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HEALTHCARE WITHOUT CHOICE: REPRODUCTIVE DECISION-MAKING AMONG RURAL WOMEN IN BIHAR

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ABSTRACT:

The reproductive decisions of women in rural areas of Bihar are ingrained in complex systems of patriarchal structure, caste and class distinctions, and local values that collectively strip women of their bodily autonomy and life opportunities. The article examines how women's decisions on marriage timing, fertility, contraception, and access to maternal healthcare are influenced by gendered power relations. These choices are often subject based on qualitative research methods; the study combines in-depth interviews and focus group discussions with rural women, including members of self-help groups, as well As interviews with frontline health workers and community leaders from selected Bihar villages. The study reveals that husbands, senior in-laws and other community gatekeepers often "override or even outmode women's expressed preferences", while lack of gender-sensitive, reliable public health services means people are increasingly dependent on family control networks and informal providers. In the same way, women leverage shared areas of proximity, family ties, and experiential knowledge to establish limited forms of control over children, interpret reproductive choices, and reassess traditional norms concerning sexuality, childbirth, or spacing. The article presents a perspective on how reproductive decision-making is conceptualized as 'a crucial intersection between gender norms, structural poverty and state programmes' and calls for feminist, community-based interventions that focus on women's voices while rejecting policy frameworks that make them passive participants in population control or maternal health agendas.

KEYWORDS: Reproductive decision-making; rural women; gender norms; bodily autonomy; patriarchy; qualitative research; maternal health.

INTRODUCTION:

Despite the increasing emphasis on reproductive health in international and domestic policy discussions, women's ability to make meaningful choices about their bodies and fertility remains highly variable across social, geographic, and cultural boundaries. Formal responsibilities for reproductive rights in India are intertwined with gender hierarchies, regional differences, and fragile healthcare systems, which impact the implementation of policies in daily life. The state of Bihar, known for its high socio-economic status, presents a unique opportunity to investigate how rural women in India structure, constrain, and negotiate reproductive decision-making. High poverty rates, low female literacy rates and early and universal marriages, along with patriarchal control over women's sexuality and mobility, are characterized by poor maternal and reproductive health indicators in the state.

In rural Bihar, reproductive decisions are not often seen as isolated decisions made by women, but rather as a result of complex networks of family connections, castes, and community norms that dictate appropriate femininity, ideal family size, contraception use, spacing deliveries, etc. Generally, husbands and senior in-laws have the ultimate control of household decisions, as their preferences and concerns about heritage, prestige, and financial stability play a significant role. How they determine when to wed, what time to be married, how many children to have, etc. The caste-based hierarchies and class positions that impact access to education, information, and health services reinforce the gendered power relations. Consequently, women's voices are frequently silenced or marginalized, and the choice process at policy level may be more aligned with local norms of compliance, negotiation under constraint, or strategic accommodation.

The governance of reproduction is not solely based on household dynamics, but also on the overall health and policy landscape. Although rural Bihar has expanded its public health programmes aimed at maternal and child health, family planning, and institutional delivery, their success is dependent on local power structures, resource constraints, or the attitudes of frontline health workers. Concerns about the quality of care, disrespectful treatment and access to women's healthcare providers play a role in shaping these experiences by influencing whether or not they are seeking services. The interaction between institutional dynamics and prevailing gender norms results in a situation where women have access to services but lack the social and relational power to make independent decisions about their use.

Despite the complexity of the terrain, rural women are not passive recipients of familial and institutional directives. Why? They create and employ different types of control to face multiple expectations and ensure optimal outcomes for themselves and their offspring, including quiet resistance against certain contraceptive methods or selective compliance. Additionally, they use covert contraception and align with specific family members in order to achieve desired results. Emerging collective platforms like self-help groups, women's collectives and community-based organisations can provide spaces for information exchange, grievance expression and a critique of what constitutes acceptable reproductive choices in some contexts.

The paper identifies reproductive decision-making among rural women in Bihar as a crucial area to explore the intersection of gender, power, and health in an age where structural poverty and historically entrenched inequalities persist. It uses qualitative research methods to investigate how women interpret and talk about their sex, the negotiation processes surrounding marriage, fertility, birth control, and maternal healthcare in households and communities, as well state health program experiences on the ground. The study aims to explore the voices and practices of women in everyday situations, rather than solely depending on aggregate statistics and policy language. This contributes to the development of gender studies in the field of reproductive autonomy, which is not viewed as an individual trait but as a relational and structurally determined quality, and highlights the need for feminist interventions that focus on rural women's agency within communities.

