already shrunken agency by using the means of regressive medicine and technology.

A substantial analysis shows the alarming extent to which women's autonomy has been compromised in making uninfluenced decisions, having independent control over financial and economic resources, freedom in movement, and experience of abuse and violence. This has severely jeopardized the timely health-seeking behavior and timely care-seeking (Bloom, Wypji, & Gupta 2001; Jejeebhoy & Santhya, 2014; Leon, Lundgren, Sinai, Sinha & Jennings, 2014). The pedestalization of motherhood as the ultimate destiny of the female biography by the Indian Society place tremendous limitations on women when it comes to exercising active management over their SRH and rights, especially within the institution of traditional marriages. The situation is not any better for unmarried women either. With the pervasive stigmatization of pre-marital sex and pre-marital pregnancy, unmarried women in intimate partner relationships are in particular prone targets of systemic social injustice. They are predated, shackled, and infantilized by Society in a multitude of ways and are deprived of accessing social, logistical, economic, policy-related, and health services, including critical ones like safe abortion clinics, birth controls and methods of contraception.

Despite the presence of a relevant body of literature that looks into these issues and the functioning of the reproductive rights of women across different regions of South Asia and in various other international settings, there remains a limited and selective sense of understanding on how precisely women's RA can be an essential factor in efficiently analyzing the extent of freedom and control they have in exercising choices in intimate partner relationships. Therefore, this study understands and recognizes the problem of lack of reproductive autonomy and integrity historically associated with female bodies and contextualizes it further against the current patriarchal setting of Indian Society.

1.2 Defining Reproductive Autonomy (RA) in a Patriarchal Setting

In a highly patriarchal and gender stratified society like India, female bodies are often perceived as contested political landscapes that no longer belong to women but are just objects on which the patriarchal tensions are unleashed upon, and the fights for claiming power are legitimized. Such

precarious and exploitative treatment of women's bodies have forever negated the idea of autonomy or integrity and had pushed women out of crucial discussions pertaining to the fate of their reproduction, making them further susceptible to coercive practices such as sterilization, forced parenthood as well as abortions (in the form of feticide), and rampant denial of abortion, contraception and other services. Such regressive structures that enforce authority over women's bodies and their reproductive rights reveal the lack of active participation of women in decisions about their SRH, restricting their understanding of the actual female experience.

Since women's reproductive abilities like pregnancy and childbirth have always made room for their subjugation, the women's freedom movements have extensively striven to discard the biological essentialism and shift control exerted by men, husbands and fathers over female bodies back to women themselves, allowing them to take charge of their own body and make informed choices related to reproduction and fertility. In fact, it is with the advent of concepts such as abortion and contraception that women started to conceptualize themselves as women and not merely as potential mothers, departing from the conventionally assigned private spheres of life. However, there is still a clear shortage of discourse on the reproductive reality of women, partially because of the prevailing pronatalism borne out of the patriarchal structure that subjugates women to men and partly because of the hegemonic femininity (Bone, 2010).

For an effective conceptualization of Reproductive Autonomy in an unequal society like India, it is imperative to understand that a woman's capacity to fulfill her sexual and reproductive expectations is also heavily determined by many interacting societal, structural, and cultural factors. Therefore, after considering various factors, RA for the dissertation is defined as "having the power to control and decide about matters associated with contraceptive use, pregnancy, childbearing and freedom in spousal communication" (Updhayay, Dworkin, et al. 2014). Considerably higher levels of RA would then enable a woman to freely opt contraception, childbirth, and abortion without any external pressure from spouses, medical providers, any other religious doctrines, or even the government, and will also allow for active spousal communication in topics related to reproductive and sexual health.

1.3 Significance of the Study

Examining from both a health and human rights lens and as well as a demographic sense, India in the past couple of decades have exhibited very varied progress on women's autonomy to willfully decide how, when and whether to reproduce and take other crucial SRH related decisions (Hesini L, 2005). A mixture of factors, including the regressive social gender norms, political obstacles, constraints in accessing resources, and other systematic challenges, continue to withhold many women, especially in developing countries, from genuinely exercising their RA. A woman's autonomy status in each stage of reproduction is primarily derived from her social and power relations in the Society and several other intervening structural factors coupled with the barriers imposed by her gender identity. Married and unmarried women in India are in different capacities coerced into aligning with the societal expectations of becoming an "ideal woman," the consequence of which in most cases, if not all, is a severely reduced involvement in making important decisions about their sexual and reproductive health. Researches worldwide have found out how women in developing and under-developed countries continue to remain among the most disempowered groups with minimal control over major aspects of life like marriage, sex, contraceptive use, and pregnancy.

A study of young married women in India revealed that women revealed a strong wish to have delayed their first pregnancy. But among the ones with the demand, just very few had adopted any forms of birth control or contraception. The leading reasons described for non-usage of contraceptives despite their desire to delay the pregnancy included their husband's and family members' disapproval in doing so (Jejeebhoy, 2019; Santhya, 2017). In addition to this, almost one-fifth of women aged between the age group of 18-49 had given birth without going for proper hospital delivery. Again, the reasons were attributed to the demur from the spouses and their family members in doing so on a national scale (IIPS & ICF;2017).

Further, the family planning services in India also show a highly gendered nature when it comes to sterilization and contraceptive use in general. It is alarming that female-centric sterilization procedures are still the most extensively used method of family planning within Indian couples, with 36% opting for it between the age group of 18-49.

Male sterilization, on the other hand, even after being scientifically proven to have far less procedural and post-procedural complications, is an option that is considered by only 0.3% of

couples, according to the survey. The NFHS-5 reveals that the rates of female sterilization in the rural pockets of the country have risen terrifically, with the numbers being quadrupled in states like Goa. With regard to abortion, research shows that over 80% of women in India are unaware of its legality, and every day as many as 13 women die in the country because of unsafe abortion-related complications. Unsafe abortions are also the third most prominent cause behind India's maternal deaths accounting for eight percent of the total annually.

By locating the current study within the aforementioned backdrop, which is essentially the larger reality of women's reproductive control in India, the significance of the research and its contributions gets even more profound and clear. Therefore, this dissertation keeps the potential and scope to provide some very vital understandings about the reproductive landscape for women in the Thiruvananthapuram district of Kerala. It probes into the reproductive autonomy that women possess in intimate partner relationships and identifies the factors that shape their experience. It has also consciously looked at women as a heterogeneous entity characterized by a multitude of intersecting factors, moving beyond the conventional construction of women as a homogenous collective.

1.4 Purpose of the Study

The dissertation has primarily undertaken a qualitative research-based study that was aimed at exploring the concept of reproductive autonomy in both married and unmarried women engaged in intimate partner relationships and in finding out how it has affected the extent of control exercised by them in making crucial choices of their SRH. The lived reproductive experiences of these women were collected using in-depth qualitative interviews. Reproductive autonomy for the research was defined as "having the power to decide about and control matters associated with contraceptive use, pregnancy, childbearing, spacing of children and the freedom in spousal communication" (Updhayay, Dworkin, et al. 2014). Furthermore, the research has also efforted to understand the differences and similarities in the reproductive journeys of both married and unmarried women in intimate partner relationships, their perceptions regarding abortion practices, and the socio-cultural and economic barriers faced by them in accessing safe healthcare services.

1.5 Research Questions

1. What is the decision-making power of women in issues of contraception, pregnancy, childbearing, and spacing of children in Intimate Partner Relationships?
2. What are the perceptions and experiences of women regarding abortion?
3. What are the socio-cultural and economic barriers faced by women in accessing safe reproductive healthcare

CHAPTER 2

REVIEW OF LITERATURE

"No Women can call herself free who doesn't control her own body"

- Margaret Sanger

2.1 Introduction

In this chapter, the researcher will be reviewing a selected set of literature which in different lengths and breadths have tried to explore and dwell deeper into the question of reproductive autonomy of women in intimate partner relationships and its importance in the domain of SRH and rights. Many scholars worldwide have extensively worked in various aspects related to the reproductive autonomy and agency of women and in explaining the differences and similarities in the experiences of women coming from a wide range of geographical, religious, caste-class, occupational, and other backgrounds. With theoretical, methodological, and empirical studies available in the concerned area, the researcher has primarily focused on theoretical and empirical literature. Further, the selected literature is arranged coherently under five essential themes that capture the most integral concepts associated with the area of interest. These themes, which will be dealt with in detail in the following pages, are 1) Biological Essentialism and Disciplining of Female Bodies, 2) The Socio-Cultural and Economic Barriers faced by Women in Autonomously Exercising their SRH and Rights, 3) Power Dynamics in Intimate Partner Relationships and its impacts on the SRH of women, 4) The Gendered Nature of Contraceptive Use, and 5) The Societal Stigmatization of Abortion.

2.2 Biological Essentialism and the Disciplining of Female Bodies

The Female Body has been Historically Trained, Manipulated and Molded to carry the burden of its "natural" femininity

-Angela King

Biological Essentialism, in layman terms, refers to the perception and understanding of the essence of women under their biologism. Through such an essentialist framework, the existence of women

predominantly defines women only and only in terms of their biological capabilities. Such a reductionist understanding of women and their bodies has long been the root cause of their historical oppression, stigmatization, and pervasive invisibilization in modern societies. The construction of a "woman" in our community has always been innately discursive. She is considered inherently inferior yet threatening to a man and is seen in need of constant control using certain extremely regressive disciplinary techniques. A body has always been perceived by the feminists not just as a manifestation of one's biology but also as an active site of contestation of power. One, which has socially, culturally, and historically been contained with and invariably subjected to particular forms of economic and political forces. Susan Bordo says that "feminists first initiated the discourse around the politics of the human body, and by doing so, they have inverted the conventional metaphor of "body politic." Feminist scholars have redefined body as a politically active and inevitable entity with its morphology and physiology determined by the practices and histories of containment and control unleashed on it" (Bordo, 1993). They have further dwelled deeper into the subject of body and found out how female bodies have historically been the primary sites of subjugation, oppression, and male dominance. The majority of the sexist practices and perverted gender ideologies emerged from the biological differentials between various sexes, which are promoted by the binary-centric paradigms that have laid the foundations for most western thought.

Women's worth has always been judged and measured against that of a typical man, unfortunately, the de facto representation of an active human subject in our society. Men are considered a part of the human whole which is strong, moral, and therefore the most valued (Baily 1993). According to this logic, the biological differences of women that place them in an inferior position to men are regarded as "natural deviations," and women, as mere subjects of a condemnable pathological deformity (Balsamo 1996). Aristotle has earlier announced women as beings affected by natural defectiveness. Another male scholar, Thomas Aquinas, perceived females to be nothing but imperfect and distorted versions of men or, in his own words, "misbegotten males" (Tseelon, 1995). Women are a category of living subjects who do not have an existential value of themselves but are just the evil other halves created to perform the duty of procreation solely.

The conception of men and women as binary opposites is often perpetuated through dualistic categories such as mind and body or nature and culture. Man is often associated with the mind, representing the culture and attributed to qualities such as rationality, ability to think and act,

stability and composure. In contrast to that, women are reduced into bodies that are representatives of nature and are hence synonymous with irrational, hysteric, emotional, instinctual, and physically demanding (Angela King, 2004). Such a crude conceptualization of man and woman inextricably rooted in ideals of patriarchy and sexism legitimizes the dominance and control of mind/men/culture over the hapless body/women/nature through the former's superior sense of will power and knowledge (Angela King, 2004). Such a tendency to perceive women as just the total of their bodies is furthered by reductionist paradigms like biological essentialism, which inadvertently focuses on defining the existence of the female predominantly based on her reproductive physiology. Such an ideological construction portrays women as creatures characterized by passiveness, feebleness, and emotional vulnerability. They perpetuate the ideas that women exist to fulfill the desires of males and produce and nurture their offsprings. In other words, a woman is just a powerless slave to her reproductive construction, forever drowned in the burden of her physicality. When in reality they are very much capable of rising above their biological materiality and have a meaningful existence outside of their bodies (de Beavoir, 1988).

An excessive concentration on women's biology to such an extent that it becomes impossible to imagine their existence out of their biology is quite problematic and detrimental for so many reasons. When viewed through the lens of biological essentialism, the practice of unequal treatment of genders by society considers biology as the only causal factor behind such practices. Instead of viewing the rules as socially constructed due to the collective interplay of various other components (Connel, 1991). Adopting a strictly biological lens to evaluate the differences in society is very much equivalent to considering such toxic social arrangements as "natural" and therefore static and unchangeable. The issue with such a theory is that it bars the ability of the theory to consider the possibilities for changes and transformations. The naturalistic understanding of bodies is inflexible in nature and views bodies as given and therefore an impediment to action. Bodies in themselves are not inert or ahistorical or passive or non-cultural, they are active sites for contesting different political, economic, and sexual struggles. The identities and agencies of women exist very much outside of their biologies, in the social realm.

