

Gender Inequity in Reproductive Health Decision Making and Management: A Study of Rural Women of Coimbatore, Tamil Nadu, India

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ABSTRACT The paper focused to analyze the level of participation of women in decision making regarding their reproductive health and the nature of health care support they receive during pregnancy. The sample was drawn from 335 rural women aged between 25 to 45 years selected from four blocks of Coimbatore taluk, Tamil Nadu systematically. Data were collected through direct face-to-face interview method. The findings reveal that husbands' decisions are more valued on reproductive health of the wife than herself. Most women involved themselves in all the household works till the last stage of pregnancy and they were not supplemented with special diet during pregnancy. Women should be given rights to control their reproductive responsibility of conception, spacing and child birth. Imparting life skill education to the girl child during school age is strongly recommended to make them realize their role in decision making regarding their own health.

INTRODUCTION

The lives of women and men, the work they do, the income they receive and control, the roles in the society and the relationships that they share are shaped by social norms, traditions, family practices, and the family structure, especially in joint family women and men are treated differently in a more rigorous manner.

Gender discrimination has its roots not only in the seemingly senseless traditions and old-fashioned religious beliefs, but is deeply woven into the socio-economic fabric (Mullatti 1992).

The risks of reproduction borne by women alone and poor outcomes for both mother and child are inevitable for a large proportion of the population as long as many South Asian mothers are too young, receive minimal antenatal care,

and are malnourished or anemic during pregnancy. Women cite economic circumstances and spousal or familial opposition to delivery in hospital as the most common reason for delivery at home. Decisions about seeking care in such emergencies are made largely by the husband or the elder members of his family (Fikree and Pasha 2004).

India is still a society with a strong preference for sons. This is reflected in female foeticide and selective abortion, apart from other practices. Health care neglect and shorter school duration for girls are common. Women are facing brutal consequences of male preference pattern.

The nature of care received by the mother during pregnancy is very crucial for the health of the mother and child. Many studies have reported that the infant mortality, maternal mortality and morbidity, birth of premature babies and intra uterine death of the fetus were very high in India due to lack of timely care or no care received by the mother. The indifference at all levels towards women and girls adversely influence India's developmental goals. A female child is usually discriminated in most spheres of life, be it health care, nutrition, education, employment and social justice. This is reflected in their declining sex ratio which is a powerful indicator

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of women's overall status and India is one of the few countries.

Gender in Reproductive Health Disparity

Women are seen as primarily responsible for maintaining the health of the families and as informal, unpaid care givers, though they play a major role in caring for the sick, the disabled and elderly and other dependent groups. Women are considered as health care providers to whole family, but gender inequalities in health care provision and the way in which the specific health care needs of women are ignored.

The role of women in decision-making as related to family building processes is particularly critical because the major responsibility of bearing and rearing children falls upon them. An increased role of women in decision-making related to family building is likely to increase the acceptance of family planning measures. Women living in contexts of limited or no decision-making power are often pressured into early unions and pregnancies and as result have large families. There is growing recognition that fertility decisions are strongly conditioned by the wife's role in family decision-making.

Decision-making in the family is a complex process. Reproductive decision-making and behaviour are in the 'private' domain of social life. Gender inequality stemming from an entire range of values and practices that privilege men to have a significant constraining effect on the choices available to women in reproductive decision-making or behaviour. Women's work primarily refers to their economically remunerative activities significant for their autonomy, promoting their decision-making authority that in turn positively influences reproductive choice (Swapna and Savithri 1998). In socio-cultural context, the violation of fundamental human rights, and especially reproductive rights of women, plays an important part in perpetuation gender inequity (Fikree and Pasha 2004)

Reproductive health hazards are borne by many South Asian mothers, because they are too young, receive minimal antenatal care and are malnourished or anemic during pregnancy. By and large decisions of the women for taking care, type of treatment, duration of treatment are made by the husband or the elder member of his family (Chatterjee et al. 2008).

Kinoshita (2013) conducted sample survey of 1,296 households on "Women's domestic decision making power and contraceptives use

in rural Malawi" revealed that women's low status and the predominance of men's decision-making power at the household and community levels. Of particular note, women were least likely to have decision-making power regarding their own health care. Although none of the decision-making areas had significant association with ever use of modern contraceptive methods, domestic decision-making power and family planning decision-making power were significantly associated. Women's decision-making power was shaped by various socio-cultural factors including religion and tribe, education, cash employment, and marital structure.