Statement of the Problem

This research highlights the recurring discrepancy between official commitments to reproductive rights and the limited freedom of rural women in Bihar to make reproductive choices. Maternal health, family planning and women's empowerment have been the main policy priorities for decades, but the intersection of patriarchy, caste, class and rural poverty still severely restricts women’s ability to make meaningful choices about marriage timing, fertility rates, contraception and access to health care. Why is this so? "Reproductive choice" is frequently seen as a policy statement in this setting, where women's preferences are often subordinated to the interests and worries of their husbands, elder sisters (often deceased), or community gatekeepers.

Despite expanding coverage through institutional delivery and contraceptive services, the health system often provides care that is misguided or gender-insensitive due to poor access,

trustworthiness of care, and other factors. Women in rural areas face challenges such as long distances, unpredictable service offerings, uncoordinated expenditure, and a dearth of female resources, all while dealing with environments where their mobility and decision-making abilities are closely monitored. In such situations, women tend to follow the expectations of their family and community due to the high social and material costs associated with avoiding or negotiating. Current studies and programs tend to focus on service utilisation statistics and performance measures, while neglecting the ways in which women perceive, articulate, and react to reproductive decision-making under constraint.

The main issue in this study is the gap between policy frameworks that presume individualistic, informed choices and the practical realities of reproductive decisions within unequal gender roles and rural settings. Despite the availability of qualitative research that considers gender and household power dynamics, there is limited research on reproductive decision-making in rural areas of Bihar. The study emphasizes the importance of this process within households and communities as well as between themselves and their health care systems. The lack of attention to the structural and relational aspects involved in reproductive decision-making can have significant implications for interventions that aim to reinforce existing hierarchies by targeting women as mere instruments of demographic or maternal health goals rather than as agents with complex desires and limited capacities to act. The present research focuses on the problem of women's lives and investigate how "healthcare without choice" is created, standardized or challenged in rural Bihar.

Research Objectives:

1. To examine the level of autonomy rural women have in reproductive decision-making.
2. To analyze the role of patriarchy and family structure in shaping reproductive choices.
3. To study women’s access to reproductive health services and their ability to exercise informed consent.
4. To assess the influence of caste, education, and economic status on reproductive decision-making.
5. To explore women’s perceptions of reproductive health programs and providers.

Research Questions:

- Who makes decisions regarding contraception, childbirth, and sterilization in rural households?

- How do patriarchal norms restrict women's reproductive choices?
- Do government health schemes translate into real autonomy for rural women?
- How do caste and class intersect with gender in reproductive health decision-making?

Hypotheses:

1. Rural women in Bihar have limited autonomy in reproductive decision-making.
2. Patriarchal family structures significantly influence reproductive choices.
3. Higher education levels among women increase participation in reproductive decisions.
4. Government reproductive health services focus more on targets than on women's consent and choice.

Literature review:

According to both classical and modern feminist perspectives, the role of women in producing and upholding patriarchal social structures is central to this process. Friedrich Engels argues in The Origin of the Family, Private Property and the State that women's subordination is not a result of natural inevitability but rather derived from material relationships as influenced by patrilineal inheritance and private property. The Second Sex by Simone de Beauvoir presents another perspective on the "Other", stating that women's bodies are used to confine them to immanence, domesticity, and reproductive service during pregnancy, while men assert transcendence and subjecthood. In their argument, Engels and de Beauvoir assert that reproductive capacity is not a scientifically neutral concept but an essential location of social control and gender inequality. Additionally,

Several foundations have been built upon by feminist and gender studies scholarship to explore how reproductive decision-making is affected by intersecting structures of patriarchy, class, caste, religion, and the state, particularly in the Global South. The ability of women to choose if, when and how to have children is not solely dependent on formal rights but also depends on access to resources, education, social support, and safe environments as stated by intersectional and materialist feminists. Investigations into reproductive rights in India reveal a persistent conflict between the legal-constitutional guarantees and the prevalence of structural inequality, coercive or target-driven family planning, and uneven implementation of health policies. The literature condemns the use of rights-based and "choice" framing as a self-determining, informed individual decision-maker, which obscures significant structural

and relational constraints faced by women who are rural or marginalized in reproductive matters.

