SOCIAL SUPPORT AND QUALITY OF LIFE OF YOUNG MARRIED WOMEN IN AIZAWL, MIZORAM

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CATHERINE LIANHMINGTHANGI

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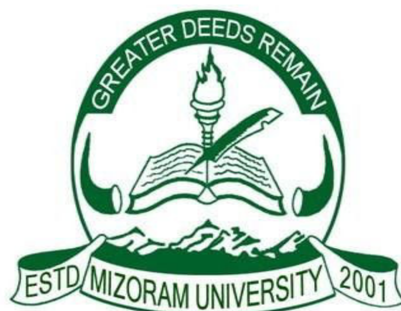

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SOCIAL SUPPORT AND QUALITY OF LIFE OF YOUNG MARRIED WOMEN IN AIZAWL, MIZORAM

BY

Catherine Lianhmingthangi
Department of Social Work

Dr. Grace Lalhlupuii Sailo

Submitted
In partial fulfillment of the requirement of the Degree of Doctor of Philosophy in Social Work of Mizoram University, Aizawl.

Mizoram University

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Certificate

This is to certify that the thesis, *Social Support and Quality of Life of Young Married Women In Aizawl, Mizoram* submitted by Ms Catherine Lianhmingthangi for the award of Doctor of Philosophy in Social Work is carried out under my guidance and incorporates the student's bonafide research and this has not been submitted for award of any degree in this or any other University or institute of learning.

(DR. GRACE LALHLUPUII SAILO)
Research Supervisor
Department of Social Work
Mizoram University
Aizawl- 796004

Date: 8th February 2021

Place: Aizawl, Mizoram

Mizoram University
February 2021

Declaration

I, **Catherine Lianhmingthangi**, hereby declare that the subject matter of this thesis is a record of work done by me, that the contents of this thesis did not form basis of the award of any previous degree to me or to the best of my knowledge, to anybody else; and that the thesis has not been submitted by me for any research degree in any other University/Institute.

This is being submitted to the Mizoram University for the degree of Doctor of Philosophy in Social Work.

(**CATHERINE LIANHMINGTHANGI)**
Research Scholar
Department of Social Work
Mizoram University
Aizawl -796004

(**Dr. KANAGARAJ EASWARAN)**
Professor & Head
Department of Social Work
Mizoram University
Aizawl -796004

(Dr. GRACE LALHLUPUII SAILO)
Research Supervisor
Department of Social Work
Mizoram University
Aizawl -796004

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LIST OF ABBREVIATIONS

AMC	: Aizawl Municipal Area
CSR	: Child Sex Ratio
HRW	: Human Rights Watch
HS	: High School
HSS	: Higher Secondary School
IMR	: Infant Mortality Rate
IPV	: Intimate Partner Violence
MDG	: Millennium Development Goal
NFHS	: National Family Health Survey
PG	: Post Graduate
PTS	: Post Traumatic Stress Disorder
QOL	: Quality of Life
RTI	: Reproductive Tract Infection
UG	: Under Graduate
US	: United States
VAWG	: Violence Against Women and Girls
WHO	: World Health Organization
WHOQOL-Bref	: World Health Organization Quality of Life-bref

CHAPTER I
INTRODUCTION

The present study attempts to assess the Quality of life of Young Married Women in Mizoram. The study also explores the perceived social support and coping strategies of Young Married Women.

1.1 Social Support

The term "social support" is used to demonstrate various phenomenon in formal and informal relationships. It is a broad term that portrays the supportive behaviours and actions that people perform in a society (Helgeson 2003). It has also been defined as a concept and perceptions of a person about the available support, which serves in a particular function. It is commonly understood as an individual's sensitivity towards the things they care for, their regard that are closely involved with other people (Bennett et al., 2001). Social Support thus refers to a broad variety of phenomenon that characterizes the social environment, or the people who surround individuals in their network.

Baheiraei et al (2012) expressed that individuals are provided with emotional and material needs and resources through interpersonal communications and relationships which is known as social support. When resources are exchanged between two or more persons, it is referred to as social support. Social support is believed to enhance self-confidence, sense of empowerment efficiency, and quality of life. Social support has been found to improve emotional and physical well-being of a person (Specht, 1986). Antonucci & Jackson (1987), in Schwarzer & Leppin (1991) highlighted that studies of social networks frequently find a link between social support and increased psychological well-being and physical health, generally demonstrating beneficial effects whereas Antonucci & Jackson (1987), in Cohen and Wills (1985) remarked that both psychological and physical health has been widely studied in relation to social support. Studies examining measures of well-being (e.g., depression, overall happiness, life satisfaction) have concluded that social support is emotionally beneficial (Cohen & Wills, 1985).

Albrecht & Adelman (1987) defined social support as "verbal and nonverbal communication between recipients and providers that reduces uncertainty about the situation, the self, the other, or the relationship, and is function is to enhance the

perception of personal control in one's life experience, while Cobb (1976) defines it as information that prompts the individual to believe that he or she is cared for, loved, esteemed, valued, and a member of a network of common and mutual obligation.

Social support is a complex phenomenon that has been conceptualized in terms of either functional or structural properties, or both. The functional domain encompasses the availability of support and the quantity of support to which people have access. It also includes enactment of support, or the actual use of different types of support. It covers quality of support referring to the person's satisfaction with available or received support and reciprocity of support, both giving and receiving support. The functional domain includes negative or positive support and content, or types of support (El-Bassel et al., 1998).

Women with low social support are indicated to have more stress, while those with stronger support from family and friends have less. Social support at the work place and at home significantly influences a person's wellbeing. Spousal support is most effective in helping women deal with the demands of multiple roles (Duxbury and Higgins (1991), in Eckenrode & Gore, 1990). Family members have the ability to provide support to each other resulting in reduced levels of stress and depression (Johnson et al., 2010). Children are important members of women's social network, with whom practically all of them maintain a strong bond, regardless of age or cohabitation. In particular, older children emotionally support mothers who are victims of spousal violence, comforting them in the moments after the assaults, or even advising them to seek out professional help (Netto, Moura, Araujo, & Souza, (2017) while on the other hand women benefited from supportive friends in the face of a strained partner relationship (Walen & Lachman, 2000).

Social support has an important influence on outcomes across the lifespan and its benefits are consistently found among various age groups. However, aging tends to be associated with a decrease of the social network, and both support receiving and support giving have been found to decline as age increases, with the greatest amount of support being given to one's network in midlife (Antonucci, Fuhrer, & Jackson, 1990; Carstensen, 1991).

People who feel isolated, regardless of their marital status, will also be more likely to become depressed. As a result, intense social relationships such as marriage can breed conflict as well as intimacy. Factors such as the presence of children or the

unequal division of household labour may reduce well-being by generating marital conflict. For men, marital conflict is associated with problematic use of alcohol while for women it is with depression (Horwitz & White, 1991; Horwitz et al., 1996).

1.2 Quality of Life

The concept of quality of life broadly includes how a person assesses the 'goodness' of life. These multiple aspects of measurement encompass an individual's emotional reaction to life episodes, one's outlook, sense of fulfilment and satisfaction in life, such as with work and personal relationships (Diener et al., 1999). WHO defines Quality of Life as "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" while Saxena et al., (2013) similarly stated that it is a large concept where the person's physical and psychological wellbeing, level of independence, social status, personal beliefs and relationship are affected in a complex way.

Quality of life requires multiple approaches from different theoretical viewpoints, as it is a multifaceted construct hence; exploring which domains to be covered could be a major challenge in defining quality of life. However, it is essential to view quality of life as a concept consisting of a number of social, environmental, psychological, and physical values (Theofilou,2013). In an attempt to understand quality of life, Bullinger & Ernst in Birnbacher (1999) have developed the concept of quality of life using four dimensions, physical which includes physical pain and discomfort; a psychological aspect such as fear and depression; a social aspect referring to the number and quality of social relations; and a functional dimension which includes work, household and leisure activities. In assessing the domains of Quality of Life, Kerce (1992) also recommended the inclusion of a wide spectrum of individuals and that it should be inclusive enough to represent the near total life experience.

The age-old type of question, "how are you?" is generally used in different societies as a greeting to express an interest in the health, welfare and prosperity (i.e., quality of life) of the person addressed. Szalai (1980) also remarked upon the similarity between this and the current concept of quality of life, as they tend to define a person in broad ways. Birnbacher (1999) & Kerce (1992) suggested that a comprehensive assessment and definition of quality of life should include insight

related to the aspect of life such as personal security, financial condition and standard of living, housing, health, marriage/partnership, family life, relations with relatives, relations with friends, neighbourhood/community, leisure and recreation, work, self-efficacy and personal development.

Globally, quality of life is measured in different ways with varying domains such as happiness, well-being, and satisfaction. The relationships between global quality of life and different socio-demographic variables such as age, gender, marital status, education, and occupation have been evaluated by different studies. However, studies conducted in western countries show few or no differences between men and women in quality of life measured as satisfaction with life (Headey et al., 1991 & Mastekaasa, 1992).

Quality of life (QOL) is subjective and as a complex concept, it is based on one's perception of life (Sartorius & Kuyken, 1994), and is one of the key concerns of today's health professionals. It is one of the main indicators for measuring health status and such information could lead to treatments that are more effective and develop and promote protection and rehabilitation programmes (Wiese & Moradi, 2006).

Fallowfield (2009) define and measure QOL as various domains including disease and treatment, mental health and wellbeing as well as social and economic aspects. Bowling and Windsor (2001) also agreed that QOL is a multi-faceted issue that involves all aspects of life. Personal growth, marital relationships as well as occupation, economy, industry, and policy is best affected by focusing on the elements of better life (Alborzi & Area, 2008). Marital satisfaction and adjustment (Nourani et al., 2010); and physical, mental, and social aspects (Sandelwoski & Davis, 1990) have always been associated with QOL.

QOL of women is strongly determined by their educational level where Tajvar et al. (2008) and Keshavarzi et al. (2013) in their studies found that health-related QOL was highly associated with higher education. Thus, it is acknowledged that achieving higher education enhances QOL as it contributes to increased awareness, knowledge and skills. According to FritzellIa et al. (2007), low level of education increased the risk of mortality, poverty, unhealthy, and undesirable behaviours while on the contrary, studies from western countries such as those conducted by Diener et al (1993) show a weak positive correlation between education and life satisfaction, happiness and other measures of psychological well-

being. However, if the occupations of women are controlled, this correlation becomes negative. Furthermore, Oswald (1997) found several studies that confirmed unemployment negatively affects satisfaction with life.

1.3 Social Support and Quality of Life of Young Married Women:

Social support is defined as the availability of people who make one feel cared about, valued, and loved (Sarason, Levine, Basham, & Sarason,. 1983). A study conducted by Iwanowicz-Palus, G., Mróz, M., & Bień, A. (2021) confirms the association of perceived social support and quality of life among pregnant women. Social support and self-efficacy contributed to better perceived quality of life among the respondents in which respondents who had lost a pregnancy reported lower quality of life in the psychological domain. The strongest positive correlation was found for the psychological quality of life domain. Thus, social support is evidently a significant concept that plays an important role among the factors that determine quality of life of a person.

Perceived social support has been defined as "an individual's perceptions of general support or specific supportive behaviours from people in their social network, which enhances their life's functioning or may buffer them from adverse outcomes" (Malecki & Demaray, 2002). Nikcevic, Kuczmierczyk, & Nicolaides, (1998) further demonstrate that social bonds and networks have a beneficial impact on various aspects of an individual's psycho-physical condition, including reduced health-related stress, anxiety, and depressive symptoms. Similarly, Strine, Chapman, Balluz, & Mokdad, (2008) also acknowledged the association between social support and life satisfaction. They found that with decreasing level of social support, the overall dissatisfaction with life increases.

Social support in difficult situations is understood as a method and assistance which assembles an individual's strength and resources to cope with problems. Such perceived support minimizes stress and it has a beneficial influence on various aspects of psychological well-being and is associated with the overall assessment of quality of life of an individual (Sereshti et al, 2016). Social support is further defined as any assistance available to individual in challenging situations. It is a factor known as positively affecting an individual's quality of life as it has significant contribution to the maintenance of health domain of an individual. Such domain encompasses the maintenance of health, prevention of disease and success of

treatment (Lotfi-Kashani, 2014). A positive relationship between social support and subjective opinion about psychosocial condition, health and satisfaction with quality of life among women after pregnancy of life was also observed by Iwanowicz-Palus, G., Mróz, M., & Bień, A (2021).

Women often have a greater number of close relationships and also a more extensive social network than men do (Laireiter & Baumann, 1992). Additionally, women provide more emotional support to others, and they seek and receive more social support (Ashton & Fuehrer, 1993). A study of Rostami, A. (2013) revealed that spousal support was an important indicator of marital satisfaction for women and QOL, and spousal support were significantly higher in men than in women. Apparently, women who experience better communication and receive more spousal support do not need to seek as much social support outside the marriage. When perceived spousal support is not sufficient, seeking support from other sources, such as extended family and friends, becomes more important (Namayandeh, Yaacob, & Juhari, 2010).

Parish et al., (1991) found that most young mothers in the research have access to nearby kin, and it is these kin who mostly assist them with child care and income support followed by next closest kin. Almost a fourth (17%) of young married women in the study had female kin in the same household who offered support. When the research combined household and neighbourhood statistics, more than half (58%) of women had female kin either at home or in the neighbourhood who then provide support and assistance to half of these women. The research concluded that kin networks evidently improve the quality of life for some young mothers as they turn to kin for assistance and support.

1.4 Young Married Women

According to Bruce & Clark (2003), adolescent period is an important stage and due to early marriage, many young women in India lose this important time of transition. Early marriage is not uncommon in India where the decision to marry is usually made by the family. Kishor & Gupta (2004) found that the median age at first marriage is only 16 years for women aged 25-49 years. The roles and responsibilities of adulthood particularly motherhood are imposed on adolescents because of early marriage thus resulting in unfavourable physical health and well-being Madhurima (1996). Early marriage places young women at risk of abuse by their intimate

partners (UNICEF, 2001).Young women who had married post 18years were more likely to involve in planning their marriage, to fight against partner abuse and to exercise their reproductive rights than those who had married before age 18. The latter were less likely to experience physical and sexual violence in their marriage or to have had a miscarriage or stillbirth (Santhya, 2007).

Newly married women in India are largely adolescent women who experience remarkable change in the lives such as change in bodies, emotions, and daily life experiences. As most marriages in India tend to be patrilocal, newly married adolescent women reported that such changes happen in unfamiliar surroundings and often among virtual strangers. They are yet to display their values to the marital household in terms of emotions, employment, reproductive and household maintenance which makes them vulnerable. Marriage in India especially patriarchal and patrilocal cultures' inherent expectations of sexual activity and reproduction consider women's bodies to become a body-for-others (George, 2002). The period of being a newly married woman is a time when they begin to value and acknowledges their sexual and reproductive capacities; which are an important source of power especially when they lack it from other sources (Puri, 1999). Young married women in India often enter new families who have clearly defined gender roles and hierarchies (Agarwal, 1995). An assigned gender role places a heavy load on women (Dyson et al., 1983). Once a woman is married, her social ties and networks are limited or detached and importance is given to proving her fertility especially within the first year of marriage.

Newly married women along with their husbands have very limited autonomy to make decisions about their personal lives as throughout the early days of marriage, they stay under the authority of the husbands' parents and other older relatives. Contact with birth families; and social contacts and support from outside the marital home become limited for the newly married woman (George & Jaswal, 1995). Young daughters-in-law have to live up to many expectations as she enters the marital home. Such expected behaviour had to do with respecting family elders and unknown males, adjustment into the defined gender roles such as household chores, mobility, so-called behaviours of modesty, and sex (Kapadiaet al., 2007).

The proportions of currently married women participating in decision-making are significantly lower than unmarried ones. Kishor & Gupta (2004) found that 81% of unmarried women freely decide their own health care while it is only 50% for

married women. The differences determined by marital status are also found similar in their participation in household decisions and mobility as well. Thus, clearly participation in decision making even for their own selves is limited among all married women.

The study made by Rammohan & Johar (2009) emphasized that women's autonomy is largely influenced by kinship norms. Education level of married women is an important dominant of household autonomy and freedom of movement (Gupta & Yesudian, 2006). Kishor & Gupta, 2004 found that social, environment, psychological and physical values significantly improved with the increase in level of women's education. However, Gupta & Yesudian (2006) found age to be a more significant factor than education, for household autonomy and freedom of movement.

Ahmad, M., & Khan, A. (2018) ratified that in an Indian society, a married woman has a numerous roles to play such as role of a wife, mother, daughter in law which is indeed a deeply stressful and full time job. It has now become a need that women and men work side by side in order to smoothly run the house. Such roles and responsibilities of women bring a number of challenges which in turn influence the quality of life of women.

1.5 Married Women in India

In ancient India, women enjoyed a position of respect and reverence despite the fact that patriarchal system was highly prevalent (Jayapalan, 2001; Mishra, 2006).The Indian cultural tradition begins with the Vedas which states that women had the right to remain unmarried throughout their life, or select their own life-partners; and marriages were not forcefully imposed on them. Girls were given in marriage only after completing their education and child marriage was unknown (Punam & Sharma, 2017). Gender discrimination in education and other rights and facilities were seen since the Later-Vedic period. Child marriage, the purdah system, and polygamy weakened the women's position in society (Nandal & Rajnish, 2014). Child marriage was a norm in ancient India where they were married off at the age of 8-10 which resulted in problems such as increasing birth rate, poor health of women due to repeated child bearing and high mortality rate of women and children (Punam & Sharma, 2017).

The High Level Committee on the Status on Women (2015) highlighted that India is a male dominated society where its men largely control the economic, religious, political, cultural, and social institutions. Traditional expectations dictate that a woman's place is in the home where she should be performing household tasks, and that they should not be employed outside the home. In Indian traditional society, women's autonomy such as their ability to influence decisions about themselves or household members, their ability to control economic resources and information, and their ability to move freely, is confined to the domestic sphere (Dyson & Moore, 1983; Bloom et al., 2001). Married women are more likely to suffer from depressive symptoms as they are restricted to performing household chores (Krause, 1982). As such, gender discrimination of any form is prevalent because females are confined to the house (Bhawana & Neetu, 2014).

Girls are normally considered unwanted and a burden yet they are expected to support men. Women suffer in silence through atrocities such as abuse, violence, rape, and early marriage and speaking out results in huge repercussions (High Level Committee on the Status on Women, 2015). The Indian social norms mandate its women to marriage, sexual activity, and childbearing, regardless of her class, caste or religion (Uberoi,1994). Child Bearing and rearing are considered central to women while sexual activity and procreation hold the potential to consolidate her bond with her spouse, improve her status and position in the joint or extended family she merged in (Puri, 1999).

Thapan (2003) found married women based their sense of well-being on their everyday experience of sexuality, motherhood and work. These women may not be entirely happy or content in their lives as married women yet they attain respect and status through marriage and childbearing, which further allows them to speak out against the oppressive conditions or abuse that they experience in their marriage. Narayan et al., (2000) states that marriage is considered essential to women's sense of self-worth and well-being relating to material, psychological, physical and social well-being, security, and freedom of choice and action. Thapan (2003) derived how a fully functioning body is essential for women to play their role as wife and mother, yet even though they take control of reproductive and related health, they are unable to challenge patriarchal control over their sexuality. Narayan et al., (2000) added that women's sense of self-worth depends on a range of factors, including her educational

level, the sex and number of children to whom she has given birth and relations with members of the extended family.

In recent years, the role and status of women has undergone some drastic changes however continue to be in a disadvantaged position. Female IMR is always higher than the male IMR (Jaisingh, 1995; Hegde, 1996; Prasad 1999, in Gupta & Yesudian, 2006). According to the 2011 census, the child sex ratio (CSR) is 914 girls to 1000 boys. Even today, many communities in India consider girls as only reproductive machines that do not require any formal education. Women's movements outside the home are often highly restricted and they are raised to follow traditional norms that ask them to accept and tolerate their lower status including domestic and public violence.

A large number of women do not have power and are unable to make decisions independently. They are subjected to seek permission from male members for every issue and cannot exercise their right to free movement (Punam & Sharma, 2017). The status of women in modern India is inconsistent. If on one hand she is successful, on the other hand she is silently suffering the abuse afflicted on her by her own family members. There are many problems which Indian women go through daily so often so that these problems have become a part of life while some have even accepted them as their fate (Punam & Sharma, 2017).

Indian women were excluded from the educational field since medieval period as they were perceived as needing just household education. The perception that women should be trained only for domestic duties persists in many Indian villages (Punam & Sharma, 2017).For a long period, the educational opportunities for girls were denied because of child marriage and purdah. More than a third of Indian girls and women are illiterate, representing possibly the largest number of illiterate women and girls across the world. Various reasons result in School dropout for girls including long distance of school from home, responsibility to take care of siblings, the need to take up a paying job and increasing gender based violence (High Level Committee on the Status on Women, 2015).

After the Indian Constitution granted equal rights to women and the right to education, Indian women's participation in higher education is gradually growing and women now seek employment outside the home (Pruthi et al., 2001). A study conducted by the Carnegie Commission found that women with college level education spend more time on childcare than women with lower level of education,

though such educated women spend the same amount of time on domestic chores and meal preparation. Educated women were expected to be efficient in all her responsibilities and any mistakes and errors made will be blamed on her education saying it is wastage (Pruthi et al., 2001).

1.5.1 Reproductive Health and Maternal Health

Reproductive health is a state of complete physical, mental, and social well-being in the matter of reproductive system (WHO, 1998). Defining reproductive rights is not easy as they are women's rights, and women's rights are human rights; and as part of human rights, control and choice are central to women's reproductive rights (Moodley, 1995).

Studies have indicated that the risks of maternal mortality and morbidities are high among young married women as young women in their early marriages are facing pressure to bear children in many parts of India today (Barua et al., 2004). Further, newly married women often have less decision-making autonomy and are considered a subordinate member in the family (Jejeebhoy, 1998). Studies made by Barua & Kurz (2001) emphasized that in India there is a culture of silence and shame around discussing reproductive health problems and seeking care. In such circumstances, the husband's attention and attitudes, knowledge, and behaviour related to reproductive health of women in particular can strongly influence women's health choices (Barua & Kurz, 2001).

Over the years, reproductive health of women has always been considered as only a woman's concern (Becker, 1996); and the husband’s knowledge and engagement in the maternal care of their wives is rarely found studies (Carter, 2002). A study made by Barua et al., (2004) found that newly married women have little or no autonomy in decision-making, in financial matters or mobility to seek care during pregnancy and childbearing; and therefore suggest that husband’s involvement is crucial since they are often the decision makers in any matters.

Indian cultural norms and values discourage early use of contraceptive in marriage. The demand for contraception to delay first pregnancy is high among young married women in India but largely unmet (Melhado, 2014). Rural Indian women especially northern Indians are impeded by cultural barriers from postponing childbearing, encouraged by parents and relatives who are eager to see newly married women giving birth soon after marriage and cohabitation. The fear that the

capacity to bear child may decline with age is another reason they believe that it is wise to have children as early as possible (Daniel et al., 2008).

It has been observed that across regions, high level of education has positive association with contraceptive use to delay first pregnancy (Melhado, 2014). In developing countries, the disapproval by male counterparts to use contraceptives and the side effects of contraceptive use are the important factors that cause women's low reproductive health status. The use of contraception was more common among women with eight or more years of education as compared to uneducated women. Some statistics indicate the neglect of women's reproductive health and well-being because young married women do not have access to the necessary family planning services and treatment (Bongaart & Bruce, 1995). The World Health Organization has estimated that there are 500,000 pregnancy related deaths each year.

1.5.2 Crime against Women

According to Bhawana & Neetu (2014), any crime exclusively “directed against women” and where women are the “victim,” are known as crimes against women. One of the most universal human rights violations is violence against women and girls (VAWG) in which at least a billion women are affected across the globe. VAWG takes many forms such as physical, verbal, and emotional abuse, forced and unwanted sex, early marriage, trafficking, and deprivation of opportunities and human rights. Crimes against women also include threats, verbal abuse, battering, rape, murder and are considered a costly public health problem (Masson, 2019). Crime against women as is "an anti-social act" (Mower (1959) in Mitra, 2015). It is a pattern of behavior that comprises physical, sexual, and psychological assaults (Bhawana & Neetu, 2014). Violence against women is a violation of human rights. Global estimates published by WHO (2016) show that about 1 in 3 women have experienced either physical or sexual violence from their intimate partners. More than a third of women murders are also committed by an intimate partner (World Bank, 2019).Women are lauded for silently suffering through violence (Narula & Narula, 2012) while Human Rights Watch (2017) also reported that women victims are often unable to attain justice and support.

In India, one of the major reasons for discrimination and injustice towards women is dowry (Bhawana & Neetu, 2014). Girls are treated as a burden on the family because of the huge dowry to be given at the time of her wedding due to

which many of them are discouraged to continue their education. Indian courts are filled with cases relating to dowry deaths and dowry harassment by husband and in laws (Saravanan, 2000). The rate of dowry deaths has decreased by 1.8% during the year, 2013 as compared to the previous year (8,233 cases). Bihar reported the highest rate of dowry deaths in India followed by Uttar Pradesh (Punam & Sharma, 2017).

Young married women in India often experience all forms of violence at the hands of their partners. Younger women (less than 19 years) are more likely to experience such violence than their older counterparts. Young women who are sexually intimidated or coerced are more likely to experience negative sexual and reproductive health outcomes such as genital tract infection, STIs, and unintended pregnancy (Madhurima, 1996; Kapadia- Kundu et al., 2004).Power imbalances in patriarchal norms result in women's inability to negotiate sexual matters which further places women at risk of non-consensual sexual experiences (Santhya et al., 2007).

A study across seven sites in India conducted by Inclen (2000) found that 40% of ever-married women experienced physical abuse in their lifetime. Physical violence against women is considered an extreme form of discrimination (Barzellato, 1998). A cross-cultural analysis made by Levinson 1989 found that among 90 societies around the world, physical violence against women exists in at least 75 of them. Several studies found that the individual, family, and cultural levels are the combining factors that promoting physical violence against women (Dhawan, 1999).

1.5.3 Women's Decision making

The freedom to control and make decision in the domestic, community and market is linked to autonomy and empowerment for women (Jejeebhoy 2000). Autonomy as defined by Dyson and Moore (1983) is the technical, social and psychological ability and freedom to obtain the necessary information for deciding about oneself and the others (close relation). Jejeebhoy recognized five interdependent aspects of autonomy for women: autonomy of knowledge, decision-making autonomy, physical autonomy, emotional autonomy and economic and social autonomy and self-reliance. The autonomy of knowledge gives women a wider view about the world and that decision-making autonomy strengthens their ability in decision making that affects their own lives. Physical autonomy signifies that educated women have more contact with the outside world, while emotional

autonomy states that educated women carry on their loyalties from their families to conjugal families. Economic and social autonomy and self-reliance indicates a woman's economic independence.

Kishor and Gupta (2004) stated that women in India experience an extremely limited freedom of movement. This was proven by their studies where only a third of women can visit the market without the need for permission and only one in four had the freedom to visit relatives or friends without permission from husband and family members. The findings in this study confirmed the fact that currently unmarried women have much more freedom than currently married women. They further stated that currently unmarried women are more than twice as likely to enjoy freedom of movement. The decline in infant mortality is greatly influenced by women's involvement in the decision making process and autonomy in the movement.

Young married women normally experienced early pregnancy and birth outcomes that might be influenced by the cultural norms that limits women's' autonomy. A community based cross sectional study carried out by Jean et al., (2006) among young married women aged 16-22 years in India found that there was a high prevalence of RTI among the participants yet they rarely seek treatment. Two thirds of young married women in the study had not sought any medical treatment and the reasons cited includes lack of female health care provider, lack of privacy, distance of health centre from home, the cost of treatment and ignorance of symptoms. Even though the participants are young at age, the proportion of RTI's is high as an influence of women's limited autonomy.

1.5.4 Child bearing

The ability to conceive children by women is perceived to be her central role as well as her obligation to her family and society. However, infertility itself is not a life threatening disorder from a medical condition point of view while it is considered a condition that threatens her social status and family reputation (Izubara, 2000). Thapan (2003) stated that women attained a sense of achievement by not only bearing a child, but also her ability to produce a male child in appropriate time. Experiencing childlessness is not rare and uncommon in today's world yet women who cannot bear children at all, or who do not bear a male child are regarded as family dishonor. Char & Kulmala (2010) stated the widespread of son preference in India where a fifth parents in their study preferred sons than daughters while only 2-

3% of the participants preferred daughter over son. Son preference in Indian society is also considered to have an influence on sterilization of women.

According to Uberoi (2005), male child is considered as the inheritor of the family while female child is considered as 'parayadhan', other's property. A narrative analysis conducted by Mishra & Dubey (2014) revealed the influences of social, religious and medical issues on women's view regarding conception and childlessness. The view on having a baby as a symbol of motherhood as essential and valuable for women was observed in their study. According to those women, children in the eyes of in-laws bring about honor and esteem and in the case of involuntary childlessness, most of them practiced religious and medical treatment for conception. The same study also highlighted that childless women bear many taunts and hostile behavior from others in society. Those women perceived that their families were incomplete without kids and that it also reduce their prestige in in-laws' house and their sense of womanhood. Many women believe that children play a crucial role in family formation and couples bonding, therefore, having a baby is crucial for their personal and to fulfill family obligation.

15.5 Women's education and employment:

Education of women is significant point in women empowerment as it provides them with the ability to react to situations and difficulties. Yet, women are faced with certain problems both in the past and till today including Gender discrimination, Lack of Education, Financial Constraints, Low Mobility, Family Responsibility and Atrocities on Women (Raped, Kicked, Killed, Subdued, humiliated almost daily) (Saxena, 2017).

In view of the same, Ahmad, M., & Khan, A. (2018) conducted a study in Uttar Pradesh among 80 married women from 25-40 years where half of the respondents were married while the remaining respondents were housewives. Their study employed WHOQOL-BREF (1996) to measure the QOL of working and non-working women where significant difference between working women and housewives on psychological domain was found. The non-working women in this study had a poorer mental health as well as the lower self-esteem as compared to the working women. The nonworking married women also reported more depression with poor social life as the most common stressor.

1.6 Women in North East India

Women in North East India are often depicted as enjoying a good social status as compared to their female counterparts across the country (Zehol, 1998). However Nongbri (1998) emphasized that gender equality or higher status of women in North East is a myth if it is to be viewed through customary law. Such customary law in North East India includes laws related to marriage, property, inheritance and so on. Such customs was originally practiced with the intention of compensation to the bride's family, as women are economically active members of the family. Khamrang (2012) states that women in North East India enjoy greater mobility and freedom than many women across the country and the fact that evil practices like dowry and bride burning are not common, and this is often cited to illustrate gender equality in the region. According to Lodha (2003), tribal women are given low status and are generally suppressed while some scholars opined that women are assigned high status by some traditional societies.

Zehol (1998) argued that in the modern context, North Eastern tribal women do not receive the deserved attention particularly in terms of access to education, food and nutrition, job opportunity and political participation. Bride price, as with dowry, has been used to justify the abuse women experienced form their husbands as this system has been exploited by wealthy men who marry a number of wives by paying the price. Elwin, in Zehol (1998) comments North East women are in the same position with any other women as they hold the same fear, faults and virtues; and they pay the same devotion to the husband, in laws and their children.

With the advent of modernization and globalization, Wahlang, J. (2015) attempted to analyse the changes in the social status and role of Khasi women where Khasi tribe of Meghalaya is one of the few matrilineal groups in the world. For this purpose, Dewlieh village represented the Khasi women in which it was found that out of a total number of 20, only 4 households were headed by women and the decision making ability lay in their hands. Although a very few households claimed that decision making was done jointly by both the male and female heads of household the study observed that the village under study at the level of the household decision making power belonged to the men and women's participation in this matter was limited to only 4 households. At the same time, the Khasi family structure represented by Dewlieh exhibited that the role of women were confined to

caring and nurturing of children and taking care of the domestic chores while the authority within the family was male-centered. In an attempt to understand the reproductive performance of Garo women in Meghalaya, Aimol, K. R., & Shipra, N. (2009) observed that fertility among women in Garo community was high with early marriage, lack of proper formal education, lack of awareness on family planning methods, and desire to have children of a particular sex as the main factors leading to high fertility. In this particular community, husband decides the number of children in a family, while women lack decision making power in this regard.

The North East Indian society follows a patriarchal culture that values the birth of a boy. Not excluding the Naga women, Kumar, S., & Goowalla, H. (2016) stated that a Naga woman is traditionally expected to be obedient, humble and submissive. In their attempt to analyze the background of Naga women entrepreneurs, they observed that although women enjoy considerable freedom and play an important role in family and community life, women are traditionally not included in the decision-making process of the clan or the village. Women have a countless range of responsibilities, from domestic work - within and outside the homestead - to various agricultural activities. When women in their study attempt to enter business arena they need approval form their husband or male and head of the family and that it placed a break in the growth of women entrepreneurs. Such prevailing traditions and practices present impediments for women to grow and prosper.

The situation of women in Manipur is not different from the other parts of the region. According to Leisan, W., & Geetha, V.J. (2017), women in their study do not have a recreation time as they have to devote their time around the family and the never ending obligations as a mother or as sister weakens their quality time. By and large, women in the study village are uneducated and that they are very little mindful of their well-being. Such uneducated women in their study had to sacrifice their well-being for the sake of family and the more educated they are the more well-being mindfulness she will give to herself.

1.7 Women in Mizo Society

Mizo society is deeply a communitarian society where both sexes freely mingle. The social life is free as far as the intimacy of men and women in society are

concerned. Therefore, the observer from outside often assumes that gender discrimination does not exist (Lalhriatpuii, 2010). Nevertheless, the fact remains that in traditional mizo society, women are generally discriminated simply on the grounds of sex (Zodinsanga, 2017). Although women enjoy social freedom, they are considered the subordinate gender and they face discrimination in various aspects of life despite their significant contributions in the family and society (Lalhriatpuii, 2010).

According to census 2011, almost half (49.3%) of Mizoram constitutes of the female population where 52.7% are residing in Urban areas. The female literacy rate is 89.3% and 79.8% of women in Mizoram need permission to visit a health centre (IHDS survey, 2012). Zodinsanga (2017) noted that women do not have decision-making power either at home or outside the home. They were oppressed and often looked down upon by male members of the society. Some traditional Mizo phrases such as, "A wife and a rotten fence can always be changed", "A woman's opinion is not an opinion", "Crabs and women have no religion" and so on, reflect this belief.

A focus group discussion conducted by Lianhmingthangi (2014) revealed that regardless of their intellectual abilities, worth and dignity, many women in Mizo society considered themselves subordinate gender who gets what they deserve even if the society punishes them when they are being violated. The group members also believed that it is the society who teaches its men that women are physically and mentally weak, therefore, women must remain under men's control and they must also accept domination and abuse as normal. The participants are also strongly of the opinion that atrocities against women is part of the Mizo culture and the society gives less weight to the incidents report even to the extent of blaming the victim. Such women used passive endurance as their main coping mechanism. Although emotional support was reported the most helpful coping strategy, many women continue to silently bear the pain believing that women's rights would not be recognized in a patriarchal society.

Namchoom & Lalhmingpuii (2014) observed that Mizo women in the traditional society were discriminated in all spheres of life where men ruled the home and outside of it. Regardless of the transformation and improvement brought about by Christianity, education and developmental efforts of the state, the status of women in Mizo society is still subordinate to men the patriarchal settings of Mizo society. Hmingthanzuali & Chhangte (2020) perceived that Mizo women in the historical

writings have been portrayed as a victim who needs to be saved and that the real voice of women, their real life stories, life experiences and perspectives needs to be explored. The historical writing focused on the male story while women were portrayed as just 'also there'. Therefore, in order to truly understand the whole life experience and functions of Mizo women, it is necessary to incorporate the alternative sources of information such as personal narratives, case study or autobiography which will further contribute to more inclusive Mizo history.

1.8 Statement of the problem

Looking to the history of men and women's relationship, it has long been seen that women have always been dominated by men in all cultures. It is a matter of concern not only in the Indian context but in almost every society of the world. Women are considered the weaker section and are regarded as weaker compared to men in social terms.

The status of women refers to the position a woman has by virtue of her being a woman. The status of women, as compared to men generally being lower in patriarchal system directed the world to battle this social evil and fight against gender based discrimination. Women's full and effective participation and decision-making in public life, as well as the elimination of violence, for achieving gender equality and the empowerment of all women and girls is very much essential and it has become the common concern of global community (UNESCO,2021)

Although some legal steps were taken to improve the status of women, the status and role of women in India even after independence remains one of the major issues of discussion. The high dowry demands, incidence of domestic violence against women, the limited physical autonomy, and low level of women's participation in decision making matters have also contributed to the general detestation for a female child in India. Women are instructed to live under the influence of parents before marriage while under the influence of husbands after marriage. Young married women in Mizoram are also undergoing a lot of changes in their personal-family life domains post marriage. Their relationship with own family, mobility, decision making, freedom etc. is curtailed and reshaped as per the demands of the husband and his family. Thus the study seeks to understand how women perceive their quality of life and the available perceived social support.

1.9 Objectives

1. To understand the socio economic and structural information of young married women.
2. To assess the psychosocial challenges and Quality of Life of young Married Women in Aizawl.
3. To identify the social support and coping mechanism of young Married women.
4. To suggest policy and advocacy interventions from a social work perspective.

1.10 Research Questions

1. What is the status of young married women in Mizo society?

2. What challenges do young married women face in their marital home?

3. Do young married women have awareness and access to reproductive rights?

4. What are the differential experiences of young married women in nuclear and joint family?

5. Does higher level of education increases the prestige of married women in their marital home?

6. Does quality of life of married women increase with age or years of marriage?

7. What are the issues related to child bearing and childlessness of a married women?

1.11 Chapter Scheme

The study is organized into eight chapters. The first chapter introduced the concept of Quality of life of women and its related issues at global and local levels. It also illustrates the statement of the problem and objectives of the study.

The second chapter presented the review of literature that was sub divided into ten sections. It displays studies on quality of life of women; general status of women, status of married women and other key issues of women in the global, national and local context. Literature on social support available for women has also been reviewed.

The third chapter discussed the methodology used in the study. It encompasses details of the study area, research design including sampling, methods and tools of data collection, data analysis and limitation of the study.

Socio economic information and structural bases of the respondents are discussed in the fourth chapter. It includes the Educational & Socio-Economic details of the respondents.

Challenges and experiences of young married women in the study are presented in the fifth chapter. It includes description of challenges pertaining to spousal and in laws relationships. Women's experiences on the various forms of abuse and the level of women's autonomy in decision making in various aspects of life are likewise discussed.

The sixth chapter contains a study on lived experiences of married women which is explored through case studies.

The final chapter presents the conclusion and suggestions for policy implications.

Chapter II

REVIEW OF LITERATURE

Review of literature helps the researcher to understand the theoretical background and empirical dimension of the research problem. It is also useful in identifying the various issues and possible gaps in literature. Therefore, the following literature highlights the existing studies on quality of life and perceived social support of women.

The preceding chapter introduced the concept of quality of life and social support. It describes the quality of life of young married women as measured in various domains. It also includes the statement of the problem, theoretical frameworks and objectives of the study. This chapter presents a critical view of literature on various aspects related to married women in society, in six sections. The first section discusses the social support aspect while the second section presents the quality of life facets. The third section is devoted to the status of women in the global, national and state levels and the fourth section is a review on married women and it encompasses the various domains of women's quality of life. The status of women in extended families is present in the fifth section while the sixth section is devoted to understanding women in women in Mizoram.

2.1 Studies on Social Support and Network

In the research studies on perceived social support in the literature, Malkoç & Yalçın (2015) observed that perceived social support and its subscales were found to have positive significant relations to psychological well-being and psychological resilience of a person. **Wellman (1981)** defines social support as doing things, giving and lending things, helping with personal problems, information help, and shared activities, values, interests, and interaction. Social support system according to **Cutrona & Suhr** involves five general categories such as informational, emotional, esteem, social network support, and tangible support. On the other hand, **Turner (1999)** defines social support as social bonds, social integration, and primary group relations. Social support has a multidimensional factors and majority of the studies have focused on the received support rather than support provided. Of the studies on

received support, perceived social support is more than actual support **(Song, L., Son, J., & Lin, N. 2011).**

According to **Albrecht & Adelman (1987)** social support as a verbal and nonverbal communication happens between the recipients and providers in order to reduce uncertainty in various aspects of life. Such communication enhances one's perception about life's experiences. **Berkman (1984)** also sees it as a social network that provides emotional, instrumental and financial help. The access to and use of a person, group and organization in the management of ups and downs in life are considered social support by **Pearlin et al., (1981).** More recently, **House et al., (1988)** considered it as "the emotionally or instrumentally sustaining quality of social relationships". Social support as defined by **Dean & Lin (1977)** is a role of primary groups to meet the significant needs and later redefined by **Lin et al., (1979)** as "support accessible to an individual through social ties to other individuals, groups, and the larger community". Another interesting finding from **Diener & Suh (1997)** suggested that those nations who rated friendship as being extremely important reported a higher level of well-being. A similar pattern is stated by **Argyle (1987)** that life satisfaction has strong relations with friendships and social support. The findings of **Rani (2016**) indicate that male and female significantly differ in terms of perceived social support. Females perceived higher social support than males and females also scored higher in social support from family and friends than their counterparts. Besides, her study also found that family support was the highest form of perceived social support for young males and females studied.

Kosterina (2012) acknowledged that young women exercised networks in order to create a sense of power and control over their lives. Networks are used to access advice, economic and emotional support when women do not receive them from their husbands. Making networks with other women continue to be important for attaining advice and accessing emotional space to disclose and share emotions and frustrations in marital relationships. The everyday communications and networking with other women provides an important space for young women, particularly relatives and close female friends offered an emotional support that was considered missing from their marriage. In assessing kin networks and support, and the consequences of this support for women's work.

Horwitz et al., (1996) reported that among the white people, women with higher income and greater social support are less likely to suffer from mental health

problems. This finding highlighted the significant association of marital quality and mental health that indicated the better marital quality results in better mental health among the married women. **Miller & Ingham (1976)** noted that chances of suffering from psychopathology is relatively higher among women who are socially isolated than women who are socially active. In a study conducted by **Edmonds, Paul & Sibley (2011)** in Matlab, Bangladesh among women aged 18-49 years, women perceived eight types of support during their pregnancy. Such support includes practical help with routine activities, information and advice, emotional support and assurance, resources and material goods, logistic communication, prayer and spiritual rituals, nutritional support, and accompaniment outside the homestead. Mothers (48%), sisters-in-law (48%), and husbands (44%) were the three most frequently mentioned sources of emotional support and women frequently mentioned their husband's participation in securing monetary resources for healthcare, foods with increased nutritional value, transportation, and other related expenses. In their study, almost half of the respondents perceived their husbands were the primary source of resources and material goods followed by mother's resources and mother-in-law's resource. The study revealed the need of family members support, friends and health professionals. Therefore, it is suggested that social support is protective during pregnancy.

Horwitz et al., (1996) conducted a cross sectional study among 532 married women of reproductive age with an aim of assessing their quality of life and its predictors. Half of the women in the study were young (25-24 years) and the age at married for three quarters were 15-24. The study employed self-administered questionnaire and found that reducing sexual problems and dysfunctions and enhancing marital satisfaction are considered essential for the improvement of women's quality of life and therefore the family life will also be strengthened. The same study also highlighted that marital satisfaction, higher sexual function and education level were predictors of health related QOL for women.

Alexander et al in Johnson and Johnson (2013) acknowledges that social support can be a motivator and resource to help women leave their violent and abusive partners to achieve safety. On the other hand, if battered women are encouraged to stay with abuser, such social support decreases their likelihood of change. Johnson & Johnson (2013) also noted that frequent social support help women in recognizing their situations as troublesome thus increase their readiness

for change. A study conducted by **Kosterina (2012)** viewed women's network as an important resource as it provides support in the absence of emotional support from their husbands. The physical and emotional absence of men compelled women to rely and form support group. In the absence of men from daily family life, women often form network with other women for all kinds of support. The networks with others also offer an opportunity to access information and knowledge, financial assistance, and advice to confront the life constrain.

2.2 Studies on Quality of Life

QOL is a multidimensional concept. It looks into many domains and facets that have an impact on lifestyle. It is used to measure an individual access to provisions of life such as education, sanitation, clean water, information about reproductive health-care and services, adequate housing, ownership of means of transportation, and ownership of household appliances **(Andrew & Withey, 1976).**

Kwan et al., (2003) noted that satisfaction in life and with life, adequate food, enough rest, good family support and networks, and satisfactory financial conditions are essential to good quality of life. Furthermore, **Lee (2005)** found that QOL has a relationship with marriage and family life. Therefore, physical and mental health, social network, financial stability and good family relationship influenced quality of life of a person.

According to **Liégeois (2014),** there are two sets of components in measurement of quality of life: subjective and objective aspect. The characteristics of life situation that are observed and experienced by a person in an objective manner is referred to as objective quality of life however **Rice (1984)** further identifies objective quality of life (QOL) as the standards of living, activities and consequences of an individual's life. The subjective aspects according to **Liégeois (2014)** are subjective perceptions and reception of life situation hold by a person whereas Rice (1984) defined it as a set of affective beliefs directed toward one's life. For valid and reliable assessment of quality of life, one needs to take into consideration both the aspects although subjective aspects are largely considered essential.

Grayson & Young 1994: Massam, B. H (2002) noted that there are two aspects in defining Quality of Life such as internal and external aspect. The internal aspect produces fulfillment and contentment in life while the external aspect triggers the internal. It has long been known that quality of life is complex to assess and

measure. There are certain common elements of quality of life to measure the concept of QOL, however, people's needs, desires, and the fulfillment of such aspirations in a given time, place and society can be used to measure an individual's QOL **(Findlay, Rogerson & Morris, 1988).**

Saxena et al., (2013) conducted a community based cross sectional study to assess the QOL and its correlates in MP using the WHOQOL-bref. The study highlighted that higher education has a significant association with most of the domains mentioned in the scale. Most of the rural population depends on farming and semi-skilled labour for livelihood. Lower level of education and limited resources dragged them to live in a poor QOL. Although rural inhabitants enjoy more physical and environmental health and have better perception for overall QOL, they are more vulnerable to psychological problem and social relationship problem as compared to urban population. In measuring the QOL using WHOQOL-bref, more than half (53.9) in the study stated that they have self-satisfaction while only 34.4% felt that their life has a meaning and is purposeful. A larger number (59.2%) of respondents in the study agreed that they are satisfied with their sex life while a lesser number (54.3%) stated that physical pain prevents them from fulfilling certain activities. In terms of support and networks, 40.8% received support from friends whereas 17.9% feel that they lack sufficient information for daily needs. Almost half in the sample are satisfied with their health while only 31.3% could access health services according to the study.

