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Decentring decision-making autonomy in locating young women's claims on care in rural India

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Abstract

This paper examines how women's decision-making autonomy is decentred and contested if we foreground women's claims on care, especially within the spaces of family and community. It is based on my ongoing empirical research in the eastern Indian state of Bihar, which studies how household gender dynamics influence young married women's access to reproductive healthcare. The research uses in-depth interviews and focus group discussions with married women aged 16-24 to understand how they navigate the dynamics of the household and the larger context of kinship, caste and community to which these dynamics are inextricably linked, in order to access care. The paper presents a critique of the over-emphasis on women's decision-making autonomy in studying access to care and women's status, and of the lack of attention to other ways in which women negotiate access to care. I argue that women particularly make claims on care in three different forms — care as value, care as moral responsibility, and care as love.

Keywords

healthcare; autonomy; agency; gender dynamics

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Introduction

Sonali is 17 years old and has been married for about a year.[1] Her marriage was arranged by her parents, and her husband works in Delhi, where she is soon set to move from her home in rural Bihar. Like many young married women, whether in voluntary, arranged or forced marriages, Sonali's family and community pressurise her to have a child, "my neighbours and relatives wonder why I have not conceived yet. But my husband is very nice, he says that we don't need to have a child now as I am very young, he says that we can think of it after 2-3 years." Despite her husband's seeming support and concern about her health, Sonali considers having a child because she has to put up with all the societal pressure singlehandedly while her husband is away, but she maintains that, ideally, she too does not want to have a child anytime soon. However, her husband and she have never used any form of contraception and she had been pregnant right after her marriage which ended in a miscarriage. At the time of my interview with her, she had just found out that she was

[1] All names used in the paper are pseudonyms.

pregnant again and was wondering what to do about it. Her husband was of the opinion that she should carry the pregnancy to term as it is god's wish.[2] He assured her that he would look after her health and would be there for her if something goes wrong. Before her marriage, Sonali used to suffer from severe abdominal pain during menstruation but she had not shared the problem with anyone. After getting married, she decided to share it with her mother and her husband because she thought it was important to let them know in case the underlying problem affects her reproductive capacity. Her mother and husband concurred that she should see an allopathic doctor but when allopathy did not help, her mother-in-law made her some indigenous medicine which helped the pain subside. Sonali's case illustrates that access to care and health status are determined by gendered norms, relations and institutions, and the meanings that we assign to them. Delaying seeking care for the pain was an outcome of the taboo on women's sexual health before marriage and the primacy of their fertility within marriage, her husband not wanting to have a child was based on his concern for her health, and carrying an unplanned pregnancy to term was based on social norms that deplore abortion (shared and reproduced by the husband and family) coupled with the household's economic resources that permitted providing for a pregnancy and a child. Sonali mentioned that while societal pressure was one reason she considered having a child even when her husband did not want one, another reason was that she was very fond of children. Her thoughts and actions vis-a-vis her reproductive health were guided by what would be best for her in terms of physical and mental health and in relation to her status within family and society, rather than a need or a desire to make autonomous decisions. The decision-making processes that she describes complicate autonomy, and in my reading, foreground (receiving) care in navigating household dynamics and making decisions.

Childbearing is central to marriage in Sonali's social context, as it is in most of South Asia where (heterosexual) marriage is near universal and reproduction predominantly takes place within marriage (Jones & Yeung, 2014). This social norm informs women's decisions and actions, or the lack thereof, in accessing reproductive healthcare, in as much as it informs the provision of care by the state, the private health system, and the family and community.[3] Early marriage is particularly common in Bihar, with 40 percent women aged 20-24 having been married before the legal minimum age of 18 (IIPS, 2020). For the study population, therefore, negotiating access to care is highly influenced by early marriage and the factors that enable it – poverty, gender-based discrimination and deprivation, fear of girls eloping and bringing 'dishonour', and lack of educational and social opportunities.

[2] The idea that it is god who gives children and takes children away was widespread in the study area across communities, but was not attributed to religion and religious texts but rather to morality, and is also possibly related to the high infant mortality rate in the state (46.8 deaths per 1,000 live births) which indicates that having a child cannot be taken for granted (IIPS, 2020).