As a result of these limitations, the reproductive justice framework was created by broadening access to the social-economic-political conditions that support reproductive life. The treatment of reproduction usually centred on three interdependent rights: the right to bear children, not to have a child in private, and the responsibility to raise them in safe, sustainable communities, with sensitivity to communities that face intersectional pressures from race, class, gender, identity, etc. Qualitative research conducted on a case study of reproductive justice has shown that the use of this lens illuminates the "web of power relations" that regulates sex and reproduction and delimits people's ability to choose and act, emphasizing structural intersectionality and state responsibility. In rural Bihar, where patriarchal structures shape reproductive outcomes through poverty, inadequate health services and caste exclusion, this body of work is particularly pertinent.

Evidence from empirical studies on sexual and reproductive health in rural India consistently shows that young and married women have limited control over various decisions such as the age at marriage, birth time, contraceptive use, and services available. Studies indicate that patriarchal community structures and household hierarchies entail that husbands and elders often make decisions regarding family size, contraceptive contraception, and care-seeking, while women's mobility and access to financial resources are tightly controlled. Despite policy improvements, sexual and reproductive disempowerment persists in rural areas where only slightly more than half of women are able to participate in contraceptive use decisions, as indicated by NFHS analyses or related studies. The trends are consistent with Engels's position that women' exploitation of labour and bodies is practiced in the private sphere, and with Beauvoir's observation that "women's reproductive organs become the fundamental basis of their social subordination.

The study focuses on the specifics of Bihar, where there is a convergence of negative socio-economic indicators such as high poverty, low female literacy, early and near-universal marriage, high fertility, and strong patriarchal and caste-based norms. This is supported by research. Research conducted on rural Bihar reveals that women have limited autonomy in health and fertility choices, with spousal and in-law control over mobility and healthcare use being especially prominent. Interventions implemented by women's self-help groups in Bihar, including participatory learning and action models, show that although knowledge can be

improved and contraceptive adoption rates can sometimes be increased through collective platforms, they also highlight the limitations of gender roles and familial control that still exist, leaving many women unable to translate information into autonomous decisions. The lack of change in gendered power relations without enhancing service availability or information undermines feminist concerns about the potential for reproductive autonomy.

In the same vein, feminist scholarship cautions against portraying rural women as inactive victims and emphasizes the various forms of agency they hold within restricted circumstances. Qualitative studies conducted in India reveal how women engage in daily discussions about sexuality, contraception, and care-seeking, using covert contraceptive methods, providing support to specific family members or collaborating with peer networks. This literature is in harmony with Beauvoir's focus on women' s struggle to move from objectification to subjectivity and with accounts of reproductive justice that emphasize community-based, collective claims to reproductive rights. There is still a lack of comprehensive, gender-sensitive qualitative work that specifically addresses rural Bihar and explores patriarchy, women's agency in the reproductive process, and structural injustices.

Overall, the literature suggests that reproductive decision-making in rural India is strongly influenced by patriarchal norms, material inequalities and state practices; framework for understanding these dynamics can be crucial to new approaches using frameworks such as: reproductive justice and intersectional feminism. Despite this, there is a scarcity of research that unifies Engels's materialist critique of the family, Beauvoir's theorization of woman as "Other", and contemporary reproductive justice scholarship to scrutinize the lived experiences of rural women in Bihar.

Theoretical Framework:

Using a multi-layered theoretical framework that links structural power, gendered subjectivity, and reproductive rights, the paper examines how "healthcare without choice" is produced and negotiated in rural Bihar. The examination of women's reproductive decision-making is grounded in Patriarchy Theory, Feminist Theory and the Reproductive Justice Framework, as well as an Intersectionality lens.

Patriarchy theory

Patriarchy theory characterizes gender relations as organized around male domination and the subordination of women within institutions such as family, religion, and society. Women's

subordination was reportedly intensified by the rise of private property, patrilineal inheritance, and the monogamous family, as Friedrich Engels wrote. Early and arranged marriages, strong son-focused preferences, and the assumption that fertility decisions are more often reserved among husbands or senior in-laws make up rural Bihar's logic. Patriarchy theory supports the study of reproductive decision-making, emphasizing the importance of male and elderly interests over women's physical freedom in power-based discussions.