Bognar (2005) noted the objective and subjective social indicators. Objective social indicators are information that can be registered and are observable including the occurrence of epidemics, the level of environmental pollution, the crime rate, the number of doctors per capita, the availability of housing amenities etc. However, Bognar also remarked the needs of subjective indicators that can emphasize the "meaning" or "importance" of objective conditions.

As **Rice (1984)** defined, the quality of life is "the quality of life is the degree to which the experience of an individual's life satisfies that individual's wants and needs (both physical and psychological)". Much of the discussion on the definition of Quality of life has centered on subjective and objective approaches**. Chan, Cheng, & Phillips (2002)** divided the concept of QOL into three such as Biological, psychological and social concept. The biological concept take into account the health, ability to take care of one self, absence of illness and infirmity, ability to

move around while psychological concept looks at an individual's happiness and ability to learn new things. The Social aspects take into consideration an individual's ability to keep up an active social life, ability to attain social support and being supported by family and kins in times of need.

The concept of quality of life is naturally subjective and its definitions vary. Dimensions of quality of life according to **Fitzpatrick et al.,** includes physical function, emotional function, social function, role performance and other symptoms. The physical function includes mobility and self-care while the emotional function explains depression and anxiety. Intimacy, social support, and social contact are an important dimension of social function whereas work, housework, and pain signify the role performance dimension. Dimension under other symptoms include fatigue, nausea, disease specific symptoms. A very little is known about health contribution in an assessment of overall quality of life. To explore the relative contribution of health in defining the overall quality of life, **Perneger & Garnerin (2001)** conducted a study where the participants were asked to rate their satisfaction with 13 aspects of their life. The participants were also asked to note their perceived importance of such domains for their overall quality of life. The study found that overall quality of life satisfaction for six aspects of life has independent association with quality of life. Such six domains include living environment, money, physical health, mental health, relationships, and opportunity for personal development. Satisfaction with life also has a positive association with importance ratings for the same domain. The results further show the aspects of people's lives other than health that strongly bear the perceptions on quality of life.

2.3 Studies on Status of Women in male dominated society

The studies on position of tribal women per se have not been many nor of much depth **(Xaxa, 2004). Holland & Hogg (2001)** stated that, in general, men are the head of households and are given full authority to make households decision in many developing countries while the wife do not experience equity in this process. To illustrate this, **Hossain (2015)** noted that no matter who earns the cash, men normally manage the financial matters in the family and control the household purchases. Therefore, women in such families lack financial autonomy and become financially vulnerable as woman has to depend on husband's understanding and

willingness to spend money even if she needs medical care and health services. In such cases, it can be assumed that women who have higher participation in household decision-making are more likely to receive health care services. **Pillai & Wang (1999)** argued that patriarchal system persuades the reproductive rights of women in different ways. The patriarchy firmly labels women's reproductive functions as merely bearing and rearing children while it also values children as positive economic and spiritual possessions especially male children. This system attached the reproductive decision making authority to males of the family or community. Therefore, women’s ability to control their reproductive behavior is deprived by patriarchal system. **Lalhriatpuii (2010)** also argued that while some studies considered the status of women in tribal societies are better than the mainland counterparts are, research highlighted that tribal societies being patriarchal in nature is not far better than mainland counterparts. The quality of life of young married women is not satisfactory as their status in patriarchal society continues to be compromised.

The NFHS-IV (2014-15) reported the status of women between 15-49 years. According to this survey, 84% of currently married women usually participated in household decisions while there were 68.4% of currently married between 15-49 years who use Family Planning Methods. The ever-married women who have experienced violence during any pregnancy consist of 3.3%. A study in India conducted by **Garg (2011)** noted that the Indian women’s control over their life decision is limited to visiting healthcare centre and grocery store. In his study, a large number i.e. almost 80% of women said that they had to seek permission from their family members to visit health centre. The family members whom they had to seek permission are husbands and senior family members. Majority of those women had to seek permission from their husband while almost an equal number of women needed permission from senior family members.

According to **Hossain (2015),** educated woman has the ability to effectively operate all the available information and resources. The level of women’s education, ability to influence household decision making, and freedom of movement are an important dimension of women empowerment that significantly contribute to the reduction of infant mortality rate.

The improved status of women is considered to increase their educational achievement and economic opportunities thus leading to higher decision-making power in both the households and the society**. Phan (2013)** grouped women's participation in household decisions into two major categories: authority related to the general household and decisions exclusively related to reproductive rights (fertility and birth control). Women's age and education influence their participation in general household decisions while higher levels of women's participation in decision- making pertaining to both categories leads to lower fertility. **Garg (2017)** on the other hand suggested that ability to participate in decision-making are not correlated with literacy. It is rather the social norms, which influence a women's power to make decisions regarding marriage and visit to health care Centre. The physical and mental health status of women is largely influenced by their ability to make independent decisions. **Wang & Pillai (2004)** noted that improvement in women's status is generally accompanied by an improvement in women's health. The health status of women is likely to decline as social inequality increases that resulted in the decline of reproductive health among women.

Kishor & Gupta (2004) remarked that early marriage in the Indian cultural context hurls women from being a child or adolescent one day to being women. It gives them household responsibilities and reproductive obligations at an early age. As a result, early marriage limits women's opportunities for sufficient education thereby impeding proper physical and mental development. It disempowers women as it limits them from making independent decision in many cases. According to their findings, one-fifth of women reported having experienced some form of violence since age 15, and the majority of these women reported their husband as the source of the violence.

2.4 Studies on Married Women

In defining young mothers, **Sniekers (2018)** however suggest that 'young' means recently having become a mother (at any age). Young women jumped into unplanned pregnancy and marriage due to lack of sex education and moral sex behavior **(Kamaev et al., 2004).** However, a study made by **Raley & Sweeney (2009)** expressed that many women want to become economically independent before marriage, as they perceived that chances of conflict and divorce are influenced by financial strain in the marriage.

The time allocation of women and men regardless of their marital status is affected by gender role construction in the society. **Ferree (2010)** agreed that the time spend for household chores increase for women as they enter marital relationship or as they move into cohabitation. Therefore, as compared to unmarried mothers, the leisure time for married women is loss as they consider caring for their husband and children before taking time for leisure is necessary **(Craig & Mullan2013)**. Women bear most of the family responsibilities. **Panda (2003)** highlighted that women take up child rearing, care of the elderly and family members in Kerala society. In his study, he further stated that traditional gender roles, expectations, and gender division of labour are still uphold in the society. This societal gender role construction gives married women household obligations and responsibilities that affect their time allocation. **Krause (1982)** argued that married women, and housewives in particular, are likely to experience social (interpersonal) and psychological (intrapersonal) challenges in order to redefine their roles. Such challenges in an attempt to redefining their roles arrived from spousal pressure that affects the psychological wellbeing of married women. This analysis was based on in his survey where 300 married women from Ohio were interviewed to compare women who are employed outside the home and homemakers. His study reported that housewives are more likely to suffer from depression, somatic, and interpersonal difficulties as compared to women employed outside the home. The sufferings of housewives are created by gender role expectations at home and gender role conflict. Krause therefore concluded that women who are confronted by such sex role conflict are likely to suffer from depressive symptoms than women who are not. On the other hand, **Weil (1961)** found that husband's attitude toward his wife's employment outside the home was the best predictor of the employment status of married women.

In a research conducted by **Kosterina (2012),** married women ensures the material welfare of the family by taking the responsibility of domestic work, care of the husband, children and other relatives. This is in relation to the emotional pressure given by their parents who construct the notion of fate for their daughters. A married woman in this study expressed their desire to get married as ‘natural’ which is an opposed to the strong opinion exercised by their parents regarding the construct notion. But not only in India, the married young women especially rural women in China are treated as being of less value at home, as they still confine to the traditional Confucian beliefs. As Durkheim (1951) defined, such "excessive regulation" of

marriage in rural China is likely to increase suicide risk for these young women **(Jie Zhang 2010).** In such a society, being married may limit women form social life and that the unmarried women as compared to married women enjoy better social support from their wide range of networks. On the other hand, In terms of suicides and the controls, the married women are less likely to receive support from family, friends, and society. This is true in the Confucian ideology where women especially in those rural areas are expected to stay at home to take care of husband, children and in laws. Lack of support and network increases frustrations for those women and that the unavailability of help in times of crisis in their life increases the risk for suicide among married women (Jie Zhang 2010). **Miller & Ingham (1976)** measured social isolation in terms of friendship participation and participation in voluntary association thus agreed that socially isolated women are more likely to suffer from psychological problem as compared to socially active women. **Steinberg (2002)** also notes that networking, as a form of social support is particularly important in rural areas for overcoming the problems.

2.4.1 Maternal health

Women in large part of the world are restrained in religious and economic field, education and economic or simply moving independently. Women frequently undergo any forms of violence as compared to men while many justified the incidents by certain religious beliefs. These constrain results in decline in maternal and child health including unsafe abortion. Therefore, role of religion on women's health needs more attention. Acknowledging the need of women in these areas, the Millennium Development Goal (MDG) IV and V aim to improve maternal and child health **(Borisch 2014)**. A report of **Lane et al., (2012)** highlighted that early pregnancy contributed to poor reproductive health outcome in Nigeria. Nigerian women of 15 to 19 years are married off on an average, and 23% of them have begun childbearing. The report also stated that a vast majority (90%) belonging to the age group of 25 to 49 years have given birth by age 15.

Irina Kosterina (2012) study found that that it is imperative for young married women to bear a child as soon as possible because of the established social norms that believe having a child not only brought recognition from the society but it could also improve young mothers relationships with her in-laws. Therefore, many young women in her study bear children as soon as they marry because this was seen

essential in spite of economic hardships. Although such constructed norms expect young mothers to carry child as soon as possible, the maternity care is often neglected. **Yvonne, Deirdre & Caroline (2013)** explored the young mothers' pattern of maternity care where the young mothers in their study expressed that their fear and stigma hindered them from obtaining information and making use of available support and services. Therefore, the need for support and information in seeking and accessing health care services was considered essential for young married women to avail the services especially in terms of maternal care.

In India, a number of married women are unwilling to seek medical treatment. Lack of privacy, lack of female doctor at the health centre, the high cost of treatment or the low economic status of women and the fact that women are given sub-ordinate status in the society are some of the major factors that makes married women reluctant to seek medical care **(Prasad et al., 2005). Dumas & Jette (2014)** conducted a qualitative study where young underprivileged women were interviewed. Many young women in the study did not have enough time for themselves resulting in health constrains. The perceptions of such young women on health related issue varies and their health practices were persuaded by their immediate needs (personal and family) and responsibilities. Managing their individual risk factors was not observed as they give more priority on economic stability, family needs, and problem. The study concluded that such priorities of women were influenced by the pressure to respond to social norms rather than engaging in health practices.

2.4.2 Violence against young married women

Young women experience some of the highest rates of Intimate Partner Violence (IPV) yet very few studies observed its effects on young mother's postpartum health risks. Young women's stress after pregnancy received a very less attention while a study in twelve countries conducted by World Health Organisation observed that younger married women are more likely to experience IPV. According to a report from US national survey during ten years (1993 to 2003), young married women between 20 to 24 years were at greatest risk of IPV while 16 to 19 years of women ranked third nationally. A 16 states survey in US also showed that the risk for IPV is doubled for pregnant young women **(Agarwal 2014).** According to **Kingston et al**, Stressful life events, postpartum depression, unplanned pregnancy

are more likely to be experience by young married mother as compared to older mothers.

Jejeebhoy & Cook (1997) argued that women who entered into arranged marriage and who married off at an early age have low power in marital relationships which put them at risk of domestic violence. IPV is associated with PTSD and anxiety disorders among both young and adult mothers. **Agarwal (2014)** study assessed the relationship between postpartum IPV and postpartum health risk among young mothers in the US. The study was conducted among women between 14 to 25 years who attended obstetrics and gynaecology clinics using a five point scale from 1 = never to 5 = very often. The study showed that IPV results in young mothers postpartum health risk as IPV is very common during this period. The same study demonstrated the association of IPV with psychological, sexual and postpartum health risk among young mothers.

In a study of Lianhmingthangi (2014), more than one third of women report having experience violence in their relationship with a tenth of respondents having experienced for more than four years. **Yount & Carrera (2006)** stated that more than half (56%) of women in their study agreed with the norm that justify wife beating especially when women leaves the house without seeking permission from the husband. **Santhya et al., (2007)** carried out a study in Gujarat and west Bengal to identify the prevalence and risk factors for sexual abuse among 1664 young married women. The data depicted that women who married to their well-known man, whose husbands provides support in times of conflict with other family members and who married off to economically well to do families are less likely to experience sexual abuse. The cited reasons for repeated marital sexual abuse include childlessness, unplanned pregnancy, and low level of education and approval of the societal norms that justify wife beating. The study also observed that other forms of abuse accompanied sexual abuse where 13 of 25 women in the study who are sexually abused had also experience physical and emotional abuse. Education was seen to be protective where power imbalances prevail in patriarchal society. The risk of repeated sexual abuse as a result of inability to negotiate on sexual matters was reduced for women who received education. The male partners often deploy violence in marriage to restore his power when the psychological or economic resources of women exceed those of his. **Hornung et al., (1981)** found that in Kentucky, violence

against women is more common among wives whose education and employment surpass those of the husband.

Violence against women committed by their husbands, ex-husbands, boyfriends, or ex-boyfriends is a massive public health problem **(Short & Rosenberg, 2001).** In the case of married couple, a man is never questioned even if he is seen battering his wife because it is considered purely something their personal affairs. The society also exclusively leaves the affairs to be settled by such couples. Conversely, if two neighbors get into a fight, the society immediately intervenes and demand justice. In such a society, there is no shamed attached to wife battering and the neighbors tend to be mute spectators in the case of a husband battering his wife **(Yudhistar 2003).**

2.4.3 Education and Employment of Women

Female education is generally considered an important component of women's empowerment as it exposes them to individualism and egalitarianism. Moreover, economic independence as a result of education offers them the freedom to decide for themselves in all matters of life. It is also assumed that the increase status of women improve the educational attainment and employment opportunities. The delay in marriage and child bearing is hypothesized to increase time spent in school thus giving women autonomy in decision-making including reproductive matters **(PHAN 2013).** Women with higher education tend to have a smaller number of children and **Bongaarts (2003)** found the positive association of fertility preference with education of married women. **Saxena (2017)** study to assess the significance of women education in India suggested that many regions lack women empowerment and that an attitudinal change is necessary to bring about it. For that matter, not only women but men also need to wake up and education of women should be given importance, which is the grassroots issue.

Furstenberg et al (1987) acknowledged that women who bear children at an early age are not likely to attend high school where they receive education, which is a central development aspect of adolescents. Being married at a young age and becoming young mother’s hampers the formation of essential social and human capital for mothers. Women who married early do not receive full education therefore, they do not benefit from the fruits of education including employment and economic independence. **Akpan (2003)** stated that poverty is a major factor

responsible for early marriage especially among rural communities. Women are normally considered the property of male members and the fixed 'bride price' on every bride signifies the exchange value hold by society. Furthermore, some parents perceived the bride price as a source of wealth to the family which attracts the idea of early marriage **(Akpan 2003).**

Ngo (1992) found that educated women are usually economically independent and that younger women have closer ties with formal employment. **MacMillan & Gartner (1999)** noted that man in Canada use violence to control their working partner while they remain unemployed. The increase in education among women, the improved economic position of women, working condition, increased equal pay for equal work, larger space between marriage and the birth of the first child, increasing urbanization and so on are some other factors besides husband's income that influence labour participation of married women **(Jalilvand 2000).** The traditional belief of husbands to be the sole winner and wife to be homemaker gradually vanish and Jalilvand (2000) noted that working women have a better personal value structure as compared non-working women who are largely influenced by social and religious values.

2.4.4 Women's Decision making

Women's autonomy may be influenced by traditional cause such as dowry and co-residence with mothers-in-law. However, women's education and economic independence raise most indicators of women's autonomy. **Al Riyami, Afifi & Mabry (2004)** studies in a highly stratified society like Oman argued that education was one key indicators of women's status. Their study highlighted that although the traditional and community influence remain strong, educated and empowered women were more likely to have control over their Reproductive rights. More than half are the educated women who reported that they influence the family planning while a lesser number and illiterate women in the study reported that their husbands make decision. Unmet contraceptive need for women resulted in pregnancy for almost a fourth of women in their study and the percent significantly decreased with women's education and employments outside the home.

Rammohan & Johar (2009) study observed the positive correlations between married women's autonomy and educational attainment. Working mothers are more likely to enjoy higher level of autonomy than stay at home mothers.

According to their study, labour force participation and higher educational attainment have positive effects on married women's autonomy in Indonesia. Traditional and kinship norms have a significant impact on married women's autonomy Rammohan & Johar (2009) analysed the factors influencing women's autonomy in Indonesia by taking into account the cultural settings. The study found that physical autonomy is restricted and reduced in a patrilocal community as the kinship norms play an important role in such community. On the other hand, the study suggested that living in uxorilocal improves a women's autonomy including a matter related to children. A very large group of women (90%) in the study have decision making autonomy with regard to their outfit 80% of women in the sample enjoy social autonomy where they can spend time on social activities as their wish. Women's education and their spouses' education are seen to have positive impact on women's autonomy in the study area. The study also found the influence of husband's education on women's autonomy. It suggested that the education level of the husband has a greater effect on women's autonomy than the education of the woman herself especially in the autonomy related to economics. Greatest autonomy for older women in all aspects as compared to younger women is also observed in the study

A study on Egyptian women conducted by **Kishor et al (1995)** found that education and employment enhanced women's autonomy. Around 3% of women in the study do not have a say in decision making related to cooking, contraception, child bearing, children's education and visiting friends and family. Regarding freedom of movement, women in study were asked to report on their experience on autonomy in mobility. A larger number (35%) of women in the sample reported that they could go places by themselves such as markets, health centres, recreation, homes of friends and family while 3.6% women did not have the freedom to go out alone in public places.

2.4.5 Child bearing

In the traditional family, women are often treated as an addition and instrument of the needs of other family members. They are regarded as a mere cook, cleaner, reproducer, and caretaker, rather than as a source of agency and worth in her own right **(Nussbaum 2000).** According to **George (2002),** newly married women rather powerless are often victims of patriarchal systems and its social practices. Such a society valued motherhood and women acquire further legitimization of their

status as women once they bear children. In-laws harass young married women if a child is not born after 2 or 3 years of marriage telling her she has some fault in her. Women lack the autonomy to regulate their sexual and bodily experiences. From this perspective, the practice of sexual relations represents women's bodies as machines and that childbearing is central to married women's sense of well-being

Delay childbearing has become an important matter in family formation. This trend is not only common in European countries **(Coleman 1996)** but also in many other parts of the globe. **Lane (2012)** had conducted a discussion among young married women aged 15 to 20 years where 13 of the young married participants reported three or more times pregnancy during their marriage. This finding suggested that early childbearing and closely spaced pregnancy among young married women is common as a result of pressure from mother in law, husband and religious beliefs. Young married women also mentioned in the discussion that peer pressure have a huge impact on their decision making regarding contraceptive use, child spacing and reproductive health issue. Therefore, a constructive discussion with friends regarding these issues needs to be more acceptable as young women will behave as their peers are behaving.

In a study of **Prasad et al., (2005),** the rate of infertility was high where 9% of the young couples reported themselves infertile on the basis of their medical history. The stress on women is relatively higher as society pressures them to bear children as soon as the marriage takes place even if the childlessness is caused by infecundity of the husband. The study also showed the high prevalence of RTI, Urinary tract infections, gynaecologic morbidity and primary infertility among young married couples. Young married women particularly who are given lower status in the marital households and communities do not seek medical care and treatment until the uneasiness compels them to do so. Therefore, women with such low status apparently remain in pain for a long time.

Psychological and social problems have long been identified among childless couples particularly among women. This problem has major implications especially in a cultural settings where bearing a child is highly valued. Various factors such as infertility, pregnancy loss or mortality may result in involuntary childlessness **(Van Balen, 2000)** and that being unable to conceive may not result in physical pain for couples but it has major painful social and psychological implications **(Lober 1997: Mishra & Dubey2014).** The WHO (World Health Organization (1991) defines

"infertility as the inability to conceive (organic or functional) a pregnancy after two years of regular sexual intercourse without contraception, or inability to carry a pregnancy to live birth."

Societal reaction to childlessness widely varies among societies as many societies regarded the primary function of women as childbearing and women are often insulted and judged on her ability to have children **(McQuillan et al, 2003).**

Patriarchy holds a concept that considers men as superior to women **(Rawat, 2014)** and in an Indian patriarchal family, the birth of male child is preferred to that of a female **(Uberoi, 2005).** Due to the existing social norms and gender stereotype in such a patriarchal setting, whatever may be the cause of infertility, the women are blamed if the couple is involuntarily childless. Consequently, women develop depressive symptoms, lower self-esteem and they suffer from social stigma and isolation, violence in the form of verbal and physical abuse from their husbands and in-laws **(McQuillan et al, 2003).** Some research findings also suggest that infertility often threatens marriage stability in patriarchal society. In a study of **Ma &Turunen (2019)** the association of the number and sex composition of children with divorce in China between 1980 and 2012 was explored. During most of the observation periods, it was found that childless couples in both rural and urban China had significantly higher divorce risks as compared to couples with children. The finding suggests that the divorce risk for childless couples is four times higher than that of couples with at least one child and such risk declines with the larger number of children in the family.

2.4.6 Personal Satisfaction

Life satisfaction is considered "a global assessment of a person's quality of life according to one's chosen criteria" **(Shin and Johnson 1978).** In assessing determinants of individuals' satisfaction, **Schyns (2002)** found that in 42 countries, persons with higher income as compared to lower income enjoyed greater life satisfaction. **Mammen, Bauer, & Lass, (2009)** assessed the satisfaction with life among rural low-income mothers using a sample of 163 mothers. Majority of women in the sample claimed that they were satisfied with life and certain variables that influenced their life satisfaction are mainly health and personal capital. The study concluded that symptoms of risk of depression as one variable of health capital and adequacy of income as one personal capital variable significantly influenced their

personal satisfaction with life. Mental health is noticeably essential for life satisfaction in the study. **Mammen, Bauer, & Lass, (2009)** defined Social capital as "the types of social relationships and a personal assessment of these relationships that the respondents have with their family and friends". In their study, social capital was measured in terms of a person's satisfaction with the developed social support network and found that 39% and 40% of the participants reported a high level of social support in years one and two, respectively.

Diener & Suh (2003) acknowledged that for personal happiness and general satisfaction with life, health and social relationships are far more important than income and affluence whereas **Ackerman & Paolucci (1983)** reported that quality of life increases with the adequacy of individual's income which further elevated the satisfaction with life. The employment of a person clearly reduced individual satisfaction with life **(Clark et al., 2001)** as **Rodgers (1977)** acknowledged that the currently unemployed individuals who expected to continue to work reported a higher degree of life satisfaction as compared to those who expected to stop working. In a study conducted among university students, **Dvorak et al. (2005)** found that students who engaged themselves in spiritual activities were less likely to experience mental health problem and depression in particular and at the same time more likely to report greater life satisfaction. The same pattern is found in a study of **Heilemann et al. (2002)** that the level of women's life satisfaction had a significant influence on their level of depressive symptoms. Certain variables such as unemployment, health status, gender, marital status, regional differences, and education influenced the individual's level of satisfaction. This statement is concurred by **Bukenya et al., (2003)** in their study of QOL satisfaction and health of rural residents in West Virginia.

US Bureau of Labor Statistics (2015) remarked that women have played a greater role in the economic life of families especially with the increased in labor force participation. Employment of women contributes to the increasing family resources and well-being **(Kossek & Ozeki 1999).** As sexual satisfaction is one important factor affected the well-being and QOL of women **Abdoly & Pourmousavi (2013)** argued that family consistency and marriage durability are also significantly dependent upon sexual life satisfaction. **Sprecher (2001)** concluded that marital satisfaction has a positive relation with general satisfaction of life. WHO (2010) considered sexual satisfaction a sexual right as it is an important component

of sexual health and the outcome of sexual well-being. **Raisi et al., (2015)** stated that in Iran, if a man has extramarital relations and puts the marriage in danger, the society blames the women for not giving sexual right to her husband. **Haghi et al., (2017)** conducted a study on Sexual Quality of Life and Marital Intimacy among 475 married women of 20–35 years in Iran. The study found a high prevalence of sexual problems among women as they may be the lacking sufficient sexual knowledge and skills that threatens their quality of sex life, marital intimacy, and therefore mental health. The high prevalence of sexual problems among women in the sample is an alarming issue and that due to cultural limitations and existing taboos, women preferred not to speak about their sexual problem. Lack of sexual health centers for couples to consult on the issue loosely contributed to the alarming issue.

2.4.7 Contraceptive Use

A women's lack of control over her reproductive rights are seen in the form of unplanned pregnancy **(Crissey, 2005).** Such results have negative consequences for both mother and children while it also affects the other aspects of women live as well including education and employment opportunities. **Hayford & Guzzo (2010)** stated that young and unmarried women are likely to experience unplanned pregnancy. It may be assumed that as the planning of childbirths has a strong relation with the age of women, women are expected to be obliging and submissive in their marital home. They are expected to endure hardships and difficulties and be less involved in decision-making. Traditional values and cultural norms discouraged contraceptive use in marriage consequently, the need for contraceptive use by women during this period is not known rather an ideal woman is expected to bear children preferably sons. A situational analysis conducted by **Muntean et al., (2015)** in Ethiopia identified that lack of awareness and knowledge about sexual and reproductive health and rights, unmet need for family planning, adolescent pregnancy, and sexual violence are several issues pertaining to young married women. Although the antenatal needs of young married women are addressed, the other aspects such as sexual and reproductive health needs and rights are not fully considered. The 1994 International Conference on Population and Development reported that the relationship between educational level and fertility of women has been acknowledged universally. **Al Riyami et al., (2004)** also acknowledged the education of girls and women significant contribution in the improvement of national

health sector. It is also assumed that education of women results in autonomy and it further empowers women to learn about fertility and access health care system.

Ignorance of the emotional and social aspects of fertility is a violation of women's human rights (Hartmann, 1998; in Wang & Pillai, 2001). It has simultaneously been argued that one who supports reproductive rights is one who supports the rights and desires to have control over nature and fertility (Berer, 1990). A study conducted by **Degni et al., (2010)** among married Iranian women in Findland reported that women who use contraceptive had discussed the method of birth control with their husbands. Although women's social network and friends influenced their decision of contraceptive use, communication and networking between husbands and wife had the most effect on contraceptive use decision and family planning. The data showed that 85% of women discussed family planning with their husbands and decision-making power and autonomy in the use of contraception was highly influenced by greater autonomy in husband-wife relationship.

2.4.8 Husband's involvement in reproductive health care

Husbands are more intimately involved in their wife's pregnancy and childbirth as compared to other male members in the family. **Barua et al., (2004)** assessed the husband's knowledge and involvement in maternal care and found that early marriage was highly accompanied by pressure for early childbearing to prove the fertility of young married women. The study highlighted that a very large couple (86%) lived in joint or extended families where most of the pressure in childbearing appeared. Mean age at marriage for women in the sample was 16 indicating early marriage of women. A large number (86%) of women bear child at a very early age and reported at least one-time pregnancy by the age of 18. The data also showed that it is not only the family to put pressure on young couples to have children soon after marriage, but also the expectation of friends in the same age group. In terms of access to health care services, the data showed that young married women access to health services was particularly influenced by the husband's knowledge and awareness. Men with higher education had better awareness and provided support for women in maternal care. The education of women herself also had better influence on the husbands and family members related to maternal care. Young women in the study had a very limited mobility hence they had to seek permission from the

husband and other family members. In fact, young women depend on the marital family members to assist them to health care centers although the care itself was free.

Barua (1998) stated that the involvement of husband influences the access to maternal care services for young women whereas Carter **(2000)** noted that only few husbands are aware of the need for maternal care hence a very few husband engaged themselves in the maternal care of their wives. **Khan et al (1998)** also emphasized this issue in their study made in Gujarat where husbands were unaware of the care and services received by their wives during pregnancy and delivery. Many husbands were unaware of the need for maternal care that they did not assist their wives for health centre visits and delivery while a few of them engaged themselves in the care. On the other hand, the involvement of husbands in maternal care could improve birth outcome and reduce maternal mortality. Therefore, husband involvement is necessary to increase use of services and for the overall better health status of women **(Ormel 1999; Ransom 2000).**

Melhado (2014) conducted survey among women in Andhra Pradesh, Maharashtra and Tamil Nadu to represent the country's social, economic and demographic diversity. The study enquired the demand for contraception among women and found that 51% of the women wanted to delay first pregnancy, which was considered the demand for contraception. This statistic was higher in the northern and eastern region as compared to the southern and western region in India. Only a tenth of women in the sample had used contraceptives and condoms were found to be the most common contraceptive used by those women with 65%. The data showed that women who demand contraceptives were better educated, and were more aware of the accessibility even before marriage. The data also depicted that those who demand contraceptives were mostly 18 or older at the time of cohabitation and they had the autonomy to choose their husbands. The study acknowledged the significant association of decision-making authority and contraceptive use to delay first pregnancy. Early childbearing is common in India that contraceptive use by married women below 25years is insignificant and resulted in short inter pregnancy intervals. The demand for contraception among women younger than 25 years is high, yet this remained unmet needs for young couples in India.

2.5 Women in extended family

Allendorf (2007) remarked the different status of women living in nuclear and extended families. Daughters in law living in extended family have a lesser decision making power in the family as compared to women in nuclear families. When a woman lives with the husband's family, the husband and the parents in law automatically share control over her actions and movement. Such practice of residence reduces a woman's power thus making them unable to decide for themselves in different matters **(Warner, Lee & Lee 1986).** In addition, **Santow (1995)** noted that young women's position in the patrilocal extended family is one source of poor health among women while there are also embedded statements about patrilocal extended family that weigh down young women's health. On the other hand, daughters-in-law may also benefit more from extended family as the higher economic status of patrilocal extended family provides maternal care for women. Yet, the economic status of patrilocal extended family does not help in preventing violence against women as violence such as sexual violence occurs when family member is less able to prevent it **(Allendorf, 2013).**

Family relationships are attached to women's sense of wellbeing and quality of life. The perceived quality of relationships with parents in law has a significant relation to stress for daughters in law **(Marotz & Mattheis 1994).** Likewise, **Jean Turner et al., (2006)** in their study observed the challenges of the mother in law and daughter in law relationship especially in the extended families as both members enter the new relationship. The study also observed that although some of them reported fine relationships between the two, there are times they hesitate to trust the new relationship. The disparities in goals and values and poor communication skills often arise in such new relationships.

Despite the few studies on daughter in law and mother in law relationships, **Marotz & Cowan (1987)** observed that the relationships between the two are often depicted as conflict in the extended families. The young wife enters a new family in which men and secondarily older women grasp the decision-making power.

Char & Kulmala (2010) give emphasis on the presence and influence of mother in law on childbearing decisions on young couple. In a study to assess the influence of mother in law, Char and Kulmala (2010) carried out interviews with mothers in law, daughters in law and son living in extended families. The study observed that mothers-in-law have a strong influence on family decisions relating to

household activities. They were also more likely to control the number of children young couple should produce and the timing of their daughters-in-law being sterilized. The study also noted that older women or mothers in law generally made decisions pertaining to daily chores including kitchen matters and taking care of children.

Kieren, Henton & Marotz (1975) noted the perceptions of both husbands and wives that husband's kin are more likely to be the source of conflict than the wife's kin in case of marital conflict. **Song & Zhang (2012)** carried out a study in China to assess daughters in law perspective on husband's involvement in daughters in law and mothers in law conflict. The findings suggested that as the conflicts remain unsolved, daughters in law continued to be unsatisfied with the husband's avoidance of existing conflict between daughters in law and mothers in law. The Chinese daughters in law are also of the opinion that husbands play an important role in conflict solving in such relationships and husbands support in conflict management are meaningful and crucial. Findings also indicates that daughters in law in the sample perceived that husband uses the problem solving style to manage conflict between the daughters in law and mothers in law which is very crucial for daughters in law who enter a new family and share a new family identity with the mother in law.

Hanzal & Segrin (2009) suggested that marriage quality and marital satisfaction is influenced by the souses' problem solving pattern. The positive conflict resolution style and avoiding the neglect of resolution especially predicts the marital quality and satisfaction.

The suicide rates of female are found to be higher than male in China. Hence, **Phillips et al., (2002)** noted that suicide among female in rural china remains a serious problem. As far as suicide among women in China is concerned, **Qin et al., (2016)** carried out a cross sectional study in China with an aim to explore the prevalence and correlates of suicidal ideation among daughters in law. The study observed that physical disability and the experience of domestic violence were the major risk factors for suicidal ideation among immigrant daughters in law in China. The experience of domestic violence built suicidal ideation and daughters in law with suicidal ideation had higher scores of depression and anxiety.

2.6 Women in Mizo society

Chatterji (2008) in his book on the earlier mizo Society observed that the interdependence and mutual respect among both men and women in terms of gender status and responsibilities in Mizo society appears to sum up that the status of women in Mizo society was not inferior to that of Mizo men. Mizo women in their society suffered a lesser amount of derogatory and discriminatory treatment as compared to women in more advanced societies. The society permits free mixing between two genders to the extent of pre-marital sex unless it did not result in pregnancy of the girl. However, if a child was born of unmarried mothers, a huge social stigma was attached to such matters although the unmarried mother is entitled to collect Rs. 40/- for her '*Sawn'* (illegitimate child) from the '*sawn'* father. Even though the society dealt with women who excessively indulge in pre-marital sexual relationships with more than one man, men too were dealt with in no less severe way. In the case of '*hnutedeh'* where both parties did not form close intimacy, the man who was found guilty in this matter was looked down upon by the society and normally received severe punishment from the village chief and elders. This was considered even more severe offence if the victim was a married woman. The accused in this matter was subjected to fine Rs. 20/- and '*salam*'. In the case of married women, it is important to note that the society had rigid measures against adultery. While woman who committed adultery suffered heavily in her social position and become automatically outcaste, the man was only made to pay fines.

The above statement shows how Mizo society strongly dealt with any incidence of violence and impropriety to uphold social justice. Any indecent and cruel treatment to women in Mizo society was not only condemned by its citizens but was strongly dealt with by imposing fines on those found guilty for the offence.

2.6.1. In the family

Unlike the ideology of son preference in many other societies, the birth of a female child in Mizo family was celebrated with the same joy as that of a male child. In fact, as female child continues to exist in the family constellation and initiated the responsibilities of looking after the home, some parents felt happier and advantageous to have a female child than a Male child who had to move in to '*Zawlbuk'* in his very early life. The availability of female child to keep the home

brings greater closeness to the parents that promote psychological reinforcement to the parents in Mizo society. Women continue to live under the protection of their parents to the extent that parents provide active support in the well-established social custom of '*nula rim'* (Courting) **(Chatterji, 2008).**

The Mizo women had to rise early and fetch water. On returning home, she would start to clean rice for the day and by the time her husband and family wakes up, she was expected to ready breakfast for her family **(Shakespear, 1912).** Also**,** Lalmalsawma in his book 'Zo-zia' mentioned that the real work of the day for mizo women starts only after the breakfast. Women rushed to the cultivation farm working the whole day, collected pig fodder on the way home, cooked and served dinner followed by cooking food for the pigs and weaving late into the night. Circle of mizo women's life in the olden days was hectic as they were more of slaves to every situation in society. In the winter season, women engaged themselves in cloth making while men enjoy lying in the sun during the day **(Shakespear, 1912).** Likewise**,** Lianhmingthangi (2014) observed that more than a third of women in her study experienced stress related to family. Such stress experienced in the family includes disturbed relationships, poor inter-communication, rivalries etc.

2.6.2 Courtship

In keeping with the existing custom, the man approaches the girl's parents and asks for their daughter's hand. Yet, the girl's parents would not accept without their daughters consent. This highlights the fact that since the earlier days, women in Mizo society enjoys decision-making power pertaining to their own life **(Chatterji, 2008).** In mizo society, as far as courting is concern, women are expected to welcome and treat any men equally. If a woman shows any partial treatment towards men who came to court her, she was considered ill-mannered **(Laldinpuii, 2006).**

2.6.3 Marriage

The institution of marriage in the Mizo society established an important place for its women. A marriage in Mizo society normally happen post a long period of courtship. This could be seen as a factor that lessen the chance of divorce as two parties get two know each other well during a fair courtship. The society acknowledged the child born out of wedlock and her mother that the mother was given authority to claim the main price in her daughter's marriage. The fact that the

main price of her marriage would go to her mother when a child was not recognize by her father proves that Mizo society holds a special place for its women and that any men could not just considered them as someone to be played and toyed with **(Chatterji, 2008).** On the other hand, **Parry (1928)** noted that if a married woman is defamed of having committed sexual offense, the person who defamed her should pay fines to her (married woman) brother. If a person is fined for beating a woman, or for any offence against her other than sexual nature, the fine goes to her husband.

Laldinpuii (2006) in her book entitled *'Mizo Inneih'* showed that the mean age of marriage for female is 24.15 while it was 28.17 for male. Mizo women in the 20th century tend to marry late as compared to women in the earlier days. The main reason include education where female spends much of their youth days for acquiring education that delayed marriage for women. Small family concept also loosely contributed to the reason why modern women do not marry at an early age. Since many women are satisfied with only 2 or 3 three children, they do not rush in to marriage in today's world. **Lianhmingthangi (2014)** also stated that women's education is negatively related to low level of violence experienced by married women.

2.6.4 Bride price

It is believed that the purpose of bride price in Mizo society is not to measure the dignity and worth of a woman but to protect the future of a married woman. The received bride price distributed among the brides' relations was considered a sign of responsibilities given to them if the bride faces any awful situations such as death of biological parents, death of husband, divorce and the like. *Thutphah:* This is purely practice to protect the wellbeing of a married woman. *Thutphah* means Rs.20/- is returned to the groom's side from the total bride price received. This is done so because if a man tries to divorce his wife, the wife would request him to return *'thutphah'* (Rs 20/-) on divorce. Rs20/- in the olden days in Mizo society was equivalent to one Gayal **(Laldinpuii, 2006).**

2.6.5 Child bearing

Women in Mizo society received fine recognition as long as her ability to bear child is concern. This is proven in the case of divorce where women with children were entitled to claim the balance of the marriage price while women

without children could not do the same. The marriage price used to be reduced in widow marriage or remarriage as it was normally held less desirable. However, the marriage did not endure any price reduction if the prospective bride was considered capable of bearing children. This statement clearly highlighted that status of women where they were normally considered reproductive machine in marriage (**Chatterji, 2008).**

2.6.6 Dowry

The customary details related to marriage in Mizo society point out the solicitude of society towards the establishment and maintenance of Mizo women in the Mizo society **(Chatterji, 2008).**

Dowry in Mizo society is certain property that exclusively belongs to women. It includes *Puan* (ordinary cloths), *Puanpui* (blanket), *Puanfen* (Skirt), *Thul* (basket), *Thembu* (weaving machine), etc. Cash earned by a woman in her husband's house goes to her husband except cash she received as a dowry at the time of marriage. According to the custom, woman takes all her dowry in the case of separation except if the separation was on the ground of adultery, all the property of woman including dowry would go to her husband **(Parry, 1928).** Daughters in law in Mizo society are expected to contribute to her marital home as she had done in her natal home. The elders in society are mindful about having a good daughter in law since they believed that a good daughter in law keep the marital home alive while a bad one scattered the family **(Laldinpuii 2006).**

2.6.7 Social life

Although mizo women in the earlier days were found hard working and devoted, they do not have power and authority over family property that even her own income belongs to the husband. There is a saying that goes *"Hmeichhia leh palchhia chu thlak tur'* which means women and fences can be changed and altered. If a woman in Mizo society commits adultery, the whole society condemned her and she even got expelled from the marital home while the same society is silent towards a married man who commits adultery. Sometimes, those men applause themselves saying they are the hero for such acts (Malsawma). On the other hand, women in today's world enjoy a better freedom and autonomy. The globalization and modernization largely contribute to their status. Women especially residing in the

city are becoming family defender. Moreover, more women are found in work places such as government offices, schools and colleges. The churches and market places are filled with women and large contributions of women were seen in the economic sectors.

2.7 Research Gaps

From the reviewed literature, it can be seen that there is no clear cut definition of Young married women. Married women of young age are rather referred to girls who are victims of early marriage and child marriage. Newly married women are also often referred to as young married women in many of the literature.

It is also seen that there is a scanty literature that measures the social support and quality of life of young married women across the globe. It is notable that most of the studies on women are related to reproductive health in India, while studies on women in North East India focused largely on women's status in general. The existing studies on women in Mizoram nearly restricted to women's status in politics and economics spheres while studies on other various life domains are less.

This chapter has presented a review of literature on various aspects of young married women's quality of life and the research gaps found from the said review. These studies are either international study on women's prestige, nationwide reports on women's status. The next chapter discusses the settings and methodology of the study that encompasses objectives, research design, and sampling, tools of data collection, data processing and analysis of the present study.

CHAPTER III
METHODOLOGY

To fulfil the objectives of the study in any research, a comprehensive methodology is very much essential. The methods and techniques used in the study largely determine the success of research therefore, the methodological, conceptual and operational framework needs to be developed to suit local contexts. The former chapters presented a critical review of literature and the major research gaps therein.

The present chapter discusses the settings and methodology of the present study which has been organized into two major sections. The first section presented the profile of the study areas including the core and peripheral communities. The second section deals with the methodological aspects of the present study, encompassing objectives of the study, research design, sampling, tools of data collection, data processing and analysis of study findings.

3.1. The Setting: Profile of the Study Area

The setting of the present study describes profiles of the state of Mizoram and the city of Aizawl.

3.1.1 Mizoram

The state of Mizoram is located in the North-Eastern region of India. The erstwhile Lushai Hills District of Assam became a Union territory on 21st January 1972 and received statehood on 20th February 1987. Mizoram is bound on its north by Cachar District of Assam and the state of Manipur; on the east and south by Myanmar, on the west by Bangladesh and Tripura. The state is geographically located between 21.58^{o} to 24.35^{o} N latitude and 92.15^{o} to 93.29^{o} E longitude. The Tropic of Cancer runs through the territory. Its boundary with Myanmar extends 404kms and Bangladesh over 318 kms. Thus it occupies an area of strategic importance having a total boundary length of 722kms with Bangladesh and Myanmar. The length of the state from North to South is about 277kms and the width from East to West is about 121kms. The total area of the state is 21, 081 km^{2}.

As per 2011 census, the population of Mizoram is 1,091,014 consisting of 5, 52, 339 males and 538,675 females. The population density is 52 persons km^{2}. Among the eight districts, the capital city, Aizawl has the highest population density

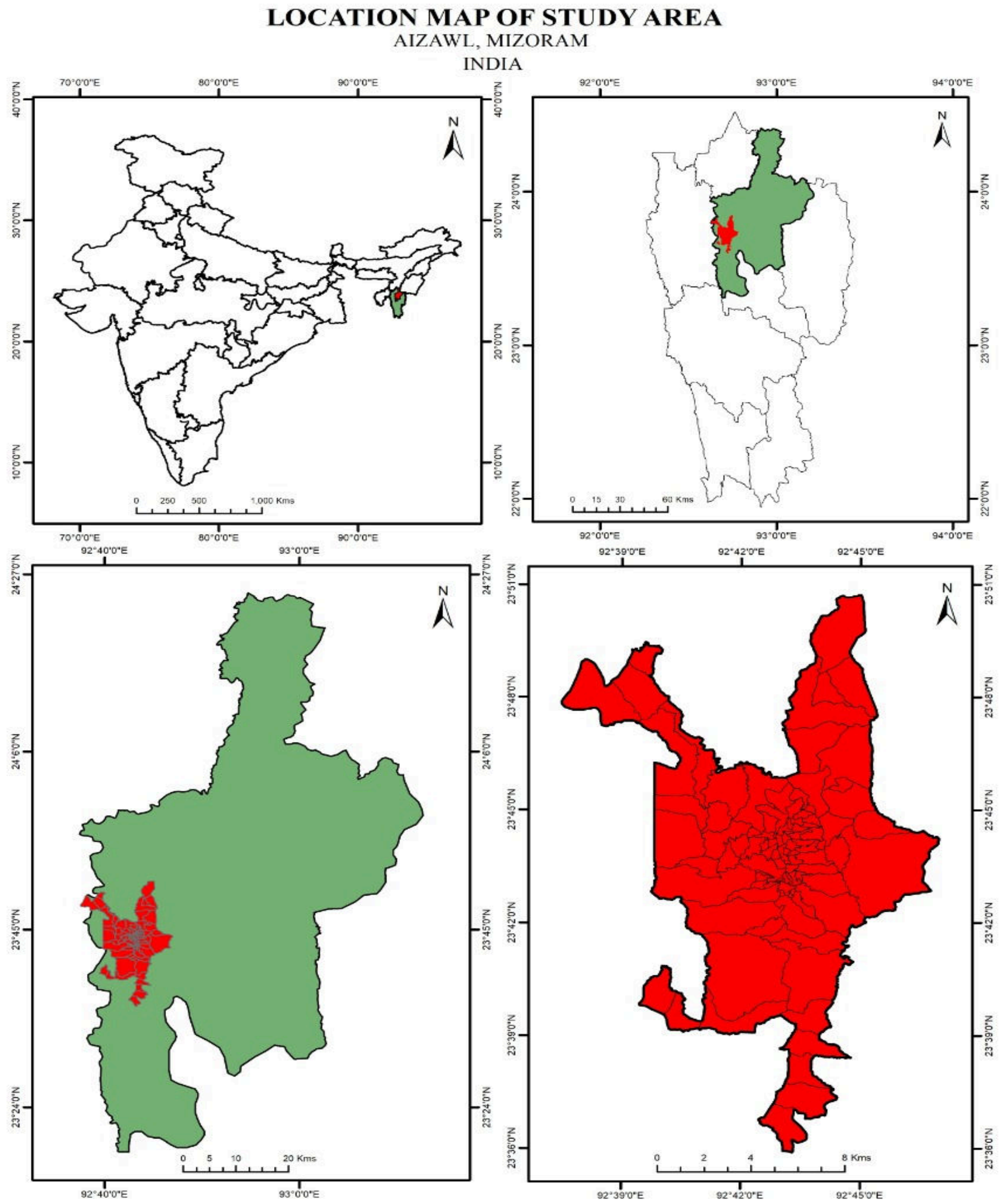
of 113 persons per km^2. As far urban areas are concerned, there are 23 towns in Mizoram. The urban population is 571,771 making up 52.11 percent of the entire state population.