A classic explanation rooted in biological essentialism or biological determinism provides a purely scientistic model that tries to account for the social hierarchies, discriminations, and inequalities in humans' biological specificities. (Lowe, 1982). One of the major issues with such a sort of theorizing is its tendency to generalize and homogenize all women's lived experiences and

realities. Therefore, disciplines, discourses, literature, other famous works, and for that matter, society, in general, should primarily undertake an anti-essentialist approach when engaging with the topic of "bodies" in general. We should adopt a way through which it is possible to talk in length about women's oppression by keeping the concept of "bodies" in the epicenter of the explanation. Still, it should also be such that the discussion does not at any cost divert to the path of biological essentialism (Pushpegandey Manicom, 2015).

2.3 Socio-Cultural and Economic Barriers faced by Women in Autonomously Exercising Control over their SRH and Rights

"The bio-physical reproductive capacity in women's oppression is not entirely derived by an iron law of biology, but rather is also significantly influenced by several other non-biological (socio-cultural and economic) factors"

- *Desiree Pushpagenday Manicom (2010)*

As discussed earlier within the chapter, the bio-essentialist outlook of society towards its women has made it difficult for women to exist as independent and equal humans. Society has constructed various social, cultural, economic, and other structural obstacles that hamper their potential to realize reproductive autonomy in its absolute sense. Such barriers invariably dictate and control the independence and agencies of women, barring them from exercising independence over their sexual and reproductive health. The key impediments are mainly embedded within the broader social, political, and economic conditions, and they often have a crucial part in shaping the sexual and reproductive priorities and behavior of women. By placing the concept of motherhood at the center of a woman's goals and emphasizing the influence that might wear in deciding the economic and social rank of a woman, sometimes even her survival, the culture dictates what's expected from, in her terms of childbearing. Women are compelled to satisfy these prescribed expectations imposed by the society to become ideal wives and childbearing mothers to date that even their dignity, safety, and treatment in marriage, and also the risk of separation and divorce are all directly associated with the achievement of those ends (Hyoung, 1997; Braam & Hessini, 2004). In this sense, there's a continuing pressure on women from husbands, families, and even society to align

with the social metrics and expectations of childbearing with stigma and ridicule as consequences in case of failure (Konje&Ladipo, 1997).

Women aren't only expected to provide and rear children as per societal norms but also are affected by the preferences related to the sex-composition of the family. Studies conducted in East Asia, South Asia, and Northern Africa have documented reasons for strong son preference, which includes the economic advantages, rank, and ritualistic components (Kamau et al., 1996). A number of the studies conducted by (Hussain et al., 2000; Westley et al., 2001) revealed that Asian countries like China, India, and even Pakistan have a historic likeness for sons over daughters and women's inability to provide sons as per the demand of patriarchal families could end in unpleasant impacts on economic, financial and physical well-being. Arnold et al. (1998), in their study, concluded that women who participated in the study, were more likely to continue bearing children after the delivery of a daughter with much shorter birth intervals.

Soon after the wedding, women are expected by society to prove their fertility and are faced with unprecedented social pressure to try to do so. Young newly married women are especially vulnerable to serious consequences like stigmatization, divorce, and a greater possibility of their husband engaging in extramarital affairs or casual relationships or perhaps a second marriage in case if they fail in producing children within 2-3 years of marriage. Barua et al. in (2009), in an important study conducted in India, discovered that girls who were incapable of conceiving and delivering were significantly humiliated and ridiculed with threats of exposing them to their husbands as "good for nothing".

Research indicates the incompetency of laws and policies in effect delaying the primary birth after marriage because of the pervasiveness of socio-cultural norms and traditions that dictate individuals' lives and particularly women (Rahman M & Daniel E, 2010).

The main barriers to women accessing and using contraception even after their desire to postpone pregnancies are the absence of awareness, misinformation, fear of side effects, infertility, and mainly the fear of ostracization from their families and partners. In another case, resistance to modern contraception by women can also have religious and cultural reasons. Lack of information in women can often end in misconceptions in sex, reproduction, contraception, and the way female bodies function in general. These could restrict their scope in making informed decisions related to their SRH (Sedgh et al., 2007). The large-scale presence of sexual double standards in most cultures considers it inappropriate for women to learn and participate in matters associated with

sexuality actively. Hence, the mediums through which such knowledge is disseminated in various societies systematically exclude women (Robey et al., 1996). This is primarily a reality within unmarried young girls who are consciously kept off from this information to preserve their virginity, sanctity, and innocence carefully.

Apart from the normative and structural barriers that undermine women's autonomy in seeking contraception and abortion, women also face several "relational" barriers. Within the reproductive and medical health care market, women have highly compromised command as consumers and are, therefore, more vulnerable and disadvantageous. In India, various NGOs providing services associated with contraception were demanding the husband's approval or the approval of the other elder members of the family to give medicines and contraceptives. At other times, healthcare providers are influenced by their biased attitudes and moral judgments regarding women's sexuality while providing medical services (Raju & Leonard, 2000). in a study conducted in Egypt (EL- Zantay et al., 1999), women reported that they have to await their husbands or other elder members to accompany them to a healthcare provider. In situations where men control and handle the resources and their partner's mobility, there's a high chance that women may encounter difficulty in freely using health services as and when they feel the necessity to. They will also find it extremely hard to form autonomous choices while accessing these services. Excessive financial dependence on their male counterparts or their in-laws can often create barriers for women in taking free decisions associated with their SRH and might even push them to accept suboptimal and lesser effective contraceptive and abortion practices.

2.4 Power Dynamics in Intimate Partner Relationships and Its Impacts on Sexual and Reproductive Health of Women

"Power imbalances operate within the context of a nearly universal sexual double standard that gives men greater sexual freedom and rights of sexual-determination than women enjoy"

- (Mason 1994; Riley 1997)

The various socio-cultural and economic barriers that the society burdens the women with, as was discussed extensively earlier, inevitably influence the extent of power they hold in an intimate relationship and is likely to position them inferior to their male counterparts. Power dynamics in sexual relationships can be understood in different ways. The previous feminist works of literature

show how gender has an inevitable impact in deciding the experiences of both "power to" and "power over." "Power to" generally reflects the capability of a person to act according to one's own free will, whereas "power over" refers to those sections of people over which goals and wishes are unfairly exerted upon even after instances of strict opposition from them (Riley,1997). Most of the time, if not all, women are usually regarded as inferior in power to men. Such a lopsided power imbalance in relationships can invariably put women in a position where it becomes increasingly difficult for them to access sufficient information crucial to their reproductive and sexual health and well-being, prevent their ability to take actions to improve and protect their body and make free, autonomous and informed choices related SRH.

These imbalances and inequality emerge a universal sexual double standard that embellishes men with a vivid sense of greater sexual and reproductive autonomy and sexual self-determination compared to their women counterparts (Mason 1994; Riley 1997). The presence and functioning of such a noticeable hierarchy in terms of power is highly consequential for women, especially when it comes to freely exercising autonomy and control over their SRH and rights. The operation of power within gender does not work in isolation. Instead, it is significantly affected by numerous social, economic, cultural, and political aspects as well.

Very few research have been conducted to measure power dynamics in sexual relationships and evaluate their role and impacts on the overall reproductive health and well-being. Such studies have employed a range of measurement approaches, one of the most common ones assessing the relative "say" of partners in a handful of decision-making areas. Studies conducted by Mason and Smith (2000) and Govindasamy and Malhotra (1996) intended to determine women's say in making economic and fertility-related decisions. The scales were prepared along these lines, including questions like who decides on purchasing major goods. Questions regarding the nature of contraceptive use and women's role in making such sexual and reproductive decisions were also asked. Both these studies also included measures for finding out women's freedom of movement. Thus, the results gave insights into the circumstances under which women were allowed to step out and whether or not the elder members of the family accompanied them and whether or not they needed to ask for approval. Majority of the women who partcipated in the study experienced limited say in financial decisions and also exhibited a constrained contraceptive autonomy. They also faced strict restrictions in stepping out of the home unescorted, other than for work-related necessities.

Power dynamics are a significant determinant of all intimate partner communications because it functions "under the surface," influencing each partner's communication choice. The amount of power possessed by a person in the structure of their relationship determines the presence or lack of communication, the kind of topics they discuss, the opinions they share, and whether or not they conform to the orders and expectations of their significant other (Jans &, Serger, 2012). Gender-based inequities due to the power dynamics can translate into a lack of communication between partners. A collective of studies is testimony to believe that verbal communication on topics related to SRH is significantly less in many of the developing nations. For example, about 35 DHS conducted from 1995 to 2002 reflect that the percentage of married women who openly discussed family planning with their husbands is less than 50 percent in as many as 12 countries, with the most prevalent in Sub-Saharan Africa. There can be many reasons for non-communication by women, including the possibility of abandonment, divorce, increasing the number of casual partners, or even chances of extramarital affairs (Rutenberg, 1999). According to study conduct by Hogan et al. (1999), it was inferred that the equality in relationships in terms of power becomes much proximal to equal with the increase in the likelihood of open verbal communication between partners related to issues about reproductive health and choices. Another study by Zeundenstein and Moore in 1996 tried to understand the barriers to communication between couples and found out that men and women are not well equipped with the right kind of language to describe their sexual preferences, fears, choices, or desires. In addition to that, men can act reluctant to acknowledging and openly discussing the shortcomings from their side, which can result in miscommunication or non-communication in most cases.

Yet another striking implication of differential power dynamics within relationships is the increasing incidence of gender-based violence between partners, which has many severe physical, emotional, and mental repercussions on women's sexual and reproductive health. The results of 50 population-based surveys conducted by (Heise et al. 1999) worldwide show that as much as sixty-seven percent of women were reported to have been victims of severe physical and sexual harm by their male partners at some point in their lives. Such damage to women's physical and mental well-being not only causes them immediate pain or ailments but can also make them further vulnerable to severe complications of anxiety, depression, and a series of gynecological problems (Kapoor, 2000).

2.5 The Gendered Nature of Contraceptive Use

"Women throughout history before the advent of birth control were at the continual mercy of their biology"

-

- (Firestone, 1971)

The unequal power dynamics in intimate relationships deeply influence the contraceptive behavior of couples, and according to work done by (Bertotti 2013; Fenell, 2011), this is one of the crucial reasons women all over the world continue to bear the brunt when it comes to contraception. The responsibility of using contraception which often makes for an essential aspect of a couples' fertility work that ideally is split equally among the partners, seems to fall on the shoulders of women entirely. The evidence from the study conducted by (Shih et al., 2000) proves that the uptake of female sterilization practices are significantly higher than the male sterilization ones despite both of them being equal in terms of effectiveness and accessibility, with male sterilization associated with far lesser physical complications and reasonable financial costs. This shows how the choice of contraception is not merely a matter of accessibility, availability, or effectiveness but rather is a consequence of structural inequality and power dynamics which viciously put the onus only and only on women. Most of the research that effort to understand the social factors responsible for contraceptive use has invariably grounded their studies on the female population, reflecting the attitude that reproduction and contraception are considered spheres closer to women than men.

A study conducted by Ezeh in 1993 in Ghanian women shows how explicitly the wife's attitude towards using contraception is affected and directed by her husband's likeness and dis-likeness whereas on the opposite side, how the husband's decision is not at all influenced by what his wife thinks or what her attitude is towards the method. In Kenya, Dodoo (1998) conducted a study that showed how the contraceptive method was twice and thrice more likely to be used when husbands wished to stop childbearing than when wives hoped for the same. Mason and Smith (2000) made an effort to understand the contexts in which gender influences each partner's fertility preferences in five of the Asian countries, including India. The study results show that women's preferences are more likely to be regarded on par with that men's preferences in communities where women exercised a greater sense of autonomy and control over their bodies. Casterline and his colleagues

(1997) found out that the disapprovals and preferences of husbands and partners easily accounted for about 20 percent of their wives' unmet needs of family planning.

As mentioned earlier in this chapter, gender-based power imbalances generally feed on the idea that men should be ideally in charge of women's sexuality and their childbearing choices. Women's active participation in the process of family planning questions the authority and control of men. Most of them who participated in the qualitative study conducted by Bawah et al. (1999) cited their fear of losing control over their partners, the position of the head of the household, and more generally, their sense of masculinity as the reasons for not considering the women's preferences when it comes to contraceptive use. Some of them also believed that their partners would become more adulterous with the liberty to choose contraception, leading to community ridicule. The pervasive refusal and stopping of men in using male-centric contraceptives are primarily owing to the false belief instilled by the society of a decreased sexual pleasure and dissatisfaction. In patriarchal societies like India, male contraceptives are largely remained unaccepted because of the notion that they would negatively impact the "manliness" and virility of men. Such a toxic understanding has further led to the promotion and practice of regressive female contraceptive methods that mercilessly put women's bodies at the receiving end of hazardous and irreversible medical procedures that can have long-lasting health implications.

