

**Context or Empowerment:  
Determinants of Women's Reproductive Health and Health-Seeking Behavior in India**

By

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"... the most effective development policies are those which are socially just and focus on the well-being of all people" (Indian National Population Policy 2000)

### **Abstract**

Reproductive health, rather than being a biological process, is deeply influenced by social, economic, and cultural conditions that affect individuals at several levels. This paper is a multilevel analysis of the determinants of women's reproductive health-/seeking behavior such as self-reported absence of STIs, type of contraceptive used, and adverse pregnancy outcomes in India. Data from the NFHS-2 is utilized. I hypothesize that: 1) Community-level variables such as access to health care and development are positively related to absence of STIs, higher contraceptive use, and lower number of stillbirths among women residing in that community. 2) The relationship persists above and beyond the women's own empowerment. 3) However, contextual effects do not negate the effect of a woman's empowerment on her reproductive health-seeking behavior. The importance of women's agency highlights the distinction between determinants of reproductive health and reproductive health-seeking behavior.

### **Introduction**

The ICPD-Program of Action was path-breaking in many respects because it signified a paradigmatic shift on the subject of fertility from quantitative and narrow demographic imperatives to broader, more qualitative aspects of women's reproductive health and empowerment (Correa, 1994).<sup>1</sup> However, despite the language of gender equity that was espoused at the ICPD, facets of women's health (or health-seeking behavior) still remain relatively under-studied.<sup>2</sup> Importantly, the *clustered* nature of health outcomes (due to neighborhood effects) or the *nested* nature of populations—i.e. areas (such as districts) as aggregates of households, and households as aggregates of women and various processes within them is overlooked (Subramanian, 2004).

Using a multilevel framework, the aim of this paper is to study the individual *micro-level* as well as contextual *macro-level* determinants of women's reproductive health (and health-seeking behavior) such as self-reported absence of STIs, type of contraceptive used, and adverse pregnancy outcomes (such as stillbirths) in India. It is motivated by the belief that reproductive health and health-seeking behaviors are not "stand-alone" or individual, but intimately connected to other larger issues. Thus, we must retrain our lenses to see health as embedded in, and deeply influenced by, social, economic, cultural, and political conditions that affect an individual's everyday life at all levels, individual, couple, family, community, and state (Correa, 1994).

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<sup>1</sup> Post-Cairo, India was one of the few countries to incorporate some elements of the ICPD-POA, by first formally abolishing contraceptive targets from the population program, and then designing the Community Needs Assessment Approach (CNAA) which envisaged a bottom-up and decentralized planning of health and reproductive needs within the community (Ravindram, 1996). Finally, in 2000, the newly-released Indian National Population Policy (NPP 2000) and state population policy documents demonstrated the attempt to incorporate the language of gender equity and women's empowerment in their goals, objectives, and strategies (Bose, 1995).

<sup>2</sup> Although, several community studies recognize the *magnitude* of women's reproductive health problems, evidence of adequate commitment to redress this neglect through development policies at the national level are unaddressed.

## Research questions

My paper seeks to understand the importance of both context **and** women's autonomy on their reproductive health and health-seeking behavior. Using stepwise multilevel models that incorporate individual-, couple-, household-, and village-level data, this study attempts to answer an important but relatively unstudied question: "to what extent is women's health-seeking behavior a function of the access to and quality of health care provided, the relative socioeconomic development of the region, the overall gender ideology of the community, *independent* of a woman's own empowerment?"

As a first step I would like to study the existing situation of women's reproductive health and health-seeking behavior, focusing on self-reported absence of STIs, type of contraceptives used, and adverse pregnancy outcomes. Because of the strong norms of virginity, the strong culture of silence, as well as the stigma associated with STDs, accessing treatment services can be highly stigmatizing for adolescent and adult women.<sup>3</sup> Lack of information about their bodies and reproductive physiology limits adolescent girls and women's abilities to identify abnormal gynecological symptoms that could signify an STD. However, even when women recognize infections, they do not necessarily seek care for their conditions, especially since their actions might be governed by the attitudes of parents, husbands, and mother in laws and because they might be socialized to perceive such problems as a normal aspect of womanhood.<sup>4</sup>

Preliminary analyses of the Indian NFHS-2 data indicates that only 39% of ever-married women report at least one type of problem related to vaginal discharge, and of these, almost two-thirds have not seen anyone for advice or treatment (p. 311). The percentage of women who have not obtained advice or treatment is higher in rural areas (69%) than in urban areas (55%). 49% of ever-married Indian women are not involved at all in decisions about seeking health care for themselves (p. 64-65). In summary, NFHS-2 results indicate that although a majority of Indian women report at least one reproductive health problem that could be symptomatic of a more serious RTI, the majority of them bear the problem silently, thus opening themselves up to future infections, reduced life-expectancy, and disempowerment.

As a second step, I would like to explore the effects of women's empowerment on their reproductive health-/seeking behavior. Does an unequal power balance in gender relations (that tend to favor men) translates into an unequal power balance in health-seeking behavior due to which male needs supersede female needs? Do education and labor force participation empower women in terms of health-seeking behavior or is that contingent on context and socioeconomic development of the community? To what extent does tolerance/experience of domestic violence have consequences for women's health, their reproductive health-seeking behavior, adoption of a small family norm, as well as the health of their children?<sup>5</sup>

Again, descriptive analyses from the NFHS-2 indicate that 61% of respondents in India between the ages of 15-49 did not participate in work other than their regular housework during the

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<sup>3</sup> For example, adolescent girls are the most vulnerable to STD/HIV infection and the least able to protect themselves because they are doubly disadvantaged due to their gender as well as young age (Datta, 2000).