The present study has been conducted in Aizawl city, the capital of Mizoram. The profile of the studied area is presented.

3.1.2. Aizawl City

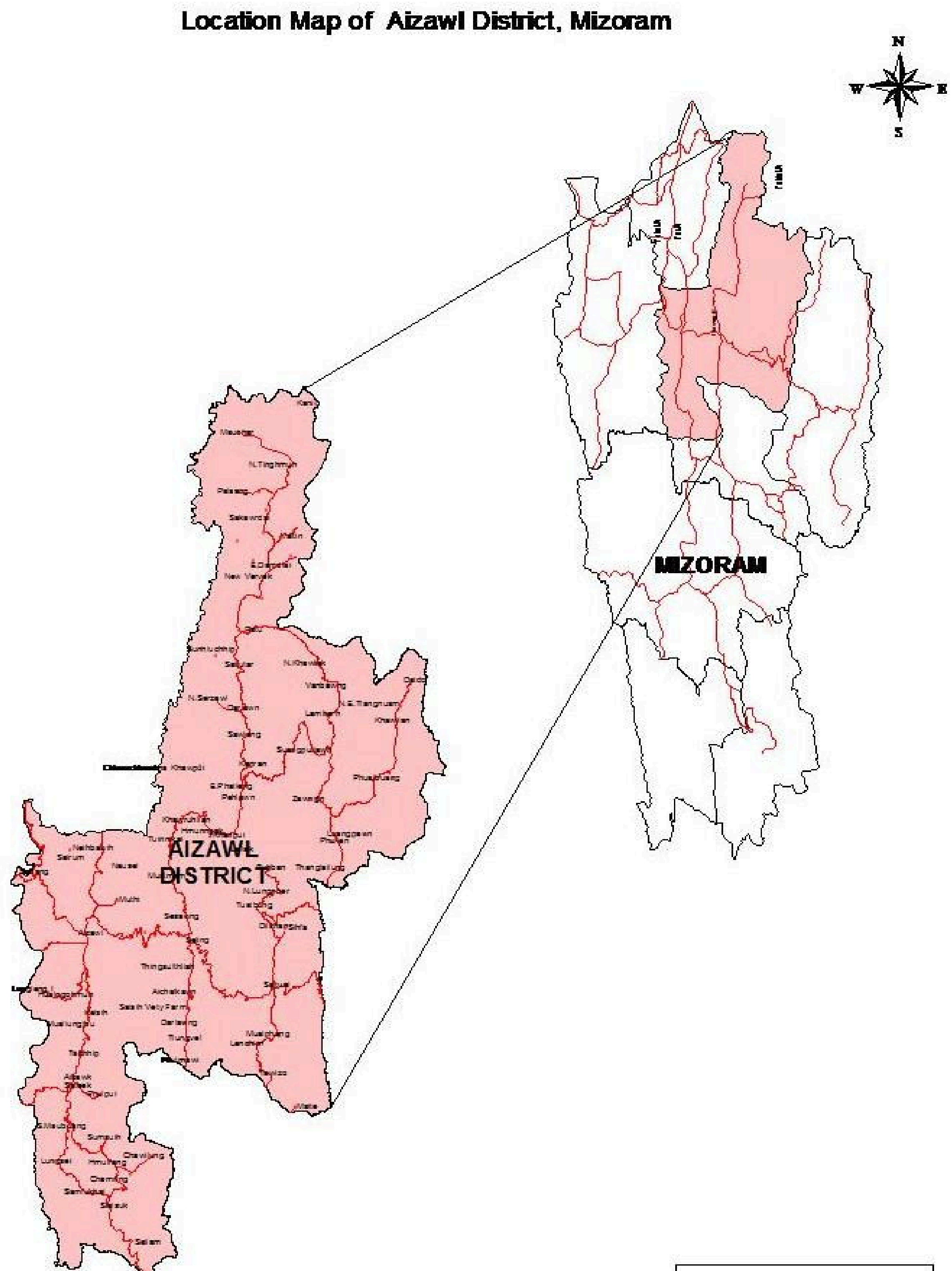
As of 2011 Indian Population Census, Aizawl has a population of 404,054. Males constitute 49.8 per cent of the population and female constitute 50.2 per cent. Aizawl is located north of the Tropic of Cancer in the northern part of Mizoram. It is situated on a ridge of 1132 meters (3715 ft) above sea level, with the Tlawng river valley to its west and the Tuirial river valley to its east. Thirty seven per cent of the population of Mizoram reside in Aizawl. It is also the storehouse of all important Government offices, State assembly house and Civil Secretariat.

Figure 3.1. Map of Mizoram



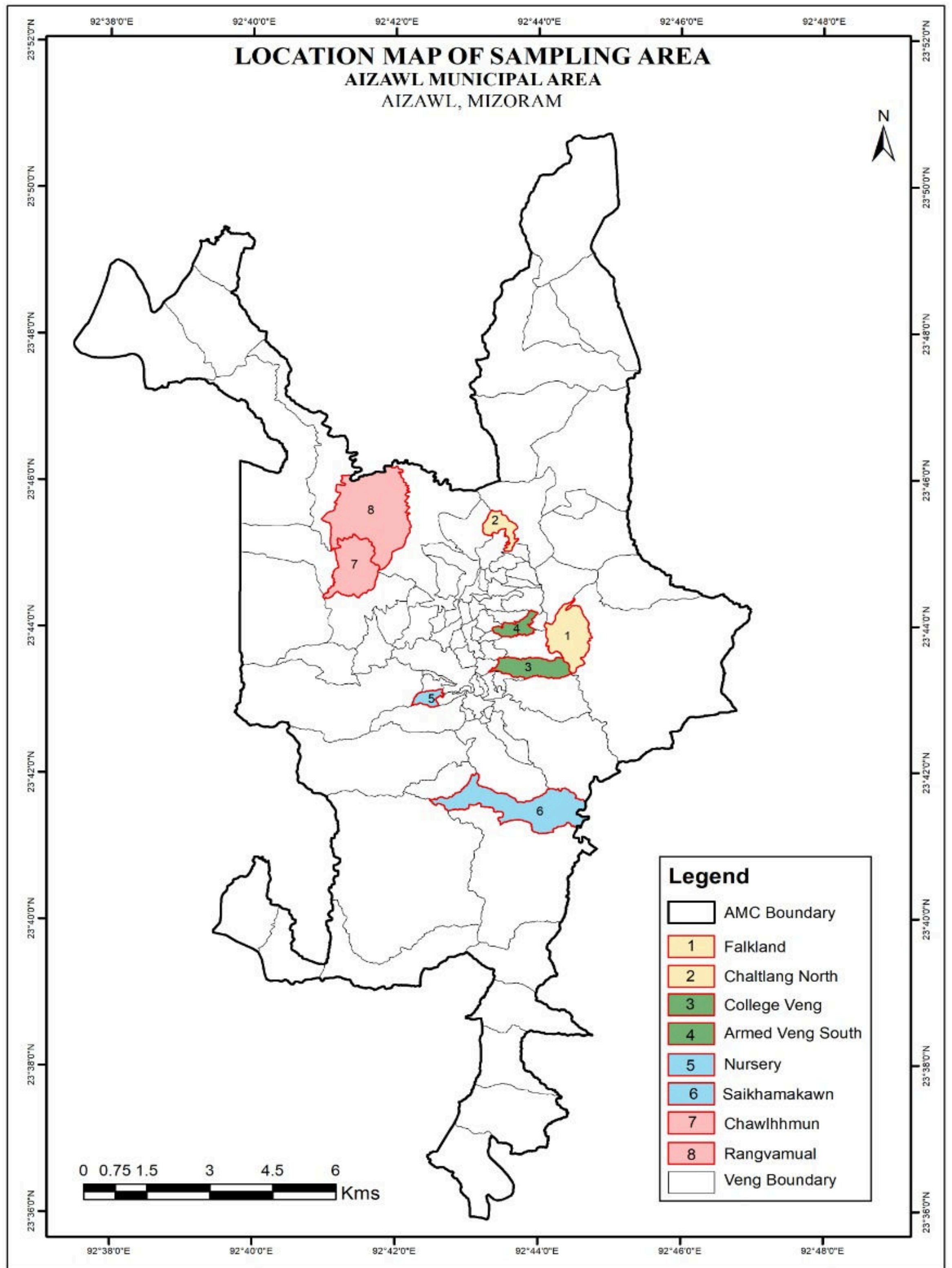
Source: Mizoram Remote Sensing Application Centre (MIRSAC)

Figure 3.2 Aizawl City



Source: Mizoram Remote Sensing Application Centre (MIRSAC)

Figure 3.3 Map of Aizawl Municipal Area



Source: Mizoram Remote Sensing Application Centre (MIRSAC)

3.2. Research Design

The study is descriptive in nature and employs both qualitative and quantitative methods of data collection. Data was collected from both primary and secondary sources. Field Survey using pre-tested Interview Schedule was administered among young married women from eight communities of Aizawl to probe into their quality of life. Case Interviews were conducted to understand the lived experiences and perceived social support of young married women. Secondary data was drawn from relevant books, research articles and online sources.

3.2.1. Sampling

A multi stage sampling procedure was adopted for identification of study sample.

Selection of Study Area

In the first stage, Aizawl the capital of Mizoram was selected. In the second stage, four zones were selected based on location within AMC area. In the third stage, two localities each were identified from each of these zones. A total of eight localities were identified as study area such as Falkland, Chaltlang, Armed Veng South, College Veng, Nursery Veng, Chawlhhmun,and Rangvamual.

Selection of Respondents

In Mizoram, the Mizo Hmeichhe Insuihkhawm Pawl (MHIP) is a women's organization which exists in each locality of the state. The MHIP have all the records of women in the respective locality and the respondents were purposively chosen from the list procedure from the MHIP of each of the eight localities.

The sample was proportionately distributed across Aizawl Municipal Area where 30 respondents each were selected from the identified eight localities to represent each zone. The size of sample is 240.

Sampling Criteria

The following criteria were used in selection of sample:

i) Married women between the ages of 18 to 40 years.

ii) Has been currently married for a period of at least two years.

iii) Willing to give informed consent both on perceptions and experiences.

3.2.2. Ethical Considerations

Ethical considerations were followed in the research process. Informed consent was obtained from respondents before conducting interview for survey as well as for case studies.

3.2.3. Tools of Data Collection

A pre tested Interview schedule was used for data collection which consists of 13 sections with various queries. The major sections of the Interview Schedule are Profile of the respondents, Particulars of the respondents, Relationship with spouse, Relationship with in-laws, Personal Situation, Social Domain, Psychological Domain, Health Domain, Financial Domain, Awareness/Knowledge regarding Reproductive Health, Perceptions related to Reproductive Health/Rights, Perceptions on Married life and experiences of Childless respondents (see appendix).

A Pilot study was firstly conducted among 10 respondents and in the light of which a structured interview schedule was constructed. Some modifications were made in the light of findings from pilot study. The final survey was then conducted using snowball sampling among young married women.

3.2.4. Data Processing and Analysis

The quantitative data collected through field survey was processed with computer packages of MS Excel and SPSS. Data is analysed and presented in simple statistical methods of averages and percentages along with Karl Pearson's product moment correlation coefficient, t-test and Chi Square to find association between different variables.

3.3 Concepts and Operational Definitions

In this section, some of the important concepts related to the study are presented along with their operational definitions.

3.3.1 Social Support

Perceived social support measures differ in terms of the specificity of support sources to which they refer (Procidano & Smith ,1997). Social support in this study is operationalizes as perceived available support in terms of respondent's access to support and assistance that friends, family, and others provided if needed and such

perceived supports of the respondents are linked to have beneficial effects on self-confidence, self-esteem and well-being.

3.3.1.1 Quality of Life

The WHO defines Quality of Life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.

As there is no collective determination of quality of Life, an individual's health including physical and mental health, the amount of independence and one's relations with his dynamic environment largely influenced and determines a person's quality of life (Ruževičius, 2012 & Shin, 1979; Ruževičius, 2014)

In this study, the concept of quality of life is operationalized based on WHOQOL-bref which a quality of life assessment tool developed by the World Health Organization. The WHOQOL-Bref includes four domains with multifaceted compionents incorporated in each of the domains as given below:

Table 3.1 WHOQOL-BREF DOMAINS

Domain	Facets incorporated in the domains
Physical health	Activities of daily living, Dependence on medicinal substances and medical aids, Energy and fatigue, Mobility, Pain and discomfort, Sleep and rest, Work capacity
Psychological health	Bodily image and appearance, Negative feelings, Positive feelings, Self-esteem, Spirituality, religion and personal beliefs, Thinking, learning, memory and concentration
Social relationship	Personal relationship, Social support, Sexual activity
Environmental	Financial resources, Freedom, Physical safety and security, Health and social care: accessibility and quality, Home environment, Opportunities for acquiring new information and skills, Participation in and opportunities for recreation, Leisure activities, Physical environment(pollution, noise, traffic, climate), Transport

.

Based on the WHOQOL-Bref, QOL is categorized into five domains for the purpose of the study. It includes five domains such as Health domain, financial domain, Social Domain, Personal Domain and Psychological Domain.

Table 3.2 QOL Domains operationalized for the study

Health Domain	Access to health care, energy, liberty in health care decision making, Dependence on medicinal substances and medical aids,, health attention, physical pain, reproductive health issues, Sexual activity.
Financial Domain	Employment status, sufficient money, savings, Financial resources
Social Domain	Environment, Religious participation, education, support and network, participation in social activities,
Personal Domain	Quality time with spouse and family, autonomy, to be free from abuse, ability to perform daily activities, peaceful life, family relationship,

Table 3.3 Reliability test

Cronbach's Alpha	.739
Guttman Split-Half Coefficient	.61

The reliability of the tool used in the study have been tested using Cronbach's Alpha and Guttman Split-Half Coefficient.

3.3.1.2 Health Domain

Quality of life is a subjective perception of how an individual feel about their health status and the non-medical aspects of their lives. Therefore, it is a distinctively personal issue (Repić, G., & Ivanović, S, 2014).

The study operationalizes the health dimension of quality of life of young married women in terms of their health condition, access to general health care, and other maternal and reproductive health related issues.

3.3.1.3 Financial Domain

For the purpose of the study, the earning respondent's pattern of savings, their autonomy and liberty in using their income to meet an ends are covered under financial domain. The final domain of young married women is also operationalizes in terms of respondent's autonomy to engage in employment outside the home.

3.3.1.4 Social Domain

Social dimension is a wide concept, encompassing several factors of an individual's life. Therefore, the study operationalizes social dimension of quality of life in terms of available social support and opportunity of engagement in social activities.

3.3.1.5 Personal Domain

Women established their well-being from the amount and quality of relationship they encounter with their spouses and family members. Therefore the study operationalizes personal domain in terms of respondent's family relationship, their bond with the spouse and family members, self-determination in terms of performing daily activities and prospect to live a peaceful life.

3.3.1.6 Young Married Women

In this study, the concept of young married women is restricted to married women who are 18-40 years of age and who had been married at least two years at the time of the interview.

3.4 Limitations of the study

The study is confined to Aizawl city area therefore it may not represent all married women in Mizoram. Lack of previous studies on the experiences of married women/young brides is another limitation found in the present study.

This chapter has made an attempt to present the settings of the study area. It also conceptualized and highlighted the operational definitions used in the study. Limitations of the study are also presented. The next chapter discusses the socio-economic and structural bases of the respondents.

Chapter IV

SOCIO-ECONOMIC AND STRUCTURAL BASES OF YOUNG MARRIED WOMEN

The former chapter presented the methodology used in the study. In this chapter the socio-economic and structural bases of the respondents from eight localities of Aizawl are presented. It is presented in four sections whereby the educational, socio-economic status and structural bases of the respondents are discussed. The first section presents findings on education, employment and socio economic details of the respondents. The socio structural bases including religion, denominations are discussed in the second section. The third section is devoted to understanding the structure of family whereby the type of family, form of family and family strength are discussed. The fourth section entails marital details of respondents which deliberate the respondents' age at marriage, type of marriage, number of children and current duration of marriage.

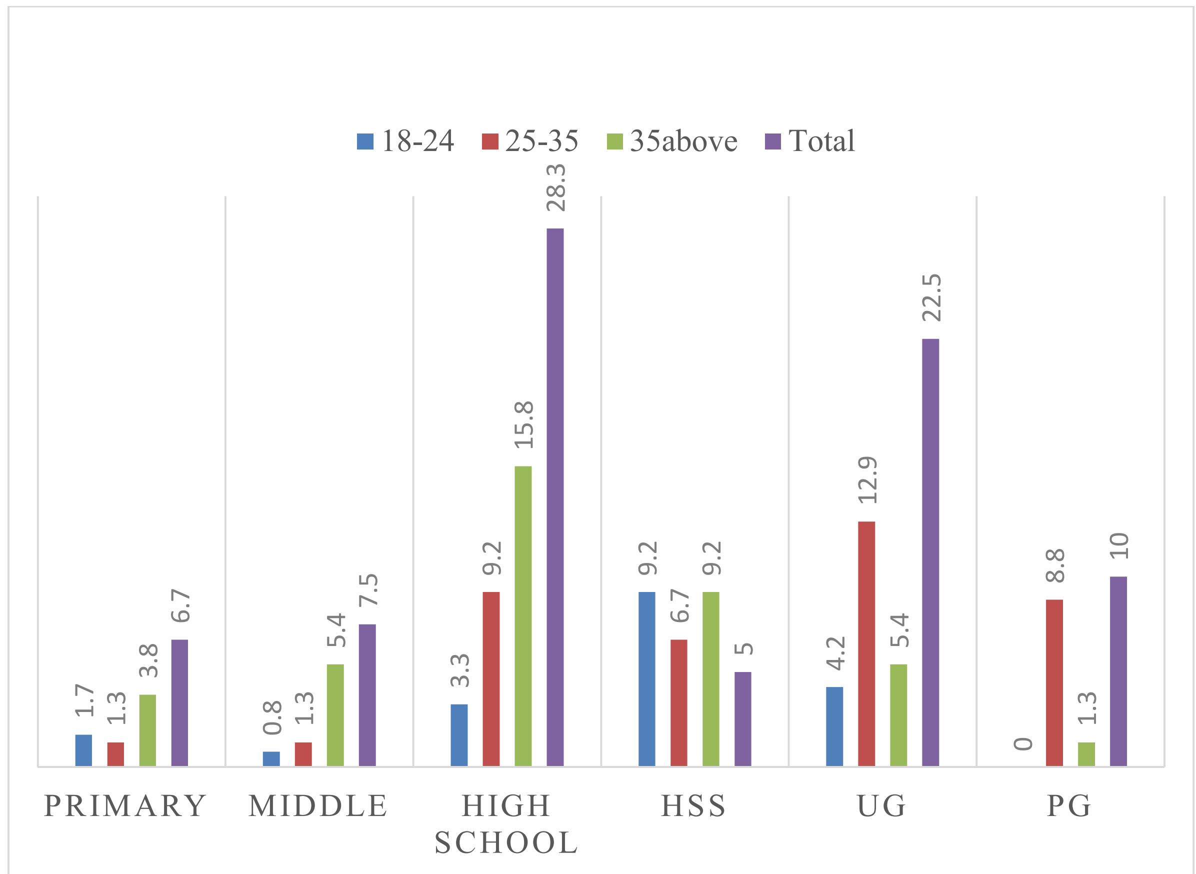
4.1 Profile of Respondents

The profile of the respondents consists of education and economic status of respondent's socio-structural bases, family structure and marital particulars of respondents which are discussed below.

4.1.1 Educational and socio economic status of respondents

The socio economic status focuses on the relationship between social behavior and economics typically involves education, occupation and income. Women's ability to earn income, the educational achievements and livelihood status are critical for understanding the factors influencing their quality of life. Therefore, the socio-economic status is significantly associated with the subjective well-being of women. In this sub section, discussion on the level of respondent's education, employment status and income is presented.

Fig 4.1 Educational Status of the respondents



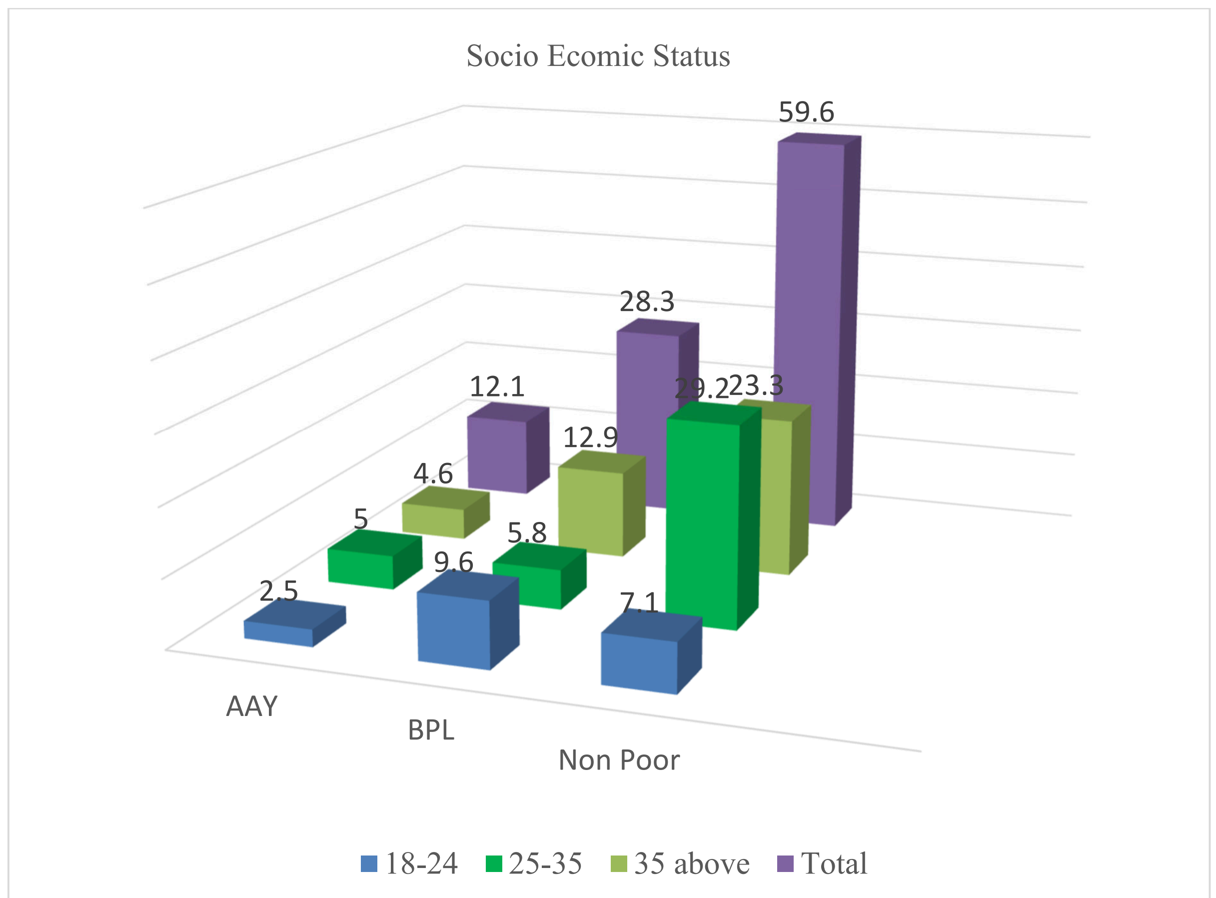
Education provides a person with important knowledge, essential skills and thus improves personal life. Educational level of the respondents was classified into seven levels viz., primary, middle, and high school, higher secondary, graduate and postgraduate. More than a fourth of the respondents (28.3%) have completed High School level of education followed by Higher Secondary (25%), Graduate (22.5%), Postgraduate (10%), idle (7.5%) and Primary (6.7%).

Among those having completed Primary level of education, the maximum respondents were found in the 35years above age group, followed by the groups of 18 to 24 years and 24 to 35 years. Those having completed middle school level of education are found to be the highest in the 35 years above category followed by 25 to 35 years and the least is found in the 18 to 24 group. Respondents having completed high school are similarly found to be the highest for 35 years above and 25 to 35 years followed by 18 to 24 years. The number of respondents having reached higher secondary level of education is found to be similar for both groups of

18 to 24 and 35 years above. Graduates are found to be the highest in the 25 to 35 age group, followed by 35 above respondents, and only 4.2% in the 18 to 24 age group.

Apparently, there are no postgraduate respondents in 18 to 24 age group, while the maximum Post graduate respondents were found in the 25 to 35 age group although it is only 1.3% for those aged above 35years. There are variations in age group for level of education where in the 18 to 24 group; those having completed high school are the majority. In the age group of 25 to 35 years, graduates comprise the majority (12.9%) whereas among the 35 years above group, majority has completed high school.

Fig 4.2 Socio-Economic Status of Respondents



Information was also sought on the socio-economic status of the respondents. Majority of the respondents are non-poor (59.6%), followed by BPL category (28.3%) and AAY (12.1%). Most AAY respondents are in the 25-35 group (5%), followed by above 35 group (4.6%) and 18-24 group (2.5%). Most of those

belonging to BPL category are found in the 35 above group (12.9%) while the least are found in the 25-35 group. The latter corresponds with the above finding where this group has the highest number of earners among the respondents. Non-poor respondents are also highest in this same age group (29.2%).

Table 4.1 Employment Status of Respondents

Dependent	35 (14.6)	47 (19.6)	53 (22.1)	135 (56.3)
Earner	11 (4.6)	49 (20.4)	45 (18.8)	105 (43.8)

Figures in parenthesis are percentages   Source: Computed

The employment status largely determines the ability to meet people's needs and their daily requirements. Today, the number of working women is escalating drastically. It provides them with opportunities to decide for themselves in financial matters. Financial independence contributes to the ability to control and manage one's own life in any relationships. Many of the working married women, who control their own income, do contribute towards the economic needs of family compared to the economically dependent women. They often participate in discussions in and outside the home and their views are given due weightage before any final decision. In the current study, there are more dependents than earners where more than half (56%) are found to be depending on their partners and family in financial matters. Whereas a little more than two fifth of respondents (43.8%) report earning for themselves and their family. Respondents in the18 to 24group have a greater number of dependents (14.6%) than earners (4.6%). This is reasonable as the respondents would have been married at a young age and are either unemployed or because they are still in the job-seeking age. The 25 to 35 group show equal distribution of dependents (20.4%) and earners (19.6%); and also represent the largest group of earning respondents. Surprisingly, there are a greater number of dependents (22.1%) in the 35 above category.

4.1.2 Socio-structural bases: Religion & Denomination of Respondents.

Religion is a person's belief and worship in relation to which he regards as holy, divine and sacred. The religious particulars of respondents is presented in this sub section which were categorized into Christian and Others. Denomination denotes

a recognized autonomous church under religion. The denominations for the purpose of this study were categorized into Baptist, Presbyterian, Roman Catholic, Salvation, Seventh Day Adventist, UPC and any other group.

Table 4.2 Religion & Denomination of Respondents

I. Religion	Age Group			Total N=240
	18-24 years n=46	25-35 years n=96	35 aboveyrs n=98	
Christian	45 (18.8)	96 (40.0)	98 (40.8)	239 (99.6)
Others	1 (0.4)	0 (0.0)	0 (0.0)	1 (0.4)
II. Denomination				
Baptist	3 (1.3)	11 (4.6)	8 (3.3)	22 (9.2)
Presbyterian	14 (5.8)	52 (21.7)	66 (27.5)	132 (55.0)
Roman Catholic	2 (0.8)	7 (2.9)	4 (1.7)	13 (5.4)
Salvation	16 (6.7)	3 (1.3)	9 (3.8)	28 (11.7)
Seventh Day Adventist	5 (2.1)	12 (5.0)	4 (1.7)	21 (8.8)
UPC	4 (1.7)	9 (3.8)	4 (1.7)	17 (7.1)
Any other	2 (0.8)	2 (0.8)	3 (1.3)	7 (2.9)

Figures in parenthesis are percentages Source: Computed

Religion is an important dimension in research as it has a large influence on people's attitudes and perceptions. A vast majority (99.6%) of respondents is Christian and only 1 person who blends into the age group of 18 to 24 years belongs to *Others* category. Majority of the studied population are Christian as it is the dominant religion in Mizoram. Various denominations exist in the Christian community in Mizoram such as Baptist, Presbyterian, Roman Catholic, Salvation, Seventh Day Adventist, UPC, and others. Since there are various small local churches, they have been categorized as *any other* for the purpose of the study (See Table 4.2).

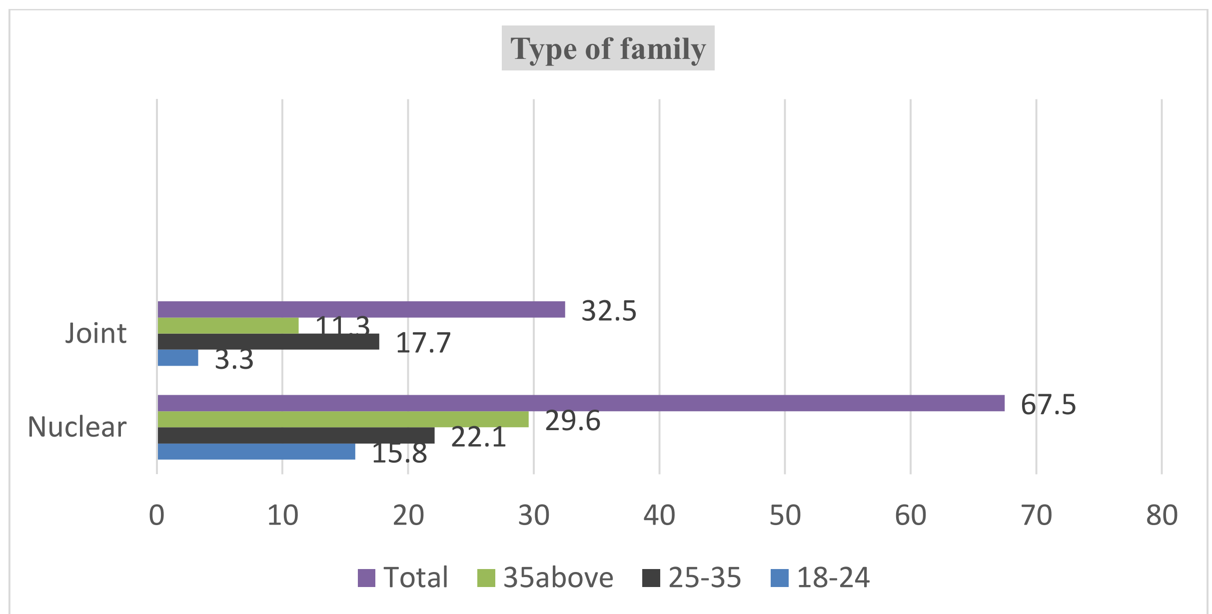
It is found that more than half of the respondents in this study (55%) belong to Presbyterian. This is followed by those belonging to Salvation Army (11.7%),

Baptist (9.2%), Seventh Day Adventist (8.8%), UPC (7.1%), Roman Catholic (5.4%) and others (2.9%).

4.1.3 Structure of Family

Family structure represents members of a household and their support system in the family. Figure 4.6 shows the structure of respondent's family and Figure 4.7 shows the form of respondent's family while Figure 4.8 shows the family strength. The type of family was further categorized into the traditional family type known as joint family and modern family type called nuclear family. The form of family was also grouped into Stable, Broken and Reconstituted family. The family strength for the purpose of the study was classified into less than five and more than five members.

Figure 4.3 Structure of Family of Respondents

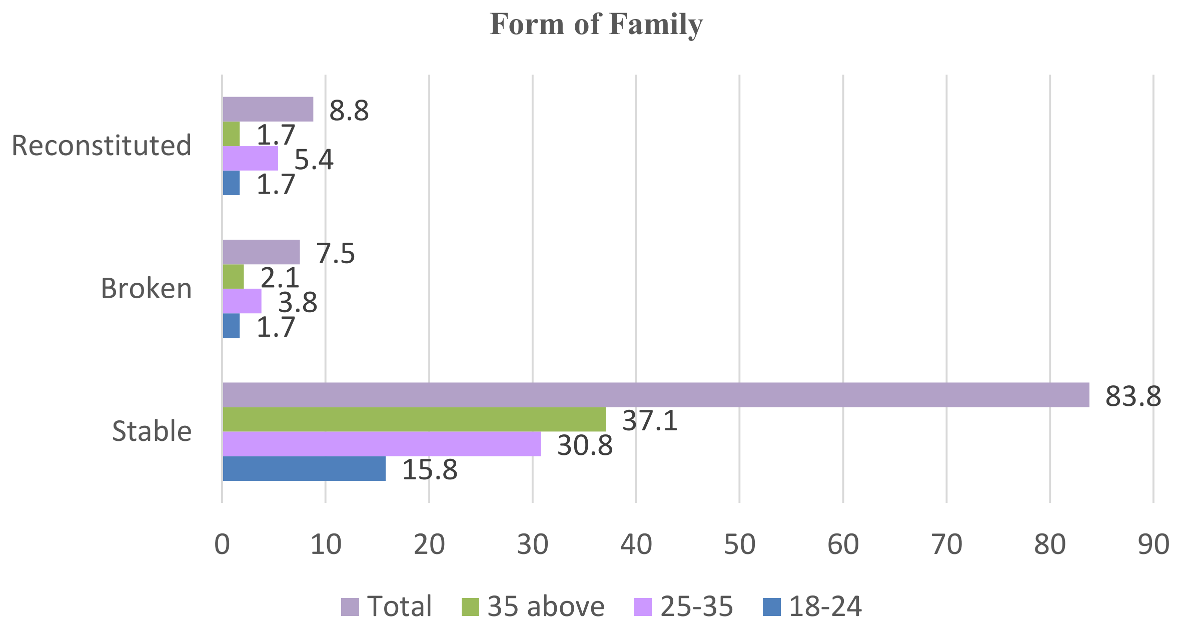


Type & Form of Family is presented in Table 4.3. It is imperative to understand the family of respondents as it determines the terms of gender equality, decision-making and personal freedom of respondents.

Type of family has been categorized into Nuclear and Joint Family where it is found that more than two thirds of the respondents (67.5%) live in Nuclear families while less than a third (32.5%) belong to Joint family. Most 35 above respondents (29.6%) belong to nuclear families perhaps because by this age, they have

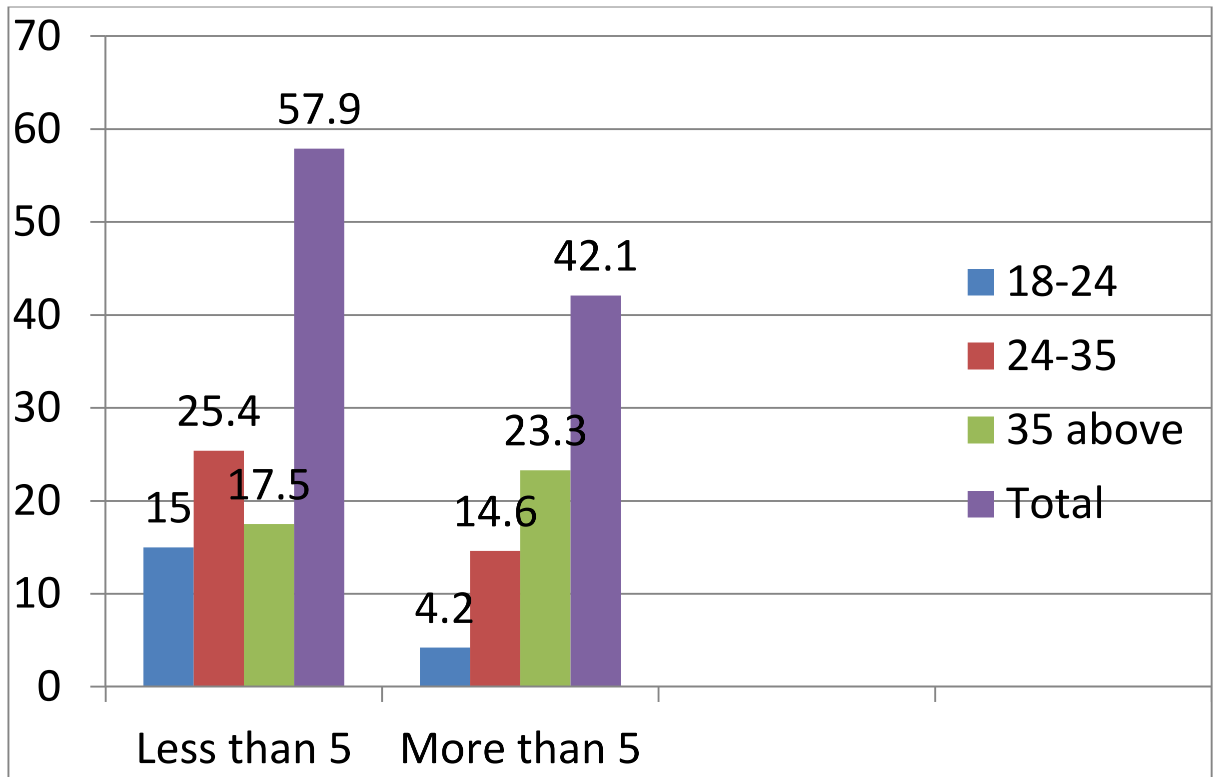
established a family of their own though a little more than a tenth (11.3%) still do live in joint families. However, findings show that younger respondents do not necessarily live in joint families as only 3.3% of the respondents of 18-24 years live in joint families.

Figure 4.4 Form of Family of Respondents



Form of family is categorized into Stable, Broken and reconstituted where more than fourth fifths of respondents (83.8%) enjoy a stable family life. This is followed by reconstituted families (8.8%) and broken families (7.5%). Most of the respondents reporting a stable family are in the age group of 35 above (37.1%), followed by 25-35 years (30.8%) and 18-24 years (15.8%). From this finding, it may be inferred that higher the age group, higher the stability of family. However, broken families are found to be of greater number in the age group of 25-35 years (3.8%), followed by 35 above (2.1%) and 18-24years (1.7%). Those belonging to reconstituted families are highest among the 25-35 age group (5.4%) whereas it is only 1.7% each for both 18-24 and 35 above age groups.

Figure 4.5 Respondent's Family Strength



Family strength greatly decides the family dynamics and refers to the number of family members living together. Family strength, for the purpose of the study is categorized into those families which have less than 5 members (small) and those having more than 5 members (large). A higher number of respondents (57.9%) belong to small families while more than two-fifths (42.1%) are from large families. It can be assumed that, family size increases with the increase in age of respondents. This is evident where 35above group constitute the majority (23.3%) of those belonging to large families, followed by 25-35 age group (4.6%) and 18-24 age group (4.2%). The largest number of age group living in small size families are those in the 25-35 age group.

4.1.4 Marital details of respondents

The marital details of respondents are an important variable in the present study. The age at marriage is another important variable therefore the respondents' age at marriage is discussed in table 4.4. The type of marriage varies from culture to culture and it may change over time. The type of marriage in the study is grouped

into love marriage and arranged marriage. The number of children and the current duration of marriage are also discussed in the following table.

Table 4.3 Marital details of Respondents

I. Age at Marriage	**Age Group** 18-24 years n=46	25-35 years n=96	35 & above years n=98	**Total N=240**
Below 18yrs	27 (11.3)	17 (7.1)	9 (3.8)	53 (22.1)
18-30 years	19 (7.9)	76 (31.7)	77 (32.1)	172 (71.7)
30 years& above	0 (0.0)	3 (1.3)	12 (5.0)	15 (6.3)
II. Type of Marriage				
Love	45 (18.8)	87 (36.3)	86 (35.8)	218 (90.8)
Arranged	1 (0.4)	9 (3.8)	12 (5.0)	22 (9.2)
III. No of Children				
1-2	34 (14.2)	52 (21.7)	41 (17.1)	127 (52.9)
3-4	3 (1.3)	15 (6.3)	40 (16.7)	58 (24.2)
5 above	6 (2.5)	5 (2.1)	7 (2.9)	18 (7.5)
NA (childless)	3 (1.3)	24 (10.0)	10 (4.2)	37 (15.4)
IV. Duration of current marriage				
1-2 years	25 (10.4)	18 (7.5)	11 (4.6)	54 (22.5)
3-5 years	13 (5.4)	53 (22.1)	9 (3.8)	75 (31.3)
6-9 years	7 (2.9)	13 (5.4)	20 (8.3)	40 (16.7)
10 years and above	1 (0.4)	12 (5.0)	58 (24.2)	71 (29.6)

Figures in parenthesis are percentages Source: Computed

Marriage details of young married women respondents are highlighted in Table 4.4. Marriage details have been operationalized into age at marriage, type of marriage, number of children and duration of current marriage.

The average marriage age varies hugely across the world. A minimum age of marriage at 18 years ensures that girls can attain a minimum level of maturity needed to maintain a health marital life. In this study, age of marriage of respondents is grouped into those married before 18 years of age, at 18-30 years, and those married after 30years of age. Majority of respondents (71.7%) were married in the ages between 18 to 30years, followed by those who were married before 18 years (22.1%) and those marrying after 30 years (6.3%). The maximum number of those who married before a legal age are highest among 18-24 years respondents, followed by 25-35 age group (7.1%) and 35 above (3.8%). Those married when they were 18-30 years of age are highest among those who are currently above 35 years (32.1%) while it is 31.7% among 25-35 age group and 7.9% among 18-24years group. Marriage after the age of 30 years is highest among respondents who are currently 35 above years of age (5%) while it is only 1.3% among 25-35 years' respondents. Respondents age at marriage illustrates the level of knowledge of safe motherhood awareness that determines their quality of life.

Type of marriage has been classified into Love and arranged marriage. In Mizo society, people have the freedom to choose their partners and therefore most marriages can be identified as love marriage. However, unlike arranged marriage practiced in other parts of the country, it is found that friends or family with the consent of both parties may set up a union. A vast majority of respondents (90.8%) reported having married for love while almost a tenth (9.2%) had an arranged marriage. The age group of 25 to 35 years is the highest (36.3%) to report having a love marriage followed by those above 35 years (35.8%) and 18-24 years (18. 8%).A similar pattern is found for arranged marriage where the age group of 25 to 35 years is the highest (3.8%) to report having an arranged marriage followed by those above 35 years (5%) and 18-24 years (0.4%).

The number of children in the family persuades the parent's decision especially in times of conflict and inconsistency. Number of children is classified into 4 categories, viz., 1-2 children, 3-4 children, more than 5 children and those without children (NA). The study found that more than half of the respondents

(52.9%) have only 1 to 2 children and 15.4% are childless. Whereas almost a fourth (24.2%) have 3-4 children and 7.5% have more than 5 children. Among those aged 18-24 years, majority of them have 1-2 children (14.2%), followed by more than 5 children (2.5%) and those with 3-4 children and childless respondents constitute 1.3% each. Among the age group of 25-35 years, the largest number of respondents has 1-2 children (21.7%) while 6.3% have 3-4 children and only 2.1% have more than 5 children. Childlessness is mostly found among the age group of 25 to 35 years (10%) followed by 35years above (4. 2%). Surprisingly, 1.3% of respondents aged between 18 to 24 years are also childless.

Duration of marriage in some ways indicates the marital endurance and fulfillment. Duration of marriage, in this study is grouped into 4 types, viz., those having been married for 1-2 years, 3-5 years, 6-9 years and those married for more than 10 years. Almost a third of respondents (31.3%) are currently married for 3 to 5years. This is followed by 29.6% who have been married for more than 10 years, more than a fifth (22.5%) married for 1-2 years and 16.7% who have been married for 6-9 years. Of the respondents aged 18-24 years, a tenth (10.4%) have been staying in a marital relationship for 1-2 years and 5.4% have been married for 3-5 years while 2.9% have 6-9 years of marriage. Surprisingly, 0.4% report having been married for more than 10 years. It is found that more than a fifth (22.1%) among 25-35 years' group have stayed married for 3-5 years, 7.5% have been married for 1-2 years, 5.4% for 6-9 years; and 5% for more than 10 years. Among those aged 35 above, almost a fourth (24.2%) has a marriage of more than 10 years and almost a tenth (8.3%) has stayed married for 6-9 years. While 4.6% are currently married for 1-2 years, a lesser number (3.8%) have been married for 3-5 years.

The duration of marriage shows a normal pattern where age of respondents corresponds to their duration of marriage. There are slight deviations where a few respondents above 35 years of age had experienced only 1-2 years of marital relationship and only 1 respondent in the age group of 18-24 years who had been married for more than 10 years.

This chapter discussed the socio-economic and structural bases of the respondents whereby the education, religion, family form and structure and marriage details are encompassed. The following chapter discusses the experiences and challenges of young married women.

Chapter V

EXPERIENCES OF YOUNG MARRIED WOMEN

The preceding chapter contained the structural bases and socio-economic profile of young married women. The current Chapter describes the challenges and experiences of respondents. It encompasses the discussion of such in five sections. The first section presents the details of respondents' relationship with their spouse. The second section is devoted to details of experiences of abuse from husband, if any. Family decision making pattern is shown in the third section while the fourth section presents the various forms of abuse experienced by the respondents from their family members. The fifth section is devoted to childless respondents where their experiences on childlessness are discussed.

5.1 Respondent's marital relationship

In this section, various measurements were used to understand the quality of respondents' relationship with husband. The liberty of both employed and unemployed respondents in employment decision making matters was also probed in this section. Another important variable in this section incudes exploring the respondents' experience of spousal abuse.

5.1.1 Respondents' relationship with Spouse

Respondents' relationship with husband measures the quality of rapport and support received by the respondents. The following table looked into the respondent's relationship with spouse examined based on various statements including the amount of time spend together, the willingness of husband to listen to respondents' problem, and support given by husband in times of family conflict.