In the neighboring country of Pakistan where males are the decision-maker in families, they also make decisions relating to having or not having a child. In such settings the role of healthy husband-wife communication inducing fertility becomes unavoidable. Many women who are favourably inclined to practice family planning did not practice it because of not receiving enough encouragement from their spouses. A large number of unwanted (by the women) pregnancies are particularly the outcome of the inability of the women to take approval from husbands (Khan and Khan 2010).

Women's autonomy in reproductive health decision making is extremely important for better maternal and child health outcomes, and it is also an indicator of women's empowerment. However the age old traditions and patriarchic nature society will keep the women in the dark and do not expose their real strength and capacity. The present scenario is further more worsening, where society as a whole and male in particular show "half hearted" and "piece meal" approach to keep women power less, even to control their own biological responsibility.

The major setback in sex ratio is mostly due to poor socio-economic background. Poverty limits the household's ability to fulfill basic needs, such as food, shelter and education and adversely affects health directly and fertility behaviour indirectly. Further, poor back ground limits the household's capacity to spend on food and medical services in times of pregnancy and lack of power in the hands of women to make decision on their own reproductive health.

The aim of the paper was to analyze descriptively the level of participation of women in decision making regarding their reproductive health and the nature of health care support they received during pregnancy.

METHODOLOGY

Coimbatore District is one of the more prosperous and industrially advanced district of the state of Tamil Nadu consisting of eight *taluks*. Coimbatore *Taluk* is classified as North and South divisions, and each division consists of two Panchayat Blocks. Coimbatore North *Taluk* includes Periyanaickenpalayam and Sarkarsamakulam Panchayat Blocks, and Coimbatore South consists of Thondamuthur and Maddukkarai Panchayat Blocks. The sampling process involved selection of one village panchayat from each blocks by using of lottery method in the first stage. The selected village panchayat were Arisipalayam from Maddukkarai block, Pannimadai from Periyanaickenpalayam, Keeranatham from Sarkarsamakulam and Ikkarai Boluvampatti from Thondamuthur Panchayat block. Selection of rural women aged between 25 to 45 years from the sample frame as second stage through a systematic random sampling method. Out of selected 1674 rural women 20 percent of the (335) women were chosen as the sample. Interview schedule was adopted as the tool for the data collection to fetch both quantitative and qualitative information.

FINDINGS AND DISCUSSION

The study findings are presented in terms of socio-economic background of the women and certain their behaviour on decision making relevant to healthy reproduction during prenatal and post natal.

Socio-economic Background

The data related to socio-economic status of the women gives valuable lead to any social science study and further it provides detailed and deeper assessment with the main study variables. In the study more than 65 percent of them aged between 26-35 years and in excess of half of them belong to backward community and on an average their family income falls between Rs. 2000 to Rs.4000. The educational status of the women was considerably poor, 60 percent of them learned up to secondary level education and 30percent were illiterate. Due to their poor economic conditions and lack of education, they were forced to work as an agricultural labourer

(39 %) and 38 percent remains as house wife. Majority of them (94 %) had no savings and 65 percent of them were non-migrants.

More than half of the (53%) women were living in a single room house and 77 percent of them lived in a tiled house. Seven out of ten houses (71%) have no toilet facility. With respect to availability of electricity, most of the women have facility through free electricity and 11 percent of them live in darkness.

Accessibility to Health Services

Hierarchical health service network in India widened to small hamlets and terrain areas, but the inaccessibility is inevitable due to the composition of population. In the study area 37 percent of women have primary health centers in their village itself; the rest of them have to travel from 0.5 kilometer to 15 kilometers. The 43 percent women have to cover a distance of 0.5 kilometer to reach medical shop and 53 percent of them have accessibility to private clinics for to treat minor illnesses. They visit primary health centers seeking treatment for minor illnesses and maternal care, but 18 percent do not prefer primary health centers as place of treatment because they quoted reasons as treatment is not 'up to the mark', non-availability of medicines and other health care facilities.

Reproductive Health Decision Making and Management

Decision making is a major aspect in the maintenance of socio-economic functioning of the family, moreover the capacity and knowledge to make suggestions or opinions with regard to the reproductive health is very crucial and critical to women and further it has considerable impact on family building process. The present study revealed that over a half of the women, the decision on reproductive health of the women in relation to visits to anti-natal clinic, plans in case of pregnancy complications, place of delivery, plans for financing delivery, usage of contraceptive and spacing between children were made jointly by both the respondent and her husband. The 42 percent of the samples, the husbands were the sole decision makers. On the whole the husband tends to play a significant role either individually or partnering with his wife.