Multiple studies have looked into the patterns in the gendered use of contraception and revealed how most of the women engage in something called "contraceptive gatekeeping" because of perceiving themselves to be fundamentally and solely responsible for the uptake of contraception in their relationship (Fenell, 2011; Lessard et al., 2012). Renne (1993) and Blanc et al. (1996) have conducted studies that provided insights on how practicing contraception in the open, against the wishes of their partners whom they are financially dependent on, can have heavy consequences amounting to separation, divorce, and even physical violence. When there are hurdles in a relationship that make it tough for women to openly express and exercise their choice, women often resort to methods that they would not opt otherwise to retain peace and harmony, even if it means putting their bodies in jeopardy. Women in Brazil and India have been observed to be going for permanent sterilization procedures like tubal ligation and hysterectomy over other safer options just because they could avoid conflicts arising out of discussing sex and contraception with their partners (Gupta & Weiss, 1993).

2.6 Societal Stigmatization of Abortion

"One is not born, but rather becomes Women"

- (de Beauvoir, 1949)

As discussed earlier in the chapter, the literature on the gendered nature of contraception reveals the extent of compromised autonomy women has in deciding whether to get pregnant. In modern societies where women do not have such a strong command over contraception, they tend to use medical abortions as adjunct contraception (Sam Rowland, 2007). Abortion is one of the most crucial gynecological procedures that many women put themselves through during their lifetimes (Aahman & Shah, 2004). Despite the existence of abortion across cultures, spatial locations, and communities, the experiences and impacts it has on women vary significantly in different parts of the world. The absence of accessible, affordable, quality abortion provisions and medically-trained practitioners to conduct the procedures are among the significant reasons why there is such a high proportion of women who opt for unsafe practices. Social Science researchers worldwide have understood that the stigmas related to abortion and their manifestations are not the same everywhere. They impact different women differently and shape their experiences which differs across communities, cultural and social contexts (Weiss & Ramakrishnan, 2006). Despite their pervasiveness across the world, social relationships and cultural constructs play a pivotal role in understanding how it takes shape and its consequences on women, and how it can be countered. Most of the moral controversies surrounding the termination of pregnancies tend to take place around- the beginning of life, fetal pain, fetal personhood, normative sexuality of women, the legal status of abortion and who would bear the cost, who should be the ultimate decision-maker, various religious-cultural norms, prevailing demographic and political patterns and most importantly existing family dynamics. By falsely portraying a fetus as an actual baby with biological autonomy, the popular media and culture have globalized abortion stigmas and embedded a false image of women undergoing abortion in the popular discourse (Mitchell, 2011).

Stigmas surrounding Abortions are socially constructed dominant ideas that get produced and reproduced locally in a plethora of ways. Stigmatization of women who decide to get an abortion done usually means ascribing such women with highly negative attributes and considering them to be internally and externally inferior to the ideals of womanhood. Women who make these choices are seen to be deviating from the "essential nature" of women thereby transgressing many

of the societal archetypes of "feminine" including the ideas such as, female sexuality is solely in existence to serve the purpose of procreation, motherhood and nurturance which are considered to be inherent, instinctual characteristics of a woman. A woman's independent and autonomous choice to terminate the pregnancy either by induced abortions or clandestinely breaches and contradicts the current view of women as perpetual givers and is seen as a deliberate attempt at escaping their reproductive physiology and the divinity of motherhood (Rylko-Bauer, 1996; Bradshaw et al., 2008). Phelan (2001) has studied the reasons behind the existence and perpetuation of abortion-related misconceptions and found out that most often than not, the primary causes for such pervasive disregard for women undergoing abortions are borne out of the patriarchal systems that create unequal access to power and resources for women and deprive them of their agency to make free choices by virtue of their gender roles and repeatedly attempt to constrain and control the female sexuality. Female sexuality can be placed at the heart of abortion stigma as being able to access abortions would mean women being at power and exercising the authority to when who, why, and how to have sex, which is fundamentally against the stated norms. In addition to the social and cultural hindrances on women, the socio-economic status, race, ethnicity, occupation, medical and political location are significant factors that could also effectively regulate and determine the choices and their implications (Foucault, 1973). Women living in societies with limited mobility and financial independence can have a tough time accessing safe abortion care.

Attaching derogatory labels such as sinful, murderous, dirty, immoral, and so and so forth to women who abort not only socially discriminate them but also overlook the fact that many of these women do it as a means to preserve their own mental and physical well-being and for the greater good of their family (Guttmacher Institute, 1999). Practicing such stigmas on women can often result in explicit and implicit forms of discrimination which can include denial of opportunities in terms of employment or denial of accurate medical information and safety provisions, demanding excessive money for accessing basic services, public humiliation, social or marital abandonment or even physical, verbal or sexual abuse (Schuster, 2005). Ultimately Abortion stigma delegitimizes and disregards an essential medical procedure, the people who procure or provide it and also discredits the efforts of people who advocate and vouches for its universal legality and accessibility (Farmer, 2005).

2.7 Gaps in the literature

After reviewing the above literature it has been understood that while they do make very pertinent and valuable contributions to the concerned area of study, they are not entirely barren of shortcomings and pitfalls of their own. There are areas wherein they could have used other optimal probe methods, which could have significantly improved the standard and effectiveness of the studies. It's hugely concerning and worrying that most studies conducted and published around such a sensitive subject remain widely inaccessible to the target population in terms of the language used and the strictly intellectual way in which they are written. Most often than not, these studies tend to ignore the underlying social and cultural contexts that outline the areas within which the research focuses. Few of the studies conducted in countries like Pakistan and India tend to completely avoid the influence and impacts caused by the patriarchal system governing the society while conceptualizing reproductive autonomy. Additionally, an oversized portion of the studies are conducted across a large population and are primarily quantitative and mainly use data collecting tools like survey questionnaires or measurement scales. While they help cover an excessive number of individuals, they do not provide in-depth insights into the detailed intricacies, nuances, and complexities of the particular lived experiences in a manner a qualitative study or case study-based studies would offer.

While there are a plethora of studies that explore the autonomy status of married women, there's a substantial dearth of studies that are focused on the agency of unmarried women, their experiences, and their SRH and rights. Even within the studies conducted on the gendered use of contraception, an excessive focus can be seen in assessing the contraception trends in married couples. This is especially concerning in a social context where premarital sex is becoming more and more pervasive in the world and, at the very same time, is also a historically tabooed practice by society. Studies in this direction that look at the questions of reproductive and sexual autonomy from the perspectives of unmarried and sexually active women are much essential. A vast portion of the present literature dwells on autonomy and analyses the data from a predominantly gender-driven angle. It overlooks the other interacting factors which could have also shaped and accounted for the experiences of women. In other words, women are perceived mainly as a homogenized population with little to no differences rather than a strongly heterogeneous group with varying identities, occupying different social positions within the social stratum, and hence experiencing

considerably different realities. Most of the work around sexual and reproductive health and women's fertility rights come from the developed part of the globe, which are already most in an advantageous position compared to the developing and underdeveloped countries. There are only a handful of researchers from India who have contributed seminal works on this domain, with India being the positioning of the study. Therefore, the highly stratified nature of Indian society needs research that identifies and considers the plurality of society, its social institutions, and social organizations. One that creates space for women to inform their stories in their own terms and considers and addresses the multifaceted nature of this issue.

CHAPTER 3

METHODOLOGY

3.1 Introduction

This chapter intends to explain the research questions, research design, tools used for data collection, methods used for data collection, the preparation of the interview schedule used for both married and unmarried women engaged in intimate partner relationships, who were the respondents for the study. Further, the chapter also aims to provide a detailed description of the field site in which the study was undertaken, the Thiruvananthapuram district of Kerala. It also discusses the various tools, procedures, and sampling methods employed by the researcher to carry out the study efficiently. The later part of the chapter also deals with the ethical considerations encountered by the researcher while conducting the research, which took place in March 2021. The chapter ends with the limitations of the research. The researcher extensively talks about the study's limitations and the difficulties faced by them during the fieldwork. The ontological aspect of conducting this study is that the patriarchal Indian society has historically subjugated, controlled, and regulated the female bodies and has deprived women of their authority to independently make the critical choices related to their sexual and reproductive health. The epistemological assumption in which this study is foregrounded fundamentally aims to explore and understand the reproductive autonomy status of women in intimate partner relationships by looking at the aspects of contraceptive use, pregnancy, childbearing, child-spacing, and freedom in spousal communication. It also intends to look at the factors that shape the reproductive experiences of both married and unmarried women and the similarities and differences between them.

3.2 Research Design

This study initially intends to examine the autonomy status of women in exercising control over their sexual and reproductive health and rights in intimate partner relationships. Therefore the research adopted a phenomenological approach to interviewing the respondents who were both married and unmarried women in the reproductive age groups of 18-49. A phenomenological approach is an effective qualitative method where the researcher either uses one or a combination

of methods to holistically understand the meaning respondents place or attach to the topic that is being examined. For the current study, the aim was to understand in detail the extent of autonomy women enjoyed in intimate partner relationships to take free, independent, and informed decisions about contraceptive use, childbearing, pregnancy, child-spacing, and other sexual and reproductive health decisions and the freedom they had in having open spousal communication. The study also intended to dwell deeper into the perceptions of women regarding abortion and associated stigmas and the socio-cultural and economic barriers they had faced in accessing safe health care services. Hence, it can be said that the researcher entirely relied on the participant's own perspectives and personal narratives to provide insights into their motivations. Under the category of women who were interviewed for the purpose of the study, eight were married, and the remaining seven were unmarried, and all of them came from different caste-class, religious locations in the society. The primary motive behind selecting such a diverse group of women was to acknowledge the heterogeneity in women and, at the same time to ensure inclusivity. It also helped look at very different and diverging experiences of women within the same topic of reproductive autonomy.

3.3 Sampling

For the present study, the researcher selected married and unmarried women in the reproductive age group of 18-49 from the Thiruvananthapuram district of Kerala as the universe for the study. Further, the study was exclusively conducted among the women who belonged explicitly to the Sreekaryam ward of the Thiruvananthapuram district. Fifteen such women (both married and unmarried) who were involved in an intimate partner relationship at the time of the interview have then been selected as the respondents. Among the chosen sample, 8 were married women, and the other seven were unmarried.

The researcher adopted the method of purposive sampling for selecting the sample. As the researcher had a particular set of predetermined criteria that were considered to be highly crucial for the efficient conduct of the study, the method of purposive sampling was found to be undeniably the best-suited method of sampling. The sample was also considerably diverse and consisted of respondents from across the class-caste spectrum, thus ensuring inclusivity and enabling the opportunity to record significantly different experiences.

3.4 Tools of Data Collection

Data for the present study was collected using primary and secondary sources. Primary data was gathered from the field, directly from the respondents using qualitative tools of data collection. It is important to have firsthand information to understand the real-life experiences in their entirety to establish and satisfy the originality and validity of the study. The qualitative data were collected using structured, in-depth face-to-face interviews. To utilize the interview method in its best possible capacity, an interview schedule containing a well-drafted structured set of questions was prepared prior to the interviews. The questions were curated such that they could efficiently elicit in detail the vital information connected to the reproductive experiences of the respondents who participated in the study and their general perspectives about sexual and reproductive health and rights.

The interview schedule was formulated to allow the researcher and the participants to have a very comfortable, interacting, and free conversation while also in due course helping the researcher gather crucial insights that are cardinal to fulfill the objectives of the study. Some of the questions that were included in the interview schedule for the respondents consisted of questions such as Has a boyfriend/partner ever forced you to have sex when you did not want to? Please tell me what happened. Is it easy to communicate to your partner(s) about sex? If not, what do you think are the reasons behind it? Questions along these lines immensely facilitated an environment that positively encouraged the respondents to come forward and very openly share their highly intimate and personal experiences, which proved to be highly beneficial for the study. The structured interview schedule prepared for the study respondents has been included in the appendix section of the dissertation. Secondary data was also used for the research collected from different sources, including journals, academic articles, project reports, newspaper reports, and other E-databases.

3.5 Field Site

The study happened in the Thiruvananthapuram District of Kerala, which also happens to be the capital city. The district accounts for 5.3% of the total geographic area of the state and accommodates 9.88% of its total population. The community has a female population of 1,719,749

and a sex ratio of 1087 females per 1000 males. The labor workforce participation of women in the district is 21.37%. The state also has a female literacy rate of 91.7%. (Census; 2011). I have particularly focused on the Sreekaryam ward of the Thiruvananthapuram Municipal Corporation. The ward has a population of 12,061 females with an average literacy rate of 96.8 percentage and a female sex ratio of 1052 according to the 2011 census.

One of the significant reasons for selecting the district of Thiruvananthapuram as the site of this study is that it is the native residence of the researcher. Hence, they are very familiar with the geography, locality, and local and cultural practices of the area that they believe would positively aid data collection and enable its conduct with much ease. The researcher is also well versed with spoken and written Malayalam and English, which happen to be the two vastly spoken languages of the city. Such an excellent familiarity with the regional language is a crucial factor in conducting in-depth interviews, especially considering the topic's sensitivity being researched.