Table 5.1 Respondent's relationship with Husband

Sl No.	Relationship with Husband	Age Group			Total N=240
		18-24 years n=46	25-35 years n=96	35 & above years n=98	
I	**My spouse and I often spend time together**				
	Yes	44 (18.3)	80 (33.3)	86 (35.8)	210 (87.5)
	No	2 (0.8)	16 (6.7)	12 (5.0)	30 (12.5)
II	**My spouse is willing to listen to my problems**				
	Yes	44 (18.3)	84 (35.0)	89 (37.1)	217 (90.4)
	No	2 (0.8)	12 (5.0)	9 (3.8)	23 (9.6)
III	**My spouse supports me when in conflict with another family member**				
	Yes	42 (17.5)	79 (32.9)	77 (32.1)	198 (82.5)
	No	4 (1.7)	17 (7.1)	21 (8.8)	42 (17.5)
IV	**My husband would be happy if employed (for unemployed respondents)**				
	Yes	29 (12.1)	36 (15.0)	34 (14.2)	99 (41.3)
	No	6 (2.5)	16 (6.7)	24 (10.0)	46 (19.2)
V	**If employed, my husband is happy with my employment**				
	Yes	11 (4.6)	50 (20.8)	50 (20.8)	111 (46.3)
	No	5 (2.1)	11 (4.6)	4 (1.7)	20 (8.3)
VI	**My husband allows me to go out alone**				
	Yes	26 (10.8)	85 (35.4)	85 (35.4)	196 (81.7)
	No	20 (8.3)	11 (4.6)	13 (5.4)	44 (18.3)
VII	**I am satisfied with my personal relationship**				
	Yes	22 (9.2)	84 (35.0)	77 (32.1)	183 (76.3)
	No	24 (10.0)	12 (5.0)	21 (8.8)	57 (23.8)

Figures in parenthesis are percentages Source: Computed

Table 5.1 assesses the perception of respondents using various statements that probe into the personal relationship of the respondents with their spouse. This is based on the personal relationship indicators of WHO-QOL BREF. The pattern of relation with husband determines the respondent's quality of life. A large majority of the respondents (87.5%) agreed that they spend quality time with their partners, while a little more than a tenth (12.5%) disagrees to this statement. Respondents of 35 years above (35.8%) are found to be having more quality time with their husbands as compared to 18 to 25 years (18.3%) and 25 to 35 years (33.3%) respondents. On the contrary, 25 to 35 years (6.7%) are the largest age group who reported not having enough quality time with their husbands followed by 35years above (5.0%) and 18 to 25 years (8%).

Listening to each other's problem in relationships is a form of social support as it provides an individual with emotional needs. Specht (1986) suggested that such support enhance self-confidence, sense of empowerment efficiency, and quality of life. Interestingly, majority of respondents (90.4%) stated that their spouses are willing to listen to their problems while less than a tenth (9.6%) disagreed to this statement. More respondents above 35years of age (37%) had husbands who listened to their problems while the same can be said for only 5% of respondents in the 25 to 35 age group. This finding suggests that the duration of marriage and chronological maturity of respondents has an implication on the communication between spouses.

Majority of respondents (82.5%) acknowledged that their male counterparts support them when in conflict with another family member. A third of 25 to 35 years' respondents (32.9%) agree to the statement, which is closely followed by those above 35 years (32.1%), and the least was reported by those in the 18 to 25 years' group (17.5%). A similar pattern is found for respondents who felt that they were not supported by their spouses in times of conflict with another family member where the majority are those aged above 35 years (8.8%). A study conducted by Song & Zhang (2012) among the Chinese daughters in law suggested that husbands play an important role in conflict solving and husbands support in family conflict management are meaningful and crucial.

The fourth indicator of personal freedom in relationship is assessed for both employed and unemployed respondents. For those who are currently unemployed,

the statement queried on whether their spouses would be happy if they are employed. Much less than half of respondents (41.3%) agree to the statement and the number is almost similar across age group (12.1% for 18-24yrs, 15% for 25-35 years, and 14.2% for above 35 years). Ngo (1992) however found that younger women have closer ties with formal employment.

Not much variation is found even in personal freedom in relationship of employed women respondents where less than half (46.3%) agree that their spouses are happy that they are employed. This accounts for a fifth (20.8%) each of 25-25yrs group and those respondents above 35 years; and only 4.6% for those aged 18-24 years. This shows that many women still do not have the freedom to choose their employment status. It is also indicative of a patriarchal society where the societal attitude is that women's place is inside the home. Phillips-Miller, D. L., Campbell, N. J., & Morrison, C. R. (2000) also found that working women reported greater marital and family stress and that they receive less support on their career than their male counterparts. Panda (2003) also confirms that traditional gender roles, expectations, and gender division of labour are still uphold in the society and this societal gender role construction gives married women household obligations and responsibilities.

Personal freedom in relationship includes women's mobility where restriction in freedom of movement denotes less freedom and the subjugation of women by men. Majority of respondents (81.7%) stated that their spouse allows them to go out alone in public as opposed to almost a fifth who are restricted by their spouses (18.3%).

Quality of life is dependent on how one perceives one's relationship with the other. In terms of satisfaction in their personal relationship, most respondents (76.3%) claim that they are satisfied with their personal relationships. This is found to be relatively higher among 25 to 35 years (35%) respondents as compared to 18 to 25 years (9.2%) respondents. Conversely, there are only a small number (23.8%) of respondents who do not find their personal relationships satisfactory. A tenth of 18 to 25 years' respondents (10%) are the prime group to state their dissatisfaction whereas 25 to 35 group are the least contributors (5%) to the statement.

5.1.2 Experience of spousal abuse

Violence against women is a significant problem that has short and long term consequences for women. One of the most common forms of violence against women is perpetuated by a husband or intimate male partner (L Heise). Violence against women as proposed by Centres for Disease Control and Prevention includes Psychological abuse, physical abuse, physical abuse and sexual abuse. The present section attempts to probe such abuse experienced by the respondents.

Table 5.2 Respondent's Experience of Spousal Abuse

Sl No.	Experience of Abuse	Age Group			Total N=240
		18-24 years n=46	25-35 years n=96	35 & above years n=98	
I	**My husband abuses me physically**				
	Yes	21 (8.8)	14 (5.8)	14 (5.8)	49 (20.4)
	No	25 (10.4)	82 (34.2)	84 (35.0)	191 (79.6)
II	**My husband abuses me psychologically**				
	Yes	3 (1.3)	5 (2.1)	14 (5.8)	22 (9.2)
	No	43 (17.9)	91 (37.9)	84 (35.0)	218 (90.8)
III	**My husband abuses me verbally**				
	Yes	21 (8.8)	28 (11.7)	31 (12.9)	80 (33.3)
	No	25 (10.4)	68 (28.3)	67 (27.9)	160 (66.7)
IV	**My husband abuses me sexually**				
	Yes	15 (6.3)	8 (3.3)	5 (2.1)	28 (11.7)
	No	31 (12.9)	88 (36.7)	93 (38.8)	212 (88.3)

Figures in parenthesis are percentages Source: Computed

Experience of abuse from spouse has been categorized as Physical abuse, Psychological abuse, Verbal abuse and sexual abuse (PWDVA 2005). Table 7 represents the types of spousal abuse experienced by respondents.

While a fifth (20.4%) report having experienced physical abuse from their spouses, it is noteworthy to find that most respondents (79.6%) have had no

experience of the same. Physical abuse is found most common among 18-24 age group of respondents (8.8%), while it accounts for 5.8% each in the 25 – 35 and 35 above age group.

Less than a tenth of respondents (9.2%) reports psychological abuse by their partners. The largest age group who experience this is 35years above respondents (5.8%), followed by 25-35 years (2.1%) and 18-24 (1.3%).

Experience of verbal abuse from spouse account for a third of the respondents (33.3%) in the sample. Findings suggest an increase in verbal abuse with age of respondents where it is most common among those above 35 years of age (12.9%) followed by those aged 25-35 years (11.7%) and 18-24 years (8.8%).

More than a tenth of respondents (11.7%) report sexual abuse from their spouses where it may be mentioned that there is more experience of sexual abuse by the younger respondents. While their spouse has sexually abused 6.3% of respondents aged 18-24 years, the same can be said for 3.3% of 25-35 age group and 2.1% of those aged above 35 years.

5.2 Respondents' relationship with In-laws

Healthy relationships are imperative at all levels as it increases one's emotional wellbeing, stability and security. Hence, this sub section attempt to enquire the level of respondents' participation in the family decision making, experience of family abuse and the lived experiences of childless respondents in the study.

5.2.1 Respondent's participation in family decision making

Respondents' relationship with in laws largely decides the amount and level of their autonomy in family decision making matters. The following table attempts to enquire respondents' participation in family decision making related to health, family planning, problem solving and authority in family kitchen.

Table 5.3 Respondent's Family Decision Making matters

		Age Group			
		18-24 years n=46	25-35 years n=46	35 years above n=46	Total
Final say on health care	*Father in law*	6 (2.5)	5 (2.1)	7 (2.9)	18 (7.5)
	Mother in law	3 (1.3)	15 (6.3)	14 (5.8)	32 (13.3)
	Sister in law	0 (0.0)	1 (0.4)	0 (0.0)	1 (0.4)
	Husband	11 (4.6)	46 (19.2)	43 (17.9)	100 (41.7)
	Self	25 (10.4)	29 (12.1)	33 (13.8)	87 (36.3)
	Other family member	1 (0.4)	0 (0.0)	1 (0.4)	2 (0.8)
Final say on problem solving	*Father in law*	9 (3.8)	23 (9.6)	8 (3.3)	40 (16.7)
	Mother in law	3 (1.3)	13 (5.4)	6 (2.5)	22 (9.2)
	Sister in law	0 (0.0)	1 (0.4)	0 (0.0)	1 (0.4)
	Husband	13 (5.4)	46 (19.2)	56 (23.3)	115 (47.9)
	Self	20 (8.3)	13 (5.4)	28 (11.7)	61 (25.4)
	Other family member	1(0.4)	0(0.0)	0(0.0)	1(0.4)
Final say on family planning	*Father in law*	9(3.8)	14(5.8)	2(.8)	25(10.4)
	Mother in law	2(0.8)	9(3.8)	7(2.9)	18(7.5)
	Husband	29(12.1)	49(20.4)	70(29.2)	148(61.7)
	Self	5(2.1)	21(8.8)	17(7.1)	43(17.9)
	Other family member	1 (0.4)	3 (1.3)	2 (0.8)	6 (2.5)
Final say on cooking	*Father in law*	0 (0.0)	2 0(.8)	1 (0.4)	3 (1.3)
	Mother in law	2 (0.8)	25 (10.4)	1 (0.4)	28 (11.7)
	Brother in law	0 (0.0)	1 (0.4)	0 (0.0)	1 (0.4)
	Sister in law	0 (0.0)	2 (0.8)	0 (0.0)	2 (0.8)
	Husband	23 (9.6)	6 (2.5)	7 (2.9)	36 (15.0)
	Self	20 (8.3)	60 (25.0)	81 (33.8)	161 (67.1)
	Other family member	1 (0.4)	0 (0.0)	8 (3.3)	9 (3.8)

Figures in parenthesis are percentages Source: Computed

Women's participation in decision making in the domestic, community and market is linked to their autonomy and empowerment (Jejeebhoy, 2000). Patterns of decision making in the family is shown in Table 8 where respondents across age

groups stated who has the final say on different matters in the family decision-making. The various family matters include health care, problem solving, family planning, mobility, cooking and religious participation.

Less than half of the respondents (41.7%) reported that their husbands decide decision making for health care while the respondents themselves make more than a third (36.3%) of the health care decision. More than a tenth (13.3%) of such decisions are made by the respondents' mothers-in-law while only 7.5% state that their Fathers-in-law have the final say. Authority in health care decisions accounts very less for other members in the family (0.8%) and sisters in law (0.4%).

It was found that most problem solving is made by their husbands (47.9%), followed by decisions made by the respondents themselves (25.4%), their fathers-in-law (16.7%), mothers-in-law (9.2%) and very few state that their sisters-in-law and other family members have the final say in problem-solving (0.4% each). Most family planning decisions are made by their husbands (61.7%) and only 17.9% say that they have the final say in family planning decisions in the family. While a tenth (10.4%) state that their fathers-in- law have authority over this matter, only 7.5% of mothers-in-law and 2.5% of other family members account for the same. Lee et al., (2014) also observed that husbands' perceptions about family planning had an influence on their wives.

More than two-thirds (67.1%) of respondents are given the authority to manage the family kitchen while 15% state their husbands have authority over decisions in the kitchen. While 4.7% of respondents state their mother-in-law have the final say in cooking, 3.8% of them state that other family members are in control of the same. A few respondents report their fathers-in-law (1.3%) and brother-in law (0.4%) have the final say in the family kitchen.

5.2.2 Family abuse

Domestic violence or abuse from family members is serious and pernicious as it ruin lives and breaks up family. According to Miller & Mullins (2002), experience of abuse can take the form of controlling behavior in order to maintain the imbalance of power between the abuser and battered women involving any act that includes sexual, physical, psychological, financial and verbal abuse. The table below shows the various forms of abuse that respondents experienced from their marital family members.

Table 5.4 Respondent's Experience of Family Abuse

	Experience of Family Abuse				
Age Group	**Sexual**	**Physical**	**Psychological**	**Financial**	**Verbal**
By Mother- in-law					
18-24	00 (0)	00 (0)	15 (32.6)	3 (6.5)	7 (15.2)
25-35	00 (0)	00 (0)	35 (36.5)	4 (4.2)	20 (20.8)
35	00 (0)	00 (0)	28 (28.6)	3 (3.1)	20 20.4)
Total	00 (0)	00 (0)	78 (32.5)	10 (4.2)	47 (19.6)
By Father- in-law					
18-24	1 (2.2)	0	0	2 (4.3)	2 (4.3)
25-35	0	0	0	2 (2.1)	1 (1.0)
35	0 (0)	0	0	1 (1.0)	0 (0)
Total	1 (0.4)	0(0)	0(0)	5 (2.1)	3 (1.3)
By Brother- in-law					
18-24	0 0.0	2 (4.3)	0 (0)	1 (2.2)	3 (6.5)
25-35	2 (2.1)	0 (0.0)	0 (0)	0 (0.0)	1 (1.0)
35	0 (0)	1 (1.0)	0 (0)	1 (1.0)	0. (0)
Total	2 (0.8)	3 (1.3)	0 (0)	2 (0.8)	4 (1.7)
By Sister- in-law					
18-24	1 (2.2)	0 (0)	0 (0)	1 (2.2)	3 (6.5)
25-35	1 (1.0)	0 (0)	0 (0)	1 (1.0)	5 (5.2)
35	1 (1.0)	0(0)	0 (0)	2 (2.0)	1 (1.0)
Total	3 (1.3)	0 (0)	0 (0)	4 (1.7)	9 (3.8)

Figures in parenthesis are percentages Source: Computed

Table 5.4 report experience of abuse by family members where the family members consist of Father in law, Mother in law, brother in law and sister in law. The various forms of family abuse are grouped into sexual abuse, physical, psychological, financial and verbal abuse. Across the age group, the most common form of abuse performed by mother in law is psychological abuse (32.5%) followed by verbal abuse (19.6%) and financial abuse (4.2%). A similar pattern is found among aged 18-24 years where almost a third (32.6%) reported psychological abuse,

verbal abuse (15.2%) and financial abuse (6.5%). There are no reports on sexual and physical abuse by mother in law.

Financial abuse of respondents (5%) is seen to be the most reported form of abused by fathers in law whereas 1.3% of respondents report an experience of verbal abuse by their fathers in law. Unfortunately, this study found that few respondents (2.2%) of aged 18-24 years are sexually abused by their fathers in law. Respondents of 18-24 years also reported that they are financially (4.3%) and verbally (4.3%) abused by their fathers in law. Among the 35 years above age group, only 1% have had an experience of abuse which is financial abuse by fathers in law. No reports on physical and psychological abuse

Experience on abuse by brothers in law was explored where verbal abuse (1.7%) is found to be the most common form of experience followed by physical abuse (1.3%) and 0.8% each of sexual and financial abuse. Physical abuse is (4.3%), verbal (3%) and financial 2.2% in the age group of 18-24 years. Respondents belonging to 25-35 age group reported that they are sexually (2.1%) and verbally (1%) abused by their brothers in law. Only a few forms of abused was identified among 35years above age group, where 1% each for physical and financial abuse. The largest form of abused experienced from sister in law was verbal abuse for respondents across age groups.

5.2.3 Experiences of childless respondents

Child bearing is central to women's live in many society. Such society expects its women to bear child in the initial years of marriage and for this reason involuntary childless women often met with disapproval in their marriage. The following table examines the various experiences of childless respondents including family history of involuntary childlessness, husband and in laws reaction to her situation, the frequency of initiating pregnancy and the duration of medical examinations and treatment regarding fertility.

Table 5.5 Respondent's Experiences of childless respondents

Sl No.	Experiences of Childlessness N=37			
I	**Infertility**	**Self**	**Husband**	**Not Applicable**
	Problem with fertility	2 (5.4%)	1 (2.7%)	34 (9.7%)
II	**Family history**	1 (2.7%)	0 (0.0)	36 (97.3%)
III	**Reactions to Childlessness**	**Positive**	**Negative**	**Not Applicable**
	Doctor's finding	5 (13.5%)	0(00)	32 (86.5%)
	Spouse reaction to childlessness	30 (81.1)	1 (2.7%)	6 (16.2%)
	In laws reaction to childlessness	28 (75.7%)	3 (8.1%)	6 (16.2)
IV	**Problems with Childlessness**	**1 to 3 years**	**More than 4 years**	**Not Applicable**
	Attempt to initiate pregnancy	16 (43.2%)	15 (40.5%)	6 (16.2%)
	Problem with child bearing	20 (54.1%)	1 (2.7%)	16 (43.2%)
V	**Duration of treatment**			
	Self	20 (54.1%)	1 (2.7%)	16 (43.2%)
	Husband	31 (83.8%)	0 (00)	6 (16.2%)

Figures in parenthesis are percentages Source: Computed

Table 5.5 discusses the experiences of childless respondents. Childlessness was found among 37 (15.4 %) of respondents. With regard to infertility, a few (5.4%) respondents reported that there was a problem with them while only 2.7% reported that the problem was with their husbands. Almost a tenth (9.7%) claimed that they do not know who the infertile partner is. Many respondents hesitated to acknowledge that they are "infertile". With regard to family history of infertility, only 2.7% reported that there have been cases of infertility in their family history. At the same time, a huge majority (97.3%) were not aware of such cases in their family. Similarly, Patra & Unisa (2007) highlighted that an estimated number of 13-19 million couples are expected to be infertile in India at a given point of time. Their findings also reveal that the prevalence of ever experienced and current infertility is considerably higher among women from socio-economically disadvantaged group.

Reactions to childlessness can be both positive and negative. More than an eight (13.5%) received positive reaction from their doctors regarding their childless situation. A huge majority (81.1%) of said that they received positive reaction from their spouses. While 2.7% reacted negatively to their situation, three fourth (75.7%) of in laws reacted positively and another 8.1% were negative in their reaction towards childlessness. George (2005) also found that In-laws harass young married women if a child is not born after 2 or 3 years of marriage telling her she has some fault in her.

Out of childless respondents, more than four-fifth (43.2%) have attempted to initiate pregnancy using various treatments for 1 to 3 years while 40.5% have attempted the same for more than 4 years; while 16.2% have not taken any initiative as they do not consider it as a problem. More than half (54.1%) have problems with child bearing for 1-3 years but have not undergone necessary treatment and the same was reported by 2.7% who had experienced the same for more than 4 years of their marriage.

More than half (54.1%) of respondents have undergone medical treatment regarding fertility for 1 to 3 years; while 2.7% reported that they have taken medical treatment for the same for more than 4years. A large majority (83.8%) of respondents reported that their husbands have been undergoing medical treatment related to infertility for 1 to 3 years.

In this chapter, an attempt has been made to discuss the various experiences and challenges faced by young married women in Aizawl. The different forms of violence experiences perpetuated by both husband and family members are also discussed. In the next chapter, quality of life of young married are examined.

Chapter VI

QUALITY OF LIFE OF YOUNG MARRIED WOMEN

In the previous chapter, the details of experiences and challenges of young married women were presented. The family decision making pattern as well as the relationship between young married women and their husbands were also presented. Quality of life is a subjective measurement of happiness or a level of happiness and comfort a person or group. It is not limited to a person's wealth and employment; in fact it is influenced by various domains including personal, financial, health and social domain.

In this chapter, the quality of life of young married women assessed in various domains is presented in four different sections with sub sections. Various domains are used to measure quality of life because people's sense of wellbeing is heavily contributed by their feelings about various aspects of life that concerns them. Hence, the present study includes personal domain, social domain, health domain and financial domain for assessing respondents' quality of life.

6.1 Personal Domain

Personal autonomy (PA) is the ability to have control over one's own life and it is accompanied by the feeling that it is possible to exercise this control and make an informed decision (Caldwell et al., 2003). Personal domain as a measurement of quality of life refers to the knowledge and understanding of one's own conduct and how it affects that of others. It is the formation of self, personality and individuality as well as an attempt to learn the root causes and its meanings (Smetana, 2013).

6.1.1 QOL and autonomy

Autonomy refers to the ability of an individual to decide for himself/herself. It denotes the independence and freedom of a person in the field of decision making. The following table discusses the respondents' family decision making pattern and its association with respondents' age, education and employment status. The level of respondents' participation in family decision making pattern on health care, problem solving, family planning, visiting friends and relatives, kitchen matters and religious participation can be said to indicate the respondents' quality of life.

Table 6.1 Respondents' Level of Autonomy in the family

Respondents	Final say on health care	Final say on problem solving	Final say on family planning	Final say on visiting friends and relatives	Final say on kitchen matters	Final say on religious participat ion
Age	-.041	.113	.173**	.035	.226**	.135*
Education	-.205**	-.415**	-.258**	-.127*	-.377**	-.141*
Employment status	.072	-.098	-.127*	.119	-.021	-.054

P<0.05*; P<0.01** Source: Computed

Table 6.1 depicts the relationship between particulars of young married women such as age, education and employment status with decision making in their marital home. Age is found to be highly significant with having final say on family planning and decision making in kitchen matters. This finding supports Phan (2013) who stated that women's age influence their participation in general household decisions and also Hayford & Guzzo (2010) who found that planning of childbirths has a strong relation with the age of women. Age is also related to decision making in religious participation. On the other hand, age is negatively co-related with financial say on health care. Education has surprisingly negative relationship with problem solving, cooking, family planning, health care and religious participation and visiting friends and families. However, a similar finding is observed by Phan (2013) regarding the negative relation of women's education on health and reproductive issue. On the other hand, the current study contradicts Al Riyami et al., (2004) which reveals the increase in autonomy of women as a result of their education. In the current study, employment is found to have negative relationship with family planning dimension. Similarly, Kishor et al (1995) found that employment enhanced women's autonomy in decision making related to contraception and child bearing.

6.1.2 Quality of Life and Age Group

Age of a person is an important demographic variable and people of the same age group are often assumed to have common values, attitudes and experiences. Here in the sub section, the level of respondents' satisfaction in different dimensions of

QOL such as personal, psychological, health, social and financial are compared among different age group.

Table 6.2 Comparison of different domains of QOL with age group

Domains	Level of Satisfaction	Age Group			X^2	P
		18-24	25-35	35		
Personal	Moderate	41 (25.3)	51 (31.5)	70 (43.2)	19.54	.000**
	High	5 (6.4)	45 (57.7)	28 (35.9)		
Psychological	Moderate	44 (19.6)	87 (38.7)	94 (41.8)	2.670	.263
	High	2 (13.3)	9 (60.0)	4 (26.7)		
Health	Moderate	43 (19.1)	90 (40.0)	92 (40.9)	.009	.996
	High	3 (20)	6 (40)	6 (40.0)		
Social	Moderate	29 (14.2)	90 (44.1)	85 (41.7)	23.38	.000**
	High	17 (47.2)	6 (16.7)	13 (36.1)		
Financial (Dependent)	Moderate	10 (15.2)	28 (42.4)	28 (42.4)	.956	.629
	High	36 (20.7)	68 (39.1)	70 (40.2)		
Financial (Earner)	Moderate	10 (10.6)	43 (45.7)	41 (43.6)	7.432	.024
	High	36 (24.7)	53 (36.3)	57 (39)		

$P<0.05^{*}$; $P<0.01^{**}$ Source: Computed

Satisfaction is a state of happiness, contentment or fulfillment; therefore it is possible for a person to lack satisfaction (Adah and Emmanuel, 2015). Lina and Simon, (2008), identified income, occupation and social status, opportunities and social mobility, welfare provision, and social network and family tradition as the components of life satisfaction. Table 6.2 compares the level of status of different domains with age group. In the personal domain, moderate level of satisfaction was found highest among 35 above age group followed by 25-35 years and 18-24 years of respondents. High status in personal domain was found highest among 25-35 age group followed by 35 above and 18-24 years of respondents. Similarly, Jan, & Masood (2008) found that high level of personal satisfaction is found among women

at average level of age group whereas low level of personal satisfaction is found among women at high level of age group.
Baird, Lucas, & Donnellan (2010) found that life satisfaction does not decline over much of adulthood while in a study of adults between the ages of 25 and 75 years, Prenda and Lachman (2001) found that age was positively correlated with life satisfaction.

In psychological domain, 35 above age group were moderately satisfied followed by 25-35 and 18-24 years of respondents. High level of psychological satisfaction was found highest among 25-35 followed by 35 above and 18-24 years of respondents. Satisfaction can be the reflection of individual's psychological make-up, the belief and value systems, and environmental and cultural factors. Jan and Masood (2008) observed that with an increase in age, the overall life satisfaction decreases.

In health domain, moderate level of satisfaction was found to be highest among 35 above respondents followed by 25-35 years of respondents and lowest for 18-24 years. High level of satisfaction was found to be highest in 35 above and 25-35 years equally. The least satisfaction in health domain was for 18-24 years of respondents. On the other hand, Darling, Coccia, & Senatore, (2012) found that women in midlife experienced more stressful life changes and greater health stress which resulted in lower life satisfaction.

Ruut (2004) defined life satisfaction as the degree to which a person positively evaluates the overall quality of his/her life as a whole. In social dimension of the current study, 25-35 years are found to be highest moderately satisfied followed by 35 above and 18-24 years. High satisfaction was found highest among 18-24 age group followed by 35 above and lowest for 25-35 age groups. This finding contrasts Jan and Masood (2008)'s finding that high level of social satisfaction is found among women at average level of age group, whereas the average level of social satisfaction is found among women at low age group, low level of social satisfaction is found among women at high age group. Life satisfaction can reflect experiences that have influenced a person in a positive way.

In the measurement of financial dimension, dependents of 35 above and 25-35 were equally moderately satisfied while a study of Jan, & Masood (2008) found that with an increase in personal income, the overall life satisfaction increases. Dependents of 35above were highly financially satisfied followed by 25-

35 years. The least financial satisfaction was found among respondents of 18-24 years. Earners of 25-35 years are moderately satisfied in financial total followed by 35 above and 25-35 years. On the contrary, respondents above 35years of age were highly financially satisfied followed by those who were in the 25-35 and 18-24 years age group. Singh (2014) also found in his study that working women were more satisfied with their life and dependent women tends to have higher level of stress as compared to earning respondents.

6.1.3 Married life and age group

It is believed that marriage affects a person in different ways. The transition to married life may also bring changes in one's outlook and perceptions about life. However, personal experience and age group may influence the outcome. Gender roles and expectations play a significant role in couple interaction, family decision-making, and perspectives on marital satisfaction. The perceptions and experience of married life for the purpose of the study involves "*Woman's place is in the home", "Employment of mother leads to bad parenting", "Housewives are more likely to develop depressive symptoms than women who are employed outside the home", "Housewives in joint family are more likely to develop depressive symptoms than women who are employed outside the home"*. Table 6.3 shows the association between respondents' age with perceptions and experience of married life.

Table 6.3 Association between age with Perceptions and Experience of married life

Statements	18-24	25-35	35 above	X^2	P
Woman's place is in the home	40 (30.1)	55 (41.4)	38 (28.6)	29.64	.000
Employment of mother leads to bad parenting	16 (18.6)	29 (33.7)	41 (47.7)	6.36	.041
Housewives are more likely to develop depressive symptoms than women who are employed outside the home	15 (12.9)	47 (40.5)	54 (46.6)	2.87	.237

Housewives in joint family are more likely to develop depressive symptoms than women who are employed outside the home	14 (12.7)	36 (32.7)	60 (54.5)	16.43	.000

P<0.05*; P<0.01**   Source: Computed

Marriage can be experienced as a developmental task and occupies the individual's mind with whom and how to do it at different age periods of life (Ercan & Uçar, 2021). Table 6.3 presents the association between age with respondents' perceptions and experiences of married life. No significance was found for respondents age with statement such as woman's place is in the home, employment of mother leads to bad parenting, housewives are more likely to develop depressive symptoms than women who are employed outside the home, housewives in joint family are more likely to develop depressive symptoms than women who are employed outside the home. Others Pollitt,Robinson., & Umberson (2018) also found that when both women and men are more gender conforming, both partners report more power equality in their marriage.

6.1.4 Education and perception and experiences of married life

Education is one of the primary needs for human development and educational status of a person as a socio demographic factor can shape the perception of a person. (Akareem & Hoassain, 2014) found that students' perception of higher education is greatly influenced by the institution they engaged themselves at, parent's education, age and former education achievement. This indicates that the environment and education level heavily influence perception. The current sub section probes the relationship of respondents' education with their perceptions and experience of married life.

Table 6.4 Relationship between Perceptions and Experiences of married life with educational status of respondents

	Perceptions and Experience of married life	Educational Status							
Sl No.	***Statements***	**Primary**	**Middle**	**HS**	**HSS**	**UG**	**PG**	**X^2**	**P**
I	***Woman's place is in the home***	8 (6)	7 (5.3)	40 (30.1)	37 (27.8)	35 (26.3)	6 (4.5)	14.3	.01**
II	***Employment of mother leads to poor parenting***	5 (5.8)	9 (10.5)	37 (43)	15 (17.4)	20 (23.3)	0 (0)	28.4	.000**
III	***Housewives are more likely to develop depressive symptoms than women who are employed outside the home***	12 (10.3)	12 (10.3)	34 (29.3)	21 (18.1)	21 (18.1)	16 (13.8)	16.4	.006**
IV	***Housewives in joint family are more likely to develop depressive symptoms than women who are employed outside the home***	13 (11.8)	11 (10)	36 (32.7)	18 (16.4)	17 (15.5)	15 (13.6)	24.38	.000**

$P<0.05^{*}$; $P<0.01^{**}$ Source: Computed

Societal changes such as increase in level of education may also impact gender roles and performance within marriage (Ogletree, S. M, 2014). Table 6.4 discusses the relationship between perceptions and experiences of married life with educational status of respondents. Educational status of respondents is found to be highly significant with statements on perceptions and experience of married life such as *Woman's place is in the home* (X^2=14.3,p=.01*), employment of mother leads to poor parenting* (X^2=28.4,p=.000*), housewives are more likely to develop depressive symptoms than women who are employed outside the home* (X^2=16.4,p=.006*), housewives in joint family are more likely to develop depressive symptoms than women who are employed outside the home (*X^2=24.3,p=.000*).* This finding confirms the findings of other study (Rostami, 2013) which reported less satisfaction in life and the probability of developing mental health issues among

unemployed women. Even though marriage is still important to many, the nature of marriage is changing, becoming more inclusive with less specified gender roles.

6.2 Social Domain

Social domain can be defined as a communicative framework which effect and are weighted by the arrangement of such contexts, including social, institutional and power-align. WHOQOL-bref includes personal relationships, social support and sexual activity in the measurement of social domain. In the assessment of quality of life, the present section attempts to understand the association and respondents level of satisfaction with social domain mainly assessed with respondents' education, socio demographic profile encompassing age, education, employment and family structure and respondents' independent perceptions.

6.2.1 Quality of Life & Demographic Profile

Socio demographic profile of the respondents presents the age, education, type of family and economic status of respondents. In the following table, the association between such profile and various dimensions of QOL such as perception on self, social dimension, psychological, health and financial dimension for both the employed and unemployed are discussed.

Table 6.5 Association of QOL with Socio-demographic profile of respondents

Profile of Respondents	Perception on self - total score	Social dimension total	Psychological dimension total	Health dimension total	Financial dimension (Earners) total	Financial dimension (Dependents) total
Age	$.130^{*}$	$-.170^{**}$	-.006	$.174^{**}$	-.104	.069
Education	.071	-.024	-.119	.033	$-.236^{**}$	.125
Employment status	-.015	$-.175^{**}$	$-.201^{**}$	-.004	$-.898^{**}$	$.756^{**}$
Type of family	.003	.104	$-.160^{*}$	$.144^{*}$	.101	$-.250^{**}$
Socio eco category	-.026	$-.192^{**}$	$-.245^{**}$	$.138^{*}$	$-.223^{**}$	.049

$P<0.05^{*}$; $P<0.01^{**}$ Source: Computed

Being a woman, being married or cohabiting, and reaching higher level of education and having a higher income are found positively associated with the overall quality of life (Gobbens & Remmen,2019). Table 6.5 depicts the relationship between age, education, employment and socio economic status with different dimensions of Quality of life. Age has highly positive correlation with health quality dimension total. There is an also positive relationship between perception of self and age category. Age has negative relations with social dimension total. Nevertheless, Jan and Masood (2008) observed the decline in overall life satisfaction with an increase in age of a person.

Education has negative relationship with financial dimension total for earning respondents. However other studies highlighted that higher education has a significant association with most of the QOL dimensions mentioned in the WHOQOL scale (Saxena et al., 2013). While others reported that quality of life increases with the sufficient income of a person and it eventually uplift the individual's satisfaction with life (Ackerman and Paolucci, 1983) the current study found that employment has high positive relation with financial domain of dependents while it has a negative relation with financial domain total of earners.

Type of family is positively related to quality of health total and negative relationship with financial domain of dependents and psychological dimensions' total. Socio economic has positive relationship with quality of health dimension. It also has negative relation with psychological domain, financial domain of earners and social dimension total. This study corroborates Warner, Lee and Lee (1986) which highlighted that the practice of residing in joint family reduces a women's autonomy that controls their freedom in making decision in different matters.

6.2.2 QOL & Educational Status of Respondents

Education improves the quality of people's lives as it enhances their understanding of themselves and around the world. Level of educational attainment is an indicator of individual achievement in the field of educational performance. A study of Pascarella and Terenzini (2005) also found that graduate respondents have higher extensive advantage as compared to respondents with high school degree. The present study categorized educational levels into Primary, Middle, High School, Higher Secondary, Undergraduate and Post Graduate. The current sub section

presents the association between level in various domains of QOL and Educational status respondents.

Table 6.6 Association between level of satisfaction in QOL domains and Educational status of Respondents

Domain	Level of satisfaction	Educational Status						X^2	P
		Primary	Middle	HS	HSS	UG	PG		
Personal	**Moderate**	14 (86)	13 (8)	48 (29.6)	41 (25.3)	29 (17.9)	17 (10.5)	8.2	.14
	High	2 (26)	5 (6.4)	20 (25.6)	19 (24.4)	25 (32.1)	7 (9)		
Psychological	**Moderate**	15 (16.7)	17 (7.6)	59 (26.2)	57 (25.3)	53 (23.6)	24 10.7)	9.2	.10
	High	1 (6.7)	1(6.7)	9 (60)	3 (20)	1 (6.7)	0		
Social	**Moderate**	15 (7.4)	16 (7.8)	59 (28.9)	38 (18.6)	53 (26)	23 (11.3)	32.9	.00
	High	1 (2.8)	2 (5.6)	9 (25)	22 (61.1)	1 (2.8)	1 (2.8)		
Health	**Moderate**	14 (6.2)	17 (7.6)	62 (27.6)	58(25.8)	50 (22.2)	24 (10.7)	4.4	.487
	High	2 (13.3)	1 (6.7)	6 (40)	2 (13.3)	4 (26.7)	0		
Financial (Dependent)	**Moderate**	6 (9.1)	6 (9.1)	18 (27.3)	14 (21.2)	20 (30.3)	2 (3)	8.5	.128
	High	10 (5.7)	12 (6.9)	50 (28.7)	46 (26.4)	34 (19.5)	2 (12.6)		
Financial (earner)	**Moderate**	5 (5.3)	5 (5.3)	24 (25.5)	15 (16)	26 (27.7)	19 (20.2)	24.8	.00**
	High	11 (7.5)	13 (8.9)	44 (30.1)	45 (30.8)	28 (19.2)	5 (3.4)		

*p≤0.05, **p≤0.01 Source: Computed

Education has become one of the strongest indicators of life outcomes such as employment, income and social status, and is a strong predictor of attitudes, wellbeing, and quality of life of a person (Javed, S., Javed, S., & Khan, A. 2016). Table 6.6 highlights the association between level of satisfaction in each QOL domain with educational status analyzed using Chi Square Test. Level of satisfaction in financial domain of earners is found to be highly significant with respondent's educational status (X^2=24.8, p=.00). A study of Erci, B. (2003) also found that women's educational level affected their decision making in the family.

6.2.3 Education with awareness on Reproductive Health

The United Nations experts reported that investing in girls' education and reproductive health and rights ensures sustainable development for all. The previous studies show that the longer girls stay in school or the more educated they are, the more they know about family planning and they choose their families to be. The present sub section probes into the association between respondents' awareness regarding reproductive health and their level of education.

Table 6.7 Association between level of Education with awareness regarding reproductive health among women

Statements	Primary	Middle	HS	HSS	UG	PG	X^2	P
I am satisfied with my sex life	15 (6.7)	16 (7.1)	63 (28)	56 (24.9)	53 (23.6)	22 (9.8)	2.84	.72
I get sufficient knowledge regarding pregnancy	14 (6.3)	17 (7.7)	56 (25.3)	57 (25.8)	53 (24)	24 (10.9)	14.91	.01**
Source of knowledge from friends	6 (4.1)	14 (9.7)	44 (30.3)	43 (29.7)	24 (16.6)	14 (9.7)	15.28	.00**
Source of knowledge from family	12 (7.9)	15 (9.9)	40 (26.3)	33 (21.7)	31 (20.4)	21 (13.8)	13.28	.02*
Source of knowledge from education	10 (5.7)	17 (9.7)	47 (26.7)	33 (18.8)	48 (27.3)	21 (11.9)	25.13	.000**
Source of knowledge from social media	1 (1.1)	6 (6.9)	18 (20.7)	19 (21.8)	27 (31)	16 (18.4)	23.67	.000**
I am alert regarding my menstrual cycle	4 (2.9)	15 (10.8)	50 (36)	23 (16.5)	29 (20.9)	18 (12.9)	31.39	.000**
I know how to calculate my fertile period	5 (4.1)	13 (10.6)	33 (26.8)	37 (30.1)	30 (24.4)	5 (4.1)	17.82	.003**

$P<0.05^*$; $P<0.01^{**}$ Source: Computed

Reproductive health has been a great concern for every woman and Lack of awareness and superstitions are some issues which affect the reproductive health of women (Hazarika, P., Kakati, N., & Kalita, R. K. 2015). Table 6.7 highlights the association between education and reproductive awareness. Sufficient knowledge regarding pregnancy, source of knowledge from friends (X^2= 15.28, p=.00**), from education (X^2= 25.13, p= .000**), from social media (X^2=23.67, p= .000**), knowledge regarding menstrual cycle (X^2=31.39, p=.000**) and calculating their own fertile period (X^2=17.82, p=.003**) is highly significantly associated with level of education. Source of knowledge from family is also significant with level of

education. A study of Hazarika, Kakati, & Kalita, (2015) on the other hand found that maximum number of information derives from the respondent's mothers followed by friends and relatives. Mass media disseminate the lowest level of information among all the source of information in the study.

6.2.4 Education and perceptions on Reproductive health

Lack of awareness and knowledge about reproductive health may result in problem during adolescents and the later life (Chhabra & Annapurna, 2018). A person's perception is often shaped by education and experience. The current sub section presents the association between respondent's levels of education with their perceptions on reproductive health.

Table 6.8 Association between levels of Education with perceptions on reproductive health

Statements	Primary	Middle	HS	HSS	UG	PG	X^2	P
Contraception is against my religious belief	12 (8.2)	15 (10.2)	53 (36.1)	35 (23.8)	25 (17)	7 (4.8)	28.66	.000**
My partner and I freely discuss about family planning	10 (5.2)	14 (7.2)	55 (28.4)	42 (21.6)	50 (25.8)	23 (11.9)	16.43	.006
Method of birth control	7 (12.1)	9 (15.5)	22 (37.9)	15 (25.9)	5 (8.6)	0	29.71	.001
Perception on abortion	14 (7.3)	11 (5.7)	47 (24.4)	52 (26.9)	46 (23.9)	23 (11.9)	16.17	.006

P<0.05*; P<0.01** Source: Computed

Education operates differently in various groups and sub group of population. The economic level, age at first marriage, age of husband etc also influence fertility yet education puts an indirect impact too (Azmat, Ajmal, & Shams, 2021). Table 6.8 highlights the association between education and respondent's perception on reproductive health. It was found that the statement "contraception is against my religious beliefs" is highly significant with the level of respondents education (X^2=28.6,p=.000). Respondents with higher secondary level of education (23.8%) were found to be the majority to state the same. Previous study conducted by Radulović et al., (2006) found that a larger number of women make the decision on

the use of contraception without involvement of their husbands and significant difference in sufficient information was observed among respondents with higher and lower level of education. Others like Barua (1998) also perceived that the participation of husband influences the access to maternal care services for young women whereas Carter (2000) stated that only few husbands realize the need for maternal care which dictates the number of husband who engaged themselves in the maternal care of their spouse.

6.3 Health Domain

WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" In the assessment of individuals' quality of life, health domain encompasses how a person's wellbeing may be affected by disease, illness or disability. The present section involves respondents' perceptions and awareness of reproductive health and fertility issues in the assessment of health domain.

6.3.1 Age and fertility

The American Society for Reproductive Medicine (2002) suggests that female fertility begins to decline many years prior to the onset of menopause. Involuntary childless women often experience inadequate support which exacerbates their psychological distress. The present study categorized fertility issues into fertility treatment of self, in laws reaction to childlessness and duration of current marriage and the relation of such issues with respondents' age are probed in the following table.

Table 6.9 Correlation between Age and Fertility issues

Sl No.	Fertility issues		Age			t	P-value
			18 to 24	25 to 35	35 above		
I	Fertility treatment (Self)	*1 to 3 years*	1 (33.3%)	0 (00)	2 (66.7%)	9.52	.04*
		4 above	17 (70.8%)	1 (4.2%)	6 (25%)		
		NA	2 (20%)	0 (00)	8 (80)		
		Childlessness					
II	In- Laws reaction to childlessness	*Positive*	2 (66.7%)	0(00)	1(33.3%)	9.42	.05*
		Negative	20(83.3%)	0(00)	4(16.7%)		
		NA	6(60.0%)	3(30%)	1(10%)		

		Age at marriage					
III	**Fertility treatment (Self)**		**Below 18 years**	**18 to 30 years**		8.53	.01**
		1to 4	13 (81.2%)	7(33.3%)			
		5bve	0(00)	1(4.8%)			
		NA	3 (18.8%)	13 (61.9%)			
		Attempt to initiate pregnancy					
IV	**Duration of current marriage**		**1 to 3**	**4 to 5**	**NA**	14.2	.02
		1 to 2 years	8(61.5%)	1(7.7%)	4(30.8%)		
		3 to 5	8(47.1%)	8(47.1%)	1(5.9%)		
		6 to 9	0(00)	1(00)	0(00)		
		Fertility treatment (Self)					
V	**Duration of current marriage**		**1 to 4**	**5 above**	**NA**	42.9	.00
		1 to 2 years	5(38.5%)	0(00)	8(61.5%)		
		3 to 5	13(76.5%)	0(00)	4(23.5%)		
		6 to 9	0(00)	1(100%)	0(00)		

P<0.05*; P<0.01** Source: Computed

Fertility declines as women age. Advancing maternal age increases pregnancy risks (Deatsman, Vasilopoulos, & Rhoton-Vlasak, 2016) while it is a distressing issue to both the couple and their families (George, & Kamath, 2010). Table 6.9 discusses the correlation between age and fertility issues. With regard to age of respondents, fertility treatment of self is found to have significance (X^2=9.52,p=.04). Respondents above 35years (66.7%) who have been married for 1 to 3 years were found to be majority followed by respondent of 18 to 24 years of age (33.3%). On the other hand, 18 to 24 years (70.8%) respondents were found to be highest among those who have been married for more than 4years to go for fertility treatment of self. This finding denotes that respondents who married at the later age immediately seek for medical treatment regarding fertility and it also supports George, & Kamath, (2010) where the number of older women approaching fertility clinics for treatment in is increasing with age a very important factor regard to fertility. A study of Ichikawa et al (2020) also noted that respondents' low quality of life was associated with sadness and despair due to infertility. Hence, Women continue to need more education and better reproductive counseling to allow them to make the best reproductive life plans.

With regard to the association of age with in laws reaction to childlessness, age of respondents has significance with in laws reaction to childlessness (X^2=9.42,p=.05). Respondents of 18 to 24 years (66.7%) were found to be majority to have received positive reaction from their in laws regarding their involuntary childlessness. At the same time, respondents of 18 to 24 years (83.3%) were also the majority to received negative reaction from their in laws followed by respondents above 35 years (16.7%). The findings revealed that young and newly married are vulnerable to involuntary childlessness where in laws still have hope for them to bear a child as they are still in the healthy reproductive age; thus their in laws reaction to their childlessness is positive. However, they are also vulnerable to negative reactions from their in laws regarding childlessness as childlessness itself is a negative connotation in society and inability to bear a child within a few years of marriage is often met with judgment. **George (2002), mentioned that** newly married women receives harassment from In-laws if a child is not born after 2 or 3 years of marriage telling her she has some fault in her.

