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Kajian Malaysia (early view)

A QUALITATIVE STUDY ON THE PATRIARCHAL BARRIERS TO HEALTHCARE FACED BY MALAYSIAN INDIAN WOMEN IN KULIM, KEDAH, MALAYSIA USING KABEER'S THEORY OF EMPOWERMENT

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ABSTRACT

Health is influenced by gender and can have different impacts on women in society. Women from traditional households, particularly those from socioeconomically disadvantaged backgrounds, often experience neglect in their health, as it is considered less important. B40 Indian women are among the vulnerable groups, as they are part of patriarchal households that prioritise the health issues of men over their own. The term B40 represents those with lower incomes, which consists of the lower 40 per cent of Malaysia's income distribution. This study investigated patriarchal barriers to healthcare faced by Malaysian Indian women in Kulim, Kedah, Malaysia. Data was generated from semi-structured interviews

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with 25 participants selected through a purposive sampling technique. The data were analysed using Kabeer's empowerment framework. The findings of study were resource limitations, negotiations of Indian women agency, and the distorted achievements in women health initiatives. The findings of this study contribute significantly to enlightening stakeholders on the efforts of B40 Malaysian Indian women to improve their health.

Keywords: Malaysian Indian women; B40; Health initiatives; Kabeer's theory of empowerment; Empowerment

INTRODUCTION

The United Nations Sustainable Development Goal 3 (Good Health) and Goal 5 (Gender Equality) underscore the significance of women's health (Women's Aid Organisation, 2022). The goals correspond with women and girls who suffer disproportionately from numerous health conditions together with difficulties accessing healthcare due to systemic and patriarchal barriers (Azmawati et al., 2017). The barriers include financial limitations, which are often due to a lack of employment as compared to their male counterparts, as well as internalised and externalised patriarchal behaviours. Thus, these barriers must be addressed to alleviate inequality in attaining health (Matheson et al., 2021).

Romli et al. (2019) conducted a study on cervical screening among working women in Kedah. They found that the main contributing factors for not undergoing a pap smear were a lack of information and embarrassment due to cultural stigma. Many of these women needed their spousal consent and felt embarrassed to talk about the intimate examination required for the assessment (Romli et al., 2019). The study also suggests that cervical cancer, which has traditionally impacted women more than men, has garnered less attention from women in Malaysia. The situation is particularly severe for the B40 group, which by income comprises the bottom 16.1% of Malaysian households, earning between RM3,401 and RM3,440 monthly. Additionally, Malaysia's absolute poverty rate stood at 6.2% in 2022, indicating that nearly 6 out of every 100 households are unable to afford basic food needs (Lim, 2023). Scholars have argued that the quality of life for the B40 group is a matter of concern and needs immediate attention (Kadir & Wan Puteh, 2023; Rizal et al., 2022). Therefore, the well-being and income of the B40 group must be prioritised by the Malaysian government as rapid economic development increases living costs (Kadir & Wan Puteh, 2023).

The B40 income category has around 2.7 million households, with 56% living in cities and the remaining 44% in rural areas (Jayasooria, 2016); Malaysian Indians make up approximately 89% of the group, which is a large urban concentration with lower income and poverty problems (Malaysian Indian Blueprint, 2017). Therefore, there is a pressing need to address this issue of health

problems and poverty among Malaysian Indian women, as they are frequently linked through various factors such as age, socioeconomic status, marital status, and household income (Kaur, 2022; Teh, 2014; Ab Kadir, 2022). Other than that, the research on Malaysian Indian women's health primarily focused on specific women's health issues such as disparities in chronic diseases, cancer, mental health and metabolic disorders compared with other ethnic groups in Malaysia (Teh et al., 2014; Ab Kadir et al., 2022; Choon et al., 2023; Kaur et al., 2022). Nonetheless, there is a lack of empirical evidence on linking marginalised women's health initiatives to their resources, agency, and achievements. This limits the understanding of factors that hinder Malaysian Indian women in the B40 demographics from achieving health-related empowerment, aside from the commonly discussed financial barriers.

In the context of this study, resources are defined as access to material, human, and social supports such as healthcare facilities, knowledge, and community networks which are crucial for health outcomes. Agency refers to women's ability to make informed health-related decisions and to act on them, demonstrating their power concerning their own well-being. Achievements refer to the results of these efforts such as better health empowerment. Accordingly, this article aimed to study the health initiatives of B40 Malaysian Indian women's health in Kulim, Kedah, Malaysia. The study utilised Kabeer's empowerment framework, which consisted of three components to investigate their health-related

empowerment. Access to healthcare resources, freedom of choice in seeking, utilising, and using healthcare services, and health outcomes were especially examined to understand better how empowerment affects their health initiatives. This is crucial in understanding the dynamic interplay between socioeconomic restrictions and women's abilities to effectively navigate their health concerns. To report the study's findings, this study conducted semi-structured interviews with 25 Malaysian Indian women from B40 groups on their initiatives towards their health maintenance.

