Empowerment and Health in a Low Income Community in Mumbai, India

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I. Introduction

The development efforts of the 1950s and 1960s that targeted low-income countries aimed to enhance the lives of both men and women, but it quickly became clear that in patriarchal contexts, women were not sharing equally in the benefits of these programs (Cohn, Wood & Haag, 1981; Escobar, 1995; Goetz & Gupta, 1996; Sen, 1988). Programs initiated in the 1960s aimed at improving women’s health focused on women as child bearers and nurturers but did little to enhance women’s status and development (DeSandre, 2000; Hoffman, 2003; Leslie, 1992; Marieskind, 1975). In the 1980s, activists challenged the male-dominated, pro-natal orientation of many health and development programs for disregarding women’s rights, voices and participation (Elliott, 2008). Researchers and interventionists sought to use a gender perspective that would detect gender differentiation in the control over and distribution of programmatic resources and outcomes and rectify gender maldistribution; the conceptual terminology for this new perspective was ‘women’s empowerment’.

The literature proposes a variety of definitions of empowerment including: control over decision making about personal, social and economic choices (Gollub, 2000; Kabeer, 1999); having the agency to formulate strategic choices and control resources in order to achieve a desired outcome (Alsop and Heinsohn, 2005; Kabeer, 1999; Malhotra et al., 2002; Sen, 1990); and having the power to be able to attain desired outcomes (Grown, Gupta & Pande 2005; Laverack, 2006; Narayan, 2002; Sen, 1988). Agency, the ability to define ones goals and act on them, is a dimension of power, and agency and power together contribute to the definition of empowerment (Ellion, 2008). Empowerment is also the ability, based on education and skills development, to advocate for a better quality of life (Sen, 1990). One element of a better quality
of life includes the ability for a woman to make choices about her body and have control over her body. Body empowerment increases a woman’s sense of entitlement of her body in regards to choices, health and respect (Gollub, 2000). According to Koggel (2009), relationships of power shape and reshape embodied realities and bodily needs in ways that both enhance and hinder the process of empowerment. Yet the empowerment literature often overlooks the interaction of embodied empowerment and the way specific contexts and immediate situations shape it.

Another body of literature defines empowerment as a process that occurs over time (Carr, 2003; Conger & Kanungo, 1988; Falk-Rafael, 2001; Kabeer, 2000; Page & Czuba, 1999). For example, a woman’s level of empowerment may change over the course of her life as a natural process of advancing age, entrance into income generation, or responses to familial, social, political and other contextual challenges and life changes (Kabeer, 1999). It entails a process of change and an expansion in people’s ability to make strategic life choices in a context that previously denied them this ability (Kabeer, 1999). As the utilization of the term grew, empowerment became inextricability linked to women’s well-being and was accepted as a necessary pathway to women’s overall development (Grown, Gupta & Pande 2005; Sen, 1988). Although a large body of literature associates higher levels of empowerment with better outcomes, scholars have reexamined and critiqued the assumption that higher levels of empowerment correlate with better health, social, and economic outcomes for women (Fielding, 1996; Lennie, 2001; Mitter, 2004; Parpart, Rai, & Staudt, 2002; Rocca et al., 2009).

In this thesis I use a case example, drawn from a low income community in Mumbai, to explore whether and to what extent context and situation shape women’s expressions of empowerment and under what circumstances empowerment, defined as a woman’s control over
choices that involve her body, decision making and mobility, leads to positive or potentially negative consequences/outcomes for women.

A. Empowerment and Health among Indian women

Several factors contribute to Indian women’s relative lack of empowerment including the patriarchal nature of Indian society, limited work opportunities, low levels of social, political and economic participation, and constrained mobility (Garikipati, 2008; Hashemi, Schuler et. al, 1996; Kantor, 2003). Lack of empowerment results in negative consequences such as poor health, discrimination in terms of allocation of valuable household resources such as food, medical care and education, and increased burden of strenuous physical tasks (Sharma and Sidhu, 2008; Velkokk and Adlakha, 1998). According to Patel et al. (2006), “gender disadvantage” is associated with Indian women’s poor health. They examined five domains in which gender disadvantage is situated: marital history, level of interpersonal violence, degree of autonomy in decision-making, level of engagement in activities outside the home and availability of social support. Patel et al (2006) proposed that gender disadvantage combined with poor reproductive health status is the main determinants of the poor health status of many Indian women.