Age at marriage is also found to be highly significant with fertility treatment of self (X^2=8.53,p=.01). Respondents who married before legal age (81.2%) were found to be more among those who have undergone 1 to 4 times of medical examination regarding fertility. Conversely, respondents who married at the age of 18 to 30 (4.8%) were found to be more among those have undergone medical examination regarding fertility for more than 5years. It can be assumed that the respondents who married at later age (18-30) were more frequent with medical examinations regarding fertility due to the fear of childlessness with the increase in age. In an attempt to initiate pregnancy and fertility treatment of self, the duration of current marriage has no significance. This finding supports Dommaraju (2012) who highlighted that when marriage age increases, fertility decline due to the reduced number of women at risk of childbearing. In addition, marriage age can lower fertility when marital fertility among women marrying late is lower than among those marrying at a younger age.

6.3.2 Perception on Reproductive Health and age group.

Inadequate knowledge and negative attitudes regarding reproductive health could be detrimental to one's sexual reproductive health and of their sexual partners. In this section, the association of respondents' age and their perceptions on reproductive health was probed in order to understand any differentials that exist among different age group.

Table 6.10 Association between Age of respondents with perception on reproductive health.

Statements	18-24	25-35	35 above	X^2	P
Contraception is against my religious beliefs	36 (24.5)	48 (32.7)	63 (42.9)	11.10	.004**
My partner and I freely discuss about family planning	37 (19.1)	80 (41.2)	77 (39.7)	.71	.69
I use birth control methods	10 (17.2)	17 (29.3)	31 (53.4)	7.46	.10
I am Pro-Life about Abortion	42 (21.8)	78 (40.4)	73 (37.8)	5.69	.58
I am Pro-Life about Abortion	4 (8.5)	18 (38.3)	25 (53.2)		

$P<0.05^{*}$; $P<0.01^{**}$ Source: Computed

Table 6.10 discusses the association between age with respondent's perception on reproductive health. The statement, "contraception is against my religious beliefs" is highly significant with the age group respondents. (X^2=11.1,p=.004). Respondents above 35years (42.9%) were found to be majority to perceived that use of contraception is against religious beliefs. A comparable result is found in Aimol & Shipra (2009) in which a larger number of respondents did not use contraceptives although the reasons for it varies such as the need for spousal consent, desire for particular sex of the child etc

6.3.3 Reproductive health awareness and age group

Reproductive health knowledge indicates individuals' awareness about safe sexual practices. The source of knowledge for a person may vary depending on the age group. Knowledge regarding fertility and reproduction related to aging is variable and differed by age (Deatsman, Vasilopoulos & Rhoton-Vlasak, 2016). Therefore, the following chapter discusses the association between respondents' level of awareness on reproductive health and their age group.

Table 6.11 Association between age of respondents and awareness regarding reproductive health

Statements	18-24	25-35	35 above	X^2	P
I am satisfied with my sex life	44 (19.6)	91 (40.4)	90 (40)	1.07	.58
I get sufficient knowledge regarding pregnancy	44 (19.9)	87 (39.4)	90 (40.7)	1.09	.57
Source of knowledge from friends	35 (24.1)	43 (29.7)	67 (46.2)	17.1	.000**
Source of knowledge from family	22 (14.5)	66 (43.4)	64 (42.1)	6.14	.04*
Source of knowledge from education	27 (15.3)	73 (41.5)	76 (43.2)	6.29	.04*
Source of knowledge from social media	14 (16.1)	43 (49.4)	30 (34.5)	5.05	.08
I am alert regarding my menstrual cycle	20 (14.4)	52 (37.4)	67(48.2)	8.88	.012
I know how to calculate my fertile period	30 (24.4)	43 (35)	50 (40.7)	5.19	.07

$P<0.05^{*}$; $P<0.01^{**}$ Source: Computed

Table 6.11 discusses the association between the age of respondents with reproductive health. In this study, reproductive health is measured with regard to satisfaction with sex life, sufficient knowledge regarding pregnancy and menstrual cycle, calculation of fertile period and young married women's knowledge of reproductive health from friends, family and social media. It was found that learning about reproductive health from friends is highly significant with age group (X^2=17.1, p=000). Age group of young married women is significant with learning about reproductive health from family (X^2=6.14,p=04) and through education (X^2=6.29,p=04). The present finding corroborates Aimol & Shipra (2009) where almost all the respondents in their study were aware of at least one or more of the contraceptives.

6.3.4 Association of socio demographic profile with respondent's reproductive awareness.

Reproductive health knowledge is important in the development of young people especially young women. The following table examines the association of respondents' age, education and employment status with level of reproductive awareness. The amount and level of sexual and reproductive can be predicted to have an impact on respondents' sexual quality of life.

Table 6.12 Association of reproductive awareness with socio demographic status.

Socio-demographic Details	Age	Education	Reproductive awareness
Age	1	-.199**	-.136*
Education	-.199**	1	-.081
Reproductive awareness	-.136*	-.081	1

P<0.05*; P<0.01**   Source: Computed

Table 6.12 shows that age is negatively correlated with reproductive awareness. Education also has negative association with age and reproductive awareness. This finding is in contrast with **Al Riyami et al., (2004)** which highlighted that education empowers women to learn about fertility and access health care system. Furthermore, reproductive awareness of young married women is negatively associated with age. This finding is in contrast to Deatsman, Vasilopoulos, & Rhoton-Vlasak (2016) where age was found to be significant with awareness on reproductive health issues.

6.4 Financial Domain

Financial domain is used to get meaningful information about the use and management of monetary funds or resources. The present section attempts to compare the financial wellness specifically respondents' employment and financial satisfaction and QOL.

6.4.1 QOL & Employment Status of Respondents

Employment status enhances a person's wellbeing as it provides financial income. It also provides a person with nonfinancial gains such as social identity,

social support and network. Employment of a person delivers a sense of achievement (Bouwmans, de Sonneville, Mulder & Hakkaart, 2015) and it can be said to improve a person's QOL. The present sub section compares the various dimension of QOL with employment status of the respondents.

Table 6.13 Comparison of different domains of QOL with employment status

Domains	Level of Satisfaction	Employment		X^2	P
		Dependent	Earner		
Personal	*Moderate*	91 (56.2)	71(43.8)	.001	.972
	High	44 (56.4)	34 (43.6)		
Psychological	*Moderate*	123 (54.7)	102 (45.3)	3.667	.055
	High	12 (80)	3 (20)		
Health	*Moderate*	126 (56)	99 (44)	.091	.762
	High	9 (60)	6 (40)		
Social	*Moderate*	106 (52)	98 (48)	10.16	.001
	High	29 (80.6)	7 (19.4)		
Financial (Dependent)	*Moderate*	64(97)	2 (3)	61.33	.000**
	High	71 (40.8)	103 (59.2)		
Financial (Earner)	*Moderate*	3 (3.20	91 (6.8)	176.76	.000**
	High	132 (90.40	14 (9.6)		

P<0.05*; P<0.01** Source: Computed

Being at workplace and at home brings a no of challenges for women which in turn influence the quality of life of women (Ahmad & Khan, 2018). Table 6.13 discusses the association between different domains with employment status. Level of satisfaction in financial domain of dependents (X^2= 61.33, p=.000**) as well as earners (X^2=176.76, p=.000**) is highly significantly co-related to their employment status. Previous study conducted by Ahmad & Khan (2018) found no difference between dependent and earning respondents health dimension while both differs on the psychological, social and environmental aspect of QOL.

This chapter discussed the various domains of quality of life of young married women. It assessed the relationships of different structural bases with various determinants of quality of life including perceptions on self, relationships with in-laws, awareness and perceptions related to reproductive health and perceptions on married life. The different structural bases are also compared with

various dimensions of quality of life. The next chapter discusses the diverse experiences of young married women in which the status of *Mo* in Mizo society is narrated from the lived experiences of the respondents.

Chapter VII

LIVED EXPERIENCES OF '*MO*' IN MIZO SOCIETY

The previous chapter was a discussion on the quality of life of young married women and its determinants. It presented the way in which quality of life of the respondents are influenced on various levels. The present chapter attempts to highlight the dynamic experiences of young married women in Mizo society. The vibrant experiences of the respondents are brought to live from the lived experiences of *Mo* in Aizawl. The condition and perceptions of young married women residing in nuclear and extended families have been described in qualitative form. Case interviews have been conducted among six young married women in Aizawl to represent their quality of life measured from various dimensions including financial, personal, social, sexual aspects and also their relationships with spouse, in-laws.

7.1 Case Studies of Young Married Women in Aizawl

Case study is an intensive investigation about a person or unit. It is a form of qualitative descriptive research that is used to analyse a single individual, group of people or some other unit. Case study helps the researcher in examining and exploring the nature of problem of the subject being studied. It illustrates the information about a particular participant and it denotes the gathering and presentation of the detail aspects.

The current study selectively presents six (6) distinctive cases which would represent the differential experiences of young married women's quality of life and they are presented in the form of first person narratives.

Case 1: A relentless Daughter-in-law

I am Joyce, 34 years of age and I got married to a Doctor in 2015 when I was 29 years of age. We have 2 sons now and my Mother-in-law lives with us. I am currently pursuing a professional training course and taking care of my husband and kids, my hands are full. To add to this, I have been facing a lot of challenges especially in dealing with my mother in law. Though we married for love, my husband and I cannot spend quality time together since our children came into our lives yet understanding and patience for each other grows stronger each day.

Going out to places/mobility in my marital home, I often skip going out unless it is extremely important. Life after marriage has taken a different turn and responsibilities at home coincide with my personal needs and wants. Before I got married, I enjoyed my life to the extent that I could leave the house and come back any time of the day to my own home. Now, as a responsible mother, I have to give priority to my husband and children. At the same time, as a daughter in law/*Mo* residing in a joint family, there is a sense of apprehension as to what my mother-in-law will think of me especially since I have been verbally abused by her on many occasions. My mother-in-law is a frank and straightforward person and therefore her words are often harsh and hurtful in moments of anger.

In terms of health care, often non-resident in-laws and relatives often try to influence my health care decisions. However, I avoid those manipulations and make decisions by myself with the consent of my husband as it affects him and my children indirectly. I am not the kind of person who would go to lengths to please anyone including my mother-in-law, and this sometimes creates problems and disagreement in my marital home. If my in-laws talk and behave hypocritically, I cannot simply conform and submit myself to their wiles. Many a times, I express my thoughts openly which far from impresses my in-laws.

I have been mentally and emotionally abused by my mother-in-law since the initial stages of my marriage and having been married for 5years now and I am now able to cope better in such situations especially when she uses the silent treatment to taunt me. I tell myself that this is a challenge and I shall not be anyone’s scapegoat; I will talk to them even when they may not feel like communicating with me. I have learnt how to use a normal and calm tone of voice which irritates them even more which makes me feel like a winner. On the other hand, my mother-in-law is not a bad person but neighbours and relatives from all corners often apprise her on how to take care of daughters-in-law which often is the source of conflict between the two of us. Other than the unnecessary involvement of outsiders, my mother-in-law is a caring person and she even washed my inner garments when I was ill with reproductive health problems.

My living place is satisfactory and I have learnt to consider the misunderstandings that often arise as normal. Though I have no income of my own and currently studying, my husband provides all my financially needs and wants. Nevertheless, I place family above everything and wish to put God first to improve

my overall life. I feel that patriarchal society expects its women to conform to traditional social norms and being a married woman in Mizo society is not a highly regarded status especially if they remain in their marital home. The do's and don'ts set up by the system often limits the freedom of Mizo women. However, I have experienced a huge attitudinal change after marriage as daily experiences of being married bestow wisdom and courage and being married has presented many positive changes in my life particularly emotional growth and prosperity. I enjoy being a young mother and a wife as it gives me a sense of fulfilment and particularly, having a husband provides me with emotional security knowing someone will always be there for me on my worst days.

Case Analysis: The above case is that of a non-working married woman who deals with the pressures of being a mother, house wife and daughter-in-law while also pursuing further education. She has developed her own strategies of coping with a verbally and emotionally abusive mother-in-law, relentlessly standing up for what is right and has learnt how to defy and overcome the stigma of being a *Mo* in a patriarchal society. The case also illustrates how non-resident in-laws and relatives often have a say in her health care matters. It also portrays the lack of freedom that *Mos* have with regard to their personal life as can be seen with Ms. Joyce who seems to be able to stand up for herself yet feels the pressure of her in-laws presence and opinions. However, she is still able to find goodness in her mother-in-law even though she has not treated her kindly. This goes to show how women persevere in a society that has afforded her gender a low status.

Case 2:The *InpuiNghaktu'*s wife

My name is Sativa (fictitious) and I got married at the age of 30years to a man who is the youngest of his siblings and is the *'Inpuinghaktu'* which means that I have to stay in my marital home since Mizo culture dictates that the youngest son has to take care of his parents and cannot leave his parents' house. My husband and I are both employed in the government sector and provide the majority of the household needs although the other members in the family have their own income too. I am 36 years of age now and we have been married for 6 years but are still childless. We have undertaken various fertility treatments but to no avail.

I cannot enjoy enough quality time with my husband as he spends a larger part of his free time for home projects and attaining personal goals etc., yet my husband remains the only source of support when in conflict with other family members in my marital home. Whenever I go out apart from work, I worry about the home. I am filled with thoughts like; will the in-laws be displeased with me when I return? Will I be late for cooking? Will they not be mollified with my reason for going out? Conflict often arises over the matter of visiting friends and family. Though my husband may consent to it, my mother-in-law responds curtly and shows negative facial gestures or gives me the silent treatment when I visit my family. It seems that my in-laws especially my mother in law is afraid that no one will be there to cook or do other household chores. They expect me to carry the responsibility of taking care of the family including provision and seeing to the needs of each member of the family. Before I enter into this marital home, all the household chores and cooking were taken care of by the mother (husband's wife), and now that I'm here, my mother-in-law expects me to do all these. She also verbally and psychologically abuses me mostly when I buy new clothes and other things.

Being a married woman and daughter in law in a joint family, the support of my husband and mother in law is very much essential in my health care decision-making even when it solely concerns my health needs. I am given authority to make decisions in many aspects of life yet prior discussion of the matter and support from my husband and in-laws especially my mother-in-law is essential to avoid conflict and misunderstanding in an extended family like mine. No matter the employment status, amount of income, level of education or family background, daughters in law especially in the extended family remain under pressure. Freedom is a far-fetched cry as we all work hard to please our in-laws. For instance, although I have a government job and sufficient income, my dream is to pursue higher education and improve my quality of life. I believe that health and spiritual satisfaction are most important in life and as someone who is not very healthy and unable to conceive even after 6 years of marriage; dependent on medication to function normally every day, I believe that if I were healthier, my life would improve drastically.

I try to embrace whatever life has to offer and we joke and make fun of each other in the family but my brother in law is very cynical and verbally abuses me. If I joke with him, he would get angry though I have no explanation for his negative

attitude & behaviour towards me. He has a personality that everyone appreciates except his family members because he acts weird at home. To my understanding, his verbally abusive behaviour would change if were to be submissive and not defend my rights in times of conflict. I feel that married women living in a joint family are more likely to develop psychological problems especially if such women do not have employment outside the home. People of different backgrounds with a diverse set of values live together in a joint family which makes it difficult to comprehend each other. A *Mo* enters her marital home with hopes of a new life along with the anxiety of adapting to a new environment, new people and new relationships. The fear of making mistakes and of not pleasing the in laws is a huge source of anxiety for a *Mo* in an extended family. The situation can be worsened if women do not receive emotional support from her husband.

On the bright side, my husband and in-laws are not prejudiced towards my childlessness though I myself am growing more insecure and frustrated over this matter. If only I could conceive, it would be the first grandchild in my husband's bloodline and it would make me feel complete as a woman. The thought of not having a child and seeing my in-laws playing with the neighbours' children stirs my anxiety for which I need professional care and medical treatment. I must mention that my in-laws are extremely supportive regarding access to medical care in an attempt to initiate a pregnancy. It is the emotional and spiritual support that makes me wish for a child even more. However, not everyone in society is negative about childlessness. Some people care and empathize with my situation. At the same time, some people pass sarcastic comments such as, "Maybe you and your husband are not meant to meet! "or "If you do not know how to conceive, let me teach you". Mizo society is a small community where on a few occasions; I have come across hurtful people who referred to me as, 'infertile'/*Ching*. When it comes to being a childless married woman, there are certain things you cannot forget because sometimes, the truth hurts. All the same, Mizo society shows respect to married women because as compared to my unmarried days when men casually teased me, there is more honour for married women although this somehow depends on the kind of person one is married to. Therefore, women need to choose wisely when and whom to marry as it narrates the rest of women's life.

Case Analysis: Sativa's case is that of a young married woman who has to deal with the pain of being childless and infertile by society especially while being the wife of the *InpuiNghaktu*. She has to deal with the anxiety of having a full time job whilst catering to the demands of being a *Mo* in a joint family system. Even though she contributes to the household income, she has no say in household matters and requires the consent of her husband and in-laws. Having health issues and being childless has decreased her self-worth while she also has to endure abuse and differential treatment from different members of the household. The case also reveals how Mizo society judges and labels women depending on whether she is married or not, to what type of person, whether she can bear children and whether she conforms to her in-laws or not, but never on who she is as a person.

Case 3: The employed *Mo*

My name is Alice (fictitious) and I am 36 years of age. I got married to my husband 6 years ago and we are both government servants who both have a busy schedule. We started out as a nuclear family which is my ideal married life but due to some family matters, we returned to his parents' house last year. Apart from our work schedule, this is one of the reasons that my husband and I are not able to spend quality time together. Due to the lack of privacy and not wanting to create any issues, I can no longer ask my husband out for lunch or dinner; or outings and other social events. We do not have children so another factor that has reduced time together is engagement in social media and online entertainment during leisure time.

I can share my secrets and everyday life happenings with my husband and he supports me unless I am wrong in my perspective or actions. But when it comes to discussing matters related to his parents and my relationship to them as in-laws, my husband often hesitates to deal with the issue which is often the bone of contention between the two of us. As far as health care is a concerned, I have minor illnesses which I do not inform my in-laws about because it doesn't feel good for a woman to be unhealthy in her marital home as they will treat me differently. Another reason is because there was an incident where I had gone for physiotherapy for 10 consecutive days but her in-laws did not show any concern or even casually enquire the matter and since then, I only inform my husband regarding my health care. The matter of

visiting friends and family becomes a long process where I first ask my husband’s permission and with his consent, I then ask permission from my in-laws.

Psychological and verbal abuse mainly comes from my mother in law though my Father in law has abused me verbally as well. I am not a submissive person and not a people pleaser while her mother-in-law is bossy and a person who likes to have followers who will do her bidding; the clash in our personalities is the cause that contributes to my being psychologically and verbally abused by my mother-in-law. I also think that my mother-in-law is not happy with my employment. I remained unemployed until the 3rd year of our marriage where I was a mere housewife, playing the role of the domestic worker to the extent of making the bed for all my in-laws, not excluding my husband's siblings. Now that I have am employed especially since it is a government job, I feel that it has enhanced my well-being and added to my value in the marital home; but which is another reason my mother-in-law further abuses me as she wants me to remain unemployed and powerless at home.

I do not enjoy married life and sometimes even regret being married purely due to my in-laws as there is no privacy and freedom in my marital home. There is always an emotional unease and fear of judgment. I also feel my life is incomplete without a child of my own and having a child would give me a sense of achievement and happiness in my married life. I also think that staying away from my in-laws to avoid unnecessary drama would calm and rest me mentally and emotionally. My mother-in-law often spreads false rumours about me in the neighbourhood and she assumes that I brainwash and manipulate my husband in every matter. My main coping strategy is spiritual maintenance and discussing problems with my friends. Good friends who are my contemporary and older ones provide constant emotional support especially in times of a mental and emotional breakdown. I believe that a *Mo* is highly at risk of developing depressive symptoms especially if they are unemployed. A higher level of education and employment has definitely saved me from worse treatment in the hands of the extended family. Such problems would be lesser and more bearable with a better and stronger family administration for which parents are the foundation. I often face confrontations and negative attitudes from my in-laws regarding my childlessness while my husband positively handles our childlessness. My mother-in-law and father-in-law often make peevish criticisms regarding my childlessness and acquaintances even make me feel guilty and blame my reproductive health for our childlessness.

Women in Mizo society are not given a high status and a *Mo* is even less valued and less regarded where the traditional mind-set is that a Mo has to be a housewife and do all the necessary household chores and submit to all the needs of her husband's family. The expectation of a *Mo* to remain unemployed, whether she stays in her marital house or in a nuclear family, still prevails according to my perception. Eve teasing including married women has not been eliminated whereby random men dare to pass comments such as "You're a married woman; but you still look so hot" and so on.

Case Analysis: The expectations of Mothers-in-law with regard to their daughters-in-law is universally complex and this case shows how one young woman deals with her emotional and mental health issues under a controlling and judgmental mother-in-law, besides having health problems and being childless. Many women till today have to be the submissive *Mo* whose employment is frowned upon and may never pass the test even if she serves her in-laws like a housemaid. Education and employment of women are empowering to women as can be seen from the mother-in-law who has lost a certain amount of control over her Mo due to her employment. Her behaviour and actions are constantly monitored and she has to try and find herself amidst a lost identity in her marital house. It also shows how men will wash their hands off the *saas-bahu* relationship while still trying to please and support both.

Case 4: A supportive husband

My name is Jovian (fictitious) and I come from a small village in Champhai district and got married to a resident of Aizawl at the age of 31 years. We were pressurized into marriage by family, friends and acquaintances as we had been courting for 8 years on the pretext that it is shameful in our society to be courting for too long, especially for girls. I think that 31 years of age is still quite early for marriage in modern times but social pressure was the main reason. I had a job of my own while my husband was out of the city due to work. I lived with my In-laws and submitted a part of my income to them and since I mainly cooked, I provided the majority of the groceries and kitchen needs. Since my husband was mostly away from home, he often requested his siblings and parents to take care of me while I was

pregnant. This was interpreted as me manipulating my husband assuming that I had reported them to my husband. The problem increased when my centrally sponsored employment was terminated and the brother-in-law whom I supplied daily pocket money started calling me *Chawmhlawm*/someone's dependent and I realized that my in-laws were "kinder and gentler" while I had an income and even nicer when my husband and I were still courting. I also experienced psychological and verbal abuse from my mother-in-law particularly around the time I gave birth and was breastfeeding. My in-laws criticized every action I took for my new born, and when the baby fell ill, my mother-in-law would go to the length of saying that my breast milk must be of poor quality and the baby's health has adverse reactions to it. This was a horrible insult for a lactating mother.

Eventually, my husband was transferred to Aizawl but to my surprise, it did not make the situation any better. My husband and I took all precautions in taking care of our child and my brother-in-law's careless smoking around the house what with wanting to protect our baby from second-hand smoke and issues like these, often aroused conflict in the family. My other in-laws always sided with my brother-in-law who when drunk, often initiated physical fights with my husband who is his older brother. Other families would not scold the one at fault but instead reprimanded my husband not to create a scene at home. For every issue, my in-laws presumed that I influence and manipulate my husband which is why he was not taking their side. After many incidents of psychological fights and abuse, we were expelled from the extended family and started to form a nuclear family of our own. The moving out came as a huge relief for me as conflict is better resolved in a nuclear family. I received enormous support from my husband in all aspects of life and married life became more fulfilling and peaceful without any physical or mental abuse. My husband helps me with household chores and we often enjoy family outings. In my nuclear family, I also receive material support from my biological family. As a person far away from my native place, I do not have many friends to share my problems and life events with, so for everything, I go to my husband for security and support. I prefer to tell him all my problems rather than to friends.

After many years of moving out, I started receiving attention and phone calls from my in-laws but only through my husband or on his phone. My mother-in-law was also mistreated by her own MIL and is doing the same to me. She would often proclaim at home that her other sons (husband's siblings) would marry a rich girl

who would be able to financially support them. As a small-town girl and not from an affluent family, this may be one reason why my mother-in-law is so against me. A single income in the family sometimes triggers marital conflict but having experienced conflict in the joint family, I believe that a couple who support each other through thick and thin is the base of a happy family. As a married woman in the nuclear family, I also experience the unnecessary instructions and involvement of the neighbours in how I take care of my family. This social intrusion into family matters and unnecessary drama are the reasons why I do not socialize much.

While I am happy with the help and support I receive from my husband, I sometimes observe that many Mizo men still distinguish the work of men and women. I am strongly against the traditional beliefs of Mizo society where a wife can be expelled any time in her married life. In a patriarchal society, women often bear the pain and disappointments as it has already become the part and parcel of our culture for women to endure pain silently.

Case Analysis: Jovian's case depicts the value of a Mo solely on her income earning power and the differential treatment of Mo in Mizo society. She is assumed to be a bad influence on her husband and his life choices and is labelled and emotionally and verbally mistreated by her in-laws. It is only when the husband takes a stand for his wife and supports her, that marital life can be peaceful as can be seen above. Jovian has been able to cope under pressure mainly because of a supportive husband. The daughter-in-law or Mo will always be the outsider and is insulted by in-laws at every opportunity they find. The case clearly portrays how Mizo society accords very little privacy and often interferes into another person's life, marriage, child-rearing and family affairs. At the same time, a woman who has faced mistreatment and abuse as a *Mo* seems to have displaced her frustrations and pain on to her own daughter-in-law.

Case 5: The good mother-in-law and the wise *Mo*

My name is Nicole (fictitious) and I am 32 years of age. I got married 3 years ago and I live with my husband and we are expecting our first child. I have a job and support our family as my husband is unemployed. We enjoy quality time together but my husband is outgoing and likes to socialize which lessens our time together. Being the sole bread earner, I received certain amount of respect from my husband and in-

laws. For a very long period, my in-laws expected me to submit some of my monthly income to them. Even my husband's siblings and cousins come to me for their wants while my own siblings never approached me this way. Married women/daughters in law need to set clear-cut boundaries in such matters since they are vulnerable of being stepped over or bullied. Now whenever they ask me for my hard-earned money, I do not just slip it away instead I make them borrow it.

For me, I had a lot of freedom even when I was living with my in-laws. The status of daughters in law is hugely determined by their mother-in-law’s management, and I met a good one so my status as a *‘Mo’* is comparatively better than many married women. Having said this, there is still the fact that as a daughter in law, I have to bear in mind that I am not of their own blood and there are many hesitations and sanctions that I have to deal with in my marital home. Marriage comes with a large number of responsibilities thus being married has enhanced my emotional maturity and well-being. In my experience, marriage becomes challenging and exciting when we can settle as separate family unit. I enjoy living in a nuclear family away from control by her in-laws and anything that could contribute to problems. My husband was into alcohol consumption for a month during my pregnancy due to which I was very stressed and had panic attacks every day during that period. However, I had good friends to provide emotional support but I always run to my mother-in-law when I face problems with my husband. Besides the support from friends, a supportive and understanding mother-in-law with a broad outlook makes my married life so much more pleasant. It is on such days that I miss my biological mother who passed away 2years ago.

Spiritual nurturing is important as our daily habit of praying together as a couple has helped us in overcoming numerous problems in life. I also highly values women's education since women are very influential in the family upbringing. Educated women can better acknowledge the importance of family relationships, healthy lifestyles, and the like. Higher learning and education of women is one way of earning respect, whether in the nuclear family or joint family. I believe that respect for one another is a key in any relationship. Although my husband is financially dependent on me, i treat him with respect and I believe that is the reason I am respected in society. From my experience, I believe that society attributes more respect to married women. The only disadvantage I face is that of being a working

mother. Household care beyond office working hours seems a little heavy for a pregnant woman like me and I hardly find time for self-care.

Case Analysis: Nicole finds fulfillment and respect through her marriage and is able to cope with life situations through a daily life of prayer. She is the bread-earner of the family while her husband is unemployed which in itself could cause struggle in marital life. Though she has had her share of marital conflict causing her anxiety to worsen, she finds comfort in her mother-in-law who is supportive of her. This could also be a clever coping strategy for a *Mo* in running to her in-laws in case of a marital conflict and making them her allies instead of fighting her husband and his family.

Case 6: The *Mo* in an extended family

My name is Elis (fictitious) and I am from Aizawl but got married to someone from Serchhip district. As my husband's work is in Aizawl, we settled with his elder brother's family who have two children. I got married at the age of 29 and we now have two children. Before I got married, I helped with my mother's business. After being married, having children, being a housewife and living in an extended family, everything is the exact opposite from my life before marriage. In terms of freedom and liberty, although I am not restricted in doing so, I rarely go out unless it is extremely important as I give importance to my children. Although my husband is very supportive, minor issues arise in an extended family like ours and even if my in-laws are nice to me, there is limited personal and emotional liberty for a *Mo*. People with different mindsets and different upbringing living under one roof is not something easy to deal with. Having to deal with such diversity on a daily basis brings me anxiety.

In a society where men are the head, a healthy family is formed if the heads are wise and understanding of the environment. As a woman, I experienced more emotional growth and maturity post marriage. Speaking on behalf of married women, I believe that being married allows us to learn perseverance, patience, and confidence. Growth in every angle is achieved especially learning the values of mothers in the family. Given my experience, sometimes the situation itself does not allow me to claim my rights being a housewife who does not contribute to the

household income family worsens her status in the family. I normally share my secrets and problems with my biological mother and husband. I eventually lost contact with friends after I got married as my family became my priority due to which I have no friends to discuss my life events with or run to during an emotional breakdown. At such times, the only coping technique I use is prayer since spiritual nourishment is the essence to a peaceful life.

Case Analysis: This case is of a young mother's issues on coping with the pressures of living in a joint family system with no monetary or decision making power. Elis has to cope with being the younger *Mo* and has no privacy but in her obligatory roles as wife, mother, housewife and *Mo*, she has learnt how to persevere and be strong for her children.

7.2 Analyses of the Cases

On becoming a married woman, the societal demands and pressure to be 'good brides' especially of the extended families to exhibit positive attitude and behaviors is burdensome and denotes the status of women in the society. Unlike common assumptions of mother-in-law and daughter-in-law conflicts, the cases reveal that not only a good relationship with the mother-in-law is crucial, but all the other members in the extended family also play a huge role in the family environment and in the marital relationship.

As is evident in the cases, besides the psychological and verbal abuse from their mothers-in-law, many daughters-in-law suffer abuse in various forms at the hands of their brother-in-law and father-in-law while the cases do not reveal any form of violence from any other members in the extended family. The cases also illustrate the lives of non-working married women who had to deal with the pressures of being a mother, housewife, student and daughter-in-law; and how young married women have developed their own strategies of coping with various forms of abuse from their in-laws. It also shows how non-resident in-laws and relatives often have a say in personal matters and the lack of freedom that *Mos* have with regard to their personal life.

A sense of immense pride and advantage among educated women was observed in the cases, as they perceived that education enhanced their ability to

function more effectively in practical terms than uneducated women. The sense of pride is even higher among working/employed women as they strongly perceive that their monetary contribution in the family added their values and worth, while they also believe that housewives have a greater chance of developing psychological problems especially housewives in extended families(Al Riyami, Afifi & Mabry, 2004). The case findings corroborates Rammohan & Johar (2009) where working mothers are more likely to enjoy higher level of autonomy than stay at home mothers; and labor force participation and higher educational attainment have positive effects on married women's autonomy.

A young mother's issues on facing the pressures of living in a joint family system with no monetary or decision making power is portrayed in one of the cases. It depicts the value of a *Mo* solely on her income earning power and the differential treatment of *Mo* in an extended family. Women who have faced mistreatment and abuse as a *Mo* themselves seem to displace their frustrations and pain on to their own daughters-in-law while the in the other case, a young married woman finds comfort in her mother-in-law who is supportive of her.

A gradual change in the amount of available leisure time post marriage is also evident in the study which is similar to a finding of Dumas & Jette (2014). Women devoted their time and prioritized the family economic stability, family needs and problems. However, the current study illustrates that many young *Mo*s continue to maintain a close relationship with their biological family particularly their biological mother.

A significant difference is observed among the women in nuclear and extended families in which women in nuclear families maintain frequent communication with their mothers-in-law while women in extended families maintain relationship with their biological mothers. Such social networks and relationships are maintained by these women to gain emotional support rather than economic ones. Although women themselves make the final decision in their reproductive health care, women in the extended family have to seek the opinion of their in-laws, especially mothers-in-law while women in nuclear families do not necessarily consult their in-laws as far as health care is a concerned.

Daughters in law in extended families reported that neighbours and relatives often prompt mothers-in-law into mishandle their daughters-in-law which often is the source of conflict between the two in extended families. Married women in the

nuclear family also experience the unnecessary involvement of the neighbours in the family administration but are otherwise free from their in-laws' direct judgments. Such case findings portray a Mizo culture where an outsider leaves no privacy and often interferes with another person's life, marriage, child-rearing, and family affairs.

This chapter described the lived experiences of *Mo* residing in the marital home and extended families. It described the differentials that exist in both the residence. The conditions of young married mothers have been probed and it can be seen that there is an enormous difference in the perceptions between *Mo* in the marital home and extended home. The next chapter integrates and summarizes the findings of the study and presents suggestions on further need for research and intervention.

CHAPTER VIII
CONCLUSION

The study aims at exploring the quality of life of young married women in Aizawl by probing into the perceptions and experiences of young married women. The previous seven chapters highlighted the qualitative and quantitative data analysis while this chapter attempts to highlight the summary of the previous seven chapters.

8.1 Integrated Discussion of Findings

This chapter summarizes the result by presenting it into different sections. The first section attempts to emphasize the profile of the respondents where the socio-economic details, religious practices, and family structure are presented. The second section discusses the relationship particulars of the respondents. The third section deals with the perceptions and experiences of young married women in various life domains. Women's experiences on childlessness are discussed in the fourth section while the fifth section presented the qualitative data where the case studies are summarized.

8.1.1 Socio-economic details

The socio-economic status represents the respondent's privilege and inequities to education, income, and occupation. In this study, a larger number of respondents have completed High school level of education and respondents having completed high school are found to be the highest for 35 years above and 25 to 35 years similarly. A very few respondents studied only up to the Primary level of education and the maximum respondents were found in the 35years above age group. The maximum Postgraduate respondents were found in the 25 to 35 age group while graduates are also found to be the highest in the 25 to 35 age group. Even though no illiterate respondents were found in the study, Aimol & Shipra (2009) corroborates the present study in which the level of education was meager. Early marriage, financial constraint for further studies may act as the main challenges for women to continue higher education. This could be interpreted in the context where female education is on the rise with the development of the nation. The findings also highlight the increasing female education rate as compared to the previous years.

In terms of level of education, a huge diversity is observed among the poor and non-poor respondents. It appears that non-poor respondents are able to access Higher education while poor and very poor households are unable to achieve the same. Among the non-poor respondents, a larger number have completed high school level of education and only 0.4% is with primary level of education. While a fourth of non-poor respondents are graduates, it is only 0.4% for poor respondents. The study found no postgraduate respondents among the BPL while 9.2% of non-poor accounts for the same.

In the current study, dependent respondents are more than earning respondents in number. More than half of the respondents are found to be financially dependent on their husbands and family. Respondents in the 18 to 24 age group have a greater number of dependents than earners while the study also found a greater number of dependents in the 35 years above category. Previous study made by Chattopadhyay & Guruswamy (2011) also observed that urban poverty is less. These particulars suggest that women who marry at an early age remain unemployed or dependent which is similar to a study of Axelrad, Malul & Luski (2018) where the rate of those who are employed declines with age among women. As is evident in the educational level of respondents, women who married in their earlier years remain unemployed as a result of a lower level of education. The 25 to 35 age group comprises the largest group of earning respondents which indicates the positive outcome of education on employment status.

8.1.2 Structural bases

As Christianity is the dominant religion in Mizoram, a vast majority (99.6%) of respondents is Christian. This findings contrast Lianhmingthangi (2014) where the entire women respondents in Aizawl belongs to the Christian. The current study found only one respondent in the 18 to 24 age category belongs to the 'Others' category. Various denominations exist in the Christian community in Mizoram and that more than half of the respondents in this study belong to the Presbyterian denomination. This is apparent even in other studies where Presbyterians are majority in Aizawl (Zaitinvawra, 2012; Sailo, 2014). There are various small local churches in Mizoram and they have been categorized as *any other* for the current study. Apart from respondents belonging to others category, Roman Catholic respondents are found to be the least in the present study.

The economic characteristic of respondents shows that the majority composes of non-poor households and is highest in the 25 to 35 age group. It appears that employment as a result of education reduces poverty among the respondents. While most of those belonging to the BPL category are found in the 35 above group the least are found in the 25-35 group. The finding also corroborates the previous findings which discussed the outcome of a lower level of education on employment status and poverty.

Family structure describes family formation which is one important support system in the social functioning of the respondents. The present study categorized the type of family into a Nuclear and Joint family. It was found that nuclear families comprised a larger number of respondents where respondents above the 35age category are found largest. While a third still does live in joint families, the age group of 25 to 35 years is found to be greatest in this type of family which indicates that young married women continue to live in such a family to a certain period. Jyothirmayee (2018) also perceived that the dissolution of joint families has made nuclear families increasingly common in Indian society.

Regarding the form of family, it has been categorized into Stable, Broken, and reconstituted families. A large majority enjoy a stable family life which was followed by reconstituted families and broken families. Most of the respondents living in a stable family are in the age group of 35 above followed by 25-35 years and 18-24 years. It appears that the age group has significant relations with family stability. While broken families are largely composed by the age group of 25-35 years, those belonging to reconstituted families are also highest among the 25-35 age group.

Family strength denotes the number of families living together in the same household. The current study categorized family sixe into the small and large-families which have less than 5 members are considered small and those having more than 5 members are considered a large family. Respondents above 35years constitute the majority of those belonging to large families, followed by the 25-35 age group and 18-24 age group. A similar pattern is found in NFHS-3 which highlighted the average size of household in India which is 4.8. This contributes to the assumption that with an increase in the age of respondents, the family size increases.

Currently, the legal age of marriage for women prescribed by Indian law is 18years. As regards age, a little more than a fourth in this study is found to be married before the legal age. Respondents in the age group of 18 to 24 years are found to be the highest in this group. While the majority of respondents married at the age of 18 to 30 years, less than a tenth of respondents married after 30years. Those married when they were 18-30 years of age and marriage after the age of 30 years is highest among respondents who are currently 35 above years of age. The findings of Aimol and Shipra, (2009) in which the mean age at marriage was 17.53 years clash with the current study.

The type of marriage found in the study depicts the marriage trends in a Mizo culture where a vast majority of respondents reported having a love marriage while almost a tenth had an arranged marriage. The respondents having reported love marriage is highest among 25 to 35 age group category followed by those above 35 years and 18-24 years. A similar pattern is found for arranged marriage where the age group of 25 to 35 years is the highest to report having an arranged marriage followed by those above 35 years and 18-24 years. The trend seen in the study can be acknowledged as the freedom of women in Mizo society in choosing their partners thus most marriages happened to be a love marriage which contrast Soy & Sahoo (2017) in which only 5% of women have chosen their husbands independently.

Findings revealed that the maximum respondents have 1 to 2 children. Almost a sixth (15.4%) of the respondents are childless and childlessness is mostly found among the age group of 25 to 35 years followed by 35years above. Surprisingly, 1.3% of respondents aged between 18 to 24 years are also found to have no children. Among those aged 18-24 years, the majority of them have 1-2 children followed by more than 5 children. The fact that 2.5% of respondents in the 18 to 24 years category have more than 5 children illustrates the early marriage of those respondents. Among the age group of 25-35 years and 35 years above respondents, the largest number of respondents have 1-2 children. This finding supports OECD (2011) in which it was observed over half of households in majority of the countries do not comprise children. Even households with children predominantly contain only one or two children.

Regarding the duration of the marriage, for the purpose of this study it has been grouped into 4 types, viz., those having been married for 1-2 years, 3-5 years, 6-9 years, and those married for more than 10 years. The maximum number of

respondents is currently married for 3 to 5 years followed by 29.6% of respondents who have been married for more than 10years. The study surprisingly found respondents having been married for more than 10 years in the 18-24 age group. Among the respondents aged 18-24 years, a tenth has been staying in a marital relationship for 1-2 years and 5.4% have been married for 3-5 years while 2.9% have 6-9 years of marriage. Among the 25-35 years group, more than a fifth have been married for 3-5 years, 7.5% have been married for 1-2 years, 5.4% for 6-9 years; and 5% for more than 10 years. Among respondents aged 35 above, almost a fourth have been married for more than 10 years and almost a tenth have stayed married for 6-9 years.

8.1.3 Determinants of Quality of life of Young Married Women

In this study, the respondent's relationship pattern with spouse was probed in order to identify the quality of relationship in marriage. It was seen that a vast majority of respondents enjoy quality time with their spouse and respondents of the above 35 years category are found to be having more quality time with their husbands as compared to 18 to 25 years and 25 to 35 years respondents. On the contrary, among little more than tenth respondents who reported not having enough quality time with their husbands, 25 to 35 years of respondents are the largest group followed by 35years above and 18 to 25 years. Kingston & Nock (1987) agreed that there is a theoretically predictable relationship between marital quality and time couples spend together and observed that time together is substantially reduced by the number of hours couples work (combined) and how they schedule these hours. This pattern shows the elevation of quality relationships with the increasing years of marriage.

Listening without being judgmental provides emotional support in relationships. As it enhances one's sense of efficiency and quality of life, a pattern on the relationship on listening was enquired where a large majority of respondents stated that their husbands are willing to listen to their problems. More respondents above 35years of age had husbands who listened to their problems without being judgmental. Less than tenth respondents reported not having a spouse who listens to their problems among which 25 to 35 years respondents are the largest group to report this. This pattern corroborates the previous finding where the quality time and support increase in the increasing years of marriage. In times of conflict with

another member in the family, more than fourth- fifth of respondents acknowledged their male counterpart's support and respondents of 25 to 35 years are the largest groups to agree on the statement. Interestingly, those above 35 years of age respondents closely followed this. On the other hand, the maximum respondents are found among 35 years of age to not experience any support from their spouses in times of conflict with another family member. Likewise, Glorieux, Minnen, & Tienoven, (2011) found that the amount of face-to-face spousal interaction is considered to be critically important for marital quality and couples in their study spend over half of their total time (53%) together.

Employment autonomy for both employed and unemployed respondents was also identified which indicates personal freedom in a relationship. Much less than half of the currently unemployed respondents stated that their spouses would be happy if they get a job or are employed in which the number is almost similar across the categorized age group. A similar pattern is found among employed women where less than half state that their spouses are happy that they are employed. This accounts for a fifth each of 25 to 35 years and 35 years above respondents while it is only 4.6% for respondents between the ages of 18 to 24 years. Besides the education of women, the influence of husband's income in labour participation of married women and the traditional belief of husbands to be the sole winner and wife to be homemaker gradually vanish (Jalilvand, 2000). This finding however highlights the patriarchal society and its attitude who expect its women to remain housewives.

Regarding freedom in women's mobility, the majority of respondents stated that their spouses do not oppose them in going out alone in public while almost a fifth are restricted by their spouses. Respondents of 25 to 35 years and 35 years above are those who enjoy the freedom of mobility the most while the least freedom of movement was observed among 18 to 24 years' respondents. Similar observations were made in a study of Egyptian women conducted by Kishor et al (1995). Freedom of movement is found to be most prevalent among respondents of 25 to 35 years as well as among those above 35 years (35.4% each). There is least freedom of movement among18 to 24years respondents (10.8%). This observation denotes the subjugation of women by men and less personal freedom among the younger married population.

Quality of life is also dependent on how one perceives and experiences one's intimate relationship. Most respondents in the study claim that their intimate relationship is satisfactory. The satisfaction level is relatively much higher among 25 to 35 years as compared to 18 to 25 years of respondents. On the contrary, only a small number of respondents are not satisfied with their personal relationships. Among those who stated their dissatisfaction, 18 to 24 years are the largest group of respondents whereas 25 to 35 age groups are the least to state their dissatisfaction. A comparable observation was made by Mammen, Bauer, & Lass, (2009) in which majority of women in the studied sample claimed that they were satisfied with life and certain variables that influenced their life satisfaction are mainly health and personal capital.

In the study, the various forms of abuse are grouped into sexual abuse, physical, psychological, financial, and verbal abuse. Regarding the respondent's experience of spousal physical abuse, it is noteworthy that most respondents have had no experience of the same while it is only a fifth who reported having experienced physical abuse. Respondents of 18 to 24 years category are found most common among those who experienced physical abuse, while it accounts for 5.8% each in the 25 to 35 and 35 above age group. US national survey during ten years (1993 to 2003) reported young married women between 20 to 24 years were at greatest risk of IPV while 16 to 19 years of women ranked third nationally.

It is also notable that only less than a tenth of respondents reported having experienced psychological abuse from their partners. Experience of psychological abuse was found most common among respondents above 35years category followed by 25 to 35years and 18 to 24 years category. The current findings contrast the observation of Karakurt & Silver (2013) in which emotional abuse was more common in younger participants in their study. Younger women experienced higher rates of isolation, and women's overall experience of property damage was higher than that of men and increased with age.

As regards verbal abuse, the study suggests an increase in verbal abuse with the age of respondents as it is found most common among those above 35years of age followed by 25 to 35 years. While the experience of verbal abuse from spouse accounts for a third of respondents, the least group to report this was respondents of 18 to 24 years. In addition, Debono, Borg Xuereb, Scerri, & Camilleri (2017) identified a number of variables that predict the incidents of verbal abuse

experienced by women during their pregnancy such as low standard of education in males, unemployment and fear of the intimate partner as the significant predictors of psychological and verbal intimate partner abuse.

Regarding spousal sexual abuse, it is regrettable to note that there is more experience of sexual abuse by the younger respondents. Among more than a tenth of respondents who reported sexual abuse from their partners, the largest age group identified was respondents of 18 to 24 years followed by the 25-35 age group and 2.1% of those aged above 35 years. The above results corroborated the findings of Lianhmingthangi (2014) in which either one form of violence is experienced by the respondents in spousal relationship.

Experiences of abuse by family members for both respondents living in extended and nuclear families are assessed which greatly determines their quality of life. The most common form of abuse perpetrated by mothers in law across all age groups is psychological abuse followed by verbal and financial abuse. Respondents in the 25 to 35 age group are found to be the most among who reported psychological abuse by mothers in law closely followed by 18 to 24-year respondents. Respondents of above 35years are the minimum group to report the same in which it can be assumed that psychological abuse minimizes with the increase in the respondent's age. Verbal abuse by mothers in law also happened to be found most common among those aged 25 to 35 years and almost the same number was found among respondents of 35 above age group. Surprisingly, the minimum age groups in the study ie 18 to 24 years are the least group to report the experience of verbal abuse from their mothers in law. The study also does not observe any report on sexual and physical abuse by mothers in law while the study made by Olutola (2012) also reveals that mothers-in-law with excessive psychological and emotional attachment to their sons are over-protective of their sons that led to the harmful and abusive relationship between mother-in-law and daughter-in-law.