3.6 Procedure

In-depth face-to-face interviews were conducted with respondents using a structured interview schedule that was drafted prior to the day of collecting the data. The schedule consisted of questions and probes that were deeply intimate and personal in nature, which would help the researcher better understand the women's reproductive experiences and the autonomy they exercised in their intimate partner relationships. The researcher conducted a pilot study among three women from the Sreekaryam ward in the Thiruvananthapuram District of Kerala, wherein they were interviewed using the prepared qualitative interview schedule to check the feasibility of the tools before inclusion into the study. The tool was practical and well aligned with the research objectives during the pilot study.

All the participants agreed to answer the questions orally. Out of the 15 women who were interviewed, 3 of them were comfortable with recording the interview, and the rest of the 12 women did not consent for the recording as they were not wholly comfortable with disclosing details relating to their bodies, sexual lives, and relationships which were very private. Respecting their choice, the researcher, while conducting those set of interviews, adopted the method of taking shorthand field notes and daily journaling and personal observations so that even the most minute trace of details could be efficiently stored to use later for the study. Face to face interviews proved

to be very much beneficial and suited for the current study as it enabled the researcher to observe and assess the participant's body language and other non-verbal cues and figure out which type of questions did they feel difficult to answer and what kind of topics made them uncomfortable. All the women who gave the interviews did not mostly seem to consciously retain any information or hold back themselves at any point. Some of them were initially awkward around the topic, but later on, after establishing a successful rapport with them, they did become really comfortable and openly conversed with the researcher. Most of the time, the researcher also observed how the women actively answered most of the questions on their own without needing much of a probe.

3.7 Data Analysis

The data collected from the field site using the structured, in-depth face-to-face qualitative interviews were analyzed using inductive methods of data analysis. The researcher used thematic content analysis and narrative analysis for this purpose. The thematic content analysis helped weed out any possible biases and the researcher's overarching impressions of the data. It involves the identification of common themes rather than approaching the data with a pre-decided framework. The ultimate goal was to find out common patterns across the available data set. The narrative analysis method helped make sense of each of the individual experiences narrated by the respondents. It enabled the researcher to highlight those aspects of their stories that are most related to the study's objectives and would best resonate with it. It has also helped in highlighting the critical points in other crucial areas of the research.

3.8 Ethical Considerations

The decision to participate in the study was an entirely voluntary decision taken by each of the participants independently. The researcher did not in the slightest way tried to influence or manipulate their choices. In fact, before the conduct of the interviews, an informed consent form was effectively communicated and authorized by all of the 15 respondents who took part in the study. All the participants were informed about all the particularities of the research and other essential aspects of it at length. They were also given the complete freedom to ask all the doubts and clarifications about the study at any point in time until they were wholly satisfied with the

answers. They were also allowed to choose the mode and location of the interview, along with the freedom to skip and not answer questions that they were not comfortable with. At any point in time, the participants could also choose to discontinue the interview even if they had agreed to it earlier. It was also thoroughly ensured that the participant's identity was not revealed to anyone or anywhere at no instance, and this nature of maintaining strict confidentiality was adequately communicated to the respondents to avoid any possible hesitations, inhibitions, or doubts the women may have especially given the intimate and deeply personal nature of the information disclosed. No one else other than the participant and the researcher was allowed in the room/setting in which the interviews took place.

3.9 Limitations

1) The data collection process was very time-consuming as it required the researcher to first establish a good rapport with the participants and make them feel comfortable and at ease with the topic and then conduct the in-depth interviews. Due to the sheer nature of the topic and the personal characteristic of the questions asked, most of the respondents even demanded breaks in between, which further extended the length of the interview sessions.

2) The various and uncertain conditions prevailing in the country due to the covid-19 pandemic at the time of the study had made it extremely difficult for the researcher to successfully reach out to participants and get their appointments to conduct the interviews.

3) The researcher also found it challenging to coordinate and conduct data collection within time with the respondent's often hectic and wavering work and time schedules.

3) Being just an undergraduate student, it was especially a task for the researcher to make the participants believe in the credibility and authenticity of the study and get them to agree to the in-depth interviews, especially related to a very sensitive topic such as their sexual and reproductive health which would require them to share their reproductive experiences in intimate partner relationships.

4) A large proportion of the women who were interviewed were hesitant and did have difficulties in explicitly opening up at the starting of the interview. This was quite understandable considering the nature of the topic being discussed. It did require much effort from the researcher's side to make them feel comfortable and get them to share their experiences without filtration.

5) Some of the women who were interviewed had extremely horrific and terrible experiences associated with reproduction, especially related to instances of abortion, and recounting those experiences did make them emotional. It was an arduous and emotionally exhausting, demanding task for the researcher to conduct the interviews with composure even after hearing such intense pieces of information and then coming back and analyzing them.

CHAPTER 4

FINDINGS AND ANALYSIS

4.1 Chapter Outline

This chapter aims to thematically analyze the reproductive experiences shared by the respondents who participated in the in-depth qualitative interviews conducted with the help of a structured interview schedule. A total of 15 women were interviewed for the study, out of which eight were married and seven were unmarried. These participants belonged to the specific reproductive age group and were involved in an intimate partner relationship at time of the interview. They were chosen using purposive sampling, such that they fit into the requirements of the study. The women also happen to belong from significantly different socio-economic backgrounds. The main intention of the interview was to evaluate in detail the extent of reproductive autonomy enjoyed by these women in taking control of their contraception, pregnancy, and abortion-related decisions and the freedom experienced by the women in communicating with their partners about issues related to SRH. Subsequently, the study also tried to understand the various socio-cultural and economic barriers women face in effectively accessing reproductive health services. The key findings made by the researcher are given under different subsections. It also includes the personal anecdotes, quotes, and perceptions as shared by the respondents themselves in the interviews regarding their reproductive journeys.

Table 1: Profile of the Respondents

Respondents	Age	Religion	Caste	Occupation	Marital Status
1.	22	Muslim	Mappila	Student	Unmarried
2.	28	Hindu	Nair	Government Employee	Unmarried
3.	25	Hindu	Ezhava	Ph.D. Student	Unmarried
4.	31	Christian	Roman Catholic	Software Engineer	Unmarried

5.	20	Hindu	SC	Student	Unmarried
6.	35	Muslim	Thangal	Media Manager	Unmarried
7.	21	Christian	Nadar	Student	Unmarried
8.	36	Hindu	Pulayar	Domestic Help	Married
9.	45	Hindu	Nair	College Professor	Married
10.	38	Muslim	Mappila	Municipal Corporation Sweeper	Married
11.	49	Christian	Marthoma	Housewife	Married
12.	40	Hindu	Ezhava	Tailor	Married
13.	42	Muslim	Ashraf	Housewife	Married
14.	36	Hindu	Ezhava	Cleaning Staff	Married
15.	40	Christian	Bandhacose	Engineer	Married

4.2 Contraceptive Behavior among Women in Intimate Partner Relationships

The qualitative interview schedule drafted by the researcher for the in-depth interviews contained particular questions that intended to understand the contraceptive behavior of the respondents precisely. Out of the 15 women who were interviewed, all 15 of them have, at some point in their lives undertook different methods of contraception under different circumstances with differing extents of autonomy.

One of the respondents, a 22-year-old Muslim Dalit Student, when asked about her contraceptive behavior, said:

I am in a sexual relationship for the past two years, and my boyfriend has never been okay with using condoms; he thinks that using condoms would diminish the quality of sex and hence does not use it. I have absolutely no other choice in such a situation but to take the birth control pills every time after sex. It most often than not, has so many negative impacts on my health. It messes up my menstrual cycle, causes nausea, dizziness, and vomiting, making me feel exhausted and drained.

Out of the seven unmarried women who were interviewed, 5 of them had somewhat similar experiences to share. In all of those relationships, it was always the women who had to assume the responsibility of contraception and put themselves on pills immediately after the sexual intercourse irrespective of the side effects it could have on their physical well-being. It was seen that their male partners strictly refused and denied the use of condoms due to the perceived belief that the use of condoms would decrease their sexual pleasure. This common misconception that usage of condoms leads to compromised sexual pleasure, reduced erection, and a sense of sexual inferiority to women still pervasively exists in the minds of men across various intersections and continues to be one of the foremost reasons for the gendered use of contraception (Fiaveh, 2012). It was also observed from the responses of some of the young women how the risk of unwanted conceptions did not bother their partners at all as it was invariably assumed to be the women's "department" of concern. The onus had always been on the young women to keep themselves "safe," even if that means putting themselves through terrific physical and mental distress (Randrianasolo, 2008).

Another 45-year-old upper-caste Hindu women who are a college professor by profession said:

I already have three children and do not wish to have more. But the problem is my husband is crazy about sex and wants to do it all time, like literally every day. He does not use condoms despite me begging him to use them. I don't know what exactly his problem is, but he feels less of a man by putting a condom on. Until six months back, I used to get pregnant repeatedly, and it was not only physically and emotionally tiring for me to get an abortion done every single time,

but it was also highly embarrassing to be the object of laughter in the family. That is when I decided to get a copper T inserted inside my uterus covertly so that I can temporarily escape from this cycle of pain and shame without my husband's knowledge. But ever since I got it inserted, I am having irregular bleeding, pain, and periodic discomfort, making it further difficult for me to focus on my job. Maybe there is an infection. I honestly can't decide what to do at this point. Should I keep it or get rid of it?

Testimonies such as these stand as a piece of real evidence that the majority of the burden of contraception is still brunt by the women, and the larger part of the family health work is inadvertently feminized in intimate heterosexual relationships. Despite condoms being the most effective, painless, and economical mode of contraception that exists, which can both act as excellent birth control and an STD preventative, it is still not used by many men because of the fear of being conceived as "less of a man" (Govindasamy & Malhotra, 1996). Such societal stigmas then put the bodies of women at the receiving end of demanding and exhausting birth control methods which are far more painful and consequential, as can be observed in the case of the above women who are battling with excruciating pain due to the improper implantation of the copper T but is still hesitant to remove it because that would mean going back to the turmoil of getting repeated abortions. Such is the pathetic and vicious loop in which many women are hopelessly stuck. Studies have also shown how the efforts by husbands and family members to destruct women's efforts to realize their reproductive intentions is one of the leading reasons why women resort to invisible female-controlled methods such as IUDs because their partners cannot easily detect them (Castle et al., 1996 & Ashraf, et al., 2009) and be used covertly like the participant mentioned.

A 38-year-old woman who is a Municipal Corporation Sweeper says:

I got my tubes tied about three months back because my husband did not want us to have any more children. The doctors in the government hospital strictly advised against the procedure as I was already physically fragile due to other underlying health conditions. This procedure could only further complicate my health. They asked him to get the surgery done instead. But my husband wouldn't listen to them, he wanted me to undergo surgery, so I did. I was afraid that I would die.

But I thankfully did not, although the 2-3 weeks after the surgery was excruciating and challenging with nobody to take care of me. I had to get back to work immediately as I am the only breadwinner of the family. These days I cannot work straight for long hours, as it starts to hurt and now I am afraid one day I won't be able to work anymore.

For the longest period of time, India had relied on tubal ligations, with, in fact conducting as much as 4 million sterilizations per year. It is shameful that female sterilizations continue to be the most widely accessed and performed mode of contraception in India. About 39 percent of women currently undergo female sterilizations every year in our country, which is about twice as much as the worldwide number (NFHS 5). The procedure is permanent and includes the cutting and tying up of fallopian tubes. It is medically deemed as painful, risky and comes with the probability of increased postoperative complications in improper care. This procedure can be far more dangerous for women who already face other underlying conditions, as in the case of our respondent. Despite the denial of medical practitioners, the woman was still coerced into sterilization speaks volumes of the lack of bodily autonomy possessed by her in making reproductive decisions that can have such long-term repercussions on her body. Women coming from marginalized communities such as her stand the chance of facing much worse implications of permanent sterilization practices due to the lack of proper rest, regular check-ups, and in some cases, long working hours. At the same time, their male counterparts contribute nothing towards the fertility work (Bansal A & Dwivedi L. K, 2020).

A 49-year-old Christian housewife, upon asking whether she has ever been coerced into using a method of contraception against her full and informed consent, remarks the following incident:

I was taken to the nearby government hospital in 2009 to give birth to my first child. My water had broken, and I could not sense any movement in my womb; the doctors told me that I was immediately rushed to the theatre for a c-section but what they never told me was that I was also going to be sterilized. I did not even have the slightest idea about it until I visited my gynecologist some three years later owing to an infection in my urinary tract and vagina. Later I realized that my husband had asked the doctors to perform the procedure on me, and they had quietly followed

him without even consulting or informing me. I wanted another child, a sibling for my son, but that opportunity was unfairly snatched from me. Every day I feel violated and betrayed.

This horrific incident very clearly reflects the grave negligence and un-ethicalness exhibited rampantly by the Indian biomedical system. It shows the degree of compliance shown by the doctors and healthcare professionals in subjecting women, especially those coming from a marginalized background, to forced, coerced, and uninformed sterilization procedures without even properly making them aware of the procedure, let alone taking active consent from them. Despite such non-consensual sterilizations being condemned by the law of the land, it happens extensively. A third party decides on behalf of the women, and the doctors take their word for it. Such a faulty practice adopted by the healthcare system unfairly denies women of their rightful contraceptive autonomy to make decisions related to pregnancy and childbirth, as happened in the respondent's case (Patel P, 2017).