B40 women are denied the ability to make decisions due to 'inequalities' rather than 'differences in choices (Abdul Latip, 2024).' They lack power over their lives, indicating restrictions due to poverty as well as 'gender disadvantage' (Kabeer, 1999). For instance, women are willing to bear children at the expense of their health and survival to satisfy their own or their husband's preference for sons (Kabeer, 1999). Notably, it is possible to predict how changes in women's resources will affect their choices depending on other circumstantial factors (Kabeer, 1999). Their behaviours, including the acceptance of their secondary claims on household resources and tolerance towards domestic violence, could jeopardise their well-being. Furthermore, women's involvement or contribution always comes at the expense of their ability to negotiate their efforts in the setting of beliefs, practices, and norms about the superiority of men in society (Azmawati et al., 2017). Therefore, the use of Kabeer's theory allows for the investigation of

poor health among B40 women due to existing systemic inequalities instead of personal choices. Correspondingly, this study intends to contribute to the body of knowledge on health-related empowerment and gender studies, particularly in the context of Malaysia's marginalised ethnic communities.

LITERATURE REVIEW

Malaysian Indian women endure health disparities compared to women of other ethnic groups in Malaysia. Teh et al. (2014) using bivariate analyses and hierarchical logistic regression examined the ethnic and gender differences in high blood pressure (HBP), diabetics, coronary heart disease (CHD), arthritis, and asthma among older people in Malaysia. Their study revealed that Indians were more likely to report poor health, namely, diabetes, CHD, and arthritis, compared to other ethnic groups. However, the cross-sectional designs limit causal interpretations and overlook the intersections of ethnicity, gender and socioeconomic status. Tan et al. (2001), employed a cross-sectional design to study the health beliefs related to oral cancer and found that half of the Malaysian Indian women population were susceptible to oral cancer. The study, however, used a small, convenient sample which restricted the broader applicability of the findings. In addition, the study did not offer a comparison with other high-risk communities.

Recently, Ab Kadir et al. (2022) in their retrospective cohort study, using predictive modelling, explored the development of a predictive model for survival

among women with breast cancer in Malaysia. The result discovered that Malaysian Indian women had a greater risk of mortality than Malay women. They posited that Indians have lower survival rates for breast cancer due to their lower socioeconomic levels. However, the retrospective design and concentration on a particular treatment centre may pose a bias. Besides, Choon et al. (2023) identified the incidence and prevalence of a skin disorder, generalised pustular psoriasis (GPP), in Malaysia, as well as its flares and triggers. The result showed a prevalence of 179 instances and an incidence of 25.0 cases per million person-years among Indian women. While the study considered health beliefs, it had limitations, including a lack of standards to assess treatment effectiveness regarding severity and outcomes.

In addition, Kaur et al. (2022) conducted a cross-sectional study on the mental health of Indian women in Klang, Malaysia. The result observed a high prevalence of mental health issues among Malaysian Indian women to be depression, anxiety, and stress, which are strongly associated with demographic factors such as age, marital status, household income, education, and employment level. The study concentrated on socioeconomic variables, but it overlooked cultural stigma associated with mental health, which could have an impact on how people seek treatment and the effectiveness of interventions.

Also, Tan et al. (2011) used multiracial samples to examine the differences in metabolic syndrome prevalence between Malays, Chinese, Indians, and other ethnic groups in Malaysia. The study discovered that Indian women had a higher frequency of metabolic syndrome (45.5%) compared to Malays (33.8%), Chinese (34.5%), and other indigenous ethnic groups (34.2%). This indicated that Malaysian Indian women were at a disadvantage in terms of health issues in comparison to other ethnic groups in Malaysia.

While demographic factors such as age, income, duration, and employment are often highlighted, these studies discuss cultural beliefs, socioeconomic status and healthcare access that intersect to influence health outcomes. In addition, many of the abovementioned studies depend on cross-sectional data, which limits the ability to make causal inferences. Despite the fact that various studies have articulated health disparities, there are still gaps linking the data under an integrated theoretical framework. Specifically, the application of Kabeer's theory in the context of health disparities among Malaysian Indian women requires more argumentation. Thus, Kabeer's theory would provide a valuable framework for understanding how Malaysian Indian women navigate health limitations and also focuses on how marginalised groups, particularly women, utilise cultural practices and social networks to cope with systemic inequalities. By combining theoretical knowledge with empirical data, this study

provides a more nuanced understanding of how structural determinants intersect with the health outcomes among Malaysian Indian women.