Regarding respondent’s experience of abuse from fathers in law, financial abuse is seen to be the most reported form of abuse followed by verbal abuse. It is also regrettable to note that sexual abuse by fathers in law is found among respondents aged 18 to 24 years while there are no reports on physical and psychological abuse, fortunately. Both financial and verbal abuse performed by fathers in law is most common among respondents of 18 to 24 years whereas 35 above age groups are the least group to report the same. Verbal abuse accounts for

the most common form of abuse performed by brothers in law followed by physical abuse. The respondents experience sexual and financial abuse account the same across all age group although age group variation exists in both the experiences.

Respondents in the 18 to 25 age group are the largest respondents group to experience verbal abuse from brothers in law while there are no reports on the same from respondents above 35 years. The former are also the largest group to report experience on physical abuse while the 25 to 35 age group do not report any experience on this. While there are no reports on respondent's experience on physical and psychological abuse from sisters in law, verbal abuse is found to be the most common form of abuse performed by sisters in law. Financial abuse was reported and found to be experienced more among the respondents of 18 to 24 years; while this type of abuse was mainly from their sisters in law. It is aching to observe that 1.3% of respondents have experiences of sexual abused by their sisters in law where 18 to 24 age group are found to be the most vulnerable group. A study made by Gupta, Falb, Kpebo, & Annan (2012) also corroborates this particular finding.

Patterns of decision making in the family were assessed to identify the freedom and involvement of respondents in the family decision-making process. The various family matters include health care, problem-solving, family planning, mobility, cooking, and religious participation. The study found more than a third respondent who decides by themselves on a matter related to health care while it was less than half of respondents who reported that their husbands decided the matter related to health care. This finding corroborates Riyami et.al.,(2004) where illiterate women reported that their husbands exercise their reproductive health rights. Besides the involvement of respondents and their husbands in this matter, mothers-in-law are found to be active in decision making related to health care. While only 7.5% of respondents stated that their Fathers in law has the final on health care matters, authority in health care decisions account very less for other members in the family (0.8%)and sisters in law (0.4%). Among the respondents who have the freedom to decide for themselves on healthcare-related matters, respondents of the 35above age group are found largest followed by those in the 25 to 35 years and 18 to 24 years. This pattern illustrates the respondent's autonomy in decision making with an increase in their age. On the other hand, respondents of 25 to 35 years are the most common group who reported their husbands to be most active in health care

decision-making followed by 35 above age group and those 18 to 24 years. The last person to involve in this matter in the study was sisters in law were only 0.4% of respondents belonging to the 24 to 35 age group reported the same. The study found no respondents of other age groups to report that their sisters in law involved in health care decision-making. Phan (2013) also highlighted that women's participation in general household decisions is influenced by women's age and education.

The study found that the respondents themselves made most problems solving after their husbands. This was followed by their fathers in law and mothers in law. The study also found very few respondents to state that their sisters-in-law and other family members have the final say in problem-solving. Among the respondents who stated that their husbands are the main problem-solving person in the family, more than a fourth are respondents of above 35 years, a little less than a fourth are 25 to 35 years and only 5.4% are 18 to 24 age group. Self-involvement in problem-solving among the respondents is also relatively high where respondents of above 35 years are the largest group to report this, followed by those in the 18 -24 years and 25-35 age group. Following the respondents in problem-solving concern, almost half of the respondents stated that their fathers in law have the final say on problem-solving in the family. It was observed that a few mothers in law had the final say on the same.

Authority in the respondent's family planning was probed where it was found that their husbands make most family planning decisions. Only 17.9% of respondents claim that they have the final say in family planning decisions while a tenth state that their fathers-in-law have authority over this matter. The involvement and authority of mothers-in-law and other family members in this matter account for the same and relatively lesser. Respondents of 35 age above are the largest group to report their husbands to have a final say on decision making in family planning, whereas respondents of 25 to 35 years are found to be the most common among to report that they themselves have the final say on this matter. At the same time, Ahmadi, Ali & Afzali, (2010) found the husband's affection expression and the husbands as responsive and husband's communication patterns are the factors that influence the marital satisfaction of women.

Authority in matters of running the kitchen was assessed by probing into the respondent's decision-making freedom in cooking. The study found that more than two-thirds of respondents are given the authority to manage the family kitchen while 15% of respondents surprisingly state that their husbands have authority over decisions in the kitchen. Cerrato & Cifre (2018) findings confirm that the involvement of women in household chores is more than double the involvement of their male partners. In a society where many families assume that women's place is in the kitchen, it is astonishing to find that only 4.7% of respondents state their mothers-in-law has the final say in cooking. This finding of a large husband's final say and the lesser decision of mothers in law in this matter opposed the ideology and practices of a patriarchal society where most of the kitchen duties are expected to be fulfilled and rule by its women.

8.1.4 Childlessness and Young Married Women

The study found almost a sixth of respondents do not have children. Infertility is rising at a rapid rate. It is estimated that globally 60-80 million couples suffer from infertility every year, of which probably between 15-20 million (25%) are in India alone (Baranwal, Kunwar, & Tripathy, 2015). Among those childless respondents, a vast majority of them initiated pregnancy were currently married for 1 to 3 years are found to be the most common in an attempt to initiate a pregnancy. Those married for more than four years seem to have a lesser problem in childbearing and they comprise two fifths in the said matter. Also, almost a fifth of them does not report any attempt in initiating pregnancy. From the finding, it may be assumed that not all respondents consider their childlessness an issue and that they do not unnecessarily take initiative on their part. Although respondents report that both their partners and they themselves have a problem in childbearing, a greater number of childless women took the blame for their childlessness. It may be because most childless women in patriarchal societies would rather take the blame instead of their male counterparts having to be labelled “infertile.”

Regarding medical treatment, respondents who have been married for 1 to 3 years are the majority to seek medical help for their childlessness. Those who have been married for more than 4 years comparatively sought less medical help for the

same. In a study of Baranwal, Kunwar, & Tripathy (2015) more than half of the couples who sought medical help eventually succeeded in having children although the current finding shows that the perceived need for medical self-examination declined with the increasing years of marriage for childless respondents. The spousal reaction in an unenthusiastic situation seems to enhance one's perception of the quality of life. Currently married for 1 to 3 years childless respondents receive a large amount of positive reaction from their spouse while the negative spousal reaction is also low among those married more than 4years. Hayford & Guzzo (2010) stated that traditional values and cultural norms discouraged contraceptive use in marriage consequently, an ideal woman is expected to bear children preferably sons. Three fourth of the childless respondents who married for 1 to 3 years also state that their in-laws do not show any negative reaction to the childlessness while fewer (8.1%) are those married for more than 4years who received a negative reaction from their in-laws. This finding does not validate the positive reaction of in-laws to childlessness in general since it appears that negative reactions are seen towards those respondents with a longer period of marriage.

Family attitudes towards the medical treatment of childless respondents and their spouses speak aloud their outlook on childlessness. The same pattern is observed in both the context of spouse and in-law’s reaction to the respondent's medical treatment regarding childlessness. There are a little more than the fourth fifth of married for 1 to 3 years respondents who receive positive support and response from both the spouse and in-laws. Only a few childless respondents being married for more than 4years do not obtain a positive attitude regarding medical treatment from both parties.

The study observed infertility in the family history of childless respondents. A few respondents who have been married for 1 to 3 years reported that their family line has a history of infertility. On the contrary, among those who married for more than 4 years, a large majority do not report any such history. This finding corroborates Prasad et al., (2005), where the rate of infertility was high with 9% of the young couples reported themselves infertile on the basis of their medical history. This finding, therefore, suggest that family history of infertility seems to be familiar in today's world as it is found most common among respondents who married only 1 to 3 years as compared to those living in more than 4years of marriage.

8.1.5 Dynamics of being a '*Mo*' or Young married woman

Case studies illustrate the lived experiences of married women in Mizo society. Their knowledge and perceptions of the different aspects including married life and reproductive health are depicted through the case studies. Many women deeply desire the well-being of the family while a sense of insecurity and fear of not being accepted is evident in many of the daughters- in-law's comments about the relationship in joint families.

Most entered the marriage without prior knowledge of the power and connotation of in-laws approval in the marriage. The differential experience of married women in joint families and nuclear families highlights the quality of life of married women where the quality of life in nuclear families is reported higher and desirable. Although most of the women in the case enjoy freedom and liberty in terms of mobility, as women with responsibilities, they understand that they are unable to spend much time outside their home while giving selfless priorities to their husbands, children, or family.

On becoming a married woman, some women in the study eventually lost contact with their friends. After the marriage, the stay at home women spent the majority of time on household chores and responsibilities while the working women find it difficult to prioritize anything other than their work and family. Changes in the amount of available leisure time, young women in the study tend to become less socialize while at the same time, they cannot afford to spend quality time with their partners. Nevertheless, many young women in the study maintain a close relationship with their biological family particularly their biological mother. The women in extended families adopt an approach of sustaining relationships with their biological mother while women in nuclear families maintain frequent communication with their mothers-in-law. Such social networks and relationships are maintained by these women to gain emotional support rather than economic. In post-marriage, women in the case studies keep on realizing the importance of women in the family especially their biological mothers, mothers in law, and they as married women or mothers.

The case findings suggest that beyond a women's sense of herself as an individual, their well-being or quality of life depend on the level of quality interactions and relationships in her extended family. In many of the cases, married women are considered and often treated as a mere instrument, kitchen worker, family

helper, caretaker, or sexual outlet. Rather than considering their worth and their significant contribution in the family functioning, the extended family and society at large continue to see them as a mere adjunct. Working women in the study greatly derive a sense of wellbeing from their level of education and monetary earnings. Their contribution to the family economy extracted a remarkable sense of self-worth in extended families. Although the societal demands and pressure to be 'good brides' continues to exist in the society which expels many daughters in law in the extended family to exhibit positive attitude and behaviors, some daughters in law prefer to stand up for their rights without having to negotiate. This is one of the common sources of conflict with their in-laws in the extended family. Unlike a common assumption held by society, the case finding reveals that not only a good relationship with their mother-in-law was handy in their union, but all the other members in the extended family also play equal responsibility. As is evident in the cases, besides the psychological and verbal abuse from their mothers-in-law, many daughters in law suffer forms of abuse and torture at the hands of their brother in law and father in law while the cases do not reveal any form of violence from any other members in the extended family.

For all women in the study, going out to places or mobility is not an issue. They have the freedom of mobility in terms of going out alone or going out to places to fulfil their wishes. Yet, responsibilities posed by marriage oblige them in prioritizing their families, therefore, most of them avoid socializing and going out to a large extend. Another reason for avoidance in this matter also counts for the care of in-law's opinions and judgments for women in extended families. The case findings also expose women's freedom in health care decisions. Women in the case studies are well aware of their reproductive health care and health rights. Although women themselves make the final decision, women in the extended family had to seek the opinion of their in-laws, especially mothers-in-law while women in nuclear families do not necessarily consult their in-laws as far as health care is a concern. The duration and experience of marriage and motherhood neither justifies their status, level of independence nor decision making yet their daily experiences enhance their skills in managing relationships. Therefore, these women who have experienced marital life for a longer period have a greater level of emotional strength and independence. The case analyses also highlight the massive support of husbands in women's health care and decision-making. There was also a sense of immense pride

and fortune among educated women, as they perceive education enhance their ability to function more effectively in practical terms than uneducated women. The sense of fortune and pride is even higher among working/employed women as they strongly perceive that their monetary contribution in the family added their values and worth, while they also believe that housewives have a greater chance of developing psychological problems especially housewives in extended families.

Women in the case studies experience the changes in societal views on women in Mizo society. In general, married women perceive that they gain more respect post marriage. Women in the study experienced annoying and irritating comments and mockery during their unmarried days, which they perceive, is declining in their post marriage. The anti-social performance or social attitude towards them takes a different turn post-marriage although some married women still experience obnoxious teasing from men in society. Women in the case studies also speak their experience as married women where they attain change particularly emotional growth and prosperity. All the women report that being married enhances their sense of fulfillment and they attain emotional security: in a sense, the attainment of the status of established wife and mother legitimized their security and sense of fulfillment.

It is not uncommon to experience childlessness as a condition that makes a woman insecure about herself and her marriage. The condition of childlessness contributes to a lower sense of fulfillment among young married women and as a result, many of them assume that they suffer the taunts and bullies from their in-laws and society. The childless respondents indeed believe that conceiving a child would automatically enhance their quality of life as women. Childless respondents in the study seem to deliberately seek out other women with similar experiences to have something in common to discuss. The case-finding reveals that women experience a sense of wellbeing depends on a range of factors including her education, employment status, relationships with the extended family members, and her fertility. It is therefore evident from the case studies that childbearing is central to married women's sense of well-being and involuntary childless women feel incomplete and unfulfilled. On the other hand, childbearing women in the study do not report problems and stigma related to the number of children they have or if their children include boys. Becoming childless regardless of gender becomes a source of shame and mental agony, as well as family dishonor for married women.

The case studies present a wide insight into the challenges faced by married women particularly those remaining in extended families. The challenges of the mother-in-law and daughter-in-law relationship, the various forms of abused and torture married women experience in their marital home, and the strain relationships with in-laws prior to marriage expose the general status of married women in extended families. Several women talk about the effort they put in to bring positive vibes in their marital home or to achieve acceptance and recognition by their in-laws. Some women experience the outcome of the traditional outlook of Mizo society who considers daughter in law to remain housewife and take care of all the household chores. The expectation of married women to remain at home and obey the rules set by men continues to exist therefore women perceive that women's education has a huge role which can help them in voicing and standing for their rights. They also perceive that education and employment outside the home saves married women from much possible torture and violence in society. Not all married women feel hopeless, many women rather feel fortunate to be educated, to be employed, or to be married for that matter. Mrs. Nicole also reports on how fortunate she is to have a mother in law who supports her in every matter. The coping strategies evident in the cases were mostly spiritual maintenance. The daily personal prayer and joint prayer with husbands tend to help them in fighting their daily challenges.

8.2 Conclusion

Quality of life denotes the standard of wellbeing, security, comfort and happiness of a person or group of people and there are various domains that determines a persons' quality of life. The study has probed into the physical, psychological, social, economic and spiritual wellbeing of respondents which determines the quality of life of young married women in Aizawl. It also probed into the socio-economic and structural information, challenges and lived experiences of young married women and the perceived social support and network available.

It is evident in the study that there were more dependents than earning respondents whereas non poor respondents are majority among the respondents. More than half respondents reside in nuclear family and regarding age at marriage, respondents who married during 18 to 30years are the majority. A vast majority of respondents have married for love. Although married for love, almost a sixth are

involuntary childless and it is further gloomy to note that almost a tenth of respondents aged between 18 to 24 years are also found to have no children. A very few respondents reported that they do not have enough quality time with their husbands, and also they do not have a spouse who listens to their problems. Conversely, a large majority of respondents acknowledged their male counterpart's support and respondents of 25 to 35 years are the majority to agree on the statement.

The study found that age is highly significant with level of satisfaction in personal domain (X^2=19.54, p=.000**) and social domain (X^2=23.38, p=.000**). Age is also highly correlated with health quality dimension total. There is a positive relationship between perception of self and age category. Age at marriage is also found to be highly significant with fertility treatment of self.

Educational status of respondents is found to be highly significant with statements on perceptions and experience of married life. Employment has highly positive relation with financial domain of dependents while it has a negative relation with financial domain total of earners. Level of satisfaction in financial domain of earners is found to be highly significant with respondent's educational status (X^2=24.8, p=.00).

In the matter of autonomy in going out alone in public, the study found that almost a fifth are restricted by their spouses and the least freedom of movement was observed among 18 to 24 years respondents. Quality of life is also dependent on how one perceives and experiences one's intimate relationship and the study found that most respondents claim that their intimate relationship is satisfactory. The study found that the most common form of abuse respondents' experienced from their spouse is verbal abuse followed by physical abuse. It was also apparent that mother in-laws were the main family member to abuse the respondents and it involves psychological abuse across all age groups. Involvement in family decision making pattern revealed that respondents' involvement and authority is utmost in the authority in kitchen matters. In terms of health care, respondents' spouses were found to make most health care decision followed by the respondents themselves.

With regard to childlessness, a larger number of respondents' claimed that they have fertility issue and they further claimed that this issues have a history on their family while there's no report on infertility history on the spouse family. However, a larger majority of respondents' claimed that their spouse and in-laws reacted positively to their involuntary childlessness situation. With regard to age of

respondents, fertility treatment of self is found to have significance. With regard to the association of age with in laws reaction to childlessness, age of respondents has significance with in laws reaction to childlessness.

The case findings illustrate the vulnerability of young married women particularly those involuntary childless and *Mo* in the marital home. Various forms of abuse perpetuated by husband or in laws are present in each of the cases and for young married women in extended family, well-being or quality of life hugely depend on the level of quality interactions and relationships in her marital home. However, married women in the case studies perceive that they gain more respect post marriage and particularly working women in the study greatly derive a sense of wellbeing from their level of education and monetary earnings.

Women in the case studies also speak their experience as married women where they attain change particularly emotional growth and prosperity. All the women report that being married enhances their sense of fulfillment and they attain emotional security. It can also be seen that women in the long experience of marriage had a greater level of emotional strength and independence. However, in difficult circumstances, spiritual maintenance was the most common form of coping mechanism employed by young married women. The daily personal and family devotions tend to help them in fighting their daily challenges. Social support is not much evident in the cases however, young married women's' coping strategies gradually developed with the increasing years of marriage as they become emotionally established. The main sources social support is respondent' spouse, friends, respondents' biological mother and the mother in-laws of respondents.

The status of women has always been a subject of serious discussion in many societies. It incorporates several alarming issues consisting women education, health, autonomy in various fields, participation in decision making at all levels and the roles and participation of women in different social institutions. The position of women in Mizo society needs a closer look as it may be overrated in many aspects. Many women still confront abuse and torture as an expression of male dominance over women. Also a patriarchal society such as Mizo society exhibits a culture that anticipates its women to obey the rules set by its men. The status of married women is no greater as there are many imposed directions and duties set by the society. As quality of life is a measurement of the degree to which a person is healthy and able to

enjoy and participate in life events, the current status of women decides the quality of life of young married women in Aizawl.

8.3 Suggestions

The present study aims to propose suggestions at various levels with the interest of the need for uplifting women by reconsidering their experiences in Mizo society. The study aims to offer suggestions for different practitioners at different levels with the concern of the current status of women in Mizoram. Therefore, this section is presented into three section based on the findings of the present study.

8.3.1 Implications for Social Work research

1. The study reveals the status of young married women which was overrated. Therefore, for better understanding of women and their life experiences in a society, research on specific matters relating to women's experiences in different field must be initiated.
2. The method of social work research must be promoted in order to enrich knowledge about women especially in patriarchal society.
3. A comparative study on married women in nuclear families and extended families would be an interesting research which will contribute to the knowledge on traditional practices in patriarchal society.
4. Research that probes into the life experience of married women would be particularly helpful in the field of women's studies.
5. A qualitative study may be conducted to explore the quality of life of married women in their pre and post marriage
6. The role of social networking in promoting the quality of life of married women may be explored.

8.3.2 Suggestions at the Micro level

1. Psychological counseling for young married women can be initiated.

2. Promoting emergency helpline centre for women by creating need based awareness particularly for the battered young married women.

3. Formation of family counseling centre that caters the marital counseling to strengthen the family relationship and dynamics.

4. Establishing support groups for young married women who are facing similar problems in marital/family life.

5. Special support group for involuntary childless married women can be introduced.

8.3.3 Suggestions at the Mezzo level

1. Church can play active role in disseminating awareness on the importance of women in family, family resilience as well as family mental health per se.

2. MHIP can be made use to sensitize the community on current status and needs of women.

3. Community awareness on the Protection of Women from Domestic Violence Act can be promoted.

4. Collaboration with women helpline in order to identify women in distress can be initiated.

8.3.4 Suggestions at the Macro level

1. The available empowerment programs and policies for women can be strengthened for the overall women development.

2. Research on more issues of Mizo women and advocating for productive changes on the issues of Mizo women can be conducted.

3. More research and awareness on women’s issues through academics and mass media would be helpful to promote women’s well being

INTERVIEW SCHEDULE

Social Support and Quality of Life of Young Married Women in Aizawl, Mizoram.
(Confidential and for Research Purpose Only)

Research Investigator:
Ms. Catherine Lianhmingthangi
Ph.D Scholar
Department of Social Work
Mizoram University

Research Supervisor:
Dr. Grace Lalhlupuii Sailo
Assistant Professor
Department of Social Work
Mizoram University

Schedule No. Date: Time:

A. Profile of the respondents

Name : (Optional)
Age: i) 18-24 ii) 25-35 iii) 35 and above

Religion : i) Christian ii)Hindu iii)Others
Denomination : i)Baptist/ ii) Presbyterian/ iii)Roman Catholic/ iv) Salvation/ v) Seventh Day, vi)UPC/ vii) any other (Specify)________
Education : i) Primary ii) Middle iii)High School iv)Higher v)Graduate vi)Post Graduate vii)NA
Dependent/Earner
Type of family: Nuclear/Joint
Form of Family : Stable Broken Reconstituted
Socio Economic Category : Very Poor (AAY) Poor (BPL) Non-Poor

B .Particulars of the respondents

Age at Marriage : i)Below 18 ii)18-30 iii)30 and above
Type of Marriage: i)Love ii)Arrange
Number of Individuals living with the respondents: Less than 5 More than 5
Number of Children: i)1-2 ii)3-4 iii)5 and above iv)NA
Duration of current marriage: i)1-2 ii)3-5 iii)6-9 iv)10and above

C. Relationship with spouse

My Spouse and I often spend time together (quality time)
1. Yes 2. No

My spouse is willing to listen to my problems
1. Yes 2. No

My spouse supports me when in conflict with another family member
1. Yes 2. No

(For unemployed/dependent)

If unemployed, my husband/In-laws would be happy if I get employed
1. Yes 2. No

(For employed/earner)
If employed, my husband is happy with my employment
1. Yes 2. No

My husband allows me to go out alone
1. Yes 2. No

I am satisfied with my personal relationship
1. Yes 2. No

My husband abuses me physically
1. Yes 2. No

My husband abuses me Psychologically
1. Yes 2. No

My Husband abuses me Verbally
1. Yes 2. No

My husband abuses me sexually
1. Yes 2. No

D. Relationship with in-laws

1. Who has the final say on ***Health Care***
1. Father –in –law 2. Mother in law 3. Brother in Law 4.Sister in Law 5.Husband 6. Self
7. Other Family Member

2. Who has the final say on ***Problem Solving***
1. Father –in –law 2. Mother in law 3. Brother in Law 4.Sister in Law 5.Husband 6. Self
7. Other Family Member

3. Who has the final say on ***Family Planning***
1. Father –in –law 2. Mother in law 3. Brother in Law 4.Sister in Law 5.Husband 6. Self
7. Other Family Member

4. Who has the final say on ***Visiting friends and relatives***
1. Father –in –law 2. Mother in law 3. Brother in Law 4.Sister in Law 5.Husband 6. Self
7. Other Family Member

5. Who has the final say on ***Cooking***
1. Father –in –law 2. Mother in law 3. Brother in Law 4.Sister in Law 5.Husband 6. Self
7. Other Family Member

6. Who has the final say on ***Religious Participation***

1. Father –in –law 2. Mother in law 3. Brother in Law 4.Sister in Law 5.Husband 6. Self
7. Other Family Member

7. Experience of family abuse by ***Mother In Law***
1.Sexually 2.Physical 3. Psychological 4.Financial 5.Verbal 6.NA

8. Experience of family abuse by ***Father In Law***
1.Sexually 2.Physical 3. Psychological 4.Financial 5.Verbal 6.NA

9. Experience of family abuse by ***Brother In Law***
1.Sexually 2.Physical 3. Psychological 4.Financial 5.Verbal 6.NA

10. Experience of family abuse by ***Sister In Law***
1.Sexually 2.Physical 3. Psychological 4.Financial 5.Verbal 6.NA

E. Personal Domain

1. I am satisfied with myself
1.Yes 2. No

2. I am satisfied with my ability to perform daily activities
1.Yes 2. No

3. My quality of life is satisfactory
1.Yes 2. No

4.In my perception, quality of life is dependent on ***family life***
1.Yes 2. No

5. In my perception, quality of life is dependent on ***health***
1.Yes 2. No

6. In my perception, quality of life is dependent on ***spiritual satisfaction***
1.Yes 2. No

7. In my perception, quality of life is dependent on ***peaceful life***
1.Yes 2. No

8. In my perception, quality of life is dependent on ***Education***
1.Yes 2. No

F. Social Domain

1. I enjoy my life
1.Yes 2. No

2. I am happy with the environment of my living place

1.Yes 2. No

3. I am satisfied with the support I get from my friends
1.Yes 2. No

4. I am able to participate in social activities according to my wish
1.Yes 2. No

G. Psychological Domain
1. My life is meaningful
1.Yes 2. No

2. I am able to concentrate in task at hand
1.Yes 2. No

3. I often have negative feeling (Mood)
1.Yes 2. No

4. I have someone o share my problems with
1.Yes 2. No

5. I have someone to listen to my problems
1.Yes 2. No

6. My emotional state prevents me from doing what I need to do
1.Yes 2. No

H. Health Domain

1. My general health condition is good.
1.Yes 2. No

2. I am satisfied with my access to health care.
1.Yes 2. No

3. I have energy for everyday life.
1.Yes 2. No

4. I need medication to normally function everyday
1.Yes 2. No

5. I receive care when I am not feeling well.
1.Yes 2. No

6. I take my health issues for granted
1.Yes 2. No

7. Physical pain prevents me from doing what I need to do.
1.Yes 2. No

I. Financial Domain
(For earner)
1. I have a saving account of my own
1.Yes 2. No

2. I submit my income to my Husband
1.Yes 2. No

3. . I submit my income to my in- Laws
1.Yes 2. No

4. I use my money to meet all household needs
1.Yes 2. No

5. I have sufficient money to meet my needs
1.Yes 2. No

(for dependent)
1. I have to ask money to meet my needs from my husband.
1.Yes 2. No

2. I have to ask money to meet my needs from my In-laws
1.Yes 2. No

3. I have a saving account of my own.
1.Yes 2. No

J. Awareness/Knowledge regarding Reproductive Health
1. I am satisfied with my sex life
1.Yes 2. No

2. I get sufficient knowledge regarding pregnancy
1.Yes 2. No (if No, jump to **7**)

3. If Yes, I get this from my friends
1.Yes 2. No

4. I get this from my family
1.Yes 2. No

5. I get this from my education (self)

1.Yes 2. No

6. I get this from my social media
1.Yes 2. No

7. I am alert during my menstrual cycle
1.Yes 2. No

8. I know how to calculate my fertile period
1.Yes 2. No

K. Perceptions related to Reproductive Health/Rights
1. Contraception is against my religious beliefs
1.Yes 2. No

2. My partner and I Freely discussed about family planning
1.Yes 2. No

3. Method of Birth Control
1. Natural 2. Medication 3. NA

4. On abortion
1. Pro life 2. Pro Choice

L. Perceptions on Married life
1. Women's place is in the home
1.Yes 2. No

2. Employment of mother leads to bad parenting
1.Yes 2. No
3. Housewives are more likely to develop depressive symptoms than women who are employed outside the home
1.Yes 2. No

4. Housewives in joint are more likely to develop depressive symptoms than who are employed outside the home
1.Yes 2. No

M. For Childless respondents
1. How long have you been attempting to initiate pregnancy

2. Who has a problem with child bearing
1. Self 2. Husband 3.Both 4 None

3. Have you been medically treated for childlessness
1.Yes 2. No

4. If Yes, How many times/How long?

____

5. Have your husband been treated medically for childlessness>
1.Yes 2. No

6. If yes, How many times, How long ?

____

7. Doctors feedback ?
1. Positive 2. Negative

8. Does anyone in the family have a history of infertility?
1.Yes 2. No

9. If Yes, Whose side of the family?
1. Both 2. Self 3. Husband

10. Spouse's reaction to childlessness
1. Positive 2. Negative

11. in laws reaction to childlessness ?
1. Positive 2. Negative

12. Spouse's reaction to child bearing treatment
Positive negative

13.In laws reaction to child bearing treatment
1.Positive 2.Negative

REFERENCES

Abdoly, M., & Pourmousavi, L. (2013). The relationship between sexual satisfaction and education levels in women. International Journal of Women's Health and Reproduction Sciences, 1(2).

Ackerman, N., & Paolucci, B. (1983). Objective and subjective income adequacy: Their relationship to perceived life quality measures. *Social Indicators Research*, *12*(1), 25-48. doi:10.1007/BF00428859.

ADAH, P. D. ELEGBA, Emmanuel. O. Folorunso (2015). Satisfaction

Ahmad, M., & Khan, A. (2018). Quality of Life Among Married Working Women and Housewives. *International Journal of Engineering & Technology Singaporean Journal of Social Science*, 13-18.

Alborzi, S., & Area, M. (2008). The relationship between autonomy and quality of life in Shiraz University of Medical Sciences, bright, talented students. *Women's Study*, *6*(2), 47-61.

Andrew, F. M., & Withey, S.B. (1976). Social indicators of wellbeing. *New York and London: Plenum,* 20-31.

Antonucci, T. C., & Akiyama, H. (1987). An examination of sex differences in social support among older men and women. *Sex roles*, *17*(11-12), 737-749.

Agarwal, B. (1995). *A field of one's own*. Cambridge University Press.

Agrawal, A., Ickovics, J., Lewis, J. B., Magriples, U., & Kershaw, T. S. (2014). Postpartum intimate partner violence and health risks among young mothers in the United States: a prospective study. *Maternal and child health journal*, *18*(8), 1985-1992.

Ahmad, M., & Khan, A. (2018). Quality of Life Among Married Working Women and Housewives. *International Journal of Engineering & Technology Singaporean Journal of Social Science*, 13-18.

Ahmadi, K., Mahdi Nabipoor Ashrafi, S., Ali Kimiaee, S., & Afzali, M. H. (2010). Effect of family problem-solving on marital satisfaction. *Journal of applied sciences*, *10*(8), 682-687.

Aimol, K. R., & Shipra, N. (2009). Reproductive performance of Garo women in Meghalaya. *Asian Journal of Home Science*, *3*(2), 248-252.

Akpan, E. O. (2003). Early marriage in eastern Nigeria and the health consequences of vesicovaginal fistulae (VVF) among young mothers. *Gender & Development*, *11*(2), 70- 76.

Alborzi, S., & Area, M. (2008). The relationship between autonomy and quality of life in Shiraz University of Medical Sciences, bright, talented students. *Women's Study*, *6*(2), 47-61.

Albrecht, T. L., & Adelman, M. B. (1987). *Communicating social support*. Sage Publications, Inc.

Allendorf, K. (2013). Going nuclear? Family structure and young women's health in India, 1992–2006. *Demography*, *50*(3), 853-880.

Al Riyami, A., Afifi, M., & Mabry, R. M. (2004). Women's autonomy, education and employment in Oman and their influence on contraceptive use. *Reproductive health matters*, *12*(23), 144-154. DOI: 10.1016/S0968-8080(04)23113-5.

Antonucci, T. C., & Akiyama, H. (1987). An examination of sex differences in social support among older men and women. *Sex roles*, *17*(11-12), 737-749.

Argyle, M. (2013). *The psychology of happiness*. Routledge.

Ashton, W. A., & Fuehrer, A. (1993). Effects of gender and gender role identification of participant and type of social support resource on support seeking. Sex Roles, 28(7/8), 461- 476.

Axelrad, H., Malul, M., & Luski, I. (2018). Unemployment among younger and older individuals: does conventional data about unemployment tell us the whole story?. *Journal for labour market research*, *52*(1), 1-12.

Baheiraei et al. (2012). Social support for women of reproductive age and its predictors: a population-based study. *BMC women's health*, *12*(1), 30.

Baird, B. M., Lucas, R. E., & Donnellan, M. B. (2010). Life satisfaction across the lifespan: Findings from two nationally representative panel studies. *Social indicators research*, *99*(2), 183-203.

Ball, F. J., Cowan, P., & Cowan, C. P. (1995). Who's got the power? Gender differences in partners' perceptions of influence during marital problem-solving discussions. *Family process*, *34*(3), 303-321.

Baranwal, A., Kunwar, N., & Tripathy, S. (2015). Causes of increasing rate of female infertility in India. *Int J Sci Res*, *4*(7), 237-238.

Barua, A. (1998). Young husbands' involvement in Reproductive Health in Rural Maharashtra. *Population Council, New Delhi, India*, 6-8.

Barua, A., & Kurz, K. (2001). Reproductive health-seeking by married adolescent girls in Maharashtra, India. *Reproductive health matters*, *9*(17), 53-62.

Barua, A., Pande, R. P., MacQuarrie, K., & Walia, S. (2004). Caring men? Husbands' involvement in maternal care of young wives. *Economic and Political Weekly*, 5661- 5668.

Barzelatto, J. (1998). Understanding sexual and reproductive violence: an overview. *International Journal of Gynecology & Obstetrics*, *63*, S13-S18.

Becker, S. (1996). Couples and reproductive health: a review of couple studies. *Studies in family planning*, 291-306.

Beigh ,S.K..& Shafi, H. (2018). Perceived Social Support among working women with respect to various socio-demographic variables. *International Journal of Movement Education and Social Science.*

Berkman, L. F. (1984). Assessing the physical health effects of social networks and social support. *Annual review of public health*, *5*(1), 413-432.

Bhawana, D., & Neetu, S.(2014) CRIMES AGAINST WOMEN AND SOCIETAL ILLS: AN OVERVIEW.

Birnbacher, D. (1999). Quality of life-evaluation or description.*Ethical Theory and Practice*, *2*(1), 25-36.

Bloom, S. S., Wypij, D., & Gupta, M. D. (2001). Dimensions of women's autonomy and the influence on maternal health care utilization in a north Indian city. *Demography*, *38*(1), 67-78.

Bongaarts, J. (2003). Completing the fertility transition in the developing world: The role of educational differences and fertility preferences. *Population Studies*, *57*(3), 321-335.

Borisch, B. (2014). Maternal and child health–The MDGs 4 and 5–Some caveats. *Journal of public health policy*, *35*(4), 538-539. doi:10.1057/jphp.2014.34.

Bowling, A., & Windsor, J. (2001). Towards the good life: A population survey of dimensions of quality of life. *Journal of Happiness Studies*, *2*(1), 55-82.

Bouwmans, C., de Sonneville, C., Mulder, C. L., & Hakkaart-van Roijen, L. (2015). Employment and the associated impact on quality of life in people diagnosed with schizophrenia. *Neuropsychiatric disease and treatment*, *11*, 2125.

Bruce, J., & Clark, S. (2003). In technical consultation on married adolescents.

Bukenya, J. O., Gebremedhin, T. G., & Schaeffer, P. V. (2003). Analysis of rural quality of life and health: A spatial approach. *Economic Development Quarterly*, *17*(3), 280-293.

Bumiller, E. (1991). *May you be the mother of a hundred sons: A journey among the women of India*. Penguin Books India.

Caldwell, C., Wasson, D., Brighton, V., Dixon, L., & Anderson, M. A. (2003). Personal autonomy: development of a NOC label. *International Journal of Nursing Terminologies and Classifications*, *14*, 12-13.

Carter, M. W. (2002). 'Because he loves me': husbands' involvement in maternal health in Guatemala. *Culture, Health & Sexuality*, *4*(3), 259-279.

Cerrato, J., & Cifre, E. (2018). Gender inequality in household chores and work-family conflict. *Frontiers in psychology*, *9*, 1330.

Chadda, R. K., & Deb, K. S. (2013). Indian family systems, collectivistic society and psychotherapy. *Indian journal of psychiatry*, *55*(Suppl 2), S299.

Char, A., Saavala, M., & Kulmala, T. (2010). Influence of mothers-in-law on young couples' family planning decisions in rural India. *Reproductive health matters*, *18*(35), 154-162.

Chattopadhyay, A., & Guruswamy, M. (2011). Urban versus rural poverty in India: Evidence from national family health surveys. *Economic Affairs*, *56*(2), 223-230.

Chatterji, N. (2008). The earlier Mizo society. *Deepak Enterprise, Kolkata*.

Chhabra & Annapurna. (2018). Awareness of Reproductive Health amongst Rural School Dropout Girls. *Journal of Reproductive Health and Contraception.* Vol.3 No.2:10

Clark, A., Georgellis, Y., & Sanfey, P. (2001). Scarring: The psychological impact of past unemployment. *Economica*, *68*(270), 221-241. doi:10.1111/1468-0335.00243.

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological bulletin*, *98*(2), 310.

Coleman, D. (1996). New patterns and trends in European fertility: international and sub- national comparisons. *Europe's population in the 1990s*, *1*, 1-61.

Craig, L., & Mullan, K. (2013). Parental leisure time: A gender comparison in five countries. *Social Politics*, *20*(3), 329-357.

Crissey, S. R. (2005). Effect of pregnancy intention on child well-being and development: Combining retrospective reports of attitude and contraceptive use. *Population Research and Policy Review*, *24*(6), 593-615. doi:10.1007/s11113-005-5734-1.

Cutrona, C. E., & Suhr, J. A. (1992). Controllability of stressful events and satisfaction with spouse support behaviors. *Communication Research*, *19*(2), 154-174.

Daniel, E. E., Masilamani, R., & Rahman, M. (2008). The effect of community-based reproductive health communication interventions on contraceptive use among young married couples in Bihar, India. *International family planning perspectives*, 189-197.

Darling, C. A., Coccia, C., & Senatore, N. (2012). Women in midlife: stress, health and life satisfaction. *Stress and health*, *28*(1), 31-40.

Deatsman, S., Vasilopoulos, T., & Rhoton-Vlasak, A. (2016). Age and fertility: a study on patient awareness. *JBRA assisted reproduction*, *20*(3), 99.

Debono, C., Borg Xuereb, R., Scerri, J., & Camilleri, L. (2017). Intimate partner violence: psychological and verbal abuse during pregnancy. *Journal of clinical nursing*, *26*(15-16), 2426-2438.

Degni, F., Ojanlatva, A., & Essen, B. (2010). Factors associated with married Iranian women's contraceptive use in Turku, Finland. *Iranian Studies*, *43*(3), 379-390. DOI:10.1080/00210861003693919.

Dhawan, N., Punetha, D., Sinha, Y., Gaur, S. P., Tyler, S. L., & Tyler, F. B. (1999). Family conflict/violence patterns in India.*Psychology and Developing Societies*, *11*(2), 195-216.

Diener, E., Sandvik, E., Seidlitz, L., & Diener, M. (1993). The relationship between income and subjective well-being: Relative or absolute?. *Social indicators research*, *28*(3), 195-223.

Diener, E., & Suh, E. (1997). Measuring quality of life: Economic, social, and subjective indicators. *Social indicators research*, *40*(1-2), 189-216. doi:10.1023/A:1006859511756.

Diener, E., Suh, E. M., Lucas, R. E., & Smith, H. L. (1999). Subjective well-being: Three decades of progress.*Psychological bulletin*, *125*(2), 276.

Dommaraju, P. (2012). Marriage and fertility dynamics in India. *Asia-Pacific Population Journal*, *26*(2), 21-38.

Dube, L. (1988). On the construction of gender: Hindu girls in patrilineal India. *Economic and Political Weekly*, WS11-WS19.

Dumas, A., Robitaille, J., & Jette, S. L. (2014). Lifestyle as a choice of necessity: Young women, health and obesity. *Social Theory & Health*, *12*(2), 138-158.

Durkheim, Emile. 1951 [1897]. Suicide: A Study in Sociology.

Duxbury, L. E., & Higgins, C. A. (1991). Gender differences in work-family conflict. *Journal of applied psychology*, *76*(1), 60.

Dvorak, V., Heidari, S., Kennedy, B., Lawrence, K., Vega, C., & Dulin, N. (2005). The relationship between depression and attitudinal and behavioral components of spirituality in a sample of students at a Christian university. Presented at the Thirty-Fourth Annual Western Psychology Conference for Undergraduate Research, Santa Clara, CA.

Dyson, T., & Moore, M. (1983). On kinship structure, female autonomy, and demographic behavior in India. *Population and development review*, 35-60.

Eckenrode, J., & Gore, S. (1990). Stress between work and family. In *Stress between work and family* (pp. 205-218). Springer, Boston, MA.

Edmonds, J. K., Paul, M., & Sibley, L. M. (2011). Type, content, and source of social support perceived by women during pregnancy: Evidence from Matlab, Bangladesh. *Journal of health, population, and nutrition*, *29*(2), 163.

Ercan, E. U., & Uçar, S. (2021). Gender Roles, Personality Traits and Expectations of Women and Men towards Marriage. *Educational Policy Analysis and Strategic Research*, *16*(1), 7-20.

Erci, B. (2003). Women's efficiency in decision making and their perception of their status in the family. *Public health nursing*, *20*(1), 65-70.

Fallowfield, L. (1990). What is quality of life. *London: Souvenir*, 54-7

Ferree, M. M. (2010). Filling the glass: Gender perspectives on families. *Journal of Marriage and Family*, *72*(3), 420-439.

Findlay,A., Rogerson,R., & Morris,A. (1988).In What Sense 'Indicators' of Quality of Life?.*Built Environment (1978-),* 96-106.

Fritzell, S., Weitoft, G. R., Fritzell, J., & Burström, B. (2007). From macro to micro: the health of Swedish lone mothers during changing economic and social circumstances. *Social science & medicine*, *65*(12), 2474-2488.

Fitzpatrick et al 1992 Quality of life measures in health care. I: Applications and issues in assessment. *Bmj, 305*(6861), 1074-1077.

Furstenberg Jr, F. F., Brooks-Gunn, J., & Morgan, S. P. (1987). *Adolescent mothers in later life*. Cambridge University Press.

Garg,M.K.,(2011).Vitamin D status in pregnant Indian women. *British Journal of Nutrition 106(09),1383-1389.*

George, A. (2002). Embodying identity through heterosexual sexuality-newly married adolescent women in India. *Culture, Health & Sexuality*, *4*(2), 207-222.

George, K., & Kamath, M. S. (2010). Fertility and age. *Journal of human reproductive sciences*, *3*(3), 121.

Ghosh, D. (2007). Predicting vulnerability of indian women to domestic violence incidents. *Research and Practice in Social Sciences*, *3*(1), 48-72.

Glorieux, I., Minnen, J., & van Tienoven, T. P. (2011). Spouse “together time”: Quality time within the household. *Social Indicators Research*, *101*(2), 281-287.

Gobbens, R. J., & Remmen, R. (2019). The effects of sociodemographic factors on quality of life among people aged 50 years or older are not unequivocal: comparing SF-12, WHOQOL-BREF, and WHOQOL-OLD. *Clinical interventions in aging*, *14*, 231.

Gupta, K., & Yesudian, P. P. (2006). Evidence of women's empowerment in India: A study of socio-spatial disparities. *GeoJournal*, *65*(4), 365-380.

Gupta, J., Falb, K., Kpebo, D., & Annan, J. (2012). Abuse from in-laws and associations with attempts to control reproductive decisions among rural women in Côte d'Ivoire: a cross-sectional study. *BJOG: An International Journal of Obstetrics & Gynaecology*, *119*(9), 1058-1066.

Haghi, F., Allahverdipour, H., Nadrian, H., Sarbakhsh, P., Hashemiparast, M., & Mirghafourvand, M. (2018). Sexual problems, marital intimacy and quality of sex life among married women: a study from an Islamic country. *Sexual and Relationship Therapy*, *33*(3), 339-352.

Hanzal, A., & Segrin, C. (2009). The role of conflict resolution styles in mediating the relationship between enduring vulnerabilities and marital quality. *Journal of Family Communication*, *9*(3), 150-169.

Hayford, S. R., & Guzzo, K. B. (2010). Age, relationship status, and the planning status of births. *Demographic Research*, *23*, 365-398.

Hazarika, P., Kakati, N., & Kalita, R. K. (2015). Indigenous knowledge in relation to conservation and management of forest biodiversity of Assam *Life Sciences Leaflets*, *63*, 64-to.

Headey, B., Veenhoven, R., & Weari, A. (2005). Top-down versus bottom-up theories of subjective well-being. In *Citation Classics from Social Indicators Research* (pp. 401- 420). Springer, Dordrecht.

Heilemann, M. V., Lee, K. A., & Kury, F. S. (2002). Strengths and vulnerabilities of women of Mexican descent in relation to depressive symptoms. *Nursing Research*, *51*(3), 175-182.

High Level Committee on the Status on Women, 2015. Executive Summary Report on the Status of Women in India

Hmingthanzuali & Chhangte.C.L., (2020). REPRESENTATION OF WOMEN IN MIZO HISTORY. *Senhri Journal of Multidisciplinary Studies, Vol. 5, No. 1 (January - June 2020), p. 36-44*

Hornung, C. A., McCullough, B. C., & Sugimoto, T. (1981). Status relationships in marriage: Risk factors in spouse abuse. *Journal of Marriage and the Family*, 675-692.

Horwitz, A. V., White, H. R., & Howell-White, S. (1996). Becoming married and mental health: A longitudinal study of a cohort of young adults. *Journal of Marriage and the Family*, 895-907.

Hossain, B. (2015). Women empowerment and infant mortality in Bangladesh, *Applied Economics, 47*(51), 5534-5547, doi: 10.1080/00036846.2015.1051657.

House, J. S., Umberson, D., & Landis, K. R. (1988). Structures and processes of social support. *Annual review of sociology*, *14*(1), 293-318.

Ichikawa, T., Ota, I., Kuwabara, Y., Tsushima, R., Hamatani, T., Hiraike, O., ... & Akira, S. (2020). Infertility treatment hinders the careers of working women in Japan. *Journal of Obstetrics and Gynaecology Research*, *46*(10), 1940-1950.

IHMP (2004) : Baseline Survey Report: Studies on Married Adolescents in Maharastra pp 15-15 (unpublished)

Iwanowicz-Palus, G., Mróz, M., & Bień, A. (2021). Quality of life, social support and self-efficacy in women after a miscarriage. *Health and Quality of Life Outcomes*, *19*(1), 1-8.

Izugbara, C. O. (2000). Women's understanding of factors affecting their reproductive health in a rural Ngwa community. *African Journal of Reproductive Health*, *4*(2), 62-68.