1. General Health

A variety of symptoms and syndromes among Indian women in low-income rural and urban communities have been described in the literature as both contributing factors to and consequences of women’s negative health status. Tenshun (derived from the English word “tension”) is a culturally defined health problem associated with high levels of poverty, low education, excessive household chores, husband’s alcoholism, low empowerment, domestic
violence and marital difficulties (Oomman, 1996; Patel & Oomman, 1999; Prasad et al., 2003; Ramasubban & Rishyasringa, 2001). Another syndrome is kamjori, which includes a wide range of general bodily complaints such as pain related to menses, pain in joints (hands and legs), dizziness, loss of appetite and chronic fatigue (Nichter, 1989; Kostick et al., 2010). Chronic fatigue and feelings of being weak and tired have been widely reported by Indian women (Bhatia and Cleland, 1995). Patel et al (2005) found that women who suffered from chronic fatigue had significantly increased levels of disability and were more likely to report other physical symptoms associated with negative health. The most common symptom that women present to health care providers is safed pani (“white water”) or vaginal discharge (Kostick et al, 2010). Safed pani has been associated with psychosocial problems and a negative life situation (Kostick et al, 2010). Tenshun, kamjori and safed pani are associated with women’s social burdens and pressure, low self-esteem and gender-based inequalities (Jejeebhoy & Koenig, 2003; Patel & Oomman, 1999; Weiss & Gupta, 1998) all of which are associated with low levels of empowerment.

2. Pregnancy-related health

Many studies have associated higher levels empowerment with positive reproductive health outcomes (Beegle et al., 1998; Hindin, 2000; Wolff et al., 2000). Women’s greater degree of autonomy and gender equity are seen as playing an important role in shaping their ability to manage fertility as well as the health and development of children. For example, in Northern India, women with greater freedom of movement were more likely to receive higher levels of antenatal care and use safe delivery care (Bloom et al., 2001). In a study conducted in the State of Andhra Pradesh, women with greater maternal autonomy, defined as a woman's personal power in the household and her ability to influence and change her environment, and greater
freedom of mobility were less likely to have a child with low birth height and weight (Shroff et al, 2009:64).

The social status of Indian women is, in part, determined by the ability to have children (Mehta and Kapadia, 2008). Women who are unable to produce children, especially male children, experience stress when they are not able to do so within a prescribed period of time (Croll, 2000; Folmar, 1992; Riessman, 2000). Married women are defined and judged in relation to dominant family norms and associated gender ideologies; especially the ability to become mothers. Having children fulfills societal and familial obligations, while at the same time, solidifying the marital relationship and raising a woman’s social position in the household (Riessman, 2000). From the moment a woman becomes pregnant, her status in the household has the potential to change for the better. Factors such as how many sons she has produced, or if the family expects her to give birth to a son can play a role in improving way her husband and his family treat a woman. Thus, the period in which a woman is pregnant is one that affords her an opportunity to gain status within the household and thus may contribute to higher levels of empowerment.

This thesis will examine the relationship between empowerment to women’s self-reported general health status and women’s self-reported health during pregnancy in low-income communities in Mumbai. General health refers to those women’s health problems and health status exclusive of pregnancy or delivery. Pregnancy related health refers to women’s self-reported health problems specifically during the perinatal period. We propose that greater or lesser levels of empowerment will be associated differentially with general health and perinatal health.
II. Methods

A. The Study communities

The data on which this thesis is based were collected in three study communities located in a marginalized area of Mumbai, technically labeled as “slums” with a high population density and limited sanitation and access to clean water. The majority of the population (66%) residing in the study communities are migrants from other states including Uttar Pradesh (51.2%) and rural Maharashtra (22.1%). Migrant men generally move to Mumbai to establish work and residence and return to their native village to marry or bring wives left in the village to Mumbai on a permanent basis. Most (90.7%) of marriages in the study community are arranged and thus husband and wives are less likely to know much about their future partner prior to their marriage.

Households consist primarily of one room (81.3%) with an average of 6.4 people per household. Nuclear households are most common (47.0%), followed by joint and extended household (37.1%); 15.8% of households consist of men only that can include same age relatives, friends and co-workers sharing a single residence. Men are the primary income earners in this community with only 4% of wives working for cash income either inside the home (40.6%) or outside the home (59.4%). On average women earn significantly less than men per month (mean of Rs 1353 ($31) for women and Rs 3272 ($72) for men. The general situation of women in this study community appears to be significantly constrained with women having limited access to power.