THEORETICAL FRAMEWORK

Naila Kabeer's theory of empowerment

Health and empowerment are inseparable. Empowerment theories have been applied across various disciplines, including public health to improve health outcomes by addressing social determinants and human agency (Wallerstein, 2006). Psychological empowerment stresses interpersonal, interactional and behavioural characteristics as a means of achieving autonomy and making health decisions (Zimmerman, 1995). In addition, Schulz and Nakamoto (2013) emphasise that empowerment manifests as confidence, self-worth and control facilitate individual participation in health decisions. According to Weisman (2000), empowerment decreases inequality, elevates women's status and power, and enables other factors that positively impact health, such as increased education.

Gender perspective analysis examines how women's access to resources, autonomy, and choices is profoundly influenced by social norms and power relations. In this study, health-related empowerment is defined as women's ability to exercise agency when making critical health decisions within structural inequality and patriarchy. While Wallerstein's framework highlights empowerment as a means to enhance health outcomes, Kabeer's empowerment framework offers intricate details regarding women's empowerment. Accordingly,

this study employed Kabeer's empowerment framework to explain how structural barriers like patriarchy and class influence health initiatives of these marginalised women.

Kabeer (1999) defines empowerment as the process by which people acquire the capacity to make wise decisions in their lives in situations where they have previously been unable to do. This multidimensional concept involves both the expansion of agency and enabling circumstances that allow the agency to exist. It includes the ability to set objectives and carry them out, rather than just make them. Kabeer asserts that empowerment is intrinsically relational, reflecting a change in the power dynamics and disparities in institutions and relationships.

Kabeer (1999) underlines three key components that underpin women's empowerment, namely, resources, agency, and achievements. The first component is resources. Resources are defined as the material, social, and cultural assets that could aid people in attaining their goals. Resources are the means, techniques, or endeavours one uses to acquire commodities (Ayuningsasi et al., 2023). Women are disadvantaged regarding resources as they lack control over their bodies, lives, political representation, and education (Addabo et al., 2004). However, the goal is not resource equality because it ignores the fact that different levels of resources are required for different people to reach the same level of functional competence (Nussbaum, 2007). Instead, the focus should be on ensuring fair access to resources.

The second component of Kabeer's theory of empowerment is agency. Agency refers to the potential of an individual in deliberating on one's priorities and executing them effectively (Kabeer, 1999). The agency of an individual could have both negative and positive connotations in the context of power (Kabeer, 1999). From a positive standpoint, power or the 'power to' enables individuals to make their own decisions and pursue their objectives amid resistance from others (Kabeer, 1999). In contrast, the negative perspective can be defined as 'power over'. Power is seen as the potential of an individual to thwart the will of others using coercion, extortion, and intimidation (Kabeer, 1999). Women from socioeconomically disadvantaged households are often found lacking in their 'power to' exercise agency due to the male figures in their lives having 'power over' them.

The last component is achievements. Achievements are the outcomes of women's exercise of agency and resources. It results from people's efforts or the degree to which potential is realised or fails to be realised (Kabeer, 2005; 1999). Without the presence of and accessibility to agency and resources, achievements cannot be achieved. Achievements are thus evaluated based on the utilisation of agency and its effects in connection to empowerment (Kabeer, 2005).

Kabeer's framework is useful in explaining the individual ability to engage in health-promoting behaviours. Individual can attain their goals with the assistance of material, social and cultural resources such as financial income, education and

social support. Agency represents an individual's ability to make informed decisions such as engaging in proactive health choices. Achievements are the outcomes of effective resource and agency utilisation, indicating success in attaining personal and health goals.

Kabeer's theory of empowerment has been demonstrated in various studies. For instance, the study by Kunka (2019) analysed the impact of education on migrant women's empowerment to recognise their political and social growth in Sweden. The results indicated that education empowered migrant women to become socially and politically active agents in Sweden through resources (i.e., income, skills, civic education, social capital) and agency, leading to achievements such as political participation. This indicated that attaining all components was necessary for the growth and development of an individual in society. Similarly, Hansson (2022) applied Kabeer's empowerment theory and intersectionality to investigate how Roma civil society organisations (CSOs) in Serbia work on the reproductive empowerment of Roma women and girls. The study discovered the challenges that Roma women faced to make reproductive choices. The results revealed that the inability to access resources, lack of agency, and lack of critical awareness were the obstacles that must be overcome while making reproductive decisions. The difficulties faced by Roma women in developing their resources, making decisions, and developing critical consciousness were influenced by

intersecting variables based on external racial discrimination, class, and gender disparities.