Despite being devalued and not visible, women's unpaid domestic and reproductive labor is crucial to the family and economy. Engels' materialist account emphasizes this fact. This is especially important in Bihar, where women's daily work of care, housekeeping and agriculture are routinely taken for granted while their reproductive health is often framed under the guise of family or community rights. ". Exploring patriarchy theory in rural women's experiences highlights that "healthcare without choice" is not a result of chance, but rather engenders the structure and structures of social interaction.

Feminist theory

Feminist theory provides a critical perspective on the construction of women as gendered entities and their management of constraints and agency in patriarchal environments.[]. In The Second Sex, Simone de Beauvoir argues that women are "the Other", and her reproductive bodies serve as the foundation for restricting them to domesticity, motherhood, and immanence; men also assert transcendence and public subjecthood. This is an interesting critique of Femininisme. Women in rural Bihar are regarded as the most important of all social class wives, mothers, and bearers of heritage, with their social status being closely linked to marriage, fertility, success in raising sons, etc. The reason why reproductive decisions are treated as collective obligations related to family values and economic security rather than individual preferences is due to this.

Contemporary feminist scholarship asserts that women are not passive victims, but rather actors who exhibit situated and relational agency within constraints. Despite having no formal decision-making power, this perspective is crucial for understanding how rural women in Bihar negotiate with their husbands and in-laws, use contraception selectively, or engage in activities such as joining self-help groups and kin networks to influence reproductive outcomes. Women's narratives, everyday tactics, and affective experiences are scrutinized in

light of feminist theory, which views them as places where gender norms are internalized, challenged, or subtly altered.

Reproductive justice framework

The Reproductive Justice Framework prioritizes the broader social, economic, and political factors that contribute to reproductive health, rather than solely considering individual reproductive "rights" or "choices.". The emergence of women-of-colour activism in relation to reproductive justice is often summarized as including three related rights: the right to have a child, the ability to refuse bringing children home, and the freedom to raise children in safe and sustainable settings. These three rights are intertwined. The framework explicitly links reproductive autonomy with poverty, discrimination, violence, and access to quality healthcare, stating that legal rights are inadequate when individuals lack the necessary material and social resources to enforce those rights.

When applied to rural Bihar, reproductive justice highlights the impact of caste-based exclusion, chronic poverty and poor health infrastructure, disrespectful care, and inadequate women's friendly services on their options around marriage and contraception. The right to contraception or safe abortion may be a noble goal for countless women, but in reality, social consequences, transportation issues, informal fees, and concerns about being mistreated at facilities can all limit their choices. By utilizing this framework, the study interprets "healthcare without choice" as a type of structural injustice, where women are formally placed as beneficiaries of programmes but lack substantive power and enabling conditions to exercise reproductive agency.

Intersectionality and structural power

The research utilizes an Intersectionality lens to illustrate how various axes of inequality intersect and influence reproductive decision-making. Additionally, Black feminist legal theory in particular demonstrates that power systems, such as gender, caste, class, religion, and location in rural areas do not operate independently but intertwine to produce specific patterns of advantage and disadvantage. In rural Bihar, a lower-caste woman living in solitary village experiences challenges and hazards that are different from those of an upper- caste women living closer to the community. However, both live within societal hierarchies. The intersectionality of different hierarchies aids in examining reproductive decisions, rather than treating "rural women" as a uniform category.

The lens highlights that interventions that disregard caste, class, or geographic marginalization may unintentionally benefit women who are relatively privileged, while those who remain most marginalized cannot take action on their reproductive choices. The study merges intersectionality and reproductive justice, integrating individual narratives within broader patterns of structural power to reveal how certain groups of women are routinely exposed to “healthcare without choice”, unsafe conditions or coercive practices.

Integrating the frameworks

Its study is grounded in a rigorous and coherent theoretical framework that includes Patriarchy Theory, Feminist Theory; the Reproductive Justice Framework; Intersectionality; and other related theories. Patriarchy theory characterizes the gendered hierarchies within households and communities that determine who has the authority to make decisions about reproduction. Women's ability to interpret, negotiate, and sometimes resist hierarchical systems is emphasized in feminist theory, which also acknowledges their subjectivity and agency. These micro-level dynamics are linked to structural conditions and state responsibility in reproductive justice, shifting the focus from formal entitlements to substantive ability of choice. The intersectionality of analysis ensures that women's experiences across different castes, classes, and regions are taken into account, rather than a single, consistent experience of "rural woman" being.