[3] On paper, the provision of institutional care is non-discriminatory and universally guaranteed regardless of marital status and social position. But in practice, social norms do inform them, even doing so in conflict with the law. For example, in the regional context of the study, women usually procure contraceptives from frontline health workers but those whose husbands live away as migrant workers are reluctant to approach health workers for contraceptives as it raise the suspicion that they have other sexual partners. Likewise, health workers too are reluctant to give contraceptives to such women, and additionally to women who don't have any children as the socially appropriate assumption is that they don't need contraceptives as they should be having a child.

Many of them are in marriages that do not have legal sanction, depriving them of sexual and reproductive rights as well as legal recourse within marriage.[4] At the same time, the guarantee of social sanction means that adolescent women are expected to fulfil all the gendered social roles of adult women in a heteronormative context, including childbearing. These roles are also expected from women in inter-caste and inter-faith marriages, that typically do not enjoy social sanction. My research, like many other works from South Asia, suggests that women's autonomy is forged at this intersection of gendered relations, caste and community, and the law, and therefore, it needs to be decentred and placed in the larger context of women's position within the household social economy. I also note, like Mumtaz and Salway (2009), that 'autonomy' cannot be translated to North Indian languages, and in my initial interviews, a loose translation was met with either surprise or disapproval, following which I asked the question through queries about health histories rather than specific instances of exercising or not exercising autonomy.

I align my understanding of and challenge to decision-making autonomy with Naila Kabeer's conceptualisation of women's agency which was developed as a critique of measures of women's empowerment used in development economics. Kabeer (1999) describes women's agency as a mix of observable action and an intangible 'sense' of agency, arguing that agency can manifest in bargaining, negotiation, deception, manipulation, subversion and resistance, as well as reflection and analysis. Kabeer's subsequent writing on women's empowerment, based on her empirical work in rural Bangladesh, argues that individual autonomy is not universally applicable as social change is forged within local contexts and constraints, making it important to study the values, definitions and processes that women employ in navigating change (Kabeer, 2011). Likewise, feminist critiques of autonomy argue that it is rooted in decontextualised individualism. Sumi Madhok (2004), in her writing on autonomy, reflects upon the role of relational autonomy in potentially envisaging autonomy for those within oppressive conditions. Relational autonomy, which was conceived as a critique of individual autonomy, focuses on relational aspects of human behaviour such as emotions, and is of two types — procedural autonomy which is centred on the process of making autonomous decisions by engaging in critical self-understanding, and substantive autonomy which is centred on the nature of the decision. However, Madhok concludes that relational autonomy too disproportionately focuses on action. Mumtaz and Salway (2009), studying reproductive health in rural Pakistan from a public health perspective, argue that the autonomy paradigm is conceptually inadequate for Pakistan and most of South Asia as it underplays negotiation and neglects the multiple sites of caste and class that help shape gender inequality. The authors especially emphasise dependency and emotional bonds as particularly crucial factors for married women because they determine access to resources, and women may, therefore, negotiate their status through acts that do not seem autonomous. My research also indicates that dependency and emotional bonds are crucial in consolidating status, and I would argue that they are additionally crucial in shaping claims on care. To study these claims, I examine the relations and values that constitute care, which the autonomy framework does not address adequately as its primary focus is

[4] The Prohibition of Child Marriage Act of 2006 of India makes child marriage (before 18 for women and before 21 for men) voidable but not void or illegal. Moreover, the law is frequently misused by families to criminalise consensual inter-caste and inter-faith relationships involving minors (Mehra 2020; Patkar, 2020).

on utilisation and uptake of care, along with quality of care in some instances. I begin by describing the methodology, expanding on the interview process, and then based on my participants' accounts, formulate different types of claims on care.

The Project

This ongoing research is based in rural parts of the Kishanganj and Purnia districts of Bihar. In Kishanganj, it is being carried out collaboratively with Project Potential, an NGO working on youth rights and health advocacy, and in Purnia, it is being undertaken with independent collaborators. The collaborators facilitate community engagement and field access, assist with analysis based on anonymised data, and will be planning community-level dissemination once analysis is well underway.