On the other hand, DiClemente-Bosco et al. (2022) studied peripartum health behaviour using Kabeer's theory in South Africa. A total of 30 in-depth interviews were conducted with women living with HIV were between 32 and 35 weeks of pregnancy. The study participants revealed that resources, including practical and inspirational support from partners and family, were crucial for empowerment. The agency of the study was the women's desire to be self-sufficient mothers in scenarios where their partners had stopped providing support. Finally, participants characterised achievements as time-bound objectives. Their objectives ranged from having a child born HIV-free to leading a long and fulfilling life. These studies found that resources (support from partners or family), agency (self-determination during health decision-making) and accomplishments (having a kid born HIV-free) all interact to impact health-related outcomes. The study by Chung et.al (2014) added to the discussion by emphasising how the link between digital health literacy and health-promoting behaviours completely mediated health-related empowerment. This study shows that having access to information, knowing health literacy, and engaging in proactive health practices enable people to make educated health decisions.

Although there are existing international studies on Kabeer's theory of empowerment in relation to health, the framework is yet to be applied to the health and gender disparity among B40 Malaysian Indian women. The current research demonstrated how women from lower socioeconomic households in Kulim, Kedah, in Malaysia negotiated their resources and agency as a part of their health initiatives. Through an investigation of empowerment amongst the B40 Malaysian Indian women's health in Kulim, the research also revealed some of the restrictions and delimitations the women faced in the different phases of empowerment.

METHODOLOGY

Qualitative research is effective for studying the meanings individuals assign to social and human issues (Creswell, 2014). This study employed a qualitative method to study the health of B40 Malaysian Indian women in Kulim, Kedah, Malaysia. Data was obtained through semi-structured interviews with 25 participants. The participants were identified through a purposive sampling technique. The inclusion criteria for the participants were: (i) belonged to B40 households, (ii) spoke Tamil as their mother tongue, (iii) were 18 years old and above (the minimum age for non-Muslim couples in Malaysia), (iv) married, and (v) resided in Kulim, Kedah. The focus on married women is due to the study's aim to explore how marital roles and responsibilities affect the health experiences of women in this socioeconomic category. Kulim was purposively selected because

Kedah had the highest prevalence of poverty in Malaysia compared to other states (Majid et al., 2016); it had a poverty rate of 10.5% in 2019 (Department of Statistics, 2019).

A pretest of the semi-structured interview guide was conducted to make necessary revisions before interviewing the participants. Prior to conducting the interview, informed consent was obtained, which explained the research background and objectives to prepare them beforehand and that they would be given pseudonyms to maintain their anonymity. The researcher also clarified that the participation was voluntary and that they were allowed to withdraw or discontinue from the study at any time during the interviews. Individual interviews were conducted with the participants at their preferred locations, mostly in their homes, using their first language (i.e., Tamil).

The 40- to 60-minute interviews consisted of open-ended questions on their health status, daily activities, and problems in maintaining health. The sessions were audio-recorded. The recordings, which were in Tamil, were transcribed and later translated into English. During the first phase of the data analysis, each transcript was examined thoroughly to identify the overall content. In the second phase, recurring ideas, concepts, and significant quotations were identified. Then, these concepts and quotations were rechecked and reorganised under the developed themes.

Table 1. The Demographic Profile of the Participants

Demographic Information of the Participants					
No	**Pseudonym**	**Age**	**Marital Status**	**Employment Status**	**Critical Health Issues**
1.	Jacintha	28	Married	Housewife	Migraine
2.	Menaga	34	Married	Housewife	Anemic
3.	Ragini	35	Married	Part-time maid	Diabetes
4.	Banu	30	Married	Caretaker	Migraine
5.	Harini	43	Married	Housewife	Sinusitis
6	Ranjitha	40	Married	Part-time nanny	Gastritis
7.	Saras	45	Married	Saree seller from home	Food allergy
8.	Anju	38	Married	Part-time data entry clerk	Gout
9.	Lavinia	36	Married	Housewife	Gastritis
10.	Tarini	42	Married	Helper at restaurant	High blood pressure
11	Thana	34	Married	Nanny	Gastritis
12	Sumathy	39	Married	Housewife	High blood pressure
13.	Rajsri	39	Married	Housewife	Chronic leg pain
14.	Banu	32	Married	Occasional caterer	Food allergy
15.	Melina	45	Married	Maid	Hormonal imbalances
16.	Mythili	38	Married	Helper at breakfast stall	Blood pressure
17.	Charu	44	Married	Tailor	Nerve pain
18	Moni	31	Married	Housewife	Sinus
19.	Veni	33	Married	Operator	Skin allergy
20.	Chandra	40	Married	Operator	Gastritis
21.	Havina	44	Married	Housewife	Migraine
22.	Kawina	36	Married	Flower/Betel leaf seller	Food Allergy
23	Surpana	33	Married	Helper in a grocery shop	Migraine
24	Gowri	37	Married	Operator	Low blood pressure
25.	Ragavi	24	Married	Clerk.	Diabetes
***Note*: Data derived from personal interviews of researcher with participants**					