A 40-year-old Christian woman who is an engineer married to a 45-year-old man who is a school principal had a different experience to share:

My husband and I mutually decided not to have kids at a very earlier stage in our marriage. Initially, we used condoms and birth control pills by taking turns to eliminate the risk of pregnancy, and it did work for a long time. Still, after a certain point, it became very exhausting to use a condom or a pill every time we got involved in sexual intercourse. That is when both of us unanimously felt the need for opting a permanent method. I know many men refrain from getting a vasectomy done, but my husband and I decided to go for it. The procedure was so easily done and that he even went to work after the next couple of days. I think there is a giant myth in society where they believe that male sterilization will affect their virility and sex drive, but that's not true.

This response stood out from the rest and perhaps was the only one of its kind where a decision on contraception was reached with the mutual consent of both partners involved and an exclusive and active consent of the person on which the birth control sterilization was performed on. In this particular case, both the partners came from an upper caste, upper-class social location, possessed high degrees of education, and were very well employed, unlike most of the other respondents in

the interview. A study conducted by David Shaiparo (1994) showed how high educational and occupational levels of both partners of a relationship are positively related to equality in contraceptive use. It was also shown that such couples tend to opt for modern and progressive methods of contraception. Vasectomy, despite being medically regarded as highly effective, safer, reversible, and a far better option than tubectomy and other female sterilization procedures, is still opted by a very meager percentage (6.8%) of men because of the fear of emasculation and deprivation of virility (IIPS & Macrointernational).

A 36-year-old Dalit Hindu women share her experience of contraception like this:

My man is neither into using condoms or getting surgery done. Whenever I ask him to use condoms, he says that he pulls out on time, so there is no need to use condoms. But it does not work like that, right. We cannot afford another child, so I started secretly taking the pills after sex. He didn't know about it until a few months before when he found them under my bed. He was furious to know about it and accused me of infidelity, beat me up, and threatened to abandon me. I had to beg before him to take me back into his life.

The withdrawal method was commonly observed to be employed by most male partners in intimate relationships, which men also often cited as a fair enough justification for the non-use of condoms. However, the withdrawal method is highly ineffective and cannot be regarded as a substitute for condoms. It can only be seen as an excuse put up by men for not using condoms and reflect how misinformed, irresponsible, and insensitive they are towards their partner's needs for effective contraception. The covert use of contraception by women can be perceived as striking examples of unequal power in intimate sexual relationships. They are practically forced to practice contraception in the dark because of their partner's disapproval of birth control or the difficulty communicating effectively with their partners regarding contraception (Rutenberg, 1999). A study by the same researcher has revealed how women who use birth control in discretion bear the risk of being sexually promiscuous and getting divorced or abandoned by their partners. It is especially tough for women coming from marginalized sections who are economically dependent on their partners.

Out of the 15 respondents interviewed, as many as six women were using birth control pills, making it the most widely used method of contraception. Out of the six women who were on pills, 5 mentioned that their respective partners performed the method of withdrawal, which was seen as ineffective by the participants themselves. 2 of the respondents, both of whom were married, have undergone female sterilization (tubectomy) procedure. Both these women were unjustly coerced into the operation against their full, informed, and active consent. Another two married respondents had intrauterine devices such as copper T inserted inside their uteruses. They were also circumstantially compelled to opt for these methods without the knowledge of their partners as their partners either refused to use condoms or wanted more children against their will. Only as few as 2 respondents cited the regular use of condoms, and just one of the respondents mentioned vasectomy as the chosen birth control mechanism. In addition to this, it was also observed how the majority of the contraceptive use among the participants, along with being inadvertently women centric in nature were also exclusively directed towards achieving the goal of birth control.

4.3 Autonomy of women in taking decisions on pregnancy, childbearing, and child spacing

One of the significant aspects of reproductive autonomy, as per its definition in the study, is having free and fair control over making independent decisions about when and whether to get pregnant and whether or not to keep the baby. The study, therefore, with the help of the structured interview schedule had focused on understanding women's experiences of reproductive coercion and control during the period of conception, birthing, and the burden placed by the social and cultural expectations, the dominance of partners in decision-making and their crippling feelings of isolation.

A 42-year-old upper-caste Muslim woman with 5 children, a housewife, shares her experience upon asking, "whose decision was it to fall pregnant and keep the pregnancies?"

I have given birth to 5 children so far. 4 of them are girls and the younger one is a boy. It has been challenging for me to complete each of these pregnancies. I gave birth to 4 of my children with less than two years' of spacing between each of the pregnancies. There was constant pressure from my husband and in-laws to give birth to a son. They wouldn't let me stop until I provide them with

a son. After my 4th delivery, I was so tired; even the doctors advised us to stop for at least a while. But none of it mattered; it seemed as if my existence in this home depended entirely on my ability to birth a son. I got pregnant again, and I remember how much relieved I was to know that it was finally a boy; I do not have to go through this hell again. But I couldn't hold my son, neither could I breastfeed him properly because I was tired; I felt as if I was barely alive after the 5th childbirth. I am still physically very weak; I get frequent spinal aches due to all the epidurals that were injected into my back. I did not deserve all this pain.

Married women are often faced with an un-parallel pressure to bear a certain number of children. Not only that but women are also influenced by the traditional social norms pertaining to the sex composition of the family they desire. Some of the studies conducted by the researchers like Kamau and Randrianasolo (2008) in the countries of Asia document the presence of a strong son preference owing to economic advantage, social status, and other ritualistic prospects that the sons present for the families. "The womb is often credited when it when it produces sons" (Aafreen, 1991). Studies also show the historic compulsion unleashed on daughters-in-law in countries like India for producing sons, which in most cases lead to the inadequate spacing between births, leaving the women with no time to rest and recuperate from the last pregnancy. Women's failure to bear and rear a minimum number of sons inevitably jeopardizes their social, physical, financial, and marital well-being, just like in the respondent's case (Hussain et al., 2000).

A 36-year-old Hindu Pulayar woman who is working as a domestic help shares her horrifying experience of pregnancy with teary eyes:

I never had full control of my pregnancy, childbirth, or child-spacing ever in my life until this point. These decisions were always taken by my husband, in-laws, and the community members on my behalf. I have two children, and I birthed both of them at times when I did not want to. I was very young and was not ready to become a mother, but I had to prove my worth as a wife and a daughter-in-law, and that was somehow inevitably related to my fertility. I worked all through my pregnancy and did not receive even an ounce of care or support from anyone. It seems as if I am just a machine to reproduce children, devoid of any worth beyond my capacity to procreate. I do

not have any bodily autonomy. My husband needs a third child now and coerces me to have unprotected sex with him. I am scared.

This experience shared by one of the respondents reflected a highly patriarchal and bio-essentialist view and resonated with the responses of certain other married participants, wherein the worth of a woman is unequivocally reduced to her reproductive physiology and her ability to procreate. As long she caters to the maternal gender role, all other considerations pertaining to her status as an individual remain unimportant. The gendered norms and institutions, by placing motherhood on the pedestal, control and dictate women's choices in terms of childbearing so much so that their economic status, survival, treatment in marriage, security, and risk of divorce are all derived from the number of children they bear (Dharmalingam & Morgan, 1996). Such a situation essentially deprives women of their agency to independently control the crucial reproductive decisions and make them surrender their bodies to the discretions of others.

Another 40-year-old married Hindu Ezhava women who run a tailoring shop shares her earlier experiences with pregnancy like this:

I was married at 19, and ever since our marriage, there has been a lot of pressure from both our families and society, in general, to get pregnant. But I was terrified of having a child at that point as both my husband and I were practically jobless. We did not have any means of rearing a child. Every time we had sex without a condom, my heart used to race. Then one day, I got pregnant. I was scared and instantly went to two gynecologists in our locality to get an abortion, but both refused to do the procedure unless they have my husband's consent and presence. I was left with no choice but to complete the term of pregnancy, but our baby was severely underweight and died within 2 days. I still live in that trauma and guilt. Things would have been so different if I had the autonomy to decide if the doctors had listened to me or if my husband had listened to me.

This incident reveals the utter failure of government healthcare professionals to conceive women as independent and autonomous individuals capable of making desirable decisions that are directly related to their bodies. Many medical practitioners still view women, especially women from the lower class, lower caste backgrounds, as secondary individuals who are incapable of making

effective reproductive choices without the consent and sanction of their male counterparts (L Prudy, 2006). Even after the law legalizing the medical termination of pregnancy, with only the permission of the involved person needed, certain shrewd and flawed notions of gender still fogs the mind of gynecologists such as our respondent's case. An excessively ignorant, discriminatory, and unethical decision from the doctors violated the woman's bodily autonomy, put her through the unwanted physical labor of pregnancy, and caused her a severe life-long emotional trauma and guilt that she did nothing to deserve.

A 36-year-old Dalit Hindu women remarks on her pregnancy in this way:

"It's not about what I want; it is a tradition in the society in general and our community, in particular, to have a child at least within two years of marriage. Otherwise, people will speak ill about the woman, to the extent that her marriage could be in danger. I was honestly afraid when I could not get pregnant in the first year, but thankfully it happened at the starting of the second. Otherwise, I don't know what would have happened to me!"

This experience is a testimony that shows how women's personal and reproductive decisions are never borne of out of what they want to do with their bodies but are most often than not inextricably linked towards exclusively catering to the patriarchal constructs of what the society expects them to do. While sharing this response, the researcher could sense the fear that guided the women to get pregnant. She got married at a young age and did not want to birth a child, but the scary realization that the meaning of her existence, her entire worth as a person, and even the longevity of her marriage are all inevitably dependent on her fertility and how soon she bores a child compelled her to get pregnant. Such a tendency to non-consensually and unwantedly manage reproduction to solely comply with the social pressure and traditions of becoming ideal childbearing wives and good mothers was extensively shown by most of the respondents because that was the only way for them to gain social acceptance, even if it required to subject themselves to sexual and reproductive decisions that violated their bodily autonomy (ICRW, 2012)..

4.4 Freedom of partner Communication in Intimate Partner Relationships

One of the critical aspects that constitute the conceptualization of reproductive autonomy as defined for the current study is the freedom of communication between partners in intimate relationships regarding their sexual and reproductive health and choices. The ability to healthily and freely have intra partner communications on issues related to fertility such as the desired number of children, use of family planning methods, and spacing and timing of children are all extremely crucial, especially for women when it comes to taking an active part in making decisions that are so intimate and intrinsic to their bodies. Several studies have even established a very positive relationship between active partner communication in sexual relationships and the consensual use of contraception, greater autonomy, and equality for women in making pregnancy and childbirth decisions (Cox, Larsen 2013). Therefore, a section of the questions in the interview schedule was aimed at specifically understanding the extent of communication that existed between the respondents and their partners regarding SRH and related topics.

An unmarried 22-year-old college student, upon asking whether it is easy to communicate about sex with your partner, responds like this:

He likes sex and is borderline crazy about it. I am not like that. I do enjoy getting physically intimate and engaging in sex sometimes. But some other times I don't want to do it. However, I have always found myself at a place where I have to hold back from expressing my feelings, so I don't make him sad or angry. When I do communicate to him about sex, he laughs it off by saying that he knows things better than I do since he is an upper-class Hindu guy and I am just a conservative Muslim girl.

Women might refrain from openly communicating about their sexual and reproductive preferences to their spouses or partners due to various reasons. One of the most prominent reasons amongst others is the fear of making their partner sad, angry, or irritated. Women may think that their partners are aversive towards their choices and therefore, may deliberately hold back themselves out of the dreading fear of creating a conflict in the relationship (Ruttenberg and Watkins; 1998). When they do manage to communicate about these issues related to sexual and reproductive health, they are meted out with condemnation and trivialization of their opinions which completely discourages them from opening up the next time. They then choose to remain quiet and dormant,

fearing the mockery and shame that may follow. The presence of gender, caste, and class-based divides and inequities in a relationship can also lower the extent of communication between partners, as observed in the above instance (Uzma S et al., 2018).
36-year-old Dalit Hindu married women talks about communication in their relationship like this:

"I am genuinely petrified to talk about anything related to contraception or sex in general with my husband because it gives him an impression that I am sexually promiscuous or is having an extramarital affair with someone. He might also think that I doubt his ethics and intentions towards our relationship, which could disrupt the harmony of our relationship. So I don't talk to him about these kinds of stuff".

About 4-5 of the married respondents shared this concern. They cited the same as a fundamental reason for consciously disengaging in any conversation with their partners about matters related to sex and reproduction. Women feared that by openly communicating about contraception, childbearing, and pregnancy, they increase their partners' chances of perceiving them as sexually promiscuous and unfaithful. In other cases such as the above one, women did not want to be seen as speculative about their partner's intentions by talking about contraception or other related issues. "A discussion is mostly taken as a precursor of an accusation by men" (Marrindo; 1996). Due to these reasons predominantly borne out of fear and maintaining the "harmony" of the relationships, women often do not restrict themselves and hold back on effective partner communication (Uzma S et al., 2018).