Jalilvand, M. (2000). Married women, work, and values. *Monthly Lab. Rev.*, *123*, 26.

Jan, M., & Masood, T. (2008). An assessment of life satisfaction among women. *Studies on Home and Community Science*, *2*(1), 33-42.

Javed, S., Javed, S., & Khan, A. (2016). Effect of education on quality of life and well being. *The International Journal of Indian Psychology*, *3*(3), 119-128.

Jayapalan, N. (2001). *Indian society and social institutions*. Atlantic Publishers & District.

Jean Turner, M., Young, C. R., & Black, K. I. (2006). Daughters-in-law and mothers-in-law seeking their place within the family: A qualitative study of differing viewpoints. *Family Relations*, *55*(5), 588-600.

Jejeebhoy, S. J. (1995). Women's education, autonomy, and reproductive behaviour: Experience from developing countries. *OUP Catalogue*.

Jejeebhoy, S. J., & Cook, R. J. (1997). State accountability for wife-beating: the Indian challenge. *The Lancet*, *349*, S10-S12.

Jejeebhoy, S. J. (1998). Adolescent sexual and reproductive behavior: a review of the evidence from India. *Social science & medicine*, *46*(10), 1275-1290.

Jejeebhoy, S. J. (2000). *Women's autonomy in rural India: Its dimensions, determinants, and the influence of context*.

Johnson, V. K., Gans, S. E., Kerr, S., & LaValle, W. (2010). Managing the transition to college: Family functioning, emotion coping, and adjustment in emerging adulthood. *Journal of College Student Development*, *51*(6), 607-621.

Johnson, N.L., & Johnson, D.M., (2013) Correlates of Readiness to Change in Victims of Intimate Partner Violence, *Journal of Aggression, Maltreatment & Trauma* 22:2, 127-144.

Jones, R. K., & Dreweke, J. (2011). *Countering conventional wisdom: New evidence on religion and contraceptive use*. New York, NY: Alan Guttmacher Institute.

Jyothirmayee, C. A. Understanding family structure and women empowerment in india.

Kalmuss, D. S., & Straus, M. A. (1982). Wife's marital dependency and wife abuse. *Journal of Marriage and the Family*, 277-286.

Karakurt, G., & Silver, K. E. (2013). Emotional abuse in intimate relationships: The role of gender and age. *Violence and victims*, *28*(5), 804-821.

Kerce, E. W. (1992). *Quality of life: Meaning, measurement, and models* (No. NPRDC-TN-92-15).NAVY PERSONNEL RESEARCH AND DEVELOPMENTCENTER SAN DIEGO CA.

Keshavarzi, S., Ayatollahi, S. M. T., Zare, N., & Sharif, F. (2013). Quality of life of childbearing age women and its associated factors: an application of seemingly

unrelated regression (SUR) models. *Quality of Life Research*, *22*(6), 1255-1263.

Khan, M. E., Khan, I., & Mukerjee, N. (1997). Involving men in safe motherhood. *Journal of Family Welfare*, *43*, 18-30.

Kieren, D., Henton, J., & Marotz, R. (1975). Hers and his. Hinsdale, IL: Dryden Press.

Kingston, P. W., & Nock, S. L. (1987). Time together among dual-earner couples. *American Sociological Review*, 391-400.

Kingston, D., Heaman, M., Fell, D., Chalmers, B., & Maternity Experiences Study Group of the Canadian Perinatal Surveillance System. (2012). Comparison of adolescent, young adult, and adult women's maternity experiences and practices. *Pediatrics*, *129*(5), e1228-e1237.

Kishor, S., & Gupta,K.,(2004).Women's empowerment in India and its states: evidence from the NFHS: *Economic and Political Weekly*,694-712.

Kishor, S., Ayad, M., & Way, A. (1999, June). Women's empowerment and demographic outcomes: examining links using demographic and health surveys data. In *Arab Conference on Maternal and Child Health, Cairo* (Vol. 7, No. 10).

Kossek, E. E., & Ozeki, C. (1999). Bridging the work-family policy and productivity gap: A literature review. *Community, Work & Family*, *2*(1), 7-32.doi:10.1080/13668809908414247.

Kosterina, I. (2012). Young Married Women in the Russian Countryside: Women's Networks, Communication and Power. *Europe-Asia Studies*, *64*(10), 1870-1892. DOI: 10.1080/09668136.2012.717360.

Krause, N. (1982). Married women and depressive symptoms. *Sociological Focus*, *15*(1), 25-40.

Kumaar,S.S.. CRIME AGAINST WOMEN - AN INDIAN SCENARIO. Master Thesis 2015 Research Master Planning and Sustainability: Urban and Regional Planning

Kumar, S., & Goowalla, H. (2016) Impact of Socio-economic background of the rural Naga women entrepreneurs in Nagaland: with special reference to Dimapur District.

Kwan, A. Y. H., Cheung, J. C. K., Ngan, R. M. H., Lau, A. L. D., Leung, E. M. F., & Chan, S. S. C. (2003). Assessment, validation, and promotion for the quality of life and continuum of care of elderly people in Hong Kong.

Laireiter, A., & Baumann, U. (1992). Network structures and support functions: Theoretical and empirical analyses. In H. O. F. Veiel, & U. Baumann (Eds.), The meaning and measurement of social support (pp. 33-55). Washington, DC: Hemisphere.

L Heise; Moreno G, Violence by intimate partners

Lalhmingpuii, J. C., & Namchoom, V. (2014). The Status and Role of Women in Mizo Society. *Journal of North East India Studies*, *4*(1), 30-42.

Lalhriatpuii (2010): *Economic participation of Women in Mizoram*. New Delhi: Concept Publishing Company.

Lane, C., Joof, Y. M., Hassan, A. A., & Pryor, S. (2012). Promoting healthy timing and spacing of pregnancy with young married women in Northern Nigeria: a short report. *African Journal of Reproductive Health*, *16*(2), 263-270.

Layard, R., Barton, M., & Zabalza, A. (1980). Married women's participation and hours. *Economica*, *47*(185), 51-72.

Lee, J. J. (2005). An exploratory study on the quality of life of older Chinese people living alone in Hong Kong. In *Quality-of-Life Research in Chinese, Western and Global Contexts* (pp. 335-361). Springer, Dordrecht.

Lee, T., Lee, H., Ahn, H. M., Jang, Y., Shin, H., & Kim, M. S. (2014). Perceptions about family planning and contraceptive practice in a marital dyad. *Journal of Clinical Nursing*, *23*(7-8), 1086-1094.

Leisan. W., & Geetha, V.J (2017). A Sociological Study of Women’s Health Status In Seikhor Village, Ukhrul District, Manipur. *International Journal of Engineering Development and Research.* Volume 5, Issue 4 | ISSN: 2321-9939

Le Masson, V., Benoudji, C., Reyes, S., & Bernard, G. (2019).*Violence against Women and Girls and Resilience*. BRACED Working Paper. ODI, London.

Levinson, D. (1989). *Family violence in cross-cultural perspective*. Sage Publications, Inc.

Lianhmingthangi, C (2017). Intimate partner violence against women: Perceptions across gender. (M.Phil Dissertation) Aizawl: Department of Social work, Mizoram University.

Liégeois, A. (2014). Quality of life without spirituality? A theological reflection on the quality of life of persons with intellectual disabilities. *Journal of Disability & Religion*, *18*(4), 303- 317. DOI: 10.1080/23312521.2014.966466.

Lotfi-Kashani, F., Vaziri, S., Akbari, M. E., Kazemi-Zanjani, N., & Shamkoeyan, L. (2014). Predicting post traumatic growth based upon self-efficacy and perceived social support in cancer patients. *Iranian journal of cancer prevention*, *7*(3), 115.

Macmillan, R., & Gartner, R. (1999). When she brings home the bacon: Labor-force participation and the risk of spousal violence against women. *Journal of Marriage and the Family*, 947-958.

Madhurima. (1996) *Violence Against Women: Dynamics of Conjugal Relations*, Gyan Publishing House, New Delhi.

Ma, L., Rizzi, E., & Turunen, J. (2019). Childlessness, sex composition of children, and divorce risks in China. *Demographic Research*, *41*, 753-780.

Malkoç, A., & Yalçın, İ. (2015). Relationship among resilience, social support, coping, and psychological wellbeing among university students. Turkish Psychological Counseling and Guidance Journal, 5(43), 35-43.

Malecki, C. K., & Demaray, M. K. (2002). Measuring perceived social support: Development of the Child and Adolescent Social Support Scale (CASSS). Psychology in the Schools, 39, 1- 18.

Malsawma, J (2003). *Zozia - Ethics and Moral Principles of Mizo People*

Mammen, S., Bauer, J. W., & Lass, D. (2009). Life satisfaction among rural low-income mothers: The influence of health, human, personal, and social capital. *Applied Research in Quality of Life*, *4*(4), 365-386. DOI 10.1007/s11482-009-9086-6.

Marotz-Baden, R., & Cowan, D. (1987). Mothers-in-law and daughters-in-law: The effects of proximity on conflict and stress. *Family Relations*, 385-390.

Marotz-Baden, R., & Mattheis, C. (1994). Daughters-in-law and stress in two-generation farm families. *Family Relations*, 132-137.

Massam, B. H. (2002). Quality of life: public planning and private living. *Progress in planning*, *58*(3), 141-227.

Mastekaasa, A. (1992). Marriage and psychological well-being: Some evidence on selection into marriage. *Journal of Marriage and the Family*, 901-911.

McQuillan, J., Greil, A. L., White, L., & Jacob, M. C. (2003). Frustrated fertility: Infertility and psychological distress among women. *Journal of Marriage and Family*, *65*(4), 1007- 1018.

Melhado, L. (2014). The Need for Contraception To Delay First Pregnancy In India Is High. *International Perspectives on Sexual and Reproductive Health*, *40*(3), 157.

Miller, P. M., & Ingham, J. G. (1976). Friends, confidants and symptoms. *Social Psychiatry*, *11*(2), 51-58.

Miller, C. E., & Mullins, B. K., (2002) Lifelong Learning to reduce Domestic Violence. International journal of lifelong education,21,(5), 474–484.

Mishra, R. C. (2006). Towards Gender Equality. Authors' press. *ISBN https://www. vedamsbooks. com/no43902. html*.

Mishra, K., & Dubey, A. (2014). Indian women's perspectives on reproduction and childlessness: Narrative analysis. *International Journal of Humanities and Social Science*, *4*(6), 1.

Mirghafourvand, M., Charandabi, S. M. A., Jafarabadi, M. A., Tavananezhad, N., & Karkhane, M. (2016). Predictors of health-related quality of life in Iranian women of reproductive age. *Applied Research in Quality of Life*, *11*(3), 723-737. DOI 10.1007/s11482-015- 9392-0.

Mitra, D. (2015). Crime and Correctional Administration.

Mmaduakonam, A. E., & Obi, I. E. Sexual Behaviours and Level of Knowledge of Reproductive Health among In-School Female Adolescents in Awka Education Zone.

Muntean, N., Kereta, W., & Mitchell, K. R. (2015). Addressing the sexual and reproductive health needs of young people in Ethiopia: an analysis of the current situation. *African journal of reproductive health*, *19*(3), 87-99.

Nandal, V., & Rajnish, M. (2014). Status of women through ages in India. *International Research Journal of Social Sciences*, *3*(1), 21-26.

Narayan, D. et. al. (2000) *Voices of the Poor: Crying out for Change*, World Bank, New York, and Oxford: Oxford University Press

National Family Health Survey - 4 (2015 -16). India Fact Sheet. Ministry of Health and Family Welfare.

Netto, L. D. A., Moura, M. A. V., Araujo, C. L. F., & Souza, M. H. D. N. (2017). Social support networks for women in situations of violence by an intimate partner. *Texto & Contexto- Enfermagem*, *26*(2).

Nikcevic, A. V., Kuczmierczyk, A. R., & Nicolaides, K. H. (1998). Personal coping resources, responsibility, anxiety and depression after early pregnancy loss. *Journal of Psychosomatic Obstetrics & Gynecology*, *19*(3), 145-154.

Nourani, S., Jonaidy, E., Shakeri, M. T., & Mokhber, N. (2010). Sexual satisfaction in fertile and infertile women attending state clinics in Mashad. *Journal of Reproduction & Infertility*, *10*(4).

Nunthara, C. (1996). *Mizoram: Society and polity*. Indus Publishing.

Nussbaum, M. C. (2001). *Women and human development: The capabilities approach* (Vol. 3). Cambridge University Press.

Ngo, H. Y. (1992). Employment status of married women in Hong Kong. *Sociological Perspectives*, *35*(3), 475-488.

OECD (2011) Families are changing. http://dx.doi.org/10.1787/888932392704

Ogletree, S. M. (2014). Gender role attitudes and expectations for marriage.

Olutola, F. O. (2012). Wife-mother-in-law relationship and violence among Yoruba women of South-Western Nigeria. *American Journal of Sociological Research*, *2*(2), 11-18.

Ormel, H. (1999). Can men make motherhood safer? An inquiry into the relevance and risks increased male involvement in safe motherhood initiatives. *Public Health, Royal Tropical Institute, Amsterdam, The Netherlands*.

Oswald, A. J. (1997). Happiness and economic performance.*The economic journal*, *107*(445), 1815-1831.

Panda, P. K. (2003). Poverty and young women's employment: linkages in Kerala. *Economic and Political Weekly*, 4034-4042.

Parish, W. L., Hao, L., & Hogan, D. P. (1991). Family support networks, welfare, and work among young mothers. *Journal of Marriage and the Family*, 203-215.

Pascarella, E. T., & Terenzini, P. T. (2005). *How College Affects Students: A Third Decade of Research. Volume 2*. Jossey-Bass, An Imprint of Wiley. 10475 Crosspoint Blvd, Indianapolis, IN 46256.

Patra, S., & Unisa, S. (2007). Female infertility in India: Causes, treatment and impairment of fertility in selected districts with high prevalence. *Indicators*, 08.

Pearlin, L. I., Menaghan, E. G., Lieberman, M. A., & Mullan, J. T. (1981). The stress process. *Journal of Health and Social behavior*, 337-356.

Perneger, T.V & Garnerin,P (2001). How Important Is Health for Overall Quality of Life? *Quality of Life Research* 214-214.

PHAN, L. (2013). Women's Empowerment and Fertility Changes. *International Journal of Sociology of the Family*, 49-75.

Phillips-Miller, D. L., Campbell, N. J., & Morrison, C. R. (2000). Work and family: Satisfaction, stress, and spousal support. *Journal of Employment Counseling*, *37*(1), 16-30.

Pillai, V.K., & Wang, G.Z.(1999).Reproductive Rights In Developing Countries: An Assessment of regional variations. *Michigan Sociological Review*,10-27.

Pollitt, A. M., Robinson, B. A., & Umberson, D. (2018). Gender conformity, perceptions of shared power, and marital quality in same-and different-sex marriages. *Gender & Society*, *32*(1), 109-131.

Prasad, J. H., Abraham, S., Kurz, K. M., George, V., Lalitha, M. K., John, R., & Joseph, A. (2005). Reproductive tract infections among young married women in Tamil Nadu, India. *International family planning perspectives*, 73-82.

Prenda, K. M., & Lachman, M. E. (2001). Planning for the future: a life management strategy for increasing control and life satisfaction in adulthood. *Psychology and aging*, *16*(2), 206.

Procidano, M. E., & Smith, W. W. (1997). Assessing perceived social support. In *Sourcebook of social support and personality* (pp. 93-106). Springer, Boston, MA.

Punam, S., & Sharma, N. (2017). The role and position of women Ancient society to modern society in India.*TWENTYFIRST CENTURY PUBLICATIONS PATIALA*, 127.

Puri, J. (2002). *Woman, body, desire in post-colonial India: Narratives of gender and sexuality*. Routledge.

Qin, Q., Jin, Y., Zhan, S., Yu, X., & Huang, F. (2016). Suicidal ideation among rural immigrant daughters-in-law with multi-roles as females, farmers and immigrants in China. *Psychology, Health & Medicine*, *21*(5), 608-617. DOI: 10.1080/13548506.2015.1112414

Radloff, L. (1975). Sex differences in depression. *Sex roles*, *1*(3), 249-265.

Radulović, O., Šagrić, Č., Višnjić, A., Tasić, A., & Marković, R. (2006). The influence of education level on family planning. *Med Biol*, *13*(1), 58-64.

Rammohan, A., & Johar, M. (2009). The determinants of married women's autonomy in Indonesia. *Feminist Economics*,*15*(4), 31-55.

Rani, K. (2016). Perceived social support and psychological well-being: testing the unique association and gender differences among young working adults. *Int J India Psych*, *3*(2), 98-113.

Rawat, P. S. (2014). Patriarchal beliefs, women's empowerment, and general well-being. *Vikalpa*, *39*(2), 43-56.

Raisi, F., Yekta, Z. P., Ebadi, A., & Shahvari, Z. (2015). What are Iranian married women's rewards? Using interpersonal exchange model of sexual satisfaction: a qualitative study. *Sexual and Relationship Therapy*, *30*(4), 475-489.DOI: 10.1080/14681994.2015.1024218.

Raley, R. K., & Sweeney, M. M. (2009). Explaining race and ethnic variation in marriage: Directions for future research. *Race and Social Problems*, *1*(3), 132-142. DOI 10.1007/s12552-009-9013-3.

Rammohan, A., & Johar, M. (2009). The determinants of married women's autonomy in Indonesia. *Feminist Economics*, *15*(4), 31-55.DOI: 10.1080/13545700903153989

Ransom, E. (2000). What role do men have in making motherhood safer? Questions researchers can ask. In *Population Association of America Annual Meeting*.

Repić, G., & Ivanović, S. (2014). Physical dimension of quality of life in ostomy patients. *Acta Medica Medianae*, *53*(3), 32-38.

Rice, R. W. (1984). *Work and the quality of life.* (No. TR-2-ONR). STATE UNI OF NEW YORK AT BUFFALO DEPT OF PCHYCHOLOGY.

Robb, Y., McInery, D., & Hollins Martin, C. J. (2013). Exploration of the experiences of young mothers seeking and accessing health services. *Journal of reproductive and infant psychology*,*31*(4),399-412. DOI: 10.1080/02646838.2013.832181.

Rodgers, W. L. (1977). Work status and the quality of life. *Social Indicators Research*, (1), 267-287. doi:10.1007/BF00353134.

Rostami, A. (2013). *Marital satisfaction in relation to social support, coping, and quality of life in medical staff in Tehran, Iran* (Doctoral dissertation, Umeå university).

Ruževičius, J. (2014,). Quality of life and of Working Life: Conceptions and Research. In *Liverpool (2014): 17th Toulon-Verona Conference" Excellence in Services"*.

Sandelowski, M., Holditch-Davis, D., & Harris, B. G. (1990). Living the life: Explanations of infertility. *Sociology of Health & Illness*, *12*(2), 195-215.

Santhya, K. G., Haberland, N., Ram, F., Sinha, R. K., & Mohanty, S. K. (2007). Consent and coercion: examining unwanted sex among married young women in India.*International Family Planning Perspectives*, 124-132.

Santow, G. (1995). Social roles and physical health: the case of female disadvantage in poor countries. *Social Science & Medicine*, *40*(2), 147-161.

Sarason, I. G., Levine, H. M., Basham, R. B., & Sarason, B. R. (1983). Assessing social support: the social support questionnaire. *Journal of personality and social psychology*, *44*(1), 127.

Saxena, S., Misra, P. J., Vishwanath, N. S., & Soman, V. R. B. (2013). Quality of life and its correlates in central india. *International Journal of Research & Development of health*, 2321-1431.

Saxena, K., (2017) Status of Women Education in India with Particular Reference to Women Empowerment and Development. Matern Child Health J (2014) 18:1985–1992. DOI 10.1007/s10995-014-1444-9.

Schwarzer, R., & Leppin, A. (1991). Social support and health: A theoretical and empirical overview. *Journal of social and personal relationships*, *8*(1), 99-127.

Schyns, P. (2002). Wealth of nations, individual income andlife satisfaction in 42 countries: a multilevel approach. *Social Indicators Research*, *60*(1-3), 5-40. doi:10.1023/A:1021244511064.

Sereshti, M., Nahidi, F., Simbar, M., Ahmadi, F., Bakhtiari, M., & Zayeri, F. (2016). Mothers' perception of quality of services from health centers after perinatal loss. *Electronic physician*, *8*(2), 2006.

Shin, D. C., & Johnson, D. M. (1978). Avowed happiness as an overall assessment of the quality of life. *Social indicators research*, *5*(1-4), 475-492. doi:10.1007/BF00352944.

Short, L.M., & Rosenberg, M.L., (2001) Intervening with victims of intimate partner violence, *Injury Control and Safety Promotion,* 8(2), pp. 63–69.

Singh, S. K. (2014). Life satisfaction and stress level among working and non-working women. *The International Journal of Indian Psychology*, *1*(4), 121-128.

Smetana, J. G. (2013). 29 Moral Development: The Social Domain Theory View.

Sniekers, M. (2018). Defining dreams: young mothers' agency in constructions of space. *Social &Cultural Geography*, *19*(8), 1073-1096.DOI: 10.1080/14649365.2017.1344872.

Song, L., Son, J., & Lin, N. (2011). Social support. *The SAGE handbook of social network analysis*, *9*, 116-128.

Song, Y., & Zhang, Y. B. (2012). Husbands' conflict styles in Chinese mother/daughter-in-law conflicts: Daughters-in-law's perspectives. *Journal of Family Communication*, *12*(1), 57- 74. DOI: 10.1080/15267431.2011.629968.

Soy, N. F., & Sahoo, H. (2017). Marriage arrangements and customs in India. *Social Science Spectrum*, *2*(4), 248-262.

Sprecher, S. (2001). Equity and social exchange in dating couples: Associations with satisfaction, commitment, and stability. *Journal of Marriage and Family*, *63*(3), 599-613.

Strine, T. W., Chapman, D. P., Balluz, L., & Mokdad, A. H. (2008). Health-related quality of life and health behaviors by social and emotional support. *Social psychiatry and psychiatric epidemiology*, *43*(2), 151-159.

Szalai, A. (1980). The meaning of comparative research on the quality of life. *The quality of life*, 7-21.

Tajvar, M., Arab, M., & Montazeri, A. (2008). Determinants of health-related quality of life in elderly in Tehran, Iran. *BMC public health*, *8*(1), 323.

Thapan, M. (2003). Marriage, well-being, and agency among women. *Gender & Development*, *11*(2), 77-84. DOI: 10.1080/741954320.

Theofilou, P. (2013). Quality of Life: Definition and Measurement. *Europe's journal of psychology*, *9*(1).

Turner, R. J. (1999). Social support and coping.

Uberoi, P. (1994). *Family, kinship and marriage in India*. Oxford University Press, USA.

Uberoi, P. (2005). The family in India. *Writing the women's movement: a reader. New Delhi: Zubaan*, 361-96.

Unisa, S. (1999). Childlessness in Andhra Pradesh, India: treatment-seeking and consequences. *Reproductive health matters*, *7*(13), 54-64.

United Nations. 1994. Report of the International Conference on1 Population and Development Cairo. September 5-13, 1994. New York: United Nations. U.S. Cencus Bureau (2000)

Van Balen, F. (2000). Interpreting infertility: Social science research on childlessness in a global perspective, Amsterdam, 8-11 November 1999. *African Journal of Reproductive Health/La Revue Africaine de la Santé Reproductive*, *4*(1), 120-122.

Wahlang, J. (2015). Changes in family and households: Social status and role of women among the Khasi tribe of Meghalaya. In *Conference paper: https://www. researchgate. net/publication/288141864*

Wahl, A. K., Rustøen, T., Hanestad, B. R., Lerdal, A., & Moum, T. (2004). Quality of life in the general Norwegian population, measured by the Quality of Life Scale (QOLS-N). *Quality of life research*, *13*(5), 1001-1009.

Walen, H. R., & Lachman, M. E. (2000). Social support and strain from partner, family, and friends: Costs and benefits for men and women in adulthood. *Journal of social and personal relationships*, *17*(1), 5-30.

Warner, R. L., Lee, G. R., & Lee, J. (1986). Social organization, spousal resources, and marital power: A cross-cultural study. *Journal of Marriage and the Family*, 121-128.

Weil, M. W. (1961). An analysis of the factors influencing married women's actual or planned work participation. *American Sociological Review*, *26*(1), 91-96.

Wiese, U., & MORADI, S. (2007). QUALITY OF LIFE AND RELATED FACTORS IN THE WOMEN WITH HIV IN TEHRAN.

World Health Organization. (2010). *Measuring sexual health: Conceptual and practical considerations and related indicators* (No. WHO/RHR/10.12). World Health Organization.

WHO 2017, Violence against women Newsroom/ Fact sheets

World bank 2019, Gender-Based Violence: Violence Against Women and Girls.

Xaxa,V. (2004) Women and Gender in the Study of Tribes in India. Indian Journal of Gender studies, 11(3), 345-367.

Yount, K. M., & Carrera, J. S. (2006). Domestic violence against married women in Cambodia. *Social Forces*, *85*(1), 355-387.

Yudhistar, K. 2003: *Violence Against Women*, Reference Press, New Delhi

Zhang, J. (2010). Marriage and suicide among Chinese rural young women. *Social Forces*, *89*(1), 311-326

Bio-Data

Name	: Catherine Lianhmingthangi
Father's Name	: ACL Khawngaiha (L)
Mother's Name	: Mary Romawii
Present Address	: Ramhlun South, Aizawl, Mizoram.
Contact Number	: 8731880135
Email id	: kathy3chhangte@gmail.com

PERSONAL DETAILS

Date of Birth	: 25th April 1991
Nationality	: Indian
Sex	: Female
Marital Status	: Single

EDUCATIONAL QUALIFICATION

Degree	University/Board	Year of Passing	Division/Grade
M.Phil	MZU	2014	A
MSW	MZU	2012	1st
BSW	NEHU	2010	2nd
HSSLC	MBOSE	2007	1st
HSLC	MBSE	2005	2nd

PAPERS PUBLISHED

	Title	Name of Journal	ISSN/ISBN No
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	Missing motherhood: Mizo Women's experiences with childlessness	Mizo studies. (A Quarterly Refereed UGC Care-List Journal) Volume X	ISSN No: 2319-6041
	Violence Against Women: Perceptions Across Gender In Aizawl City	International Journal of Science and research	ISSN:2319-7064
	Nuclear Versus Extended Family: Experiences of the Young Mo in Mizo Society	Contemporary Social Scientist. (A National Referred Journal)	ISSN:2230-956X
Contribution of Chapters in Books	Intimate Partner Violence Against Women In Aizawl City	Contemporary Psychosocial Issues-1	ISBN: 978-93-89490-00-8
	Perception on Intimate Partner Violence against Women in Mizoram	Violence Against Women in North East India	ISBN 978-81-830-481-6

PAPERS PRESENTED

Name of Seminar	Topic	Organised by	Date
National Online Seminar on Family, Community, Health and Wellbeing: Patterns Process and Outcomes of Social Work Research in India	The Young Mo In Mizo Society: Lived Experiences In The Extended Family	Department of social Work, Mizoram University	23rd-24th June, 2021
International Web Conference on "Pandemic Effect and Global Economy	Mental and Spiritual challenges among Youth during lockdown in	Amity School of Business, Amity University,	31st July- 1st August 2020

: Unseen Challenges & opportunities- Post COVID-19 Diagnosis”	Mizoram	Patna Bihar	
Exploring the Marriage and Family Experiences of North East India	Intimate partner violence against women: perception on gender in Aizawl, City.	Assam Don Bosco University, India	21st-22nd February 2020
National Seminar on Contemporary Psychosocial Issues-II	Intimate partner Violence: Experience and Social Support	Mizoram University Psychology Alumni Association	30th October 2019
National Seminar on Contemporary Psychosocial Issues	Intimate Partner Violence against Women in Aizawl City	Mizoram University Psychology Alumni Association	19th October 2018
National Seminar on Contemporary Psychosocial Issues	Quality of life of Women in Aizawl: Role of PWDVA, 2005	Mizoram University Psychology Alumni Association	19th October 2018

(CATHERINE LIANHMINGTHANGI)

PARTICULARS OF THE CANDIDATE

NAME OF CANDIDATE	: Catherine Lianhmingthangi
DEGREE	: Doctor of Philosophy
DEPARTMENT	: Social Work, Mizoram University
TITLE OF THESIS	: Social Support and Quality of Life of Young Married Women in Aizawl, Mizoram.
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BOS	: 09.05.2017
SCHOOL BOARD	: 22.05.2017
MZU REGISTRATION NO	: 5009 OF 2011
Ph.D REGISTRATION NO & DATE	: MZU/Ph.D/ 985 of 22.05.2017

(Dr. KANAGARAJ EASWARAN)
Professor & Head
Department of Social Work
Mizoram University
Aizawl -796004

ABSTRACT

SOCIAL SUPPORT AND QUALITY OF LIFE OF YOUNG MARRIED WOMEN IN AIZAWL, MIZORAM

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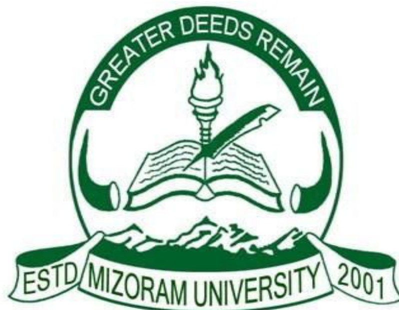
CATHERINE LIANHMINGTHANGI

MZU REGISTRATION NUMBER: 5009 OF 2011

PH.D REGISTRATION NUMBER: MZU/Ph.D/ 985 of 22.05.2017



DEPARTMENT OF SOCIAL WORK

SCHOOL OF SOCIAL SCIENCES

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SOCIAL SUPPORT AND QUALITY OF LIFE OF YOUNG MARRIED WOMEN IN AIZAWL, MIZORAM

BY

Catherine Lianhmingthangi
Department of Social Work

Dr. Grace Lalhlupuii Sailo

Submitted
In partial fulfillment of the requirement of the Degree of Doctor of Philosophy in Social Work of Mizoram University, Aizawl.

INTRODUCTION

The present study attempts to assess the Quality of life of Young Married Women in Mizoram. The study also explores the perceived social support and coping strategies of Young Married Women.

Social Support

The term "social support" is used to demonstrate various phenomenon in formal and informal relationships. It is a broad term that portrays the supportive behaviours and actions that people perform in a society (Helgeson 2003). It has also been defined as a concept and perceptions of a person about the available support, which serves in a particular function. It is commonly understood as an individual’s sensitivity towards the things they care for, their regard that are closely involved with other people (Bennett et al., 2001). Social Support thus refers to a broad variety of phenomenon that characterizes the social environment, or the people who surround individuals in their network.

Social support is a complex phenomenon that has been conceptualized in terms of either functional or structural properties, or both. The functional domain encompasses the availability of support and the quantity of support to which people have access. It also includes enactment of support, or the actual use of different types of support. It covers quality of support referring to the person’s satisfaction with available or received support and reciprocity of support, both giving and receiving support. The functional domain includes negative or positive support and content, or types of support (El-Bassel et al., 1998).

Women with low social support are indicated to have more stress, while those with stronger support from family and friends have less. Social support at the work place and at home significantly influences a person’s wellbeing. Spousal support is most effective in helping women deal with the demands of multiple roles (Duxbury and Higgins (1991), in Eckenrode & Gore, 1990). Family members have the ability to provide support to each other resulting in reduced levels of stress and depression (Johnson et al., 2010). Children are important members of women’s social network, with whom practically all of them maintain a strong bond, regardless of age or cohabitation. In particular, older children emotionally support mothers who are victims of spousal violence, comforting them in the moments after the assaults, or even advising them to seek out professional help (Netto, Moura, Araujo, & Souza, (2017) while on the other hand women benefited from supportive friends in the face of a strained partner relationship (Walen & Lachman, 2000).

Quality of Life

The concept of quality of life broadly includes how a person assesses the 'goodness' of life. These multiple aspects of measurement encompass an individual's emotional reaction to life episodes, one's outlook, sense of fulfilment and satisfaction in life, such as with work and personal relationships (Diener et al., 1999). WHO defines Quality of Life as "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" while Saxena et al., (2013) similarly stated that it is a large concept where the person's physical and psychological wellbeing, level of independence, social status, personal beliefs and relationship are affected in a complex way.

Quality of life requires multiple approaches from different theoretical viewpoints, as it is a multifaceted construct hence; exploring which domains to be covered could be a major challenge in defining quality of life. However, it is essential to view quality of life as a concept consisting of a number of social, environmental, psychological, and physical values (Theofilou,2013). In an attempt to understand quality of life, Bullinger & Ernst in Birnbacher (1999) have developed the concept of quality of life using four dimensions, physical which includes physical pain and discomfort; a psychological aspect such as fear and depression; a social aspect referring to the number and quality of social relations; and a functional dimension which includes work, household and leisure activities. In assessing the domains of Quality of Life, Kerce (1992) also recommended the inclusion of a wide spectrum of individuals and that it should be inclusive enough to represent the near total life experience.

Social Support and Quality of Life of Young Married Women

Social support is defined as the availability of people who make one feel cared about, valued, and loved (Sarason, Levine, Basham, & Sarason,. 1983). A study conducted by Iwanowicz-Palus, G., Mróz, M., & Bień, A. (2021) confirms the association of perceived social support and quality of life among pregnant women. Social support and self-efficacy contributed to better perceived quality of life among the respondents in which respondents who had lost a pregnancy reported lower quality of life in the psychological domain. The strongest positive correlation was found for the psychological quality of life domain. Thus, social support is evidently a significant concept that plays an important role among the factors that determine quality of life of a person.

Perceived social support has been defined as "an individual's perceptions of general support or specific supportive behaviours from people in their social network, which

enhances their life's functioning or may buffer them from adverse outcomes" (Malecki & Demaray, 2002). Nikcevic, Kuczmierczyk, & Nicolaides, (1998) further demonstrate that social bonds and networks have a beneficial impact on various aspects of an individual's psycho-physical condition, including reduced health-related stress, anxiety, and depressive symptoms. Similarly, Strine, Chapman, Balluz, & Mokdad, (2008) also acknowledged the association between social support and life satisfaction. They found that with decreasing level of social support, the overall dissatisfaction with life increases.

Women often have a greater number of close relationships and also a more extensive social network than men do (Laireiter & Baumann, 1992). Additionally, women provide more emotional support to others, and they seek and receive more social support (Ashton & Fuehrer, 1993). A study of Rostami, A. (2013) revealed that spousal support was an important indicator of marital satisfaction for women and QOL, and spousal support were significantly higher in men than in women. Apparently, women who experience better communication and receive more spousal support do not need to seek as much social support outside the marriage. When perceived spousal support is not sufficient, seeking support from other sources, such as extended family and friends, becomes more important (Namayandeh, Yaacob, & Juhari, 2010).

Literature Review

Review of literature helps the researcher to understand the theoretical background and empirical dimension of the research problem. It is also useful in identifying the various issues and possible gaps in literature. Therefore, the following literature highlights the existing studies on quality of life and perceived social support of women.

Social Support

According to Wellman (1981) social support is doing things, giving and lending things, help with personal problems, information help, and shared activities, values, interests, and interaction. Social support system according to **Cutrona and Suhr** involves five general categories such as informational, emotional, esteem, social network support, and tangible support. **Turner (1999)** defines social support as social bonds, social integration, and primary group relations. Social support has a multidimensional factors and majority of the studies have focused on the received support rather than support provided. Of the studies on received

support, perceived social support is more than actual support **(Song, L., Son, J., & Lin, N. 2011).**

According to **Albrecht and Adelman (1987)** social support as a verbal and nonverbal communication happens between the recipients and providers in order to reduce uncertainty in various aspects of life. Such communication enhances one's perception about life's experiences. **Berkman (1984)** also sees it as a social network that provides emotional, instrumental and financial help.

The access to and use of a person, group and organization in the management of ups and downs in life are considered social support by **Pearlin et al., (1981).** More recently, **House et al., (1988)** considered it as "the emotionally or instrumentally sustaining quality of social relationships". Social support as defined by **Dean and Lin (1977)** is a role of primary groups to meet the significant needs and later redefined by **Lin et al., (1979)** as "support accessible to an individual through social ties to other individuals, groups, and the larger community".

Another interesting finding from **Diener and Suh (1997)** suggested that those nations who rated friendship as being extremely important reported a higher level of well-being. A similar pattern is stated by **Argyle (1987)** that life satisfaction has strong relations with friendships and social support.

Kosterina (2012) acknowledged that young women exercised networks in order to create a sense of power and control over their lives. Networks are used to access advice, economic and emotional support when women do not receive them from their husbands. Making networks with other women continue to be important for attaining advice and accessing emotional space to disclose and share emotions and frustrations in marital relationships. The everyday communications and networking with other women provides an important space for young women, particularly relatives and close female friends offered an emotional support that was considered missing from their marriage. In assessing kin networks and support, and the consequences of this support for women's work.

Parish et al., (1991) found that most young mothers in the research have access to nearby kin, and it is these kin who mostly assist them with child care and income support followed by next closest kin. Almost a fourth (17%) of young married women in the study had female kin in the same household who offered support. When the research combined household and neighbourhood statistics, more than half (58%) of women had female kin either at home or in the neighbourhood who then provide support and assistance to half of

these women. The research concluded that kin networks evidently improve the quality of life for some young mothers as they turn to kin for assistance and support.

Quality of Life

QOL is a multidimensional concept. It looks into many domains and facets that have an impact on lifestyle. It is used to measure an individual access to provisions of life such as education, sanitation, clean water, information about reproductive health-care and services, adequate housing, ownership of means of transportation, and ownership of household appliances **(Andrew &Withey, 1976).**

According to **Liégeois (2014),** there are two sets of components in measurement of quality of life: subjective and objective aspect. The characteristics of life situation that are observed and experienced by a person in an objective manner is referred to as objective quality of life however **Rice (1984)** further identifies objective quality of life (QOL) as the standards of living, activities and consequences of an individual's life. The subjective aspects according to **Liégeois (2014)** are subjective perceptions and reception of life situation hold by a person whereas Rice (1984) defined it as a set of affective beliefs directed toward one's life. For valid and reliable assessment of quality of life, one needs to take into consideration both the aspects although subjective aspects are largely considered essential.

Status of Women

The studies on position of tribal women per se have not been many nor of much depth **(Xaxa, 2004). Holland and Hogg (2001)** stated that, in general, men are the head of households and are given full authority to make households decision in many developing countries while the wife do not experience equity in this process. To illustrate this, **Hossain (2015)** noted that no matter who earns the cash, men normally manage the financial matters in the family and control the household purchases. Therefore, women in such families lack financial autonomy and become financially vulnerable as woman has to depend on husband’s understanding and willingness to spend money even if she needs medical care and health services. In such cases, it can be assumed that women who have higher participation in household decision-making are more likely to receive health care services.

The NFHS-IV (2014-15) reported the status of women between 15-49 years. According to this survey, 84% of currently married women usually participated in household decisions while there were 68.4% of currently married between 15-49 years who use Family

Planning Methods. The ever-married women who have experienced violence during any pregnancy consist of 3.3%. A study in India conducted by **Garg (2011)** noted that the Indian women's control over their life decision is limited to visiting healthcare centre and grocery store. In his study, a large number i.e. almost 80% of women said that they had to seek permission from their family members to visit health centre. The family members whom they had to seek permission are husbands and senior family members. Majority of those women had to seek permission from their husband while almost an equal number of women needed permission from senior family members.

Young women experience some of the highest rates of Intimate Partner Violence (IPV) yet very few studies observed its effects on young mother's postpartum health risks. Young women's stress after pregnancy received a very less attention while a study in twelve countries conducted by World Health Organisation observed that younger married women are more likely to experience IPV. According to a report from US national survey during ten years (1993 to 2003), young married women between 20 to 24 years were at greatest risk of IPV while 16 to 19 years of women ranked third nationally. A 16 states survey in US also showed that the risk for IPV is doubled for pregnant young women **(Agarwal 2014).**

Ngo (1992) found that educated women are usually economically independent and that younger women have closer ties with formal employment. **MacMillan and Gartner (1999)** noted that man in Canada use violence to control their working partner while they remain unemployed. The increase in education among women, the improved economic position of women, working condition, increased equal pay for equal work, larger space between marriage and the birth of the first child, increasing urbanization and so on are some other factors besides husband's income that influence labour participation of married women **(Jalilvand 2000).** The traditional belief of husbands to be the sole winner and wife to be homemaker gradually vanish and Jalilvand (2000) noted that working women have a better personal value structure as compared non-working women who are largely influenced by social and religious values.

Women's autonomy may be influenced by traditional cause such as dowry and co-residence with mothers-in-law. However, women's education and economic independence raise most indicators of women's autonomy. **Al Riyami, Afifi & Mabry (2004)** studies in a highly stratified society like Oman argued that education was one key indicators of women's status. Their study highlighted that although the traditional and community influence remain strong, educated and empowered women were more likely to have control over their Reproductive rights. More than half are the educated women who reported that they influence

the family planning while a lesser number and illiterate women in the study reported that their husbands make decision. Unmet contraceptive need for women resulted in pregnancy for almost a fourth of women in their study and the percent significantly decreased with women's education and employments outside the home.

Young married women normally experienced early pregnancy and birth outcomes that might be influenced by the cultural norms. A community based cross sectional study carried out by **Jean et al., (2006)** among young married women aged 16-22 years in India found that there was a high prevalence of RTI among the participants yet they rarely seek treatment. Two thirds of young married women in the study had not sought any medical treatment and the reasons cited includes lack of female health care provider, lack of privacy, distance of health centre from home, the cost of treatment and ignorance of symptoms. Even though the participants are young at age, the proportion of RTI's is high.

In the traditional family, women are often treated as an addition and instrument of the needs of other family members. They are regarded as a mere cook, cleaner, reproducer, and caretaker, rather than as a source of agency and worth in her own right **(Nussbaum 2000).** According to **George (2002),** newly married women rather powerless are often victims of patriarchal systems and its social practices. Such a society valued motherhood and women acquire further legitimization of their status as women once they bear children. In-laws harass young married women if a child is not born after 2 or 3 years of marriage telling her she has some fault in her. Women lack the autonomy to regulate their sexual and bodily experiences. From this perspective, the practice of sexual relations represents women's bodies as machines and that childbearing is central to married women's sense of well-being. In addition to this, **Thapan (2003)** stated that women attained a sense of achievement by not only bearing a child, but also her ability to produce a male child in appropriate time. Experiencing childlessness is not rare and uncommon in today's world yet women who cannot bear children at all, or who do not bear a male child are regarded as family dishonor.

Diener and Suh (2003) acknowledged that for personal happiness and general satisfaction with life, health and social relationships are far more important than income and affluence whereas **Ackerman and Paolucci (1983)** reported that quality of life increases with the adequacy of individual's income which further elevated the satisfaction with life. The employment of a person clearly reduced individual satisfaction with life **(Clark et al., 2001)** as **Rodgers (1977)** acknowledged that the currently unemployed individuals who expected to continue to work reported a higher degree of life satisfaction as compared to those who expected to stop working. In a study conducted among university students, **Dvorak et al.**

(2005) found that students who engaged themselves in spiritual activities were less likely to experience mental health problem and depression in particular and at the same time more likely to report greater life satisfaction. The same pattern is found in a study of **Heilemann et al. (2002)** that the level of women's life satisfaction had a significant influence on their level of depressive symptoms. Certain variables such as unemployment, health status, gender, marital status, regional differences, and education influenced the individual's level of satisfaction. This statement is concurred by **Bukenya et al., (2003)** in their study of QOL satisfaction and health of rural residents in West Virginia.

A study conducted by **Degni et al., (2010)** among married Iranian women in Findland reported that women who use contraceptive had discussed the method of birth control with their husbands. Although women's social network and friends influenced their decision of contraceptive use, communication and networking between husbands and wife had the most effect on contraceptive use decision and family planning. The data showed that 85% of women discussed family planning with their husbands and decision-making power and autonomy in the use of contraception was highly influenced by greater autonomy in husband-wife relationship.

Family relationships are attached to women's sense of wellbeing and quality of life. The perceived quality of relationships with parents in law has a significant relation to stress for daughters in law **(Marotz & Mattheis 1994).** Likewise, **Jean Turner et al., (2006)** in their study observed the challenges of the mother in law and daughter in law relationship especially in the extended families as both members enter the new relationship. The study also observed that although some of them reported fine relationships between the two, there are times they hesitate to trust the new relationship. The disparities in goals and values and poor communication skills often arise in such new relationships.

Char and Kulmala (2010) give emphasis on the presence and influence of mother in law on childbearing decisions on young couple. In a study to assess the influence of mother in law, Char and Kulmala (2010) carried out interviews with mothers in law, daughters in law and son living in extended families. The study observed that mothers-in-law have a strong influence on family decisions relating to household activities. They were also more likely to control the number of children young couple should produce and the timing of their daughters-in-law being sterilized. The study also noted that older women or mothers in law generally made decisions pertaining to daily chores including kitchen matters and taking care of children.

Kieren, Henton and Marotz (1975) noted the perceptions of both husbands and wives that husband's kin are more likely to be the source of conflict than the wife's kin in case of marital conflict. **Song and Zhang (2012)** carried out a study in China to assess daughters in law perspective on husband's involvement in daughters in law and mothers in law conflict. The findings suggested that as the conflicts remain unsolved, daughters in law continued to be unsatisfied with the husband's avoidance of existing conflict between daughters in law and mothers in law. The Chinese daughters in law are also of the opinion that husbands plays an important role in conflict solving in such relationships and husbands support in conflict management are meaningful and crucial. Findings also indicates that daughters in law in the sample perceived that husband uses the problem solving style to manage conflict between the daughters in law and mothers in law which is very crucial for daughters in law who enter a new family and share a new family identity with the mother in law.

Unlike the ideology of son preference in many other societies, the birth of a female child in Mizo family was celebrated with the same joy as that of a male child. In fact, as female child continue to exist in the family constellation and initiated the responsibilities of looking after the home, some parents felt happier and advantageous to have a female child than a Male child who had to move in to '*Zawlbuk'* in his very early life. The availability of female child to keep the home brings greater closeness to the parents that promote psychological reinforcement to the parents in Mizo society. Women continue to live under the protection of their parents to the extent that parents provide active support in the well-established social custom of 'nula rim' (Courting) **(Chatterji, 2008).**

Statement of the problem

The status and role of women in India even after independence remains one of the major issues of discussion. It is a matter of concern not only in the Indian context but in almost every society of the world. Young married women in Mizoram are also undergoing a lot of changes in their personal-family life domains post marriage. Their relationship with own family, mobility, decision making, freedom etc. is curtailed and reshaped as per the demands of the husband and his family. Thus the study seeks to understand how women perceive their quality of life and the available perceived social support.