A unified framework is used to support the paper's central argument that rural women in Bihar make reproductive decisions without considering how gender, structural inequality, and institutional factors influence "healthcare sans choice"; however, women also have limited forms of agency in such settings.

Research Methodology:

Research design

The research design is both descriptive and analytical, documenting the socio-demographic profile, reproductive histories, and decision-making patterns of married women of reproductive age, as well as examining how these relationships are related to factors such as age/education, caste, economic status, or household power relations. Additionally, this research approach highlights several key areas of interest for researchers: It enables the systematic description of current conditions and allows for the evaluation of relationships and analysis of women's stories in light of the chosen theoretical frameworks.

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Study area and universe

The study is conducted in specific rural areas of Bihar, where variations in socio-economic status, healthcare provision, and gender roles are observed. Due to their direct involvement in reproductive decision-making, the sample population of married women aged 15–49 years living in rural areas of the selected districts is included in the study universe and is targeted by most reproductive health and family planning programmes.

Sampling design

Using multistage sampling, the study respondents are selected to be included in the analysis. The initial stage entails the selection of districts, blocks, and villages within those districts. In the following stage, households were listed in the sampled villages along with systematic or random procedures for eligible married women (15–49 years). The sample size is calculated by Yamane's formula for finite populations, with a reasonable margin of error and confidence level, and then distributed proportionally across specific districts, blocks, villages, etc.

Tools of data collection.

There are two main methods of gathering data:

Brief and structured interview schedule: Women who participated in the study are given a pre-tested, structured questionnaire that gathers quantitative and categorical data on various socio-demographic characteristics, such as their past experiences with marriage and fertility, their use of birth control methods, decision-making processes, health service access, and community involvement. There are both closed and open-ended questions on the list to allow for elaboration.

In specific villages, FGDs are conducted with married women and self-help group members to explore their collective perceptions of reproductive narrations, negotiation tactics within households that negotiate accessing services, and experiences of "healthcare without choice.". Participants can present their concerns and questions in a way that aligns with the theoretical framework, as described in an FGD guide.

Informal notes from community leaders or health workers can be used to supplement the main tools, but the essential data is obtained through interviews and FGDs with married women.

Data processing and analysis

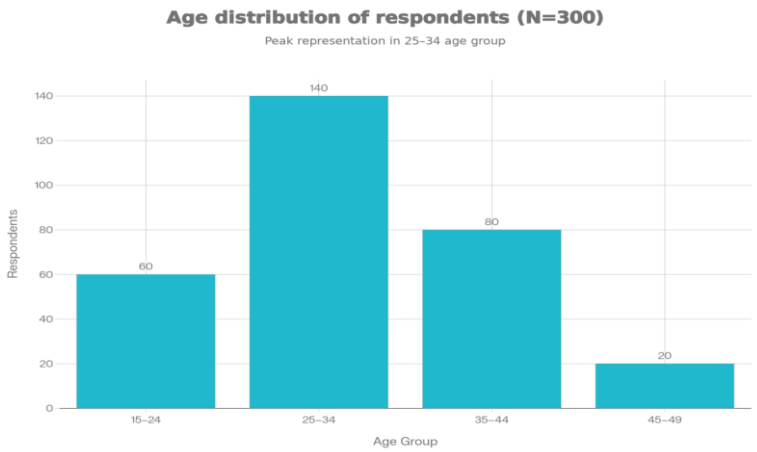
Structured interviews yield quantifiable data that is then coded and entered into statistical software for analysis. Profile participants are profiled using descriptive statistics that include key indicators such as age at marriage, parity, contraceptive use, and reported decision-making patterns. Cross-tabulations are used to investigate the links between women's decision-making power and variables such as education, caste, economic status, type of household, and involvement in self-help groups.

Thematic analysis is conducted on qualitative data obtained from FGDs and open-ended interview responses, which are transcribed. The coding frame is initially constructed using deductive principles of patriarchy, feminist agency, reproductive justice, and intersectionality, but it is then refined inductively as new themes arise. To understand how women negotiate and make reproductive decisions in constraints, codes are categorized into broader categories such as household discussions or community surveillance, and patterns are used to interpret them.