B. Data Collection Procedures

The data were collected as part of a National Institute of Mental Health (NIMH)-funded project entitled “Assessing Risk for HIV/STD among Married Women in Urban India (2002 to
a part of the program, *Research & Intervention in Sexual Health: Theory to Action* (RISHTA, an acronym meaning “relationship” in Hindi and Urdu). Data collection consisted of formative research on women’s issues related to risk of HIV infection, leading to the development of a pilot intervention to reduce the risk of HIV/STI transmission within marriage. Here we draw on two data sources: qualitative interviews and a survey sample of 260 women. Field staff conducted in-depth qualitative interviews among Hindu and Muslim married women ($N=66$). Women interviewed as part of the qualitative sample ranged in age from 18 to 40 years with an average age of 30 and had at least one child at the time of the interview, with an average of 3 children per woman. In terms of religion, 19 (29%) women identified as Hindu and the other 47 (71%) were Muslim. Although level of education varied, most women in the sample had low levels of education with only 2 of the 66 women having post high school education and 17 (26%) women with no formal education. Data were analyzed using Atlas.ti v 7 (Muir 2010) to identify the major domains, and variables in a structured survey instrument was developed. The survey instrument was administered to 260 women in their homes who were asked about many aspects of their lives including empowerment and health. Written consent was obtained for all qualitative interviews and surveys and the Indian and U.S. collaborating institutions and the Indian Council of Medical Research granted Institutional Review Board (IRB) clearance. The age range of the survey sample of 260 women was 18 to 48 with a mean age of 28 years. The number of pregnancies ranged from 0 to 11 with an average of 3 pregnancies per woman. The analyses for this thesis were limited to the 244 women who had at least one pregnancy. The age of first pregnancy ranged from 12 to 29 years of age. The number of years these women were residing in Mumbai ranged from 1 to 48 years with an average of 12
years. About half of the sample (49.6%) identified as Muslim, 47.7% identified as Hindu and 2.7% (7 individuals) identified as “Other” religion. SPSS 17.0 was used for analysis of data.

**C. Measures**

The **general health** scale is a composite of seven symptoms that women reported experiencing in the last three months. Women were asked to answer yes or no to whether they had experienced the following problems: low backache, headache, giddiness (dizziness), pain in body, loss of appetite, chest pain and palpitations that principally focus on *kamjori* (alpha = .71).

The **pregnancy-related health** scale is a composite of eight items (alpha = .83) asking if women experienced the following during their last pregnancy: excessive bleeding, backache, dizziness, and white discharge, lack of sexual desire, anemia, nausea and pain during intercourse.

To account for the time difference between general health (within the past three months) and last pregnancy-related health, we calculated the number of years between the last pregnancy and the time of the interview; the range for women in the sample was from 0 to 23 years. We created a variable of “age at last pregnancy” included it in the analysis to control for the time difference between the two scales. The covariates of age, education, and religion were also included in the analysis.

A **Women’s Empowerment Scale** was constructed containing 23 questions regarding various domains of women’s empowerment (alpha = .82). The measures of empowerment included questions on participation in domestic decision-making, control over sexual relations and freedom of movement/mobility. Women responded to the statements with a three point Likert-type scale: “not at all true of me, somewhat true of me, or very true of me”. The distribution of responses was relatively normal with a slight positive skew (mean= .98, standard deviation= .30 skew =.30) indicating somewhat greater levels of empowerment reported among
women in the sample. We recoded items to ensure common directionality, and level of empowerment, which was coded as high, medium or low.

The correlation between two dependent variables, General Health and Pregnancy Related Health was low (Pearson Correlation = .108, Two-Tailed Significance Level = .096), confirming them as separate and independent constructs. We then utilized survey data to examine the relationships of empowerment as an independent variable in two separate regressions to assess the independent effect of empowerment on these two different and non-overlapping health outcomes.
III. Results

A. Empowerment

Three themes related to empowerment were evident in both the qualitative and quantitative data. The first theme, *control over body*, included statements about decisions that the woman is able to make about her own body. Women were asked several questions about their ability to refuse sex, their duty to have sex, and if they would fight back or seek help in the event they were being physically beaten by their husband. The second, *control over decisions/finances*, included statements about women’s involvement in financial and other decisions that are made within the household. Women discussed what their responsibilities were in terms of saving money or purchasing goods for the household. They were also asked if they had access to money and if they were able to make economic decisions. The third, *access to community/mobility*, included statements on whether the woman is able to access resources and services outside of her home. It also included a woman ability to travel both within and outside of her community.

1. Control over her body

Women interviewed stated that they were in control of their bodies when they had the ability to negotiate sex or refuse it despite the desires of their husbands. Conversely, women expressed a lack of control over their bodies when they had to give into their husbands desires for sex in spite of their desire not to have sex. Women who had less control feared that if they refuse their husbands desires for sex, then their husbands might find another woman. Some women also described that they could not refuse to have sex with their husbands, or in the instances when they did refuse, their husbands would still force them.
But I cannot say no to my husband if he wants to have sex…if I say no to him sometimes, then he really forces me to do sex. I also understand that if I say no to him then he might get involved into some other activities [like going to be with another woman]… ladies don’t have the ability of saying no to her husband. (25-year-old Muslim woman, 3 children)

Women described certain contextual factors that allowed them to have more control over their bodies in terms of marital sex. These included, being pregnant, menstruating, the lack of privacy with children and/or family members frequently in the same room.

Once a lady doctor said to him not to do sex during pregnancy, at that time, he did not do for few months, but after that, again he started doing it. (39-year-old Hindu woman, 3 children)

I felt in the beginning whether sex is necessary for marital life. I was happy whenever I got my periods because there was no sex. I could sleep nicely. (45-year-old Muslim woman, 2 children)

The lack of privacy also played a role in the frequency and nature of sex.