Most of these women, especially those who admitted to having migraines did not explicitly share how they deal with the pain. However, during the fieldwork observation, the researcher noticed that some of the respondents often have remedies with them such as balm, *minyak angin* (medicated oil), which are assumed to be consumed to alleviate migraines and other bodily pains. For woman with diabetes, they obtain their medicines from nearby government clinics, however, this is not frequent as they often skip medicinal intake as well as visits to nearby clinics. For other illnesses, they do seek time to obtain immediate solutions such as buying medicines from the pharmacy, but this is not frequent. The component of critical illness reflects how these women do negotiation.

FINDINGS AND DISCUSSION

The following section is organised around the three components of Kabeer's theory of empowerment (1999), namely resources, agency, and achievement. The themes that emerged after data analysis were resource limitations, agency restrictions, and underachievement in health initiatives.

RESOURCE LIMITATIONS

Time, support, and money

Participants of the study described that resource limitations are, namely, the time constraints that they faced in their households, which impeded their efforts to manage their health. Their time was preoccupied with domestic responsibilities as wives and mothers. For example, Jacintha (aged 28), who is married with three children, suffers from migraine. She laughed when describing her situation:

> 'Hmmm … how can I make an effort … my time is already very occupied with domestic work … and also the big responsibility is that now I am taking care of children … time flies just like that.'

Malaysian Indian women lack time for themselves due to juggling domestic chores and caregiving responsibilities, which inadvertently causes them to neglect their health. This indicated that time was scarce in lower socioeconomic households, making extreme poverty commonplace (Guna Saigaran and Karupiah, 2020). Even if the participants viewed their health as worth their time, they had difficulty accessing social support such as emotional validation and practical assistance from their surroundings, i.e., from their spouses and friends. Their male spouses preferred that they remained at home and did not support their wives' health iniatives due to gendered and patriarchal expectations. Even when women took the initiative to engage in improving their health such as performing exercises they received oppositions from their spouses. For Jacintha, taking initiative through her behaviours, such as resting, seeking medical attention, and making

dietary changes, is challenging. Despite her efforts, systematic constraints such as poverty and gendered expectations prevent these health initiatives from being fulfilled.

For instance, Rajsri (aged 39), a housewife who is married with two children, suffers from diabetes. She has expressed that:

> 'When I had this leg pain after having my second daughter, I tried walking in the morning with my neighbour. Not even a month [of doing that], my husband stopped me from going, saying that there was no need. So, what else can I do when my own husband is saying no? You should be devoted to your husband and abide by his words.'

Resources can be intangible, such as social support that helps people make more informed decisions (Kabeer, 1999). Rajsri's narrative showed that her neighbour acted as an intangible resource that assisted her in taking action (i.e. exercise) to manage her health issue. However, her husband curtailed her agency to do what she wanted to do freely. Given that the activity did not require a financial resource, the husband's refusal to support Rajsri's effort of walking for exercise suggested the workings of the patriarchal ideology that expected men to be the primary decision-makers and have 'power over' their wives (Kabeer, 1999). Rajsri's lack of agency is evident as she was pushed to prioritise her household responsibilities rather than taking care of her health. As a result, marriage becomes an unfair

arrangement dictated by gendered stereotypes (Chowdhory et al., 2022). It shows the husband dominance over the efforts of Rajsri's agency and also his dictation on decision-making even when no financial resources are involved. As a result, she was forced to ignore her health and forgo her effort of walking to better her health. There is a widespread consensus in Malaysian society, particularly in traditional Indian and Malay Muslim households, that women have little social independence in marriage (Joseph, 2014). Their behaviour is always subject to their husbands' control, permission, and approval. Accordingly, any act of defying their husbands and exercising agency by prioritising their own health is considered as deviating from the norms. In doing so, the wife is not categorised as a 'devoted wife, and thus suffers undesirable social repercussions, for instance, turmoil in her relationship.