My research follows a qualitative design, using in-depth interviews and focus group discussions with women aged 16-24, all of whom had married as adolescents. The data collection was preceded by a pilot, which included a review component where participants provided feedback on the consent process, the interview questions and experience, and the focus group vignette.[5] Altogether, 32 interviews and six focus group discussions were conducted between November 2021 and April 2022, and the analysis is currently underway. The potential vulnerability of my participants, especially those who were minors, was a key concern in developing the methodology. The participants could be vulnerable to my position as a researcher with greater access to material and cultural resources (owing my economic and caste location which was higher than most participants) and the institution that I represent (the institution of the university, to which most of them do not have access, and the University of York's location in the global north). While participants did not voice these as concerns, it was evident when they agreed to participate despite not being certain of the consent process and participated in the belief that I would do something good because I was educated. Additionally, they were also vulnerable to control and violence from their families as participating in the research amounted to a transgression of the permissible level of social mobility that most families assign to young married women. Participants identified this as a concern and it led prospective participants to withdraw and confirmed participants to often participate in secrecy or ask for their partners or families to be consulted first. A common apprehension among both participants and their families was that the collaborators and I, as affiliates of an NGO and a university, could potentially take punitive action against them for their status as married minors or adult women who had married as minors (which was not possible as the anti-child marriage law is not applicable retrospectively). Another apprehension arose from the project information sheet which mentioned the data protection law (General Data Protection Regulation) and the consent form which required real names to be put down. To a population with low levels of literacy and a group with poor access to protective laws, these documents seemed suspect. I sought to address all of these vulnerabilities and concerns by an extensive community engagement process which involved formal community meetings, private visits and conversations with partners and family members, and involvement from frontline health workers who are highly trusted and the first point of contact for reproductive health matters. The interviews often took place in non-private settings, either because participants wanted that or did not mind, and sometimes because family and

[5] The focus groups were based on vignettes on access to health to protect participants' privacy.

neighbours insisted that they be around out of curiosity or concern. The formulations of care below, therefore, were produced in different contexts, sometimes against the backdrop of support and sometimes neglect.

Rethinking claims on care

I typically started my interviews by asking participants to describe a time they were unwell and how they got better, eventually asking them about all who were involved in the key decisions and how. But in many of the interviews, questions about how decisions were made and who made them were met with answers that began with a description of who cared or did not care for the participant. Care was articulated as "being nice", "listening to me", "thinking of me" and "chiding me." On the other hand, lack of care in the marital household was expressed by explaining instances where participants had to reach out to their natal kin or make a decision (and an expense) by themselves. Making an autonomous decision was frequently associated with crises, and participants used the Hindi word *majboori* to describe the circumstances under which they made such decisions, which indicates compulsion or the lack of a better option. Most participants did not want to make an autonomous decision as they preferred being supported and cared for, and a few said that it is wrong for women to do whatever they feel like. The latter type of decision-making was referred to as choice or *marzi* in Urdu and Hindi and was looked down upon. However, not wanting to make autonomous decisions did not mean that women did not actively seek care. Whether they influenced and negotiated decisions, resisted them, or accepted them, they usually did so with the goal of maximising care-seeking.

I identify three different ways in which women make claims on care, or three different formulations of care — 1) care as value, which is based on the fundamental idea that women's lives have intrinsic value, 2) care as a moral responsibility which positions husbands and marital families as caregivers to married women, an idea that forms the basis of many filial responsibility norms globally, and 3) care as love, which is based on dependency and emotional bonds, and sometimes bound up with patriarchal benevolence. I propose these formulations as ways to understand care, and not necessarily as acts of agency in conditions of subordination. At the same time, I am interested in seeing where agency is placed in these ideas of care.

Care, as a term, came up in several interviews but its most common articulation was a negative expression — "they don't care about me" or "it makes no difference to them", usually directed at the husband's family. These articulations indicate indifference and neglect. Families were indifferent and inattentive towards their daughters-in-law in as far as their health needs like rest, nutrition or institutional care were concerned. The burden of household labour, which women frequently raised as a determinant of their health, was not seen as a sign of lack of care as women acknowledged it as their work, but the lack of concern – not acknowledging that the daughter-in-law is tired or not knowing that she is having a difficult pregnancy – was a sign of lack of care. Such indifference could possibly be attributed to the conventional expectation of household labour from women, which normalises women's burden of household work - *If the mother-in-law was able to do the same amount of work, why can't the daughter-in-law do it?* but the undercurrent of this expectation too is the negative value assigned to women's lives and well-being.