A 28-year-old upper-caste Hindu unmarried Women says:

"Whenever I communicate with him about the things that he is doing wrong when it comes to our sexual life, he suddenly becomes extremely uncomfortable, irritated, and shows utmost reluctance to accept and acknowledge his ignorance. I think his male ego gets hurt every time I (a woman) points out his mistakes."

Most of the time, men find it extremely hard to encourage and facilitate free and open communication in intimate partner relationships. They are heavily reluctant and ignorant, as rightly

mentioned by the respondent, inadequately acknowledging, accepting, and taking cognizance of the areas where they are failing or disappointing their partners. The popular perception that men are supposed to be the dominant and commanding ones in a sexual relationship continues to be deeply ingrained in the minds of men. Because of this, whenever their female partners express concerns and opinions, men feel incredibly threatened and tend to reclaim their power and agency by neglecting, avoiding, or hijacking these conversations. Again it is the women who have to make amends, compromise, and adapt to the situation.

A 31-year-old Christian unmarried woman who is working as a software engineer, upon being asked "how freely do you discuss and communicate about your SRH issues with your partner (like missing periods, discharge, cramps, etc.), response:

"I have tried talking to him about periods, the cramps, the mood swings, and how weak and tired I feel during those days, but he does not really show any interest in listening and instead shames me for being open about it. He thinks that it is all girl's stuff and therefore I should deal with it myself rather than going around and talking about it. Sometimes he even wants to have sex while I am on my periods despite knowing the kind of pain I am in"

The unmarried respondents showed much greater freedom of expression and communication in their relationships in discussing matters related to sex. Most women were not afraid to openly express their desires and negotiate about what they want and desire from their partners, unlike married women. These respondents cited that there was no such definitive contractual bond between the partners and that it is the reason for the lack of fear and free and non-judgmental communication.

However, two unmarried respondents felt highly uncomfortable in openly talking about periods, cramps, and sex to their partners because of the probable shaming that would follow. The popular misconception that women are not supposed to be vocal about their sexual biology and that these are topics that should be exclusively hushed within just the female circles underlie such an insensitive male attitude. Such an inability of men to efficiently understand their partners' biological experiences and needs can lead to sexual insensitivity and sexual coercion, just like what happened in the respondent's case (G. Karen et al., 2018).

A 45-year-old married woman who is a college professor remarks:
"Honestly speaking, I do not like the way he treats me during sex. Is it almost like I am some object, you know? I barely enjoy our sexual life. His preferences on the bed are very different from mine. I wish I could tell him openly about the way I want it to be, about my desires and interests. But unfortunately, I can't talk to him about any of these because we women are socialized to be passive and dormant when it comes to vocalizing matters related to sex, right?"

For some women, it is so challenging to even remotely talk about sex as in many settings as they are socialized in a way where they are supposed to be not aware and dormant about sex, and uncomfortable than their male partners in openly discussing sexual matters, particularly about their sexual pleasure and satisfaction. There is a construction in society that women are inherently indifferent towards sex, and it is the men who have dominant sexual impulses. Women are supposed to be always available for sex without really appearing to be sexually active or too involved in the process (Aggleton et al.;, 1999). Such maligned, sexist, and flawed understandings immensely influence how females communicate, demand, and autonomously seek sexual pleasure within intimate partner relationships.

4.5 Experiences of Women regarding Abortion

One of the respondents, an unmarried Ph.D. student, shares her experience of abortion:

Just 6 months into our relationship, I unexpectedly got pregnant. My partner and I decided to get an abortion done as soon as possible. Still, to our misfortune, none of the gynecologists in the government hospitals agreed to do the procedure without parental consent since we were a young unmarried couple. I was emotionally and physically so flushed, and I had absolutely no other way but to try the abortion pill by myself. By that time, it was already past two months into the pregnancy, and the pill kind of made things worse for me. It caused heavy bleeding and vomiting, and I was rushed into a private hospital where the doctors had to conduct the abortion because of the severe damage and inflammation in my uterus. The whole treatment cost both of us a fortune. I honestly despise those doctors who refrained from treating me.

Another 20-year-old student says:

Last year I got pregnant because my then-boyfriend violated me by engaging in stealthing. When I shared the news of pregnancy with him, he of course, bailed on me, and me, a 19-year-old college student, was left all alone with a filled womb. Time and again, my demand for abortion was turned down by several gynecologists because I was a "kid" with loose morals. Finally, I had no choice but to disclose the news to my parents, and with their consent, I got the abortion done. But it cost me my studies, my passion, my freedom, and a chance at living my life on my terms.

The above two experiences of abortion, as narrated by two of the young unmarried respondents, speak volumes about the insensitivity and negligence internalized by the country's reproductive health care providers. It mirrors the prevalent perceptions of abortion providers towards sexually active unmarried women in India. One of the prominent reasons for the vast denial of safe abortion services to young women is inevitably rooted in the skewed beliefs of medical practitioners. The idea that women's "illegitimate" and overt sexual indulgence has been primarily responsible for the situation of abortion, and therefore, they do not deserve to access it. Such an attitude leads to the ill-treatment and exploitation of the patients. The women's desperation to get an abortion at the time of consultation tends to be high, which puts them in a position of reduced bargaining power with the doctors and the medical community. As a result, it becomes further likely that the women are either denied the services and treated judgmentally, or infantilized, asked for permissions from parents or partners, or are provided with extremely poor services in quality. This sort of hostility and unreceptiveness showcased by the healthcare providers leave the women with no other choice but to opt for unsafe, self-induced abortions or clandestine procedures (Jeejebhoy et al., 2010)..

Another one of the respondents, a 31-year-old unmarried Christian woman, shared her experience of being compelled to access an unsafe abortion clinic pretty late in her pregnancy because the doctors in the government hospitals out rightly denied performing the abortion. She later suffered severe infection and post-abortion complications due to the unhygienic and unspecialized way the procedure was conducted. Such kinds of abortions put light on the vulnerability and stress experienced by young women and the lack of access to safe and evidence-based abortion procedures.

Another 38-year-old married women says:

Due to the non-use of condoms, I got pregnant for the third time, and I did not want to keep the child at all as we could not bear the responsibilities of another child. I decided to abort the baby, but my husband, his mother and his entire family, and even our gynecologist were all strictly against this decision. The doctor even tried to guilt-trip my husband and me on how sinful an act it was and how can I, especially being a mother of two, agree to kill my unborn baby. His words further influenced my husband, and I was literally coerced to keep the baby against my repeated resistance. But the baby died in my womb itself because it was too weak to survive. From that day on, I am repeatedly blamed for my infant's death. As it is, it was tough for me to go through these things, but all the name callings and heartless acquisitions by my husband, mother-in-law, and the community members just made it unbearable.

The construct of motherhood is considered too holy and too divine by our society. It has become the most significant hindrance that restricts women from rightfully claiming their abortion rights. Women have to battle with issues of confidentiality, non-availability of resources, limited awareness, and extreme ostracization and stigma for successfully undergoing an abortion procedure. Most of the doctors providing such services either refrain from conducting the procedure altogether, manipulate and instill false notions in the patients' minds as can be seen in the respondent's case, or else demand strict spousal consent even though it goes against the MTP mandate. In addition to these, married women are also made to feel worse than they already do by society about losing their babies, when what they need at these times of turmoil is care, reassurance, and support (R. C David, 2018)

4.6 Perceptions of women regarding abortions

The following are some of the responses of the participants when asked about their thoughts on the women who seek abortion services and on who should make the ultimate decisions pertaining to abortion.

"I am strictly against these young unmarried girls getting abortions done and all. Young women should not in the first place get into such immoral relationships that there ever arises a need for an abortion before marriage. They should be extra careful in these kinds of things because there is so much to lose for them."

Out of the eight married women who were interviewed, 6 of them had perceptions similar to this one regarding sexually active unmarried women who seek abortions. The two women who opined otherwise actually came from the synonymous upper-caste, upper-class locations and were also very well educated and employed. While agreeing to the conduct of abortions among married women, the respondents despised the same in unmarried women. This statement made by one of the respondents mirrors the prevalent perception of society regarding pre-marital sex, pregnancy, and abortions. The responses also explain how socialization has a huge role in molding up, fostering, and internalizing such problematic attitudes among people and how women's age and marital status could exacerbate one's judgments on abortions (Kumar et al., 2009).

42 year old married women said:

"In our community, abortion is regarded as nothing but an absolute act of sin. People here consider a baby as the greatest gift of god. To even think of getting rid of it is equivalent to committing a murder. If a woman has undergone an abortion, be it a miscarriage or a chosen abortion, they are severely looked down upon and is even labeled in our locality. Women are terrified to even think about it."

A woman's decision to undergo an abortion was found to be influenced mainly by many social, religious, legal, and cultural factors and as well as by individual characteristics such as marital status, age, and religion, among others. The injunctive and descriptive norms present in society contribute at length to the abortion stigma that women may encounter when obtaining an abortion (Kumar et al., 2009). The stigma is generally a shared understanding that abortion is against the morality of society and hence unacceptable. Such a notion can manifest itself in many ways and limit access to autonomous and safe abortion. These curtailing norms are often originated from the

firm belief in the primacy of motherhood in women and the socio-cultural expectations around pregnancy and parenting. The pervasive dehumanization, defamation, and condemnation of women who terminate their pregnancies or undergo miscarriage, gravely restricts and petrifies other women to freely and independently choose to seek the service. Even if they do, they feel threatened to reveal it. It is the fear of getting judged and gossiped about by the community, family members, and sometimes even healthcare providers that guides their decisions to seek abortions and not their own free will (Petchezky, 1990).

"Since the baby cannot be formed without the efforts of two people, a decision as huge as getting an abortion should be made consensually by both the partners. It cannot be the woman's word over the man's or vice versa when it comes to ending your unborn child's life."

This is the response given by a 35-year-old unmarried Upper caste Muslim woman upon being asked who, according to her, should have the ultimate decision-making authority in issues related to abortion. The response is so much in alignment with the larger consensus of the society and, in its very essence, overlooks the reproductive and bodily autonomy of women. It is precisely the existence of beliefs like these that act as a massive impediment for women in accessing abortion services without the consent of their partners or other older family members even when the law favors it. Such an attitude completely negates the fact that pregnancy and abortion are very much intrinsic to the bodies of the women and they are the ones who have to physically and emotionally live through the repercussions. So even when their male counterparts contribute to the formation of the fetus, the physical labor is exclusively done by the women alone.

"Being a young unmarried woman, I think it is all the more difficult for girls like me to access safe abortion services in comparison to married women because we are often considered as characterless, and our relationships are seen as illegitimate. Both the medical practitioners and the people, in general, are prone to judge us, question our morals, deprive us of safe abortions, ostracize and police us incessantly. I think these are the reasons behind so many unsafe abortions and maternal deaths in India."

This statement from a 28 year old unmarried woman, is a piece of evidence of the perpetual pressure and fear under which unmarried women involved in intimate partner relationships live in our society. These words speak their angst and vulnerability. They constantly breathe the fear of getting pregnant, mainly because of the sheer difficulty in accessing safe medical abortions in such a situation anywhere in India. Women are often circumstantially forced to approach illegal and unsafe abortion clinics, putting their entire life in danger. Therefore, the medical system and society have repeatedly failed the sexually active unmarried women by constantly depriving them of their reproductive rights and further by burdening them with unsolicited moral and value judgments (G Caitlin et al., 2015).

A 40-year-old married Christian woman who is working as an engineer said:

"I believe that decisions related to pregnancy, abortion, etc., should be solely taken by the woman as these are processes that are inevitably tied to her body. The partners, family members, and doctors can have their opinions and suggestions, but the authority to make the final call should always be vested in the woman. But unfortunately, this does not happen in our society, does it??"

This response very rightfully addresses the importance of women's reproductive and sexual autonomy and place the decisions made by women on the highest pedestal. It recognizes the pressing need for respecting women's authority and command over issues that are directly concerning their bodies. But the participant also realizes that while this is how the society should ideally function, the current situation is anything but this.

4.7 What are the Socio-Cultural and Economic Barriers faced by women in exercising reproductive autonomy and accessing reproductive healthcare?