Another respondent, Banu (aged 30), who suffers from migraine, has expressed:

> 'My time is not really my time; I have tasks piled up that need to be done. These 24 hours are not mine alone … [I] need to cook, clean, wash … I cannot skip even one day as my husband will start yelling and saying that I am not good enough to be a wife or mother. Those words are painful to hear …'

Time is structured in gendered ways (Matulevich and Vollaz, 2019), whereby the women's capacity to exercise time and agency depends on power dynamics and home restrictions that mirror societal gender norms (Eissler et al., 2022). A woman who breaches these norms suffers from the anxiety that she could lose her household. This interplay prevents a woman from deviating from the set norms, hence, reinforcing the idea that she has little control over her time (Eissler et al., 2022). While women share some control over deciding when and how to spend their time on normative and expected tasks and responsibilities, men control the decision-making on all tasks beyond such activities (Eissler et al., 2022). The relative resources perspective underlines that a spouse can obtain more authority from material or economic resources, which, in turn, can limit their participation in performing unwanted tasks such as taking care of the children or doing domestic work (Fendel and Kosyakova, 2023). To illustrate, full-time housewives, such as Rajsri and Banu, have no autonomy to express their desire to choose their health over domestic work. As such, the roles, behaviours, and social interactions that are deemed suitable for the decent Indian girl are moulded by patriarchal notions of Indian femininity (Joseph, 2014).

On the other hand, resources include tangible items such as income determine the women's ability to adopt health practices. Women in these B40 households, such as Menaga (aged 34), who suffers from anaemia, mentions how her neighbour has encouraged her to invest in her health.

> 'Since I was young, I have been anaemic; I have always been weak since young. I had regular check-ups in government hospitals, and they suggested that I eat healthy foods, but buying them is expensive. Money is important. Now, the money my husband earns is only sufficient for household expenses. Buying this kind of food and supplements will be unnecessary expenses [for us].'

Menaga suggested that Malaysian Indian women's dependency on the family's breadwinner limited their ability to make wise decisions in acquiring primary sources of access to resources (Kabeer, 2005; Klesment and Van Bavel, 2022). For example, spending income on preserving women's health seemed 'unnecessary'. This indicated that the hierarchical nature of patriarchy exacerbated the prioritisation of Malaysian Indian women's health as secondary. In addition, as a housewife who was financially unproductive, Menaga's situation revealed that limited income caused further deprivation of potential resources such as health supplements. She is unable to determine the importance of how her health is influenced by a restricted household income and her dependence on her husband as the sole breadwinner. In her opinion, healthy foods that are being recommended by doctors (nutritional foods that could cure her anaemia such as dairy, fruits, meats and eggs) are perceived as pricey and impossible to get with the single income that is earned by her husband. This reflects a hierarchical importance that

occurs in the lower-income individuals and families who are pressured to concentrate only on the most critical matters while ignoring others (Loibl, 2017).

Increased control over income and ownership of assets by women can lead to changes in customs and attitudes. This could impact social behaviours within and outside the home (Gammage et al., 2016). Harini, a 43-year-old housewife, suffered from sinusitis. She stated that she had no control over the family's finances. Her husband's discomfort with Harini's questions about income revealed the boundary or division of labour in the patriarchal system.

> 'Only my husband works. He keeps all the income … He only gives some money for everyday purchases, like buying vegetables and fish. The bulk of his salary, I don't know where he spends it. He doesn't like it when I ask. The funny thing is, I am not aware of how much his salary is. And we have been married for 15 years …'

In short, the women's lack of control over family finances stemmed from the lack of transparency on individual resources with family members (Deschênes et al., 2020). The utility of resources is the platform where the exercise of agency occurs (Kabeer, 2005). However, the patriarchal system prohibited Malaysian Indian women from having the authority to dictate their husband's income distribution

and usage. For example, Harini stood in a subordinated position in ensuring that her husband had full authority over all aspects of the household as the breadwinner. Significantly, the participants in the study identified resource limitations, specifically time limitations, lack of emotional and practical support and financial restrictions as significant hurdles to their their efforts to manage their health. These elements were strongly embedded in their roles as wives and mothers in patriarchal households

AGENCY: RESTRICTED AND MANIPULATED

Participants in this study indicated that their opportunities to exercise or assert their agency significantly changed gender expectations, patriarchal norms, and economic dependency within the household. Thus, the most viable option when they were caught between household responsibilities and taking care of their children, was to surrender their agency to the situation. For example, Ranjitha (aged 40), who suffered from gastritis, expressed that:

> '…I wake up at 5.30 am every day from waking up my husband and children, cooking food for them, ironing their clothes, and packing food … After they leave, I have to prepare lunch, wash clothes and clean the house … After lunch, I cannot rest. Also, I have to look after the children when they return from school … the

> time I exercise is walking and doing the household chores ... absolutely no separate time to exercise (she sighed).'