Neglect, which is the opposite of care, is practised as an extension of these forms of indifference. Neglect is evident when families categorically deny care or deprive women of whatever access to care they may have by controlling their material resources, disrupting their relations with care-givers (not allowing them to see health workers or their natal kin), and subjecting them to violence. Underlying indifference, neglect and deprivation is the devaluing (undermining of value) of women's lives, which is what women pointed to in complaining about the lack of care. An outright expression of undermining women's lives is telling daughters-in-law that they are replaceable. For example, Saroj, a participant in a focus group discussion said that if a daughter-in-law is unable to do the household chores when she is unwell, the in-laws can threaten them by saying that they will get their son remarried, "go away if you can't do the household work, we can get another daughter-in-law." Similarly, another participant's in-laws, who refused to call a doctor when she was unwell, told her that they do not care if she dies because they can get their son remarried.

In practice, families may not cast out their daughters-in-law as easily but using these expressions, coupled with material deprivation, indicates that women's lives are not valuable, especially beyond their fertility. Gender-based discrimination and neglect of young girls and women is very common in India, regardless of marital status, but being a daughter-in-law exacerbates women's vulnerability as their position within the household is not only shaped by gender but also by the relationship of power shared with the in-laws, which manifests in forms of control that are intentional and strategic like sending the daughter-in-law away or culturally embodied like controlling her everyday mobility (Gangoli and Rew, 2011; Rew, Gangoli and Gill, 2013).

Although most participants did not seek acts of care, they sought the underlying principle behind acts of care, which is value, and which could be expressed through simple acts such as an acknowledgment that they need rest when they are unwell. One of the participants, Radhika, referred to this principle, that I call value, as respect, "families don't *respect* daughters-in-law." In the Indian context, respect for women is closely tied to a patriarchal and brahminical sense of modesty, which is accorded to 'good' women.[6] The participant used the Urdu term *izzat* for respect, denoting value, further evidenced by the examples she used to illustrate lack of respect — dowry violence, material deprivation and female infanticide. The idea of women's lives being valuable is fundamental in principle but in the context of structural inequality, claiming recognition of their lives as intrinsically valuable becomes a claim on care.

This formulation of care (as value) has not been studied as 'care' in scholarship on women's access to healthcare which predominantly focuses on institutional care, nor has it featured in advocacy on the body and sexuality, which, in the Indian context, is centred on (self) care and autonomy. However, I would argue that it was and is a central theme in early and contemporary advocacy on dowry, sex-selective abortion, and patriarchal and caste-based violence against women in India as all of these are essentially based on the premise that women's lives are valuable. These advocacy and protest movements, which emerged in the 1970s in India are now collectively referred to as 'the women's movement,' and alongside asking for women's lives to be valued in society, they also sought legal reform. The

[6] Brahminical stands for 'caste-based' but with particular reference to the hierarchical and puritanical norms created and maintained by Brahmins, the 'highest' of the Hindu castes.

participants in my study did not frame their claim on care as a right, and certainly not as a legal right, but as something that should arise as concern on part of their marital families. Valuing women's lives features as a theme in scholarship on women and girls' health and development, frequently through the empowerment framework. But in this framework, the underlying principle is not necessarily intrinsic value but value towards an end, or utilitarian value. For example, Bhog and Mullick (2015), writing about the collectivisation of adolescent girls in India, argue that girls are always viewed as tools in a process of economic and social change, often by a crude cost-benefit method. In contrast, when women claim care as intrinsic value for their lives, a more fundamental claim is made on being valued within the family, which is seen as a natural site from which to claim care, as opposed to the state.

In contrast to indifference and denial of care in the marital household, women frequently described their birth home as a place of care. They particularly referred to the care they received from their mothers, who did not burden them with work, facilitated financial and physical access to timely and quality healthcare, and were concerned about their overall well-being. At the same time, women described feeling a sense of entitlement as a member of the marital household, living there and having access to its resources. The idea that a married woman is a member of her marital household and not of her birth household is informed by social norms of patrilocal residence, but the underlying belief is that after marriage, a woman is no longer a part of her birth family. A common Hindi phrase to describe daughters is *paraya dhan* which means 'someone else's wealth or property' indicating that from the time daughters are born, they are destined to belong to another family. This idea prevails across castes and classes in North India, even though increasing mobility and communication have alleviated the disruption of married women's relations with their natal kin. However, women did not seek to be a member of the marital household only to fulfil a social norm but also to access a right within marriage: the moral responsibility of their husband to care for them. "If my husband has married me, he must take care of me," said Ranjana, who was not on good terms with her marital family ever since her marriage. It is important to note that most of these marriages were arranged by parents or relatives, some by mutual consent of the couple, and some by the men alone, for example, cases where a man wanted to marry a woman and asked her parents to marry her to him without her consent.