Socio-demographic profile

Table1. Age distribution of respondents. (N = 300)

Age group (years)	Number	Percentage
15–24	60	20.0
25–34	140	46.7
35–44	80	26.7
45–49	20	6.6
Total	300	100.0



Educational status and caste

Table 2.Educational status of respondents. (N = 300)

Education level	Number	Percentage
No formal schooling	**90**	**30.0**
Primary (1–5)	**80**	**26.7**
Upper primary (6–8)	**70**	**23.3**
Secondary (9–10)	**40**	**13.3**
Higher secondary & above	**20**	**6.7**
Total	**300**	**100.0**

Table 3.Caste-wise distribution of respondents (N = 300)

Caste group	Number	Percentage
Scheduled Castes	90	30.0
Scheduled Tribes	15	5.0
OBC	135	45.0
General	60	20.0
Total	300	100.0

Table 5.Current use of contraception by method. (N = 300)

Method type	Number	Percentage
Female sterilisation	90	30.0
Male sterilisation	6	2.0
IUD/Injectables/Implants	24	8.0
Oral pills	36	12.0
Condoms	24	8.0
Traditional methods	30	10.0
Not using any method	90	30.0
Total	300	100.0

Table 6.Decision-making autonomy (cross-tabulation)

Education level	Mainly others decide (No say)	Joint decision	Mainly woman decides	Total
No formal schooling	54 (60.0%)	30 (33.3%)	6 (6.7%)	90

Education level	Mainly others decide (No say)	Joint decision	Mainly woman decides	Total
(n=90)				
Primary (n=80)	36 (45.0%)	36 (45.0%)	8 (10.0%)	80
Upper primary (n=70)	24 (34.3%)	36 (51.4%)	10 (14.3%)	70
Secondary & above (n=60)	12 (20.0%)	36 (60.0%)	12 (20.0%)	60
Total (N=300)	126 (42.0%)	138 (46.0%)	36 (12.0%)	300

Perceptions of "healthcare without choice"

Table 7.Major barriers reported in focus group discussions (multiple responses, n = 12 FGDs)

Barrier/theme	Number of FGDs mentioning	Percentage of FGDs
Fear of in-laws/husband opposition	11	91.7
Lack of money/hidden costs	9	75.0
Distance and transport problems	8	66.7
Absence of female providers	7	58.3
Disrespectful behavior at facilities	10	83.3
Lack of privacy/confidentiality	9	75.0

SCOPE AND LIMITATIONS:

Scope

This study is focused in the rural areas of Bihar and covers married women of reproductive age from 15 to 49 years, so findings can be applied across similar conditions at state level. ». By focusing on specific districts and villages, the research provides comprehensive information on localised patterns of reproductive decision-making, household dynamics, and interactions with the health system, but doesn't aim to provide statistically representative estimates for all of Bihar. This study is centered on married women, which highlights the importance of negotiations in both marital and familial settings, but avoids directly discussing the lives of unmarried or widowed women.

Using structured interviews and focus group discussions, the research is both quantitatively descriptive and qualitatively probing how women perceived their own strategies in response to an employer's constraints. The aim is to establish a theoretically sound understanding of

"healthcare without choice" among rural married women, rather than providing statewide prevalence figures or causal impact estimates. This is an important consideration.

LIMITATIONS

The limited sample size of the study area makes it impossible to apply the findings in Bihar's urban areas or regions with diverse socio-economic and cultural characteristics across different regions. The study sites' patterns may not accurately reflect the realities of women in other settings due to differences in health infrastructure, programme execution, and gender norms across different states. Additionally, the second point is that the study focuses on sensitive issues such as sexuality, contraception, abortion, and intra-household power relations in order to avoid underreporting or social desirability bias. Additionally, Even though women are often consulted, privacy is respected, and questions are asked to interview participants, some may choose not to disclose information, reduce conflict in the home, or present their answers in ways that align with social convention.

The study focuses on women's self-reported data, which exposes them to recall errors, selective memory challenges, and their personal interpretation of events. Although cross-checking records or triangulating accounts across participants can partially mitigate this, the study cannot completely eliminate biases associated with self-reporting.