As long as we were sharing a room with one family, my husband never forced me to have sex due to lack of privacy. Once we shifted [to a private room] I used to refuse and my husband forced me to have sex … he started abusing me. (30-year-old Muslim Woman, 1 Child)

Even when I refused to have sex, he does not say anything to me. He understands that our daughter is growing up and there is no privacy. (38-year-old Muslim woman, 2 children)

Women who stated that they were able to say no to their husbands desires, described their husbands as being ‘good’ if they did not force them to have sex. Some women also stated that with time, sex became something that they enjoyed especially in cases where their husbands did not force them.

If I am sick or when I get my menstruation he never force he understands and co-operates with me. (23-year-old Muslim woman, 3 children)

He is such a nice person that he never forced me to have it. I also realized that woman can also take initiation and can enjoy it. Before that, I didn’t feel anything about sex. I
liked it but was not having such feeling as I told just now [enjoying it]. (25-year-old Muslim Woman, 8 Children- Married at age 13)

Women in this sample exhibited great variation in terms of the control over their bodies.

Although several women mentioned forced sex by their husbands and viewed sex as a duty, which a woman had to fulfill, there were also women that described that they enjoyed sex and had husbands who did not force them to have sex.

2. Control over decisions/finances

Women’s control over decision-making varied depending on the matter discussed. In many cases, women were able to make decisions with regard to household matters such as what food to prepare, what types of groceries to buy, or matters concerning children’s day-to-day wellbeing. Women were less involved in decisions related to major finances or major household purchases. Households where the mother-in-law and other members of the extended family were present further affected decision-making. In these cases there were several individuals who had ‘seniority’ over the woman and limited her decision making capacity. Moreover, limited finances, or lack of access to personal income by the women also played a role in limiting women’s decision-making abilities.

Mine is a joint family… If the matter is related to the whole family then we all sit together and talk to my mother-in-law and father-in-law then they take the final decision…But if I want something then I tell my husband… then it is just our own decision, but we do take elder’s advice. (22-year-old Muslim woman, 1 Child)

My husband takes all the decisions. As he is the eldest son in the family, his advice is always welcomed in every occasion or matter. All the financial matters were looked by my mother-in-law and husband… a household matter decisions like what to cook, shopping and so on was taken care by my mother-in-law and me. (30-year-old Hindu woman, 5 Children)

There were also several women who expressed having more and even sole input in decision making, although many of these decisions were confined to the household/familial domain.
Decisions outside of the household domain usually required input from the woman’s husband or other members of the family.

For everything I take the decisions as my husband and children give their earnings to me. I am the person who decides on every matter. So, with that money, I try to manage the household, clothes for all the family members, education of children, other purchasing, and giving anything to anybody, as my husband is always busy he never thinks of anything, so I only do everything. (37-year-old Muslim woman, 5 children)

My husband gives his salary to me. The usual day-to-day shopping (purchasing vegetables, buying something for household or kitchen), I manage to do. But the major shopping, we do together….We take the major decision jointly, like we think about the children’s future. (22-year-old Hindu woman, 2 children)

There were also some women who described very little or no control over decision-making.

Being born as women, men expect from us that we should live under their control and domination. We cannot take any decision on our own. Since our birth, we have to live under father’s domination, and after marriage under husband’s control…This is the reason why we are not able to think about ourselves. I am fed up of this patriarchal society…. I feel that women should be independent financially. This would help them to gain their own identity. I am saying all this out of my personal experience. I am suffering a lot because of men. (32 year old Muslim Woman, 1 Child)

After marriage, I was given all sort of freedom meaning, my husband gave me enough share of his pay to run the household. I could spend it according to my wish. But from last 3 to 4 years I am not well, things changed. Earlier we used to decide on every household matter together, but now he takes the decision. (29-year-old Hindu woman, 3 children)

Decision making ability in one realm of a woman’s life did not necessarily correlate with decision-making ability in other aspects of her life. For example, the woman below describes some negative aspects of her relationship with her husband, yet she has control over decision-making.

We have quarrels only because of his idleness. Sometimes after drinking alcohol, he gives me bad words, but never says anything bad about my character. He trusts me very much. He knows I can take proper care of my responsibilities and family so he is not much bothered. I take all the decisions of the family and children. He never interferes in my decision-making matters. He never stops me by going out, but I myself prefer not going out other than work purpose. (35-year-old Muslim woman, 3 Children)
As with control over one’s body, women also expressed great variation in terms of decision-making. This variation makes more complex the notion of empowerment and illustrates that one’s level of empowerment can vary both within and across domains.

3. Mobility/access to the community

Most women reported that they were able to move freely within their communities without seeking permission from their husbands. These movements were primarily to run errands such as taking the children to and from school or going to the market for groceries and other household supplies. Although some women did exhibit relatively high levels of mobility, this mobility may still be constrained and controlled by husband and other family members.