The relationship between socio-cultural and economic factors and reproductive health is well identified in the global literature and has been recognized especially within the highly heterogeneous context of India. These factors can both positively and negatively alter the sexual and reproductive experiences of females, and therefore, it becomes even more important to examine their specific influences in the lives of these women. For the same purpose, the

respondents of the study were asked questions that tried to understand in-depth the different socio-cultural, economic and other barriers they encounter daily, which have inevitably hindered their sense of reproductive autonomy and have further barred them from accessing effective and quality sexual and reproductive health care. The following are some of their responses:

"I feel, if I had an opportunity to do formal schooling and get educated properly, then perhaps I would have known better about these things. I mean, I did not know anything about how sex worked or what contraception until after I got married. Being a girl that too from a very poor and conservative household, I never really had anybody to teach me these things. Hence, I always find myself in an inferior position to my husband in terms of knowledge and information. It is also one of the reasons why I have to comply with his decisions" (36-year-old Married Dalit Hindu Women)

Women, especially those coming from disadvantaged social positions such as the respondent, are more often than not denied access to proper formal education based on their gender and sometimes because of the household's financial situation. Such a lack of schooling puts them in a relatively inferior position in terms of knowledge to their male counterparts who have had a better opportunity at learning. A study conducted by Lloyd and Mensch (1999) shows that education increases autonomy, particularly for women, and allows them to achieve their preferences by delaying the age of marriage, efficiently negotiating and bargaining on family planning and contraception with their partners, and empowering them to timely and effectively engage with medical practitioners and seek the necessary help. Lack of convenient access, availability, and proper awareness of such crucial information regarding their SRH significantly reduces the reproductive autonomy of women, fosters their beliefs in myths, and further makes them susceptible to surrender to the wishes of others.

"Being a domestic help, I have long working hours and yet barely earn enough to keep my family alive. Low income, poor living conditions, and the nature of my work do not give me any time to spare for my own health care. Currently, I am on heavy antibiotics because I have a serious UTI, the symptoms of which I ignored for a long while until it got worsened because of the exact reasons that I mentioned earlier".(38-year-old Married Muslim Dalit Women)

This experience shared by one of the respondents shows how multiple intersecting factors can together negatively influence the health-seeking behavior of a woman. Coming from a marginalized community and being the only breadwinner of the entire household, she has many responsibilities to fulfill. Between long working hours, doing overtime for extra money, and managing the domestic chores, she is hardly left with any time to take care of herself and look after her own sexual and reproductive needs. Women mostly put the needs of their family and children before their own, essentially because that is what they have been socialized to do. They often endure the tensions of their everyday life. Such an attitude was clearly observed among the respondents. Out of the 8 married respondents, as many as 6 of them did not consult a gynecologist even once a year because they considered it a comparatively "unimportant" and "unnecessary" expenditure.

"The biggest barrier that I was an unmarried woman face is society's aversive attitude towards girls who engage in pre-marital sex and all the discriminations that come with it. The concept of virginity is so deeply ingrained in people's minds, including my parents, that it had become an important yardstick to measure a woman's morality. Many women of my age, including me, have at some point been at the receiving end of several smirks and judgments from the chemists for buying contraceptive pills, been denied the right to safe abortions, been victims of grave character assassination and moral degradation by doctors and the society in general. It is truly pathetic." (25-year-old unmarried P.hD student)

Most of the unmarried women who participated in the study shared the same concerns when asked about the socio-cultural barriers in accessing safe and trusted sexual and reproductive healthcare. Society's rampant demonization of pre-marital sex and pedestalization of virginity and chastity as desirable qualities had put the sexually active unmarried women in a very risky and vulnerable situation. Even accessing contraceptives from chemists or consulting for abortions from doctors has become a challenging task for most young unmarried women in intimate partner relationships. The traditional norms and taboos in society place various limitations on women in performing independent reproductive choices. Women who dare to act independently by breaching the societal standards and norms are meted out with outrage of social stigmas (ICRW, 2012).

Such stigmatization is often motivated by stringent gender norms that constantly put gigantic pressure on them to conform to the heterosexual institution of marriage and family. These have been considered central to achieving performed femininity.

A Dalit Married Respondent said:
"When I was pregnant with my first child, I still remember the kind of differential treatment I was mercilessly meted out within the government hospital. The behavior of the doctor and the other health care staff in the hospital was very prejudiced and discriminatory towards me in comparison to the other women because I was a poor Dalit woman. They would make me wait for hours for the consult and never really examined me properly ever. I was honestly afraid for my baby. But we could not afford a better facility either due to high service fees and lack of insurance."

In a highly stratified and divided society like India, People's health outcomes are significantly influenced by their social position/group, and there is a specific social gradient to the health outcomes in India. Some of the studies conducted by Acharya (2007) have highlighted the different kinds of discrimination encountered by Dalit women while accessing maternal health care in government hospitals. Such a pervasive denial of fair and equal treatment for women coming from disadvantaged sections of the country owing to some very regressive preconceived notions of pollution and purity serves as a major impediment to effectively utilizing the medical facilities by these women and their children. Discriminatory and exclusionary practices and inherent biases such as these continue to maliciously guide at least a section of the Indian health care system, depriving people, in this case, the lower caste and lower-class women, of their rightfully deserved reproductive rights (Archana, 2014). The bio-medical system in our country can do a better job at training doctors and other health care providers to rise above their inherent social and cultural biases and deliver perfectly equitable, sensitive and quality treatment towards all the patients.

"Being an unemployed Muslim woman, I am entirely financially dependent on my husband. The fact that I have to ask him for money to meet every need I have is embarrassing and makes it harder for me to make any free choices at all. It makes him have strong control over me. Not just that, there is also a strict restriction on my mobility. Whenever I want to go out, I am always accompanied by some older family member, mostly by my husband or mother-in-law, even if it is

to meet a gynecologist or buy medicines. Under such an environment, it becomes so difficult to be in control of your sexual and reproductive health."

This statement shows the concomitant relationship between financial independence and reproductive autonomy. Women's control, possession, or ownership over economic resources, savings, or the presence of a steady and regular income can have a positive influence on their reproductive and sexual behavior. But in the absence of the same, women become invariably dependent on their male counterparts; this dependency gives their partners a sense of entitlement and control over the sexual and reproductive decisions of the women (G. Sarah et al., 2019). Financially relying on husbands or partners would also mean placing limitations on seeking essential SRH services as and when they require it. It also makes women vulnerable to complying with the decisions made by others regarding their bodies.

The family members' tendency to accompany the woman every time she steps out essentially reflects her constraint to autonomously and freely visit places. There is constant surveillance and patrolling of her actions which inevitably place boundaries on her health-seeking behavior and hamper her need for accessing vital medical services (Nicolette, 2008). The majority of the married respondents mentioned such restrictions to their movement and its relation with their irregular medical consultations and inaccessibility of birth controls and contraceptives in time of need.

Another 49-year-old Christian woman said,

"One of the biggest reasons why my husband never used condoms, and instead got me sterilized against my knowledge was because our religion condemns and disapproves the use of condoms."

This statement reveals how religion and religious beliefs can sometimes influence SRH related decision-making and stand as potential barriers to women's reproductive autonomy.

4.8 Does women actually feel they have the reproductive autonomy to exercise control over their sexual and reproductive health and rights in intimate partner relationships?

21-year-old unmarried Christian student says:

"It is hard to say that because until I sit and consciously think about it, it is difficult for me even to understand that I do not have enough control over my SRH. Over the years it has become so normalized in our relationship for my boyfriend to take all the decisions on our sexual life that it does not feel wrong or as if he is trying to control my body. I think this is how most romantic relationships work in society, irrespective of whether it is right or wrong. It was the same for my parents, and it is the same for most of my female friends. It is how things naturally function you know."

42-year-old married upper-class Muslim Housewife says:

"I am 42 years old, and I have never felt like I was ever in complete control of my body or my sexual and reproductive choices till this date. Other people in my life always took those decisions on my behalf. I have been taught by the society and my parents only to follow the decisions made by my husband and not to make any of my own, so that is what I have been doing and continue to do, be it on deciding how many children I should have? Or what kind of contraception should I use? Or When and how to have sex? Or Whether or not to go out? He decides, and I follow. He has so much power in our relationship than I do".

These responses mentioned above show how common it is for men to entirely and independently take reproductive control in intimate partner relationships. Most often than not it is not even recognized as a pertinent problem that needs immediate and careful consideration. Such an arbitrary control and domination of men over women's sexual and reproductive choice exists on an unbelievably large scale in society. Specific built-in patriarchal structures work both directly and indirectly to validate and promote such a social order which often facilitates its unhindered continuity. The tendency of men to entirely regulate the reproductive behavior of women is so ancient, widespread, and socially accepted that it can be observed across age groups and generations and hence is rarely regarded as an anomaly that needs to be questioned or changed by society (Blanc, 2001).

The 36-year-old married woman who is a cleaning staff in a flat response:

"My autonomy and decision-making power extend only to deciding what should be made in the kitchen or how to manage all the household expenses within the limited budget. That is it. It does not go beyond that in our relationship. All the other important decisions, even those related to sex, pregnancy, abortion, etc., are taken by my man and his parents. Any objections or resistance from my side is meted out with physical abuse, and my body cannot bear the pain, so I obey. No women in our locality retaliate because they are all afraid of either getting hurt or abandoned."

This participant's response very clearly echoes how women's decision-making power is very often confined into the walls of the kitchen and taking care of the children and does not extend beyond that, into the realms of sex reproduction. Any attempt by women to reclaim and re-ascertain their reproductive autonomy in male-headed family structures only increases the likelihood of extreme physical abuse and further puts the women at the receiving end of violation. Three married women out of the 15 women interviewed expressed this explicit fear of getting physically harmed by their partners, and all three partners were also reported to be alcoholics (J. Lisa, 2014).

14 out of the 15 participants interviewed were observed to have an evident lack of reproductive autonomy in making decisions related to either one or more than one of the following areas of; contraception, pregnancy, childbearing, child spacing, and having the freedom in partner communication. As an Indian woman's body has multiple stakeholders (Unnithan-Kumar et al.,2004), the reproductive decisions among a vast majority of the participants were made under collective coercion by their male partners, family, and community members and were directed towards conforming to the patriarchal structures and traditional norms present in the society.

CHAPTER 5

DISCUSSIONS AND CONCLUSION

5.1 Discussions

From a process of biology, reproduction has now become a weapon of patriarchy to dominate, control and regulate women's bodies. By now, it's been abundantly clear that there's a multitude of factors that restrict women from autonomously making decisions and accessing required services related to SRH. The harmful, discriminatory, and enormously exclusionary norms and practices followed by the society, the unfavorable power dynamics between the partners, and also the limited and insufficient availability of resources to women to execute reproductive freedom are just some of the various reasons that are answerable for the reduced reproductive autonomy of women in intimate partner relationships. This study, specifically, had ventured to grasp exhaustive the sexual and reproductive experiences of both married and unmarried women within the reproductive cohort and identify the factors that shaped those experiences and analyze the extent of autonomy the participants enjoyed within each of those relationships with relation to making decisions on contraceptive use, pregnancy, childbirth, child spacing, and the freedom in partner communication about issues associated with SRH. The findings that were made out of the collected qualitative data sources reveal an extremely clear but yet complex and nuanced picture of women's reproductive autonomy in exercising control over their SRH in intimate partner relationships. It had captured how reproductive coercion not only violates women's autonomy but also reduces them to mere objects of patriarchal power.

In the case of contraceptive use, it was observed how the women still undertook an infinite part of the fertility work, and most of the contraceptive methods used were primarily focused on their bodies. A pervasive denial of condoms was uniformly seen across the male partners of both married and unmarried women, which successively coerced most of the women to use contraception pills, and intrauterine devices like the copper T, which were sometimes seen to possess physical and medical side effects like nausea, vomiting, physical weakness, infections,

and menstrual irregularities. A few of the participants were even made to undergo sterilization procedures without their full and active consent. There have also been women who were deliberately and forcefully curtailed from using any contraceptives against their will just because the men and his family members wanted the women to bear more children. Therefore a significant lack of contraceptive autonomy was observed in the participants.

The women were also seen to face significant impediments in autonomously making decisions related to their pregnancy and childbirth. More often than not, these decisions were taken under tremendous pressure to conform to societal norms and expectations. According to some studies (Swartz A, 2018), even when women resolute in preventing pregnancies, they cannot do so. It is pretty challenging to successfully use contraceptives against their partners' will for a long time, the threat of getting caught. Whether the woman wants to get pregnant or not and whether she is ready to keep the baby or not seemed to be essential questions asked while making such decisions. The celebrated status of motherhood and the social acceptance, marital security, and guaranteed safety that followed it were factors that predominantly influenced the decisions of married women related to pregnancy. The presence of preference for sons, the need to have large families, and the pressure to prove the fertility soon after consummation were all observed to be responsible for the early initiation and inadequate spacing between the births. In general, women, because of the unbearable pressure from their husbands, family, and society, set their bodies to childbearing to meet societal standards. These findings resonate the results of (Anju Malhotra et al., 2012) in her work Women's Demand for Reproductive Control: Understanding and Addressing Gender barriers.

The study also explored how the widely accepted ideas of sexual purity and virginity present in the society completely threatened the existence of sexually active unmarried women and made their lives extremely difficult. Several experiences were shared wherein many young girls were outrightly denied access to family planning and essential maternal health care and other medical services, including access to contraceptives and institutional abortions, depriving women seeking emergency services of their limited options. They were also meted with outrageously stigmatized behavior due to some healthcare providers' conventional and patriarchal judgments. The perceptions are borne out of the moral, religious, and socio-cultural norms that regard sexual

activity and pregnancy outside the contract of marriage as a sin or as deviant, often underlie such prejudice and consistently subject women to discriminatory behavior and community sanctions.