The cross-sectional design captures reproductive decision-making at a single point and fails to account for women's choices and constraints throughout their life or in response to changes in policy or programs. Additionally, therefore, the research presents a comprehensive overview rather than an episodic portrayal of changes in reproductive agency and healthcare access.

CONCLUSION:

The investigation reveals that the reproductive decisions of married women in rural Bihar are heavily influenced by patriarchal household hierarchies, caste and class inequality, and a health system that tends to reproduce rather than reduce gendered vulnerability. Despite being used as "choice" in policy discussions, it is frequently restricted to negotiation and tactful conformance, while husbands and senior in-laws are typically responsible for making important decisions about marriage timing.

In the meantime, women are not just passive recipients of these structures; they also use restricted forms of agency by leveraging their connections through family relationships and self-help groups, social networks, and selectively using services to ensure their well-being and that of their children. These common practices of negotiation and quiet resistance are a result of economic dependence, social surveillance during the war years, and uneven access to respectful, gender-sensitive healthcare.

Through the lenses of patriarchy theory, feminist analysis, and reproductive justice, the results suggest that "healthcare without choice" is a manifestation not so of failure by individuals but rather of structural injustice. Reproductive health outcomes in rural Bihar cannot be achieved by increasing service availability or awareness, but rather through interventions that redistribute power within households and address cast/class-based exclusion, accountability (financial) sensitivity, gender-sensitivity issues at the institution of healthcare, and creating collective spaces for rural women to articulate their reproductive rights. In this way, the study adds to the diversity of gender studies by redefining reproductive decision-making as a relational and political process, and by emphasizing the importance of feminist, community-based approaches that prioritize rural women's autonomy as an integral goal rather than allowing them to benefit from peripheral factors.

REFERENCES:

1. Lerner, G. (1987). *The creation of patriarchy*. Oxford University Press.
2. Warrier, S. (2022). Intersectionality. In R. Geffner, J. W. White, L. K. Hamberger, A. Rosenbaum, V. Vaughan-Eden, & V. I. Vieth (Eds.), *Handbook of interpersonal violence and abuse across the lifespan: A project of the National Partnership to End Interpersonal Violence Across the Lifespan (NPEIV)* (pp. 151–163). Springer Nature Switzerland AG. https://doi.org/10.1007/978-3-319-89999-2_301
3. Banerjee, S.K., Andersen, K.L., Warvadekar, J. *et al. How prepared are young, rural women in India to address their sexual and reproductive health needs? a cross-sectional assessment of youth in Jharkhand. Reprod Health* **12**, 97 (2015).
4. https://doi.org/10.1186/s12978-015-0086-8
5. **Beauvoir, S. de.** (2011). *The Second Sex* (C. Borde & S. Malovany-Chevallier, Trans.). Vintage Books. (Original work published 1949)
6. **Engels, F.** (2010). *The Origin of the Family, Private Property and the State*. Penguin Classics. (Original work published 1884)

7. **Gender and poverty in rural Bihar: Summary and conclusions.** (n.d.). *Institute for Human Development*.
8. **Morison, T.** (2022). *Using reproductive justice as a theoretical lens in qualitative research in psychology*. **Qualitative Research in Psychology, 20**(1), 172–192. https://doi.org/10.1080/14780887.2022.2121236 (Massey Research Online)
9. **Ross, L., & Solinger, R.** (2017). *Reproductive Justice: An Introduction*. University of California Press.
10. **Sexual Autonomy of Women in Rural India: Assessing SDG 5.6.1** (2024). *Social and Political Research Foundation (SPRF).*
11. **VAWnet.** (2018). *Reproductive justice, reproductive health and reproductive rights*. Retrieved from https://vawnet.org
12. **World Health Organization & Gram Varta study team.** (2025). *The impact of a participatory learning and action intervention on unmet need for contraception: a cluster-randomized controlled trial in rural Bihar, India*. **Reproductive Health, 22**, 121. https://doi.org/10.1186/s12978-025-02055-5)
13. Ministry of Health and Family Welfare. National Population Policy 2000. New Delhi: Government of India; 2000.
14. Crenshaw, K. (1989). *Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics.* University of Chicago Legal Forum, 1989(1), 139–167.
15. Fordham University Library. (2012). Reproductive justice – Women, gender, and sexuality studies guide.
16. "Reproductive justice." (n.d.). In Wikipedia.