My mother-in-law plays a major role at home. She is the head of the household. My husband gives her [mother-in-law] money to run the house. When I go to the market, I have to tell her what I am buying and according to the approximate cost, she gives me money. (35-year-old Muslim woman, 2 children)

I have a lot of freedom inside the house, meaning I can do anything within the four walls. I don’t have to ask my husband what to cook and what clothes to wear. But if I have to go out somewhere then I either have to inform him or need to take his permission. (24-year-old Muslim woman, 1 child)

A smaller percentage of women reported greater amounts of freedom in terms of their mobility and were able to move freely without seeking permission from their husbands. These women also faced few restrictions from their husbands in terms of visitation of friends and family and participation in events or outings.

My husband is a nice person. He never says anything to me. He has given me all the freedom therefore whole day I am roaming here and there. Also, he gives his whole salary to me. With that money, I have to manage all the household needs plus save money for his trip to first wife for clothes, ticket and other things. He never asks me where I have spent that money. (39-year-old Muslim woman, 2 children)
I am having one friend in the neighborhood that runs a grocery shop; with her, I used to go out and have food outside. My husband was also saying if you feel [like it] go with her. From his side no restriction is there. (24-year-old Hindu woman, 2 children)

On the other hand, some women were very restricted, and were not able to move freely within the community and were often times not allowed to leave the home; however, some of these women viewed this restriction positively, accepting the patriarchal/social-cultural norms.

In my case, not much freedom is there. I can do what I want but its good for healthy relations that wife should be under observation/control of husband. In my case also going anywhere I have to take his permission, not for the nearby area but for the long distance. I think this restriction is good, so that she (wife) will be in control and will not go on wrong way (means to other man). (33-year-old Muslim woman, 1 child)

Even if I get, I do not go out of the house because my mother-in-law does not like. We do not have purdah system as such in the house; still I prefer to avoid any misunderstandings. (35-year-old Muslim woman, 2 children)

Women with access to the community were able to join organizations and women’s groups which helped them to address some of their problems, as the women below describe.

Participation in such organizations indicates greater freedom of movement and access to information that the woman would not have access to inside her home.

I felt that there is solution for everything. The reason for joining Mahila Mandal [women’s organization] is due to my problems. I want other women to come out openly and talk about their problems. Being a woman…I understand what it means to go through marriage problems. (35-year-old Muslim woman, 2 children)

I always used to feel that why am I suffering, whenever I saw any woman in trouble like me, I started helping her, giving her moral support. One of the NGOs is active in this locality. We came to know about it whenever we went to meet women or approached police station to rescue woman…they gave us training in how to deal/handle the situation when woman approach. We formed a group of eight women to deal with marital counseling. Now we are a registered society. (35-year-old Hindu woman, 3 children)

Women’s levels of mobility varied, some women could move freely without the permission of their husbands’ or other members of the extended family and other women were greatly restricted. There were also women who viewed mobility restriction as being positive or were
accepting of certain cultural-societal norms that restricted women movement. The ability to move freely can be an asset since women with high levels of mobility had opportunities to participate in various organizations or access information, tools and resources of potential benefit.

**B. General Health**

According to the quantitative survey, the most common physical health problems were lower backache and headache, experienced by almost half of the sample. Women frequently reported pain in the body and dizziness whereas loss of appetite, palpitations and chest pain were the least reported problems. The women interviewed also commonly reported these problems. Table 1 provides the frequencies and percentages of women’s reports of general health problems.

<table>
<thead>
<tr>
<th>General Health Problem</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower Backache</td>
<td>118</td>
<td>48%</td>
</tr>
<tr>
<td>Headache</td>
<td>109</td>
<td>45%</td>
</tr>
<tr>
<td>Pain in Body</td>
<td>89</td>
<td>36%</td>
</tr>
<tr>
<td>Dizziness</td>
<td>66</td>
<td>27%</td>
</tr>
<tr>
<td>Loss of Appetite</td>
<td>41</td>
<td>17%</td>
</tr>
<tr>
<td>Palpitations</td>
<td>38</td>
<td>16%</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>34</td>
<td>14%</td>
</tr>
</tbody>
</table>

Many of the women qualitatively interviewed also described a variety of general health problems ranging in severity and duration. These included body aches, fever, malaria, backache, pain in limbs and headache. Women’s explained that these problems were associated with difficult situations in their lives. Women in the sample faced constant pressure in terms of fulfilling household duties, the needs of their husbands, children and in-laws and financial
constraints. Lack of adequate financial or social support from a woman’s husband exacerbated this pressure. Physical health problems were also associated with limited support that women were receiving from their husbands. A 28-year-old Muslim woman with three children stated: “as husband and father his love and affection towards us is lacking. This is the main reason of my ill health.”