Consistent with the previous studies conducted by Haddad, Menon, and Engle (1999) and Nogatu et al. (2014), women's financial autonomy, characterized by regular income and ownership of resources, was found to be concurrent with their reproductive autonomy. Women who had independent control over their income, savings, credit and other financial resources such as expending money for personal purposes were found to be enjoying better reproductive autonomy. They had seemingly better control over their sexual and reproductive choices and behavior.

The educational status of women was observed to be a critical factor that influenced the reproductive autonomy of women (Rahman et al., 2014) and (Jejeebhoy et al., 1996). Women with proper formal education visibly had better and adequate knowledge about sexual and reproductive health and rights. It also enabled women to identify between misinformation, myths, and facts and seemed likely to exercise their autonomy and utilize health care services independently. It also empowered women to have proper communication with their partners, answer their questions, and bargain in making decisions in favor of their needs. Married respondents with a lack of proper formal schooling and education were seen to have markedly compromised reproductive autonomy than their educated married and unmarried counterparts.

The study found that women's freedom of movement was also a significantly important factor that reflected the extent of power exerted by the respondents in their sexual and reproductive health (Bloom et al., 2000) and (Rahman et al., 2014). Many participants, especially the married women belonging to the underprivileged and marginalized sections of the society, were seen to possess minimal freedom of movement. They were reported to be accompanied by older members of the family or their husbands most of the time they step out of the home. The constraint is further worse for unemployed and financially dependent women. This makes it difficult for women to freely practice their reproductive autonomy as they are under constant surveillance and ultimately disrupt their reproductive health-seeking behavior.

Communication between partners on sexual and reproductive health-related topics was seen as a predictor of independent decision-making in women. But most of the women exhibited significantly low levels of open partner communication. They often registered reluctance in confidently initiating the conversation, primarily out of the fear of their partner's adverse reaction. Lack of proper communication also tends to be because of the conventional social construct of

male superiority and the idea that sexuality is taboo for partners to discuss in private. Married women, especially those coming from a lower caste, lower-class background, were observed to have notably less negotiating and bargaining power with their partners than unmarried women. These findings were seen to be in concordance with the studies conducted by (Malhotra et al., 2003) and (Carol R et al., 2019).

Both married and unmarried women also encountered barriers at the health system level. These barriers are mostly related to the limited accessibility and availability of patient-friendly medical services. (N Muntean et al., 2015). Lack of quality and acceptability of services which manifested in disrespectful, differential, and unfriendly treatment by the health care providers, prolonged waiting hours for women coming from a specific caste-class location, and repeated breaching of privacy were all seen as significant deterrents (C Chol & B. Debru et al., 2018).

Interviews of some of the married participants revealed a very close relationship between the presence of Intimate Partner violence from husbands and in-laws and the subsequent constraints it raised to the reproductive health and reproductive autonomy among women. IPV can have a disproportionate impact on women belonging to the reproductive cohort and heavily compromise women's reproductive well-being. Women coming from lower-class lower caste backgrounds with their partners being addicts to substances were observed to be the prime victims of IPV. These findings are in sink with the results of (Hasstedt & Rowen, 2016), who explored the relationship between IPV and sexual and reproductive health. The victims of IPV had significantly less autonomy over their bodies and lacked the decision-making power in making reproductive choices. The pricking fear of getting physically and emotionally hurt made most of them surrender to the wishes of their partners without even a protest.

The traditional gender norms deem women as submissive in sexual relations and expect them to fulfill the reproductive obligations in marriage silently. Women are supposed to appease their partners by obeying the arbitrary decisions taken by them. Such regressive beliefs mainly made it hard for women to efficiently accept the charge of their contraceptive use and other SRH needs and entirely exercise their autonomy. Similar cultural taboos exist against abortion and consider both contraception and abortion as inappropriate as they essentially disrupt the natural and God-given processes, including that of a woman's expected duty of bearing and rearing children (Srikanthan & Reid, 2008).

5.2 Conclusion

Motivated partly by the commitments made within the International Conference on Population and Development and partly by MDGs and other international agreements, India has managed to form certain progress in incorporating women's empowerment and reproductive autonomy as a priority (AbouZahar, 2003; Bernstein, 2009). But even with the slight improvements the country has made in terms of a number of the social and health indicators, the bulk of crucial outcomes associated with reproductive health and rights of women remain pretty stagnant. An extensive range of socio-cultural, financial, legal, and provider-related factors still noticeably impede the women's ability to hunt, utilize and optimize their options for accessing safe reproductive health services in India. (Bhandari et al., 2006; Wolff, 2000). Even with the researchers' continuous efforts within the past few decades to contribute to a more robust and nuanced understanding of the multitude of barriers faced by women in correctly defining and succeeding in their reproductive intentions and recommending effective strategies to handle these barriers, the case has not seen much of a change or positive transformation.

Women's bodies do not have an independent existence of their own. They exist as agencies to motherhood, sexual pleasure, and procreation, all of which are manifested through their bodies. They are the victims of reproductive coercion and dominance in varying extents, from their male partners, community, relations, and to some extent, even from the healthcare providers. They're still constrained in several ways by a heap of regressive norms and traditions from making informed and free choices concerning their own bodies (Lowe, 1982). Therefore, there's a striking need to deeply understand and immediately answer what women in India want and need to require complete control over their reproductive lives and the choices associated with it. Women must be able to unwaveringly choose their options in an otherwise patriarchal and male-dominated society. They should entirely be in authority to form any procreative decisions concerning their bodies without the coercive control and influence of any other external factors. These decisions cannot be

made for them on their behalves by their lovers, boyfriends, husbands, doctors or the other third party for that matter.

To facilitate the functioning of women as equal members of this society, it's imperative to comprehend and recognize the necessity for safeguarding their bodily integrity and self-determination. Although women are mostly made to adapt to the male "modeled" system, there still exist constitutional provisions and laws that would definitely guarantee the total reproductive freedom of women if applied effectively by the state and the judiciary. A rigorous and contextual understanding of women's reproductive autonomy in exercising control over their sexual and reproductive rights in intimate partner relationships could bring an end to the exclusionary practice of treating "women solely as reproductive machines whose decisions and autonomy are so undeserving of respect that women might not even control if, whether, and when should they reproduce" (Petchesky, 2021) and initiate a transformative change in the right direction towards women's complete reproductive emancipation.

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APPENDICES

Appendix i

Interview Schedule

Biographic Details

Age of the participant:

Age of their partner:

Religion:

Caste:

Education Level:

Occupation:

Annual Income (range):

Marital Status:

Relationship status:

1) Please tell me about yourself

Probes:

1) Where do you live?
2) Who do you live with?
3) What is your family environment like?

2) Please tell me about the people in your life

Probes:

1) Do you have a partner(s)?
2) If so please tell us about him? How old is he? Does he work?
3) Are you happy in your relationship? Why or Why not?
4) Do you enjoy spending time with them?
5) Are your parents still involved in your life? How?

3) Do you have children?

Probes:

1) If so how many and of what ages?

4) Tell me about the relationship you have with partner(s).

Probes:

1) Has a boyfriend/partner ever forced you to have sex when you did not want to? Please tell me what happened?
2) Do you think free communication is necessary in a relationship?
3) Is it easy to communicate to your partner(s) about sex? If not, what do you think are the reasons behind it?
4) Do you think your partner(s) are considerate about your opinions pertaining to sexual life? Why or Why not?

5) Tell me about your decisions around contraceptive use.

Probes:

1) Do you use condoms with your partner(s)? Why?
2) What would happen if you asked your partner to use a condom?
3) Do you use any other form of contraception (eg: Injection, pill, implant, surgeries)? If so which one and for how long? If not, would you like to and what stops you from doing so? Tell me how you made the decision?
4) Where you ever coerced to use any mode of contraception by anyone against your full informed consent? If yes, by whom?

6) Tell me about your general thoughts about whether to fall pregnant, and whether or not to keep a baby.

Probes:

1) If you have a child, did you want to have the baby at the time of falling pregnant?

2) Whose decision was it to keep the pregnancy?

3) If you do not have a child, would you like to have one now? If yes, what is stopping you from having one?
4) If you want a child and your partner does not then what do you think you will do?
5) If your partner wants a child and you do not then what do you think you will do?
6) Who do you think should have the ultimate say in issues related to child-bearing?
7) In your opinion what things shape a woman's decision to whether or not to have a children in this society?

7) Tell me about your thoughts on abortion.

Probes:

1) Have you ever had an abortion? If so, whose decision was it? How do you feel about the decision?
2) Who do you think should make a decision about having an abortion?
3) How do you feel about friends or other women who have abortions?

8) Tell me more about your relationship and whether you have the power to make your own choices in your relationship(s).

Probes:

1) In your current relationship do you feel that you are able to make important decisions and have control? If so, please tell me what those decisions are.
2) In your current relationship do you feel that you are NOT able to make important decisions and have control? If so, please tell me what those decisions are.
3) Who/What is stopping you from making important sexual and reproductive decisions in your relationship?
4) Do you want to make more decisions in your relationship than you currently do? If so what decisions would you like to make?
5) Are there any other things beyond the person mentioned above that stops you from

being in control of your relationship?

11) What are the socio-cultural and economic barriers you face in exercising control over your sexual and reproductive health?

Probes:

1) Do you have a source of regular income or savings? If yes, who has control over it?
2) Has your religion or culture ever influenced the SRH decision-making in your relationship? If yes, can you explain how?
3) Being a woman, have you ever felt compelled to conform to the social norms and expectations of reproduction? If yes, can you explain the circumstances and how that has impacted your SRH?
4) What are some of the problems/issues (it can be anything) you have faced while accessing reproductive healthcare?
5) Do you enjoy the freedom to go out whenever you want? If no, what are the restrictions that you face in doing so?

10) Tell me about your Health Behavior when it comes to your Sexual/Reproductive Health

Probes:

1) How often do you visit doctors for SRH care?
2) Who decides when to go or do you go alone or does your partner or any family member accompanies you?
3) Do you discuss the doctor's conversation with your partner?
4) Who procures the medicine?
5) How freely do you discuss about your SRH issues with your partners (like missing periods, discharge, cramps, need to visit a doctor, etc.)

Appendix ii

Informed Consent Form

This Informed Consent Form has two parts:

1) Information Sheet to share information regarding the Research
2) Consent Certificate

Information Sheet

I am Sai Devi S, Bachelor's Student of Tata Institute of Social Sciences, Hyderabad. I am conducting a Research on "Examining the Autonomy of Women in Exercising Control over their Sexual and Reproductive Health (SRH) and Rights in Relationships" and I will be asking you questions. You do not have to immediately decide whether or not to participate in the research. You can take your time, think about it thoroughly and reflect on whether or not to participate before you finally decide. This consent form may contain words or concepts that you might not entirely understand. Please feel free to stop me at any point and ask for explanation as we go through the form and I will take time to explain. If you have any more questions about the form later you can ask them at any time.

Purpose of the Research

The aim of the research is to examine women's autonomy in exercising control over their sexual and reproductive health and rights in relationships.

Type of Research Intervention

This research will need your participation in a one-two hour in-depth interview

Participant Selection

You are being invited to take part in this research because I feel that your experience as a woman can contribute immensely to my understanding and knowledge of women's autonomy status in relationships.

Voluntary participation

Your participation in this research is completely voluntary. It is entirely left to your will to whether or not to participate. If you choose not to participate it is totally fine. Your participation in research is in no ways going to impact your job or reflect on any work-related evaluations or reports. You may change your mind later and withdraw from the interview even if you agreed earlier.

Risks

I will be asking you to share with me some very personal and confidential Information and you may feel uncomfortable talking about some of the topics. You do not have to answer any question or take part in the interview if you do not wish to do so, and that is also fine. You do not have to give me any reason for not responding, or for refusing to take part in the interview.

Benefits

While there are no monetary benefits for you but the information that you share with me today, will help me to understand more about the autonomy status of women related to SRH and rights in relationships. Through our conversations, we can also discuss more concerns related to the topic. Indirectly, the study, will feed into expanding the larger understanding of the construct of 'autonomy' of women in relationships on matters of SRH as this is a much neglected area of study in the Indian context.

Confidentiality

Your personal information will not under any circumstances be shared with anyone. The information that you share during the interview about the study will be the only data that will be used for academic purposes only.

Active participation in the research

The notes that I took in during the interview will be showed to you and you can review them and ask me to modify or remove portions, if you do not agree with my notes or if I did not understand you correctly, you can help me to note down correctly.

Contact

If you have any queries, you can always ask them now or later. In case if you want to ask any questions or need any clarifications later, you may feel free to contact any of the following:

Name: Sai Devi S
Contact Number: 9XXXXXXX91
E-mail: saidevibhavans@gmail.com

Consent Form

I, ……, have understood the implications of my participation in the study as an informant/participant. The researcher has explained every aspect of the research thoroughly and has clarified my queries/doubts.

Name:

Details: (age, educational qualification, marital status/relationship status, duration of marriage/relationship)

DISSERTATION

ORIGINALITY REPORT

1%	1%	0%	0%
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