Though the reproduction is the biological responsibility of the women, invariably husband only has the say. A Western Guatemala study by Becker et al. (2006) and the Colombian Demographic and Health Survey by Pallitto and Patricia (2005) also brought out similar findings. The results of both studies show that men prefer to see themselves as the senior partners in all decisions including reproductive health decision making and further they say lack of communication between partners as a reason for low decision making role of women.

Household activities are the responsibility of women. Even the pregnant mothers are not spared from the tiring household work, which starts early in the morning and extends even until after mid night. The study shows that 96 percent of the women were performing all the household tasks including fetching water, cooking, and washing, cleaning the house, taking care of the children and the cattle till the last stage of pregnancy. There was no substitute thought of to relieve mother from energy sucking household work because of three reasons, first is poor economic background, secondly, the husband is out to work all day, and finally the cultural barriers compel women to stick on to their work irrespective of all the difficulties. The helping hand is extended by the husband (41%) performing some household works and rest of the women were supported by their mothers and mothers-in-law.

The study results shows that, 45 percent of the women were cared by their mothers and all the women were sharing their health ailments, comforts and discomforts during pregnancy with husband. The mother in the rural area could get some help from her family members especially from the husband, certainly due the effective functioning of primary health centers (PHC) and commanding work of village health nurse and health workers, who visit them and make them aware about the importance of supporting mother during pregnancy.

The expectant mother needs more physical rest and emotional support, which they get by taking rest like afternoon nap, resting their back by lay down on the bed for while and extending their legs for while, when ever they needed. The study results show improved sign that 73 percent of them had taken rest during pregnancy and 41 percent of them stopped doing heavy

work like working in the fields, construction sits, brick industries and collection of fire woods from the near by forest areas just one month before delivery; while 26 percent were working till the very end of their pregnancy. A study conducted in rural China disagree with study findings and reveals that women's position within the family is positively associated with the likelihood that a woman receives prenatal examinations, stops heavy physical work before birth (Li 2004).

The immunization status of the mother is a decisive factor during pregnancy, which protects them from infections and helps the fetus to grow healthier inside the womb. The study expose that 97.9 percent were immunized due to the effort taken by the Government through Primary Health Centers (PHC), Community Health Centers and District Government Hospitals.

The maternal nutrition is the major focusing point for the well being of to be mother and her fetus. Countries like India reported more maternal mortality and morbidity, mostly due to nutritional deficiency and consequently of anemia. In the study areas the lives of the women were very wretched owed to very limited earning opportunity, lack of knowledge about outside world and due to minimum education or no education. They think that pregnancy is the natural process; women do not need any special care and diet. The quantity and quality of food taken by the people in general and women who are pregnant in particular were deficient and mostly they were able to afford to have only staple foods. As for the diet during pregnancy, 58 percent of the sample had taken special diet, which includes milk, meat and vegetables and 42 percent did not have special diet and taken whatever available due to poor economic conditions.

CONCLUSION

Women are bearers of children, with no right to decide if, when and how many to have. For all of the above reasons there is a social stigma attached to abortions which further regulate or limit this option. Gender ideology is age old and persistent. It reflects the existing gender inequalities and also influences gender-based behaviors, which, in turn, help sustain gender ideology. It is this vicious circle which perpetuates gender issues. Of particular importance are the perceptions and values of women, since their

orientations have an impact on how they rear and socialize their children. Also, as long as women accept the “natural” superiority of men, they would not resist patriarchal views and behaviors which put the girl child at a disadvantage in every walk of her life.

The gender issues indiscriminately refer ‘women’ as the weaker sex. In spite of Government policies and legislations most favouring women in every step of their life, their life remains same as perceived from the start of the society. Women need to achieve new horizon of life to enrich their life by incorporating new skills, especially soft skills like social graces, communication, language, personal habits, friendliness, man and material management and optimism that characterize relationships with other people.

The initiation should start from grass root level by focusing every individual woman to take them to new heights in their life. The launch of such programme should not be “pushing or pulling” women from the corners of the country to teach and train them, but the willingness to learn something new, useful and life enriching skills should be the whole hearted ‘step forward’ from women themselves.

RECOMMENDATIONS

- ♦ Health education campaign on reproductive decisions should be organized by the primary health centers at the grass root level.
- ♦ Curriculum revamp should be recommended to make Girl child aware of their reproductive responsibilities at the school level
- ♦ As part of education medical personnel should address the importance of fertility decisions with women in their reproductive years and prepared to discuss about the sexual health, spacing and contraceptive usage. Encourage women to understand reproduction is their biological rights

NOTE

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