Another woman describes her husband in the following way:

   He doesn't help in any household work, everything I have to manage. Even if I am sick, I have to do everything. I don't have daughters, it would have been a great help. (35-year-old Muslim woman, 2 Children)

Although women state a desire to have a husband who is helpful in terms of household responsibilities, they have internalized a number of gender specific roles and responsibilities, which add to their burden. For example, one woman stated:

   Female should take care of children and house, if she will do this properly then there is no chance of quarrel. Another thing, a woman should take care of her in-laws and if her sister-in-law comes home, she should do all possible things for her. (30-year-old Hindu woman, 3 children)

Further, attention to women’s general health often waited until other household expenses were met.

   I am not keeping well. I have one or the other health problem. I always try to avoid taking the treatment because it is so expensive. Ordinary medicines are also so expensive that we hesitate to buy it. If you are taking treatment, then you have to lose many things and have to sacrifice many other needs. So I really have to think twice before spending the money on my treatment or any other thing. (37-year-old Muslim woman, 5 children)

In addition, some women complained that their husbands or in-laws were reluctant to spend money on their general health needs and they expressed resentment that husbands placed less priority on their personal needs and health issues.

   With the constant pressure one day when my husband was at home I poured kerosene on my body and lit with the match box. Very soon it caught fire, my husband took me to the hospital…65% of my body was burned. After my recovery, the doctor advised me to go
for plastic surgery because on the neck I feel the stretch of my skin and my shoulders grow. Whenever I talk about it he [her husband] ignores. He does not want to spend money for the treatment but I should bear the burden of household responsibilities whether I like it or not. (29-year-old Muslim woman, 5 Children)

My health was going down. I could not eat or sleep. Many times I would stand at my in-law’s doorstep with my kids. There would be having their food inside but they would never ask me or my kids to have food. (25-year-old Hindi woman, 2 Children)

Some women with potentially significant problems did not seek treatment. Below is not an example of inability to acquire treatment. She never went, that is all she says.

The only health problem I have is my lower back pains badly, even my knees, ankle and feet pains badly in the morning. When I want to keep my leg on the floor, for few minutes I cannot, but after sometimes it becomes normal. I also feel the pain below my ribs. I feel that something is moving like a small lump in the stomach. For this too, I never went to the doctor. (30-year-old, Muslim woman, 2 children)

Level of stress or tension in the home also led women to exhibit behavior that was harmful in terms of their physical health, mainly gambling and chewing tobacco.

To keep myself away from tension and worries I started going for gambling in the nearby locality. I thought I could earn a lot to repay the debts, I also got used to chewing tobacco it helps me to be away from anxieties. (30-year-old, Hindu woman, 2 children)

To overcome tension and anxiety we got into the habit of chewing paan (betel leaf) and tobacco. It gives us relief for the time being; now I am addicted to it. (30-year-old, Muslim woman, 2 children)

There were also examples of where women received support or encouragement to seek treatment from their husband or extended family, even in cases where the woman did not want to spend the money on treatment.

Nowadays I am not keeping well. I have either a cold and cough or some other problem. The sickness is quite frequent with me. I take treatment for my illness…I need to spend on this but sometimes I really avoid spending on it….But my husband doesn’t like all these things, he forces me to buy the medicine prescribed by the doctor (37-year-old Muslim Woman, 5 children).

In sum, women described a wide range of general health problems. They also reported burdensome responsibilities for family and household welfare regardless of whether they were
They noted that at times these responsibilities worsened their health, because they took precedence over their own health problems. In general, both women and their husbands placed a low priority on health problems that affected only the woman. This low level of prioritizing is reflected in women’s lack of treatment seeking for health problems. Thus, unless women had support from their husbands and extended family, many of their general health needs were unmet.

C. Pregnancy Related Health

The quantitative survey asked women about which problems they experienced during their last pregnancy. The most commonly experienced problems during pregnancy were anemia, dizziness lack of sexual desire and backaches. Nausea and white discharge and pain during intercourse were less frequently experienced pregnancy-related problems. The least commonly reported pregnancy related health problem was excessive bleeding, only 30 women reporting experiencing this problem during their last pregnancy. Table 2 presents the frequencies of reported pregnancy-related health problems.

<table>
<thead>
<tr>
<th>Pregnancy-Related Health Frequencies and Percentage (N=244)</th>
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<tr>
<td>Pregnancy-Related Health Problem</td>
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</tr>
<tr>
<td>Anemia</td>
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<td>Dizziness</td>
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<td>Lack of Sexual Desire</td>
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<tr>
<td>Backache</td>
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<td>Nausea</td>
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<td>White Discharge</td>
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<td>Pain During Intercourse</td>
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<td>Excessive Bleeding</td>
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Many of the women interviewed qualitatively described experiencing the aforementioned problems during their pregnancies.

I had spontaneous abortion before the birth of my first daughter. After that, I started getting white discharge. She (doctor) gave me treatment for the problem...Since I got satisfaction with her treatment…every time I have any problem I go there I talk to the doctor. (25-year-old Muslim woman, 3 Children)

Within three months, I came to know that I am pregnant. During pregnancy I was not keeping well, there was nausea and vomiting. (35-year-old Muslim woman, 2 Children)

Women feel pressure to have a child early in their marriage and most women in the sample became pregnant as quickly as possible after their wedding.