<sup>4</sup> Community based study conducted in Gadchiroli district, a rural area of Maharashtra, showed that, of 650 women aged 13 and above, 55% complained of gynecological problems, but on clinical examination and laboratory tests, as many as 92% were reported to suffer from gynecological morbidity (Mulgaonkar, 1996).

<sup>5</sup> In patriarchal societies such as India, women are not only socialized into being silent about their experiences of violence, but traditional norms teach them to accept, tolerate, and even rationalize domestic violence (Desai, 1998).

12 months preceding the survey. One can posit that women's dependence on others reduces their ability to negotiate healthcare services and increases their exposure to reproductive health risks. Interestingly, although women's income contribute substantially to family earnings, thirty percent of women who earn money report that only their husbands or others in the household make the decision on how the money they earn will be used (p. 65). Ironically, women working for money are more likely than non-working women to experience violence, indicating that notions of masculinity as well as the silent acceptance of violence by women undermines attempts to empower women and will continue to be a barrier to the achievement of demographic and health-seeking goals such as treatment of other STDs and safety from HIV.

Finally, I would like to study macro-level contextual effects (using village-level indicators of social and economic development) on women's reproductive and health-seeking behavior. Are women in some regions of India more disadvantaged in terms of reproductive health than women from other districts (and states)? Are reproductive health risks higher among women in Northern states such as Haryana, Rajasthan as opposed to Tamil Nadu and Kerala? To what extent is women's health-seeking behavior a function of the access to and quality of health care provided, the relative socioeconomic development of the region, the overall gender ideology of the community, and other "enabling conditions?" To what extent is it a function of culture, attitudes, and kinship patterns (Desai, 1998)? Is it possible that despite residing in regions characterized by wealth and access to good healthcare services, women might not exhibit higher reproductive health-seeking behavior? Or, despite living in poor conditions, women might possess better reproductive health because of household characteristics and spousal relations? Thus, to what extent does context affect women's ability to negotiate reproductive health care?

## **Hypotheses**

Emphasizing the social and institutional contexts in which individuals are embedded imparts a degree of realism that is often absent from single-level models (Duncan et al., 1996). In this analysis, I use multilevel stepwise models to examine the effect of context on the reproductive health-seeking behavior of women residing in geographically defined rural villages of India. I hypothesize that:

- *Hypothesis 1:* A significant and positive relationship exists between socioeconomic development and quality/access to health care facilities and a women's reproductive health in a district.
- *Hypothesis 2:* The contextual effect of development and access to health care on women's reproductive health and health-seeking behavior is likely to persist and be significant even after controlling for individual-level characteristics such as the woman's empowerment.
- *Hypothesis 3:* Women's autonomy at the individual level highlights the difference between determinants of reproductive health and determinants of reproductive health-seeking behavior.

In an attempt to distinguish between contextual (macro) and compositional (individual) effects, relevant women- and community-level predictors and controls are included in the analysis.

## **Data and Methods**

### *Data source*

This analysis will utilize two levels of data created from the 1998-99 NFHS-2.

### *Type of Analysis*

The methodology used in this study is important. Until recently, higher-level neighborhood, community, or even district effects remained unincorporated in studies pertaining to women's reproductive health and health-seeking behavior. This could primarily be due to problems in transporting these effects into individual-level models as well as choosing the appropriate units *and* levels of analysis (Raudenbusch and Bryk, 2002). However, even when such effects are included in single-level equations, the results can be misleading due to aggregation bias, misestimated standard errors, and heterogeneity of regression (Raudenbusch and Bryk, 2002). Hierarchical linear modeling (HLM), which permits simultaneous estimation of full micro- (or individual) level and macro- (or district) level models, helps correct these methodological problems.

### *Main outcome variables*

- Any reproductive disease in the past 12 months
- Number of stillbirths
- Use and type of contraceptive used

### *Main explanatory variables*

- Macro level contextual variables
  - Quality and access to health care facilities
  - Socioeconomic development index
  - Prevailing gender systems (proxied through labor force participation and exogamy)
- Micro level individual variables
  - Women's mobility, decision-making power, and autonomy within household

### *Main control variables*

- Household-level variables
  - Family socioeconomic status (measured through luxury assets index)
  - Family structure
  - Ownership of land (or irrigated land)
  - Source of drinking water/cooking fuel
  - (Source of Iodine)
  - Caste/Religion
- Couple- and individual-level variables
  - Age of woman (or age difference between respondent and spouse)
  - Current marital status
  - Parity
  - Educational attainment
  - Access to mass media (radio, newspaper, TV, cinema)
  - Type of foodstuffs consumed and when

### **Conclusion**

Context, poverty and women's reproductive health is an important area for research, and remains under explored in the case of developing countries, particularly India. While reproductive health and rights have been a major area of interest in developed countries for many years, we need to look at similar issues in developing countries. I believe that my research will contribute to understanding women's health and social status in developing countries and the implications of such arrangements for various aspects of population policy.

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