Objectives

1. To understand the socio economic and structural information of young married women.

2. To assess the psychosocial challenges and Quality of Life of young Married Women in Aizawl.

3. To identify the social support and coping mechanism of young Married women.

4. To suggest policy and advocacy interventions from a social work perspective

Chapterization

The study is organized into eight chapters. The first chapter introduced the concept of Quality of life of women and its related issues at global and local levels. The second chapter presented the review of literature that was sub divided into ten sections. The third chapter discussed the methodology used in the study. It encompasses details of the study area, research design including sampling, methods and tools of data collection, data analysis and limitation of the study. Socio economic information and structural bases of the respondents are discussed in the fourth chapter. It includes the Educational & Socio-Economic details of the respondents. Challenges and experiences of young married women in the study are presented in the fifth chapter. It includes description of challenges pertaining to spousal and in laws relationships. Women's experiences on the various forms of abuse and the level of women's autonomy in decision making in various aspects of life are likewise discussed.

Research Design

The study is descriptive in nature and employs both qualitative and quantitative methods of data collection. Data was collected from both primary and secondary sources. Field Survey using pre-tested Interview Schedule was administered among young married women from eight communities of Aizawl to probe into their quality of life. Case Interviews were conducted to understand the lived experiences and perceived social support of young married women. Secondary data was drawn from relevant books, research articles and online sources.

Sampling

A multi stage sampling procedure was adopted for identification of study sample.

Selection of Study Area

In the first stage, Aizawl the capital of Mizoram was selected. In the second stage, four zones were selected based on location within AMC area. In the third stage, two localities each were identified from each of these zones. A total of eight localities were identified as study area such as Falkland, Chaltlang, Armed Veng South, College Veng, Nursery Veng, Chawlhhmun,and Rangvamual.

Selection of Respondents

In Mizoram, the Mizo Hmeichhe Insuihkhawm Pawl (MHIP) is a women's organization which exists in each locality of the state. The MHIP have all the records of women in the respective locality and the respondents were purposively chosen from the list procedure from the MHIP of each of the eight localities.

The sample was proportionately distributed across Aizawl Municipal Area where 30 respondents each were selected from the identified eight localities to represent each zone. The size of sample is 240.

Sampling Criteria

The following criteria were used in selection of sample:

i) Married women between the ages of 18 to 40 years.

ii) Has been currently married for a period of at least two years.

iii) Willing to give informed consent both on perceptions and experiences.

Ethical Considerations

Ethical considerations were followed in the research process. Informed consent was obtained from respondents before conducting interview for survey as well as for case studies.

Tools of Data Collection

A pre tested Interview schedule was used for data collection which consists of 13 sections with various queries. The major sections of the Interview Schedule are Profile of the respondents, Particulars of the respondents, Relationship with spouse, Relationship with in-laws, Personal Situation, Social Domain, Psychological Domain, Health Domain, Financial Domain, Awareness/Knowledge regarding Reproductive Health, Perceptions related to Reproductive Health/Rights, Perceptions on Married life and experiences of Childless respondents (see appendix).

A Pilot study was firstly conducted among 10 respondents and in the light of which a structured interview schedule was constructed. Some modifications were made in the light of findings from pilot study. The final survey was then conducted using snowball sampling among young married women.

Data Processing and Analysis

The quantitative data collected through field survey was processed with computer packages of MS Excel and SPSS. Data is analysed and presented in simple statistical methods of averages and percentages along with Karl Pearson's product moment correlation coefficient, t-test and Chi Square to find association between different variables.

Concepts and Operational Definitions

In this section, some of the important concepts related to the study are presented along with their operational definitions.

Social Support

Perceived social support measures differ in terms of the specificity of support sources to which they refer (Procidano & Smith ,1997). Social support in this study is operationalizes as perceived available support in terms of respondent's access to support and assistance that friends, family, and others provided if needed and such perceived supports of the respondents are linked to have beneficial effects on self-confidence, self-esteem and well-being.

Quality of Life

The WHO defines Quality of Life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.

As there is no collective determination of quality of Life, an individual's health including physical and mental health, the amount of independence and one's relations with his dynamic environment largely influenced and determines a person's quality of life (Ruževičius, 2012 & Shin, 1979; Ruževičius, 2014)

In this study, the concept of quality of life is operationalized based on WHOQOL-bref which a quality of life assessment tool developed by the World Health Organization. The WHOQOL-Bref includes four domains with multifaceted compionents incorporated in each of the domains as given below:

WHOQOL-BREF DOMAINS

Domain	Facets incorporated in the domains
Physical health	Activities of daily living, Dependence on medicinal substances and medical aids, Energy and fatigue, Mobility, Pain and discomfort, Sleep and rest, Work capacity
Psychological health	Bodily image and appearance, Negative feelings, Positive feelings, Self-esteem, Spirituality, religion and personal beliefs, Thinking, learning, memory and concentration
Social relationship	Personal relationship, Social support, Sexual activity
Environmental	Financial resources, Freedom, Physical safety and security, Health and social care: accessibility and quality, Home environment, Opportunities for acquiring new information and skills, Participation in and opportunities for recreation, Leisure activities, Physical environment(pollution, noise, traffic, climate), Transport

.

Based on the WHOQOL-Bref, QOL is categorized into five domains for the purpose of the study. It includes five domains such as Health domain, financial domain, Social Domain, Personal Domain and Psychological Domain.

QOL Domains operationalized for the study

Health Domain	Access to health care, energy, liberty in health care decision making, Dependence on medicinal substances and medical aids,, health attention, physical pain, reproductive health issues, Sexual activity.
Financial Domain	Employment status, sufficient money, savings, Financial resources
Social Domain	Environment, Religious participation, education, support and network, participation in social activities,
Personal Domain	Quality time with spouse and family, autonomy, to be free from abuse, ability to perform daily activities, peaceful life, family relationship,

Reliability test

Cronbach's Alpha	.739
Guttman Split-Half Coefficient	.61

The reliability of the tool used in the study have been tested using Cronbach's Alpha and Guttman Split-Half Coefficient.

Health Domain

Quality of life is a subjective perception of how an individual feel about their health status and the non-medical aspects of their lives. Therefore, it is a distinctively personal issue (Repić, G., & Ivanović, S, 2014).

The study operationalizes the health dimension of quality of life of young married women in terms of their health condition, access to general health care, and other maternal and reproductive health related issues.

Financial Domain

For the purpose of the study, the earning respondent's pattern of savings, their autonomy and liberty in using their income to meet an ends are covered under financial domain. The final domain of young married women is also operationalizes in terms of respondent's autonomy to engage in employment outside the home.

Social Domain

Social dimension is a wide concept, encompassing several factors of an individual's life. Therefore, the study operationalizes social dimension of quality of life in terms of available social support and opportunity of engagement in social activities.

Personal Domain

Women established their well-being from the amount and quality of relationship they encounter with their spouses and family members. Therefore the study operationalizes personal domain in terms of respondent's family relationship, their bond with the spouse and family members, self-determination in terms of performing daily activities and prospect to live a peaceful life.

Young Married Women

In this study, the concept of young married women is restricted to married women who are 18-40 years of age and who had been married at least two years at the time of the interview.

Limitations of the study

The study is confined to Aizawl city area therefore it may not represent all Mizo Women. Lack of sufficient previous research studies is another limitation found in the present study.

Results and Conclusion

Quality of life denotes the standard of wellbeing, security, comfort and happiness of a person or group of people and there are various domains that determines a persons' quality of life. The study has probed into the physical, psychological, social, economic and spiritual wellbeing of respondents which determines the quality of life of young married women in Aizawl. It also probed into the socio-economic and structural information, challenges and lived experiences of young married women and the perceived social support and network available.

It is evident in the study that there were more dependents than earning respondents whereas non poor respondents are majority among the respondents. More than half respondents resides in nuclear family and regarding age at marriage, respondents who married during 18 to 30years are the majority. A vast majority of respondents have married for love. Although married for love, almost a sixth are involuntary childless and it is further gloomy to note that 1.3% of respondents aged between 18 to 24 years are also found to have no children. A very few respondents reported that they do not have enough quality time with their husbands, and also they do not have a spouse who listens to their problems. Conversely, a large majority of respondents acknowledged their male counterpart's support and respondents of 25 to 35 years are the majority to agree on the statement.

The study found that age is highly significant with level of satisfaction in personal domain (X^2=19.54, p=.000**) and social domain (X^2=23.38, p=.000**). Age is also highly correlated with health quality dimension total. There is also positive relationships between perception of self and age category. Age at marriage is also found to be highly significant with fertility treatment of self.

Educational status of respondents is found to be highly significant with statements on perceptions and experience of married life. Employment has highly positive relation with financial domain of dependents while it has a negative relation with financial domain total of earners. Level of satisfaction in financial domain of earners is found to be highly significant with respondent's educational status (X^2=24.8, p=.00).

In the matter of autonomy in going out alone in public, the study found that almost a fifth are restricted by their spouses and the least freedom of movement was observed among 18 to 24 years respondents. Quality of life is also dependent on how one perceives and experiences one's intimate relationship and the study found that most respondents claim that their intimate relationship is satisfactory. The study found that the most common form of abuse respondents' experienced from their spouse is verbal abuse followed by physical abuse. It was also apparent that MIL was the main family member to abuse the respondents and it involves psychological abuse across all age groups. Involvement in family decision making pattern revealed that respondents' involvement and authority is utmost in the authority in kitchen matters. In terms of health care, respondents' spouses were found to make most health care decision followed by the respondents themselves.

With regard to childlessness, a larger number of respondents' claimed that they have fertility issue and they further claimed that this issues has a history on their family while there's no report on infertility history on the spouse family. However, a larger majority of respondents' claimed that their spouse and in-laws reacted positively to their involuntary childlessness situation. With regard to age of respondents, fertility treatment of self is found to have significance. With regard to the association of age with in laws reaction to childlessness, age of respondents has significance with in laws reaction to childlessness.

The case findings illustrates the vulnerability of young married women particularly those involuntary childless and *Mo* in the marital home. Various forms of abuse perpetuated by husband or in laws are present in each of the cases and for young married women in extended family, well-being or quality of life hugely depend on the level of quality interactions and relationships in her marital home. However, married women in the case studies perceive that they gain more respect post marriage and particularly working women in the study greatly derive a sense of wellbeing from their level of education and monetary earnings.

Women in the case studies also speak their experience as married women where they attain change particularly emotional growth and prosperity. All the women report that being married enhances their sense of fulfillment and they attain emotional security. It can also be seen that women in the long experience of marriage had a greater level of emotional strength and independence. However, in difficult circumstances, spiritual maintenance was the most common form of coping mechanism employed by young married women. The daily personal and family devotions tend to help them in fighting their daily challenges. Social support is not much evident in the cases however, young married women's' coping strategies gradually developed with the increasing years of marriage as they become emotionally established. The main sources social support are respondent' spouse, friends, respondents' biological mother and the MIL's of respondents.

The status of women has always been a subject of serious discussion in many societies. It incorporates several alarming issues consisting women education, health, autonomy in various fields, participation in decision making at all levels and the roles and participation of women in different social institutions. The position of women in Mizo society needs a closer look as it may be overrated in many aspects. Many women still confronts abuse and torture as an expression of male dominance over women. Also a patriarchal society such as Mizo society exhibits a culture that anticipate its women to obey the rules set by its men. The status of married women is no greater as there are many imposed directions and duties set by the society. As quality of life is a measurement of the degree to which a person is healthy and able to enjoy and participate in life events, the current status of women decides the quality of life of young married women in Aizawl.

Suggestions

The present study aims to propose suggestions at various levels with the interest of the need for uplifting women by reconsidering their experiences in Mizo society. The study aims to offer suggestions for different practitioners at different levels with the concern of the current status of women in Mizoram. Therefore, this section is presented into three section based on the findings of the present study.

Implications for Social Work research

1. The study reveals the status of young married women which was overrated. Therefore, for better understanding of women and their life experiences in a society, research on specific matters relating to women's experiences in different field must be initiated.

2. The method of social work research must be promoted in order to enrich knowledge about women especially in patriarchal society.
3. A comparative study on married women in nuclear families and extended families would be an interesting research which will contribute to the knowledge on traditional practices in patriarchal society.
4. Research that probes into the life experience of married women would be particularly helpful in the field of women's studies.
5. A qualitative study may be conducted to explore the quality of life of married women in their pre and post marriage
6. The role of social networking in promoting the quality of life of married women may be explored.

Suggestions at the Micro level

1. Psychological counseling for young married women can be initiated.

2. Promoting emergency helpline centre for women by creating need based awareness particularly for the battered young married women.

3. Formation of family counseling centre that caters the marital counseling to strengthen the family relationship and dynamics.

4. Establishing support groups for young married women who are facing similar problems in marital/family life.

5. Special support group for involuntary childless married women can be introduced.

Suggestions at the Mezzo level

1. Church can play active role in disseminating awareness on the importance of women in family, family resilience as well as family mental health per se.

2. MHIP can be made use to sensitize the community on current status and needs of women.

3. Community awareness on the Protection of Women from Domestic Violence Act can be promoted.

4. Collaboration with women helpline in order to identify women in distress can be initiated.

Suggestions at the Macro level

1. The available empowerment programs and policies for women can be strengthened for the overall women development.

2. Research on more issues of Mizo women and advocating for productive changes on the issues of Mizo women can be conducted.

3. More research and awareness on women’s issues through academics and mass media would be helpful to promote women’s well being

REFERENCES

Abdoly, M., & Pourmousavi, L. (2013). The relationship between sexual satisfaction and education levels in women. International Journal of Women's Health and Reproduction Sciences, 1(2).

Ackerman, N., & Paolucci, B. (1983). Objective and subjective income adequacy: Their relationship to perceived life quality measures. *Social Indicators Research*, *12*(1), 25-48. doi:10.1007/BF00428859.

Alborzi, S., & Area, M. (2008). The relationship between autonomy and quality of life in Shiraz University of Medical Sciences, bright, talented students. *Women's Study*, *6*(2), 47-61.

Andrew, F. M., & Withey, S.B. (1976). Social indicators of well being. *New York and London: Plenum,* 20-31.

Antonucci, T. C., & Akiyama, H. (1987). An examination of sex differences in social support among older men and women. *Sex roles*, *17*(11-12), 737-749.

Agarwal, B. (1995). *A field of one's own*. Cambridge University Press.

Agrawal, A., Ickovics, J., Lewis, J. B., Magriples, U., & Kershaw, T. S. (2014). Postpartum intimate partner violence and health risks among young mothers in the United States: a prospective study. *Maternal and child health journal*, *18*(8), 1985-1992.

Akpan, E. O. (2003). Early marriage in eastern Nigeria and the health consequences of vesicovaginal fistulae (VVF) among young mothers. *Gender & Development*, *11*(2), 70- 76.

Alborzi, S., & Area, M. (2008). The relationship between autonomy and quality of life in Shiraz University of Medical Sciences, bright, talented students. *Women's Study*, *6*(2), 47-61.

Albrecht, T. L., & Adelman, M. B. (1987). *Communicating social support*. Sage Publications, Inc.

Allendorf, K. (2013). Going nuclear? Family structure and young women's health in India, 1992–2006. *Demography*, *50*(3), 853-880.

Al Riyami, A., Afifi, M., & Mabry, R. M. (2004). Women's autonomy, education and employment in Oman and their influence on contraceptive use. *Reproductive health matters*, *12*(23), 144-154. DOI: 10.1016/S0968-8080(04)23113-5.

Antonucci, T. C., & Akiyama, H. (1987). An examination of sex differences in social support among older men and women. *Sex roles*, *17*(11-12), 737-749.

Argyle, M. (2013). *The psychology of happiness*. Routledge.

Baheiraei et al. (2012). Social support for women of reproductive age and its predictors: a population-based study. *BMC women's health*, *12*(1), 30.

Barua, A. (1998). Young husbands' involvement in Reproductive Health in Rural Maharashtra. *Population Council, New Delhi, India*, 6-8.

Barua, A., & Kurz, K. (2001). Reproductive health-seeking by married adolescent girls in Maharashtra, India. *Reproductive health matters*, *9*(17), 53-62.

Barua, A., Pande, R. P., MacQuarrie, K., & Walia, S. (2004). Caring men? Husbands' involvement in maternal care of young wives. *Economic and Political Weekly*, 5661-5668.

Barzelatto, J. (1998). Understanding sexual and reproductive violence: an overview. *International Journal of Gynecology & Obstetrics*, *63*, S13-S18.

Becker, S. (1996). Couples and reproductive health: a review of couple studies. *Studies in family planning*, 291-306.

Beigh ,S.K..& Shafi, H. (2018). Perceived Social Support among working women with respect to various socio-demographic variables. *International Journal of Movement Education and Social Science.*

Berkman, L. F. (1984). Assessing the physical health effects of social networks and social support. *Annual review of public health*, *5*(1), 413-432.

Bhawana, D., & Neetu, S.(2014) CRIMES AGAINST WOMEN AND SOCIETAL ILLS: AN OVERVIEW.

Birnbacher, D. (1999). Quality of life-evaluation or description.*Ethical Theory and Practice*, *2*(1), 25-36.

Bloom, S. S., Wypij, D., & Gupta, M. D. (2001). Dimensions of women's autonomy and the influence on maternal health care utilization in a north Indian city. *Demography*, *38*(1), 67-78.

Bongaarts, J. (2003). Completing the fertility transition in the developing world: The role of educational differences and fertility preferences. *Population Studies*, *57*(3), 321-335.

Borisch, B. (2014). Maternal and child health–The MDGs 4 and 5–Some caveats. *Journal of public health policy*, *35*(4), 538-539. doi:10.1057/jphp.2014.34.

Bowling, A., & Windsor, J. (2001). Towards the good life: A population survey of dimensions of quality of life. *Journal of Happiness Studies*, *2*(1), 55-82.

Bouwmans, C., de Sonneville, C., Mulder, C. L., & Hakkaart-van Roijen, L. (2015). Employment and the associated impact on quality of life in people diagnosed with schizophrenia. *Neuropsychiatric disease and treatment*, *11*, 2125.

Bruce, J., & Clark, S. (2003). In technical consultation on married adolescents.

Bukenya, J. O., Gebremedhin, T. G., & Schaeffer, P. V. (2003). Analysis of rural quality of life and health: A spatial approach. *Economic Development Quarterly*, *17*(3), 280-293.

Bumiller, E. (1991). *May you be the mother of a hundred sons: A journey among the women of India*. Penguin Books India.

Caldwell, C., Wasson, D., Brighton, V., Dixon, L., & Anderson, M. A. (2003). Personal autonomy: development of a NOC label. *International Journal of Nursing Terminologies and Classifications*, *14*, 12-13.

Carter, M. W. (2002). 'Because he loves me': husbands' involvement in maternal health in Guatemala. *Culture, Health & Sexuality*, *4*(3), 259-279.

Chadda, R. K., & Deb, K. S. (2013). Indian family systems, collectivistic society and psychotherapy. *Indian journal of psychiatry*, *55*(Suppl 2), S299.

Char, A., Saavala, M., & Kulmala, T. (2010). Influence of mothers-in-law on young couples' family planning decisions in rural India. *Reproductive health matters*, *18*(35), 154-162.

Chatterji, N. (2008). The earlier Mizo society. *Deepak Enterprise, Kolkata*.

Chhabra & Annapurna. (2018). Awareness of Reproductive Health amongst Rural School Dropout Girls. *Journal of Reproductive Health and Contraception.* Vol.3 No.2:10

Clark, A., Georgellis, Y., & Sanfey, P. (2001). Scarring: The psychological impact of past unemployment. *Economica*, *68*(270), 221-241. doi:10.1111/1468-0335.00243.

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological bulletin*, *98*(2), 310.

Coleman, D. (1996). New patterns and trends in European fertility: international and sub-national comparisons. *Europe's population in the 1990s*, *1*, 1-61.

Craig, L., & Mullan, K. (2013). Parental leisure time: A gender comparison in five countries. *Social Politics*, *20*(3), 329-357.

Crissey, S. R. (2005). Effect of pregnancy intention on child well-being and development: Combining retrospective reports of attitude and contraceptive use. *Population Research and Policy Review*, *24*(6), 593-615. doi:10.1007/s11113-005-5734-1.

Cutrona, C. E., & Suhr, J. A. (1992). Controllability of stressful events and satisfaction with spouse support behaviors. *Communication Research*, *19*(2), 154-174.

Daniel, E. E., Masilamani, R., & Rahman, M. (2008). The effect of community-based reproductive health communication interventions on contraceptive use among young married couples in Bihar, India. *International family planning perspectives*, 189-197.

Deatsman, S., Vasilopoulos, T., & Rhoton-Vlasak, A. (2016). Age and fertility: a study on patient awareness. *JBRA assisted reproduction*, *20*(3), 99.

Degni, F., Ojanlatva, A., & Essen, B. (2010). Factors associated with married Iranian women's contraceptive use in Turku, Finland. *Iranian Studies*, *43*(3), 379-390. DOI:10.1080/00210861003693919.

Dhawan, N., Punetha, D., Sinha, Y., Gaur, S. P., Tyler, S. L., & Tyler, F. B. (1999). Family conflict/violence patterns in India.*Psychology and Developing Societies*, *11*(2), 195-216.

Diener, E., Sandvik, E., Seidlitz, L., & Diener, M. (1993). The relationship between income and subjective well-being: Relative or absolute?. *Social indicators research*, *28*(3), 195-223.

Diener, E., & Suh, E. (1997). Measuring quality of life: Economic, social, and subjective indicators. *Social indicators research*, *40*(1-2), 189-216. doi:10.1023/A:1006859511756.

Diener, E., Suh, E. M., Lucas, R. E., & Smith, H. L. (1999). Subjective well-being: Three decades of progress.*Psychological bulletin*, *125*(2), 276.

Dube, L. (1988). On the construction of gender: Hindu girls in patrilineal India. *Economic and Political Weekly*, WS11-WS19.

Dumas, A., Robitaille, J., & Jette, S. L. (2014). Lifestyle as a choice of necessity: Young women, health and obesity. *Social Theory & Health*, *12*(2), 138-158.

Durkheim, Emile. 1951 [1897]. Suicide: A Study in Sociology.

Duxbury, L. E., & Higgins, C. A. (1991). Gender differences in work-family conflict. *Journal of applied psychology*, *76*(1), 60.

Dvorak, V., Heidari, S., Kennedy, B., Lawrence, K., Vega, C., & Dulin, N. (2005). The relationship between depression and attitudinal and behavioral components of spirituality in a sample of students at a Christian university. Presented at the

Thirty-Fourth Annual Western Psychology Conference for Undergraduate Research, Santa Clara, CA.

Dyson, T., & Moore, M. (1983). On kinship structure, female autonomy, and demographic behavior in India. *Population and development review*, 35-60.

Eckenrode, J., & Gore, S. (1990). Stress between work and family. In *Stress between work and family* (pp. 205-218). Springer, Boston, MA.

Edmonds, J. K., Paul, M., & Sibley, L. M. (2011). Type, content, and source of social support perceived by women during pregnancy: Evidence from Matlab, Bangladesh. *Journal of health, population, and nutrition*, *29*(2), 163.

Fallowfield, L. (1990). What is quality of life. *London: Souvenir*, 54-7

Ferree, M. M. (2010). Filling the glass: Gender perspectives on families. *Journal of Marriage and Family*, *72*(3), 420-439.

Findlay,A., Rogerson,R., & Morris,A. (1988).In What Sense 'Indicators' of Quality of Life?.*Built Environment (1978-),* 96-106.

Fritzell, S., Weitoft, G. R., Fritzell, J., & Burström, B. (2007). From macro to micro: the health of Swedish lone mothers during changing economic and social circumstances. *Social science & medicine*, *65*(12), 2474-2488.

Fitzpatrick et al 1992 Quality of life measures in health care. I: Applications and issues in assessment. *Bmj, 305*(6861), 1074-1077.

Furstenberg Jr, F. F., Brooks-Gunn, J., & Morgan, S. P. (1987). *Adolescent mothers in later life*. Cambridge University Press.

Garg,M.K.,(2011).Vitamin D status in pregnant Indian women. *British Journal of Nutrition 106(09),1383-1389.*

George, A. (2002). Embodying identity through heterosexual sexuality-newly married adolescent women in India. *Culture, Health & Sexuality*, *4*(2), 207-222.

Ghosh, D. (2007). Predicting vulnerability of indian women to domestic violence incidents. *Research and Practice in Social Sciences*, *3*(1), 48-72.

Gupta, K., & Yesudian, P. P. (2006). Evidence of women's empowerment in India: A study of socio-spatial disparities.*GeoJournal*, *65*(4), 365-380.

Haghi, F., Allahverdipour, H., Nadrian, H., Sarbakhsh, P., Hashemiparast, M., & Mirghafourvand, M. (2018). Sexual problems, marital intimacy and quality of sex life among married women: a study from an Islamic country. *Sexual and Relationship Therapy*, *33*(3), 339-352.

Hanzal, A., & Segrin, C. (2009). The role of conflict resolution styles in mediating the relationship between enduring vulnerabilities and marital quality. *Journal of Family Communication*, *9*(3), 150-169.

Hayford, S. R., & Guzzo, K. B. (2010). Age, relationship status, and the planning status of births. *Demographic Research*, *23*, 365-398.

Headey, B., Veenhoven, R., & Weari, A. (2005). Top-down versus bottom-up theories of subjective well-being. In *Citation Classics from Social Indicators Research* (pp. 401- 420). Springer, Dordrecht.

Heilemann, M. V., Lee, K. A., & Kury, F. S. (2002). Strengths and vulnerabilities of women of Mexican descent in relation to depressive symptoms. *Nursing Research*, *51*(3), 175-182.

High Level Committee on the Status on Women, 2015. Executive Summary Report on the Status of Women in India

Hornung, C. A., McCullough, B. C., & Sugimoto, T. (1981). Status relationships in marriage: Risk factors in spouse abuse. *Journal of Marriage and the Family*, 675-692.

Horwitz, A. V., White, H. R., & Howell-White, S. (1996). Becoming married and mental health: A longitudinal study of a cohort of young adults. *Journal of Marriage and the Family*, 895-907.

Hossain, B. (2015). Women empowerment and infant mortality in Bangladesh, *Applied Economics, 47*(51), 5534-5547, doi: 10.1080/00036846.2015.1051657.

House, J. S., Umberson, D., & Landis, K. R. (1988). Structures and processes of social support. *Annual review of sociology*, *14*(1), 293-318.

IHMP (2004) : Baseline Survey Report: Studies on Married Adolescents in Maharastra pp 15-15 (unpublished)

Izugbara, C. O. (2000). Women's understanding of factors affecting their reproductive health in a rural Ngwa community. *African Journal of Reproductive Health*, *4*(2), 62-68.

Jalilvand, M. (2000). Married women, work, and values. *Monthly Lab. Rev.*, *123*, 26.

Jayapalan, N. (2001). *Indian society and social institutions*. Atlantic Publishers & District.

Jean Turner, M., Young, C. R., & Black, K. I. (2006). Daughters-in-law and mothers-in-law seeking their place within the family: A qualitative study of differing viewpoints. *Family Relations*, *55*(5), 588-600.

Jejeebhoy, S. J. (1995). Women's education, autonomy, and reproductive behaviour: Experience from developing countries. *OUP Catalogue*.

Jejeebhoy, S. J., & Cook, R. J. (1997). State accountability for wife-beating: the Indian challenge. *The Lancet*, *349*, S10-S12.

Jejeebhoy, S. J. (1998). Adolescent sexual and reproductive behavior: a review of the evidence from India. *Social science & medicine*, *46*(10), 1275-1290.

Jejeebhoy, S. J. (2000). *Women's autonomy in rural India: Its dimensions, determinants, and the influence of context*.

Johnson, V. K., Gans, S. E., Kerr, S., & LaValle, W. (2010). Managing the transition to college: Family functioning, emotion coping, and adjustment in emerging adulthood. *Journal of College Student Development*, *51*(6), 607-621.

Johnson, N.L., & Johnson, D.M., (2013) Correlates of Readiness to Change in Victims of Intimate Partner Violence, *Journal of Aggression, Maltreatment & Trauma* 22:2, 127-144.

Kalmuss, D. S., & Straus, M. A. (1982). Wife's marital dependency and wife abuse. *Journal of Marriage and the Family*, 277-286.

Kerce, E. W. (1992). *Quality of life: Meaning, measurement, and models* (No. NPRDC-TN-92- 15). NAVY PERSONNEL RESEARCH AND DEVELOPMENTCENTER SAN DIEGO CA.

Keshavarzi, S., Ayatollahi, S. M. T., Zare, N., & Sharif, F. (2013). Quality of life of childbearing age women and its associated factors: an application of seemingly unrelated regression (SUR) models. *Quality of Life Research*, *22*(6), 1255-1263.

Khan, M. E., Khan, I., & Mukerjee, N. (1997). Involving men in safe motherhood. *Journal of Family Welfare*, *43*, 18-30.

Kieren, D., Henton, J., & Marotz, R. (1975). Hers and his. Hinsdale, IL: Dryden Press.

Kingston, D., Heaman, M., Fell, D., Chalmers, B., & Maternity Experiences Study Group of the Canadian Perinatal Surveillance System. (2012). Comparison of adolescent, young adult, and adult women’s maternity experiences and practices. *Pediatrics*, *129*(5), e1228-e1237.

Kishor, S., & Gupta,K.,(2004).Women's empowerment in India and its states: evidence from the NFHS: *Economic and Political Weekly*,694-712.

Kishor, S., Ayad, M., & Way, A. (1999, June). Women’s empowerment and demographic outcomes: examining links using demographic and health surveys data. In *Arab Conference on Maternal and Child Health, Cairo* (Vol. 7, No. 10).

Kossek, E. E., & Ozeki, C. (1999). Bridging the work-family policy and productivity gap: A literature review. *Community, Work & Family*, *2*(1), 7-32.doi:10.1080/13668809908414247.

Kosterina, I. (2012). Young Married Women in the Russian Countryside: Women's Networks, Communication and Power. *Europe-Asia Studies*, *64*(10), 1870-1892. DOI: 10.1080/09668136.2012.717360.

Krause, N. (1982). Married women and depressive symptoms. *Sociological Focus*, *15*(1), 25-40.

Kumaar,S.S.. CRIME AGAINST WOMEN - AN INDIAN SCENARIO. Master Thesis 2015 Research Master Planning and Sustainability: Urban and Regional Planning

Kwan, A. Y. H., Cheung, J. C. K., Ngan, R. M. H., Lau, A. L. D., Leung, E. M. F., & Chan, S. S. C. (2003). Assessment, validation, and promotion for the quality of life and continuum of care of elderly people in Hong Kong.

L Heise; Moreno G, Violence by intimate partners

Lalhmingpuii, J. C., & Namchoom, V. (2014). The Status and Role of Women in Mizo Society. *Journal of North East India Studies*, *4*(1), 30-42.

Lalhriatpuii (2010): *Economic participation of Women in Mizoram*. New Delhi: Concept Publishing Company.

Lane, C., Joof, Y. M., Hassan, A. A., & Pryor, S. (2012). Promoting healthy timing and spacing of pregnancy with young married women in Northern Nigeria: a short report. *African Journal of Reproductive Health*, *16*(2), 263-270.

Layard, R., Barton, M., & Zabalza, A. (1980). Married women's participation and hours. *Economica*, *47*(185), 51-72.

Lee, J. J. (2005). An exploratory study on the quality of life of older Chinese people living alone in Hong Kong. In *Quality-of-Life Research in Chinese, Western and Global Contexts* (pp. 335-361). Springer, Dordrecht.

Le Masson, V., Benoudji, C., Reyes, S., & Bernard, G. (2019).*Violence against Women and Girls and Resilience*. BRACED Working Paper. ODI, London.

Levinson, D. (1989). *Family violence in cross-cultural perspective*. Sage Publications, Inc.

Lianhmingthangi, C (2017). Intimate partner violence against women: Perceptions across gender. (M.Phil Dissertation) Aizawl: Department of Social work, Mizoram University.

Liégeois, A. (2014). Quality of life without spirituality? A theological reflection on the quality of life of persons with intellectual disabilities. *Journal of Disability & Religion*, *18*(4), 303- 317. DOI: 10.1080/23312521.2014.966466.

Macmillan, R., & Gartner, R. (1999). When she brings home the bacon: Labor-force participation and the risk of spousal violence against women. *Journal of Marriage and the Family*, 947-958.

Madhurima. (1996) *Violence Against Women: Dynamics of Conjugal Relations*, Gyan Publishing House, New Delhi.

Ma, L., Rizzi, E., & Turunen, J. (2019). Childlessness, sex composition of children, and divorce risks in China. *Demographic Research*, *41*, 753-780.

Mammen, S., Bauer, J. W., & Lass, D. (2009). Life satisfaction among rural low-income mothers: The influence of health, human, personal, and social capital. *Applied Research in Quality of Life*, *4*(4), 365-386. DOI 10.1007/s11482-009-9086-6.

Marotz-Baden, R., & Cowan, D. (1987). Mothers-in-law and daughters-in-law: The effects of proximity on conflict and stress. *Family Relations*, 385-390.

Marotz-Baden, R., & Mattheis, C. (1994). Daughters-in-law and stress in two-generation farm families. *Family Relations*, 132-137.

Massam, B. H. (2002). Quality of life: public planning and private living. *Progress in planning*, *58*(3), 141-227.

Mastekaasa, A. (1992). Marriage and psychological well-being: Some evidence on selection into marriage. *Journal of Marriage and the Family*, 901-911.

McQuillan, J., Greil, A. L., White, L., & Jacob, M. C. (2003). Frustrated fertility: Infertility and psychological distress among women. *Journal of Marriage and Family*, *65*(4), 1007- 1018.

Melhado, L. (2014). The Need for Contraception To Delay First Pregnancy In India Is High. *International Perspectives on Sexual and Reproductive Health*, *40*(3), 157.

Miller, P. M., & Ingham, J. G. (1976). Friends, confidants and symptoms. *Social Psychiatry*, *11*(2), 51-58.

Miller, C. E., & Mullins, B. K., (2002) Lifelong Learning to reduce Domestic Violence. International journal of lifelong education,21,(5), 474–484.

Mishra, R. C. (2006). Towards Gender Equality. Authors' press. *ISBN https://www. vedamsbooks. com/no43902. html*.

Mishra, K., & Dubey, A. (2014). Indian women's perspectives on reproduction and childlessness: Narrative analysis. *International Journal of Humanities and Social Science*, *4*(6), 1.

Mirghafourvand, M., Charandabi, S. M. A., Jafarabadi, M. A., Tavananezhad, N., & Karkhane, M. (2016). Predictors of health-related quality of life in Iranian women of reproductive age. *Applied Research in Quality of Life*, *11*(3), 723-737. DOI 10.1007/s11482-015- 9392-0.

Mitra, D. (2015). Crime and Correctional Administration.

Muntean, N., Kereta, W., & Mitchell, K. R. (2015). Addressing the sexual and reproductive health needs of young people in Ethiopia: an analysis of the current situation. *African journal of reproductive health*, *19*(3), 87-99.

Nandal, V., & Rajnish, M. (2014). Status of women through ages in India. *International Research Journal of Social Sciences*, *3*(1), 21-26.

Narayan, D. et. al. (2000) *Voices of the Poor: Crying out for Change*, World Bank, New York, and Oxford: Oxford University Press

National Family Health Survey - 4 (2015 -16). India Fact Sheet. Ministry of Health and Family Welfare.

Netto, L. D. A., Moura, M. A. V., Araujo, C. L. F., & Souza, M. H. D. N. (2017). Social support networks for women in situations of violence by an intimate partner. *Texto & Contexto- Enfermagem*, *26*(2).

Nourani, S., Jonaidy, E., Shakeri, M. T., & Mokhber, N. (2010). Sexual satisfaction in fertile and infertile women attending state clinics in Mashad. *Journal of Reproduction & Infertility*, *10*(4).

Nussbaum, M. C. (2001). *Women and human development: The capabilities approach* (Vol. 3). Cambridge University Press.

Ngo, H. Y. (1992). Employment status of married women in Hong Kong. *Sociological Perspectives*, *35*(3), 475-488.

Ormel, H. (1999). Can men make motherhood safer? An inquiry into the relevance and risks increased male involvement in safe motherhood initiatives. *Public Health, Royal Tropical Institute, Amsterdam, The Netherlands*.

Oswald, A. J. (1997). Happiness and economic performance.*The economic journal*, *107*(445), 1815-1831.

Panda, P. K. (2003). Poverty and young women's employment: linkages in Kerala. *Economic and Political Weekly*, 4034-4042.

Parish, W. L., Hao, L., & Hogan, D. P. (1991). Family support networks, welfare, and work among young mothers. *Journal of Marriage and the Family*, 203-215.

Pascarella, E. T., & Terenzini, P. T. (2005). *How College Affects Students: A Third Decade of Research. Volume 2*. Jossey-Bass, An Imprint of Wiley. 10475 Crosspoint Blvd, Indianapolis, IN 46256.

Pearlin, L. I., Menaghan, E. G., Lieberman, M. A., & Mullan, J. T. (1981). The stress process. *Journal of Health and Social behavior*, 337-356.

Perneger, T.V & Garnerin,P (2001). How Important Is Health for Overall Quality of Life? *Quality of Life Research* 214-214.

PHAN, L. (2013). Women's Empowerment and Fertility Changes. *International Journal of Sociology of the Family*, 49-75.

Pillai, V.K., & Wang, G.Z.(1999).Reproductive Rights In Developing Countries: An Assessment of regional variations. *Michigan Sociological Review*,10-27.

Prasad, J. H., Abraham, S., Kurz, K. M., George, V., Lalitha, M. K., John, R., ... & Joseph, A. (2005). Reproductive tract infections among young married women in Tamil Nadu, India. *International family planning perspectives*, 73-82.

Punam, S., & Sharma, N. (2017). The role and position of women Ancient society to modern society in India.*TWENTYFIRST CENTURY PUBLICATIONS PATIALA*, 127.

Puri, J. (2002). *Woman, body, desire in post-colonial India: Narratives of gender and sexuality*. Routledge.

Qin, Q., Jin, Y., Zhan, S., Yu, X., & Huang, F. (2016). Suicidal ideation among rural immigrant daughters-in-law with multi-roles as females, farmers and immigrants in China. *Psychology, Health & Medicine*, *21*(5), 608-617. DOI: 10.1080/13548506.2015.1112414

Radloff, L. (1975). Sex differences in depression. *Sex roles*, *1*(3), 249-265.

Rammohan, A., & Johar, M. (2009). The determinants of married women's autonomy in Indonesia. *Feminist Economics*,*15*(4), 31-55.

Rawat, P. S. (2014). Patriarchal beliefs, women's empowerment, and general well-being. *Vikalpa*, *39*(2), 43-56.

Raisi, F., Yekta, Z. P., Ebadi, A., & Shahvari, Z. (2015). What are Iranian married women's rewards? Using interpersonal exchange model of sexual satisfaction: a qualitative study. *Sexual and Relationship Therapy*, *30*(4), 475-489.DOI: 10.1080/14681994.2015.1024218.

Raley, R. K., & Sweeney, M. M. (2009). Explaining race and ethnic variation in marriage: Directions for future research. *Race and Social Problems*, *1*(3), 132-142. DOI 10.1007/s12552-009-9013-3.

Rammohan, A., & Johar, M. (2009). The determinants of married women's autonomy in Indonesia. *Feminist Economics*, *15*(4), 31-55.DOI: 10.1080/13545700903153989

Ransom, E. (2000). What role do men have in making motherhood safer? Questions researchers can ask. In *Population Association of America Annual Meeting*.

Repić, G., & Ivanović, S. (2014). Physical dimension of quality of life in ostomy patients. *Acta Medica Medianae*, *53*(3), 32-38.

Rice, R. W. (1984). *Work and the quality of life.* (No. TR-2-ONR). STATE UNI OF NEW YORK AT BUFFALO DEPT OF PCHYCHOLOGY.

Robb, Y., McInery, D., & Hollins Martin, C. J. (2013). Exploration of the experiences of young mothers seeking and accessing health services. *Journal of reproductive and infant psychology*, *31*(4), 399-412. DOI: 10.1080/02646838.2013.832181.

Rodgers, W. L. (1977). Work status and the quality of life. *Social Indicators Research*, (1), 267-287. doi:10.1007/BF00353134.

Ruževičius, J. (2014,). Quality of life and of Working Life: Conceptions and Research. In *Liverpool (2014): 17th Toulon-Verona Conference" Excellence in Services"*.

Sandelowski, M., Holditch-Davis, D., & Harris, B. G. (1990). Living the life: Explanations of infertility. *Sociology of Health & Illness*, *12*(2), 195-215.

Santhya, K. G., Haberland, N., Ram, F., Sinha, R. K., & Mohanty, S. K. (2007). Consent and coercion: examining unwanted sex among married young women in India.*International Family Planning Perspectives*, 124-132.

Santow, G. (1995). Social roles and physical health: the case of female disadvantage in poor countries. *Social Science & Medicine*, *40*(2), 147-161.

Saxena, S., Misra, P. J., Vishwanath, N. S., & Soman, V. R. B. (2013). Quality of life and its correlates in central india. *International Journal of Research & Development of health*, 2321-1431.

Saxena, K., (2017) Status of Women Education in India with Particular Reference to Women Empowerment and Development. Matern Child Health J (2014) 18:1985–1992. DOI 10.1007/s10995-014-1444-9.

Schwarzer, R., & Leppin, A. (1991). Social support and health: A theoretical and empirical overview. *Journal of social and personal relationships*, *8*(1), 99-127.

Schyns, P. (2002). Wealth of nations, individual income andlife satisfaction in 42 countries: a multilevel approach. *Social Indicators Research*, *60*(1-3), 5-40. doi:10.1023/A:1021244511064.

Shin, D. C., & Johnson, D. M. (1978). Avowed happiness as an overall assessment of the quality of life. *Social indicators research*, *5*(1-4), 475-492. doi:10.1007/BF00352944.

Short, L.M., & Rosenberg, M.L., (2001) Intervening with victims of intimate partner violence, *Injury Control and Safety Promotion,* 8(2), pp. 63–69.

Smetana, J. G. (2013). 29 Moral Development: The Social Domain Theory View.

Sniekers, M. (2018). Defining dreams: young mothers' agency in constructions of space. *Social & Cultural Geography*, *19*(8), 1073-1096.DOI: 10.1080/14649365.2017.1344872.

Song, L., Son, J., & Lin, N. (2011). Social support. *The SAGE handbook of social network analysis*, *9*, 116-128.

Song, Y., & Zhang, Y. B. (2012). Husbands' conflict styles in Chinese mother/daughter-in-law conflicts: Daughters-in-law's perspectives. *Journal of Family Communication*, *12*(1), 57- 74. DOI: 10.1080/15267431.2011.629968.

Sprecher, S. (2001). Equity and social exchange in dating couples: Associations with satisfaction, commitment, and stability. *Journal of Marriage and Family*, *63*(3), 599-613.

Szalai, A. (1980). The meaning of comparative research on the quality of life. *The quality of life*, 7-21.

Tajvar, M., Arab, M., & Montazeri, A. (2008). Determinants of health-related quality of life in elderly in Tehran, Iran. *BMC public health*, *8*(1), 323.

Thapan, M. (2003). Marriage, well-being, and agency among women. *Gender & Development*, *11*(2), 77-84. DOI: 10.1080/741954320.

Theofilou, P. (2013). Quality of Life: Definition and Measurement. *Europe's journal of psychology*, *9*(1).

Turner, R. J. (1999). Social support and coping.

Uberoi, P. (1994). *Family, kinship and marriage in India*. Oxford University Press, USA.

Uberoi, P. (2005). The family in India. *Writing the women's movement: a reader. New Delhi: Zubaan*, 361-96.

Unisa, S. (1999). Childlessness in Andhra Pradesh, India: treatment-seeking and consequences. *Reproductive health matters*, *7*(13), 54-64.

United Nations. 1994. Report of the International Conference on1 Population and Development Cairo. September 5-13, 1994. New York: United Nations.

U.S. Census Bureau. (2000). http://factfinder.census.gov/servlet/GCTTable?_bm=y&-geo_id=0100.

Van Balen, F. (2000). Interpreting infertility: Social science research on childlessness in a global perspective, Amsterdam, 8-11 November 1999. *African Journal of Reproductive Health/La Revue Africaine de la Santé Reproductive*, *4*(1), 120-122.

Wahl, A. K., Rustøen, T., Hanestad, B. R., Lerdal, A., & Moum, T. (2004). Quality of life in the general Norwegian population, measured by the Quality of Life Scale (QOLS-N).*Quality of life research*, *13*(5), 1001-1009.

Walen, H. R., & Lachman, M. E. (2000). Social support and strain from partner, family, and friends: Costs and benefits for men and women in adulthood. *Journal of social and personal relationships*, *17*(1), 5-30.

Warner, R. L., Lee, G. R., & Lee, J. (1986). Social organization, spousal resources, and marital power: A cross-cultural study. *Journal of Marriage and the Family*, 121-128.

Weil, M. W. (1961). An analysis of the factors influencing married women's actual or planned work participation. *American Sociological Review*, *26*(1), 91-96.

Wiese, U., & MORADI, S. (2007). QUALITY OF LIFE AND RELATED FACTORS IN THE WOMEN WITH HIV IN TEHRAN.

World Health Organization. (2010). *Measuring sexual health: Conceptual and practical considerations and related indicators* (No. WHO/RHR/10.12). World Health Organization.

WHO 2017, Violence against women Newsroom/ Fact sheets

World bank 2019, Gender-Based Violence: Violence Against Women and Girls.

Xaxa,V. (2004) Women and Gender in the Study of Tribes in India. Indian Journal of Gender studies, 11(3), 345-367.

Yount, K. M., & Carrera, J. S. (2006). Domestic violence against married women in Cambodia. *Social Forces*, *85*(1), 355-387.

Yudhistar, K. 2003: *Violence Against Women*, Reference Press, New Delhi

Zhang, J. (2010). Marriage and suicide among Chinese rural young women. *Social Forces*, *89*(1), 311-326.