I was only about 15 years when I got married. It was only after two-three years that I could conceive a child. So my elder sister-in-law always used to tell me that I am infertile, that I don’t have the capacity of bearing the children. So my husband took me to the hospital, the doctor told me I was young and my body was not yet capable for the pregnancy…then at the age of 18 we got our first baby. (25-year-old Muslim woman, 3 children)

Having a pregnancy with limited complications, which results in a healthy child (in particular a make child), is greatly desired by not only the woman, but also her husband, natal family and in-laws.

Everything went on well and after 2 days of labor pain, I delivered a baby boy. After the birth of our first child, my life totally changed. I was so happy with the baby. Everybody in the family was happy to see a baby boy. (37-year-old Muslim woman, 5 Children)

Four months after the birth of my son, my stomach looked as if it were swollen. Everyone thought I am pregnant. We were also happy. We thought, if this would be a boy, then it would be very good (31-year-old Hindu woman, 3 Children).

Women report that the period during which they are pregnant is also a time when they received the most support from their relatives and husband.

At the time I conceived, I stayed with my in-laws only during my pregnancy and 2 months after my delivery (35-year-old Muslim woman, 6 children).

For my deliveries I was with my parent, they bore the delivery expenses, I was with them for three months after the delivery. In our community we celebrate the naming ceremony
of the child, for that also my parents paid, it was a grand celebration (29-year-old Hindu woman, 2 children).

The amount of money and effort spent when a woman is unable to become pregnant illustrates the high value placed on pregnancy and childbirth.

Three years of married life gone very smoothly but one problem was there. I was not able to conceive again. So we started taking treatment for it. I took Allopathic and Ayurvedic treatment, after one month of Ayurvedic treatment, I conceived….over 50,000 Rupees (US$1,000) - we spent for treatment. (33-year-old Muslim woman, 1 child)

Several women described the process of becoming mothers as one that improved their relationship with both their husband and husband’s family.

After the birth of the child, we were really happy, in the sense the relationship between my husband and me also became strong, and I could say to people like, “Look, I also became a mother”. With all these things, you really feel good with the children. After the birth of my children, my husband felt that his responsibility also increased. He tried to earn more money (25 year-old Muslim Woman, 3 Children).

During the pregnancy period, women often are able to obtain better health care and are more likely to acquire more power within the household. Having a child also increased the responsibilities felt by both the woman and her husband.

After the birth of my children, my husband felt that his responsibility also increased. He tried to earn more money. Then he started earning more money. I have a bank account and I put money into a bissi [piggy bank]. Every month I put money into the bissi…I will then put the money in a registered bank (25 year-old Muslim Woman, 3 Children).

Although the social context in which these women are situated is generally disempowering for women, the time during pregnancy and fulfilling the role of mother provides women with more opportunities to exercise elements of empowerment.

**D. Empowerment and Health**

We utilized multiple linear regression analysis to examine the relationship between empowerment and the two domains of health; general health and health during pregnancy. In our
analysis, we sought to determine whether the relationship between empowerment and general health differs from the relationship between empowerment and pregnancy-related health. The first regression (Table 3) examined the relationship between general health and empowerment and the second regression (Table 4) examined the relationship between pregnancy related health and empowerment.

Table 3

<table>
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<tr>
<th>Linear Regression Coefficients- General Health</th>
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The results show that more general health problems were associated with higher levels of empowerment (Table 3). Women who were more empowered were significantly more likely to report having general health problems. There was no significant relationship for the covariates of age, education, and religion. Table 4 presents the standardized and unstandardized coefficients for pregnancy related health.

Table 4

<table>
<thead>
<tr>
<th>Linear Regression Coefficients- Pregnancy Related Health</th>
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<td><img src="image" alt="Table 4" /></td>
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Table 4 shows that higher levels of empowerment were associated with fewer pregnancy-related health problems. Women that were more empowered were less likely to have pregnancy-related health problems. As with general health, the demographic variables of age, education and religion did not have a significant impact on pregnancy-related health.
IV. Discussion

The results of our analysis show that empowerment functions differently in relation to women’s general situation and their pregnancy status. We have shown that women who are more empowered are more likely to experience general health problems, and less likely to experience pregnancy related health problems. We look to our qualitative data to try to explain these differences.

Qualitative data illustrated the importance of childbirth in establishing the status of young married women in their husband’s family. The period of time in which a woman is pregnant and in the immediate post-partum period is highly valued by mother and father, as well as all members of the extended family. Pregnancy gives women special status and privilege and during this liminal time, they can claim greater attention to their bodily health and wellbeing. Pregnancy enables women to increase their power, control and decision-making over their own bodies and provides women other benefits such as increased access to the community, agency, financial support, and greater levels of respect.