Although women usually conceptualise this type of care as the moral responsibility of the husband, it has a strong economic foundation, and is articulated in most maintenance laws in India which make it incumbent upon men to provide for their wives (separated and divorced as well), minor children, unmarried adult daughter, and parents, if the latter groups cannot provide for themselves. It is based on moral thought and a conventional understanding of masculinity, and also on social and economic discrimination and deprivation that create gendered dependency. Recently, recognising women's increasing access to education and employment, Indian courts have proposed that adult daughters are equally obliged to provide maintenance for their parents as are sons, although the ruling has not been incorporated into any maintenance law yet (Vasant vs. Govindrao Upasrao Naik, 2016). In the case of maintenance for women, the conditions are not merely economic. Legally and socially, the claim to maintenance is additionally determined by the morality expected from women. If a separated or divorced wife is proven to have been in an

adulterous relationship, she and her children are not entitled to maintenance from the husband. Maintenance, then, is transactional, within or outside of the law, and that is how women conceptualised care or the act of husbands providing for them. They expected husbands to provide for them in exchange for the dowry they brought and the care-work they put in for the marital family. This type of care was also seen as a bare minimum expectation (which could be fulfilled out of moral and social obligation even if their lives are not fully valued), and where women did not receive it, they sought it for their children.

Women's claims on care of this kind, although closely represented in maintenance laws, were social and moral claims rather than legal ones. More importantly, it was not only a claim on material or monetary care but also on social support, and perhaps emotional support as well. Women recognised their husbands' support as pivotal in their navigation of the dynamics of the marital household, and claimed it in all kinds of marriages — self-arranged marriages, marriages arranged by family, marriages where husbands lived away (migrated for work) and marriages where the couple lived separately because of differences and/or violence. This kind of support, therefore, was also considered a moral responsibility or a right within marriage rather than a responsibility borne out of love and concern.

Ranjana, who demanded care from her husband based on the fact that he married her, insisted that her husband financially support their child even if he did not want to financially support her. She earned some money, with which she supported herself, albeit not substantially. But she insisted that her husband support her within the household in relation to the other household members.

> My mother-in-law is always arguing with me and telling me that my daughter and I drain the household resources. Look, I earn and support myself and try my best to support my child too. And I have to eat properly if my work is physically strenuous. But she abuses me and calls me a witch. When I tell my husband about it, he says that this is between my mother-in-law and me. What use are you as a husband if you cannot support me? You married me and brought me to your home. (Ranjana, 18)

In my reading of this account and the larger interview, Ranjana did not seek emotional support from her husband, nor did she seek affection or a display of concern. She wanted him to use his position in the household (as a husband and a son) to help her stabilise her relationship with her mother-in-law, which would give her and her daughter a secure position in the household by enabling access to its resources. The underlying goal behind her claim on support or care, therefore, is strategic. The implications of making such a claim on care as the moral responsibility of the husband is almost always more strategic for women than making a claim on care as value, which, while fundamental in principle, is not necessarily met. It is also more strategic when compared to claims on care as love, which is discussed below and is affective in nature.

Love was a common lens through which women claimed care, or articulated being cared for. The words used to describe love were closer to "nice", "thoughtful" and "caring" and were mostly used to describe husbands and mothers, and sometimes in-laws. In Sonali's case, she repeatedly mentioned that her husband is nice. He had advised to carry her pregnancy to term with the reassurance that he will take care of her. The term he used was

maintenance — *I will take care of the maintenance of your body*, which sounds closer to the moral and legal responsibility to provide for the wife, but he wasn't merely reassuring her that he will pay for her health expenses but saying that he will be there for her. Underlying this reassurance of care is the advice that she should do what he thinks is right, which in turn is based on gendered norms that vest power in husbands to give advice, even when they are not making outright decisions. Dependency and emotional bonds are evident here in the conceptualisation of and claim on care, and in line with Mumtaz and Salway (2009), I want to examine their role in shaping care within the context of gender inequality within the family and society. While care as financial support, and social support in navigating household dynamics, was claimed as the husband's moral responsibility, emotional support, which frequently translated to husbands making decisions for the wives, was perceived or laid claim to as a sign of love. The idea that, in a healthy relationship, the husband will do what is best for his wife, and therefore, the wife can leave all decisions to him, is seen as desirable. Wanting to be cared for in this manner can possibly be placed in Kabeer's (1991) definition of agency as it illustrates negotiation and bargaining through the lens of love and care — *I trust you to take care of me and somewhat give up my autonomy (in terms of observable action), but I like being taken care of and/or need to be taken care of.*