While being autonomous and committed are strong agency prescriptions for men, the same cannot be said for women (Ma et al., 2022). Like Ranjitha, Malaysian Indian women had to compromise due to their limited socioeconomic agency. Her daily routine illustrates immense demands of household responsibilities leaving her limited time to make health-related efforts. While she asserts that she does walking and is engaged in daily physical activities such as household chores, which she considers as exercise, her efforts to deal with gastritis extend beyond exercising. She stresses the significance of nutrition management including preparing balanced and nutritious meals for herself and her family, staying hydrated and reducing stress whenever feasible. Another participant, Saras (aged 45), who suffered from a food allergy, explained how her effort to rest to regain her health and recover physically was ignored:

> 'What is the point? You tell me. Even if I am sick and I want to rest for a few days, I cannot. Everything needs to be ready for them even if I am tired or not feeling well. For them, it does not matter if I want to rest. Only they and their needs matter … At the end of the day, I will get scolded by my husband, or he will throw his tantrums if he sees me taking rest.'

In Saras' situation, her husband influenced and dictated her choices, as exemplified by his reaction to her need for rest (Kabeer, 1999). Furthermore, Saras' situation demonstrated that her agency in initiating her efforts to manage her health was systematically undermined and overridden by her husband. Thus, she had no freedom over her activities.

Notably, in various circumstances, the participants in the study have expressed that they could differentiate what was good for them. Agency is defined as the capacity for purposeful action, the ability to make decisions and pursue goals without fear of retaliation, violence, or other negative outcomes. It also includes cognitive components, which are defined as a 'sense of agency' (Gammage et al., 2016). A sense of agency is important for Malaysian Indian women to realise why their health is equally important to their families. Some of the participants have expressed a sense of agency. Anju (aged 38), suffering from gout, said:

> 'My son's classmate's mother [and I] have become good friends; she is the one who is always telling me how she cares for her health, like food restrictions and eating healthy food…I thought about my grandmother's recipes that are healthy, like *kelvaragu*

kanji, *kali*, *adai*.[1] So, I changed my food style, and now I follow that.'

In short, Malaysian Indian women are aware of the importance of their health. Unless the agency is activated, Indian women's initiatives will always be restricted by various factors- household tasks, the patriarchal system, and other structural causes. Anju experienced her sense of agency when she thought that traditional foods could provide a more nutritional lifestyle and thus had transformed her eating habits. The act of seeking out health information is an example of self-health management (Ahadzadeh and Sharif 2017). Despite Anju's limited resources such as income, she could still find ways to make do with what is available.

In this study, Ranjitha and Saras illustrated their limitation of being autonomous and having poor bargaining power due to their disadvantaged economic background. Their agency is constrained by patriarchal norms, including restrictions imposed by their husbands and resource limitations due to living in a single-income household, which leaves them with little time. On the other hand, Anju made efforts to utilise the minimally available resources. However, her

[1] These are traditionally prepared Indian foods and also low-cost food: (i) Kelvaragu (Ragi) is a grain used in flour recipes, (ii) Kanji is an easy porridge made of rice, (iii) Kali is a pudding made of millet, and (iv) Adai is a flaky rice and lentil pancake.

limited agency was evident as her decisions were still determined by the limited income of her household.

Participants reported their agency is limited, confined and manipulated within their household. Patriarchal norms and economic dependency on their husbands often forced them to place efforts to manage their health second to their household responsibilities.

ACHIEVEMENTS: DISTORTED AND UNDERACHIEVED

Kabeer (1999) defines achievements as well-being. In this study, achievements refer to the health outcomes attain by women as a result of their agency and access to resources. Participants of this study agreed that their health was worrying. Most of them had chronic illnesses (refer to Table 1) and relied on medications. The shortage of resources and restrictions on their agency proved to be important determinants of their health outcomes. Supporting this, Mythili (aged 38), who was suffering from high blood pressure, and Charu (aged 44), who was suffering from nerve pain, shared:

> 'My health now is okay-okay only … I have high blood pressure and suffer from pre-diabetes. I only found out after I went to the hospital to check my dizziness. All this while I was postponing these check-ups because of my children and housework. [I am] shocked, but what to do, just going with the medication these past few years …'