However, this is a temporary situation. When women are not pregnant, husbands and families see women’s health problems as a potential interference with the maintenance of the household. Non-pregnant women who attempt to wield more power face considerable resistance to their efforts to gain greater mobility, independence, and decision-making. We suggest that the lack of attention on women’s general health problems leads to a series of general health problems with a psychosocial etiology.

Our data supports the notion that empowered, non-pregnant women in a predominantly patriarchal society constantly battle gender inequalities which results in more somatic symptoms and higher levels of psychological pain. Husbands and members of the extended family view
women’s general health problems as further reducing the households’ limited financial resources especially if the cost of treatment is high. Women themselves are raised with the cultural norm that their health problems (and other aspects of their lives) are less important, and thus tend to minimize them. Women and their husbands are congruent in the belief that the household’s scarce resources are better spent on food, clothing, education and children’s health than on addressing the health problems of the woman no matter how serious they may be. Both men and women minimize the severity of a health problem; further, men tend to blame women for their own health problems and expect them to take responsibility for “handling their treatment at home.”

On the other hand, women with higher levels of empowerment have better pregnancy related health for several reasons. First, during pregnancy women have more control over their own bodies, and are able to respond more readily to their physical needs. Pregnant women can gain more mobility, which gives them access to more effective treatment and health care remedies. Since children are highly valued in Indian society, pregnant women have greater freedom and flexibility to pursue matters that ensure the best birth outcomes and to express opinions and needs in a family context. While the period of pregnancy affords women with a higher status in the household and is associated with greater levels of empowerment, once the baby is born and her household status returns from pregnant and new mother, to junior status in the household. Empowerment may be further reduced if a woman has an unsuccessful delivery, if her first child is female, or if she has given birth to several female children.

In general, the negative consequences of empowerment are especially evident where women’s independent choice, voice, agency and income conflict with the social and cultural norms of patriarchal societies. In the context of shifts in women’s status across the lifespan and
during specific periods in their lives such as pregnancy, empowerment status may also vary. Finally, high levels of empowerment in one domain, such as mobility, do not necessarily correlate with higher levels of empowerment in other domains such control over one’s body.

This thesis raises several key points concerning empowerment and its outcomes. We argue that a globally defined empowerment measure for women is less useful than one that is contextually defined. We further argue that greater empowerment does not necessarily equate to positive outcomes. As a result, the social context mediates the relationship between empowerment and health. There are situations in which woman can manifest behaviors that indicate increased empowerment and others where they is cannot or, if they do the consequences may be negative.

Many empowerment intervention programs focus on the individual level, aiming to impact upon women without necessarily addressing or making changes in the larger social-cultural context in which the women are situated (LaVeist 1992; Rifkin, 2003; Wallersting, 2002). Empowerment programs are likely to prove unsuccessful by focusing only on the development of the woman since an individual level focus has the potential for creating conflict with the normative attitudes and beliefs of husbands, family members, and the general community. One potential outcome of individual level empowerment efforts may be conflict between women’s new capacities for independent control and decision-making and the conservative cultural norms of their families and societies. This result suggests that if community and cultural norms are not changed, targeted empowerment interventions and programs at the individual level could result in negative or unintended outcomes for women (Dalal, 2011; Rajendran and Raya, 2011).
One of the areas that several empowerment interventions have targeted is women's health since it is a key factor in ensuring both the health of new and expectant children and the family as a whole. Yet findings on the outcomes of empowerment interventions on health outcomes presented in the literature are inconclusive. Studies have found a direct relationship between empowerment and health, associating higher levels of empowerment with improved health outcomes for women and their children (Hindin, 2000; Laverack, 2006; Rifkin, 2003; Wallerstein, 2002). Higher levels of empowerment have also been associated with improved women’s health or health care utilization (Beegle, Frankenberg & Thomas, 1998; Gage, 1995; Kritz, Makinwa-Adebusoye & Gurak, 2000). On the other hand, studies have also found either no direct relationship or mixed findings in the relationship of empowerment and health (Kishor, 2000; Malhotra, Vanneman & Kishor 1995; Schuler et al. 1995) and still others have found an inverse relationship (Abadian, 1996) in which greater empowerment has led to poorer health care utilization and outcomes. These mixed findings may have more to do with women’s changing contexts and different periods in their lives than contradictory results. In the case presented here, women’s empowerment increases or is more accepted when she is performing the traditional role of producing a child. Therefore, her status and agency improve only when she is performing the constraining role of taking care of herself to produce children.

Interventions need to consider the multi-dimensionality of empowerment as a means for specific changes in aspects of women’s lives as they cope with violence, sexual risk, and perinatal and general health. Empowerment intervention needs to have a clear understanding of the social context, the specific outcomes sought and a greater understanding of change in a patriarchal community. Both researchers and interventionists need to acknowledge the complicated nature of the concept of empowerment. More studies are needed that combine an
understanding of context and stage in a women’s life with her relative empowerment to examine in greater depth the way that the cultural and social context both influence and are influenced by the concept of empowerment.
V. References