Implicit in love and care, especially the kind that thrives upon dependency, is the infantilisation of women, which assumes greater importance in the context of my research as care is being studied from the perspective of very young women. Husbands and in-laws frequently used their daughter-in-law's young age as a reason to prevent them from making decisions or from considering their perspectives on health and care both out of concern for their well-being and to exercise power over them, often in an intertwined way. The infantilisation of women can take the shape of control in the garb of care, and also assume more violent forms. *It's for your own good* is a common expression of love and care directed towards women and young people. This idea of care has been critically theorised as 'patriarchal benevolence' which suggests that men exercise privilege and power in the garb of care and equal treatment. In the study data, patriarchal benevolence is perhaps at play in cases where women utilise a particular type of care because their husbands insist on it, premised on the belief that the husbands care enough to make a suggestion or a decision. However, not all incidents of women claiming this type of care can be categorised as patriarchal benevolence. Young women, often overburdened with household work, having poor access to information and lesser exposure to institutions (such as health systems), actively sought their husbands' involvement in the form of decision-making. "I leave it up to him, why would I want to take on the headache of making decisions?" said Sunita, 21, explaining the importance of having a caring partner.

Women sought this type of care, in the form of involvement, from in-laws as well, as it demonstrated togetherness of the family. Seeking involvement from the in-laws is also strategic as it affirms the daughter-in-law's position as someone who is respectful and dependent on the husband's family (rather than being someone who acts on her own volition). But given the norms of filial piety, it is also a sign of respect to elders and an expectation of love and care from them, a defining feature of society in South Asia (Jafree and Sastry, 2020).

This type of care, though premised on love, can include value as well, in both intrinsic and substantial ways. A concept that possibly comes close is Thoits' (2011) 'social support', in

turn drawn from Rosenberg and McCollough's (1981) concept of 'mattering' which refers to the belief that one is important to another person, receives attention from them, and depends on them for the fulfilment of specific needs. The role of dependency and emotional bonds in claiming care, or the formulation of love as care, is relatively difficult to establish in comparison to care as value or care as moral responsibility. Women did not actively seek love as care, or did not articulate it, as opposed to seeking to be valued and seeking to be provided for. However, those who experienced this kind of care always mentioned it and its role in their access to healthcare and overall well-being, without being asked, and in a culture where love between partners is not usually a subject of open discussion.

Conclusion

This paper comments on two interrelated debates – the debate over decentring autonomy in studying women's health and status, and the debate on the gendered relationship between women and care. With respect to the first debate, from feminist perspectives, moving beyond the autonomy paradigm conceptually allows a nuanced understanding of the institutions and relations that shape gender inequality, insights into the values and motivations that shape women's contextual approach to injustice, and a way to account for their reflexive capacities to formulate and articulate their preferences rather than the ability to make decisions that result in action alone (Kabeer, 2011; Madhok, 2004; Mumtaz and Salway 2009). My research draws on these perspectives and suggests that studying care – women's needs and motivations for care as well as their claims on care – enriches approaches on access to care which are predominantly rooted in the biomedical framework or exclusively focus on health status (such as the prevalence of illness) rather than embedding women's health in the everyday household social economy and the structures of caste and kinship in the case of South Asia. Decentring (and challenging) autonomy to study care, more specifically women's claims on care, also adds to the second debate and has implications for a feminist positioning on care, which, so far, has largely been developed in relation to gendered social reproduction, and ethics (Himmelweit and Plomien, 2014). In the three formulations of care that I describe – care as value, care as moral responsibility, and care as love – whether or not women exercised agency or acted autonomously, they claimed care for themselves, which is not typically studied as a way in which women position themselves in relation to care. It is also distinct from the formulation of self-care as a feminist political practice, and it must be noted that the women whose lives I researched continued to participate in and even claim their role as caregivers, while claiming value, rights, and love as forms of care due to them.

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