> 'I wanted to do medical check-ups, but my husband did not want to let me do that. [These] past few years, I have had nerve pain, but he did not let me. A few months ago, I had a minor stroke … I have been very weak after the incident …'

Achievements refer to the degree to which a person's agency and resource allocation enable them to live the lives they desire (Arslan et al., 2022; Kabeer, 1999). Both Mythili and Charu expressed their disappointment regarding their health. Their limited resources (i.e., income, time, and agency) were controlled by their husbands, resulting in their lack of access to healthcare despite having clear symptoms that indicated their health was declining. To illustrate, Charu's efforts to manage their health were relatively affordable due to the availability of government healthcare. However, her husband's preventive access for her to utilise this option underscores the significant role of gendered decision-making in resource (time) allocation and health access in the household. For both Mythili and Charu, these health impacts needed medication and were irreversible in the foreseeable future. Early consultations with doctors and getting the necessary help could have prevented the occurrence of serious conditions, however, their efforts were hindered by their husbands.

Besides, participants claimed that their health status was not as significant as their male counterparts in the house. One of the participants, Havina (aged 44), suffering from migraine, stated that:

> 'My husband has [access to] panel clinic since he is working … he always goes to clinic whenever he falls sick … he needs to be healthy as he is the one looking after finances … I'm only at home, so it doesn't matter. I can manage … if he is unable to work, then it will affect the family …'

'Control over the resources' indicates who manages the household income and spending decisions (Kabeer, 1999), while 'access to the resources' measures access and freedom to purchase in a household. Being the breadwinner, Havina's husband had access to healthcare through his employment. In addition, his role in handling the finances of the household indicated his authority over the resources. Havina's limited access to and control over the resources demonstrated the lack of healthcare access and economic influence.

Women's depiction as caretakers, nurturers, and maternal figures are creations of patriarchy (Joseph 2014). Nonetheless, the current study found that Malaysian Indian women consciously chose to sacrifice their health in order to meet patriarchal expectations. Two participants, Thana (age 34), who suffers from gastritis, and Sumathy (age 39), who has high blood pressure, indicated that Malaysian Indian women find fulfilment through adherence to these patriarchal norms.

> 'My health status now is not good … But I just feel that I have done [a lot] for the good of my husband and children … They are all well now; it is enough that I have this satisfaction [even though] I have sacrificed myself and my health for them. That matters [a lot to me].'

> 'Most of the time, I have to take medication because of my blood pressure. [I] cannot go without medication. The doctor warned that I might get a stroke if I skipped the medicine even [for] one day. At any time, anything can happen. It worries me … But [at the same time] I feel proud [watching] my children grow up, and they are doing very well …'

The majority of the participants in the current study were not in optimal health. They accepted their health limitations to fulfil their family obligations, which resulted in a diminished sense of agency and a lack of resources, leading to uncertain health outcomes.

The connection between resources, agency, and health outcomes for Malaysian Indian women highlights their disempowerment in terms of health. Their sense of agency is often ineffective, and the resources available to them are extremely limited. As a result, they are left with only an illusion of good health.

Many of these disempowered women jeopardise their health by sacrificing or being compelled to relinquish their resources, sense of agency, and accomplishments.

Policies should prioritise expanding access to healthcare services and resources according to the socioeconomic conditions of B40 Malaysian Indian women. Furthermore, it is imperative to enhance the empowerment of Malaysian Indian women by implementing community-based educational initiatives, which will enable them to make informed decisions regarding their health. Additionally, the government must collaborate with community organisations and healthcare providers to support these efforts.

Conclusion

This study highlighted that the resources, agency, and achievements of Malaysian Indian women from poor households have not yet shown signs of improvement compared to findings from earlier research (Tan et al. 2011; Kaur et al., 2022). The narratives in this study highlighted the complicated nature of Indian women's agency by emphasising its constraints due to patriarchal norms and limited resources. Indian women's health-related empowerment was severely curbed by their husbands and the patriarchal system practised within their households.

Prioritising health among Malaysian Indian women indicates placing importance on themselves or being on equal footing with their husbands, which is deemed taboo among them who have internalised their subordination. Malaysian

Indian women believe that defiance would result in dire consequences, such as losing the respect and honour they expect from their households and society. Nonetheless, some Indian women have demonstrated their capacity to use the resources at their disposal, illuminating the many facets of agency. In short, resources, agency, and achievements are closely intertwined and necessary for empowerment. Thus, the strong linkage between these three aspects is significant as it shows that the lack or absence of even one of the aspects among Malaysian Indian women negatively impacts their health.

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