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UTILIZATION OF REPRODUCTIVE HEALTH CARE SERVICES: DOES WOMAN'S SAY IN DECISION MAKING COUNT?

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ABSTRACT

From time immemorial Indian society is patriarchal. This implies that the culture of India is highly gender stratified. Women's position is subordinate to man in various decision-making matters. This is manifested through gender roles, relations, unequal power in various decision-making aspects. Gender inequality damages the physical and mental health of millions of girls and women across the globe. Inequality between men and women can take many forms. Inequality between women and men can also affect women's capacity to access resources such as income, education and employment, which themselves promote health. Reproductive Health is an area where the woman suffers. Most women have neither the time nor the mind set or facilities to go in for health care. Rural women, especially, have no access to such basic health care facility. Maternal mortality and Infant Mortality are major public health problems in low and middle income countries. Most of the maternal deaths could be prevented if there is adequate and timely use of maternal health care services by women. Decision making power of women is one of the essential factors which have influence on maternal health care service utilization. Thus, an honest effort is made by the researcher to study involvement of rural women in decision making regarding utilization of maternal and child health care services.

KEY WORDS: *Utilization, decision making, reproductive, health*

INTRODUCTION

The principle of gender equality is enshrined in the Indian Constitution in its Preamble Fundamental Rights, Fundamental Duties and Directive Principles. Indian Constitution guarantees equality to women and also enables the State to assume measures of positive discrimination in favour of women (Kachhal, 2016).

In the recent past there have been significant changes in terms of women's status which has reflected their role in decision making regarding lifestyles and utilization of health care services. Economic dependence, improvement in education and awareness, changing social norms, increased participation in the family, health care and society more open to change have led to an enhancement in the role of women in the decision making. Women today are more independent in their thinking and financially too. They are the decision makers because they have gained the economic and emotional freedom. Now families are not only supporting her but also accepting her identity (Bajpai, 2008).

Autonomy defined as the control women have over their own lives, the extent to which they have an equal voice with their husbands in matters affecting themselves and their families, control over material and other resources, access to knowledge and

information, the authority to make independent decisions, freedom from constrains on physical mobility and the ability to forge equitable power relationships within families (Jejeebhy and Sathar, 2001).

Women's autonomy or say and its relation to reproductive behaviour is a major area of concern, as it reduces maternal mortality and improves child health. A number of studies examined women's autonomy and its relationship with reproductive health outcomes and found that the status of women is an important determinant of maternal mortality and morbidity. Increase in women's autonomy will lead to mortality decline and improve health outcomes for women and their children (Mahapatro, 2012).

Maternal and Child mortality continues to be a major health problem in developing countries. One estimate made in 2015 puts the maternal death at 303000. Developing regions account for approximately 99 % of the global maternal deaths. Reducing levels of maternal mortality and morbidity depends on increasing use of reproductive and maternal health services (WHO, UNICEF, UNFPA, Word Bank and UN (2015).

REVIEW OF LITERATURE

It has often been argued that child health and investments in children are determined by intra-household resource allocation decisions, which are related to gender inequalities in the household. In families where women play a vital role in decision making, the proportion of family resources devoted to children is greater than in families in which women play a fewer decisive role (Thomas, 1990; Duraisamy and Malathy, 1991; Bruce, Lloyd, and Leonard, 1995; Blumberg, 1991). This notion of "maternal altruism" assumes that power in the hands of women will lead to better child outcomes (Mason, 1986).

The study conducted by Adhikari, R. (2016) reveals that maternal health service utilization is significantly higher among those women who had autonomy in decisions regarding their household activities compared to those who were not. This study is similar to the study that suggests utilization of maternal health care services is influenced by women's roles in decision-making process. A possible explanation could be that women who have autonomy in decision making are more likely to have a higher level of autonomy on health care, which might lessen their reproductive behavior risks. Another study has confirmed that a women's control over household resources (ability to keep money aside) has a significant positive effect on both the demand for prenatal care and the probability of hospital delivery.

Prior studies showed that women's autonomy is one of the major determinants for seeking skilled care at birth and other maternal health care services. Low women's autonomy at household level is considered as a major block in increasing the utilization of maternal health care services in the developing countries. Autonomy is a relative term which is determined by various factors such as demographic factors, socio-economic factors, cultural factors and so forth (Thapa and Niehof 2013, Tuladhar 1997, Sharma et al 2007).

A study in north India shows that higher freedom of movement was to be found positively associated with the utilization of maternal health care services (Bloom et al 2001).

METHODOLOGY

The present study is an empirical study. The present study was conducted with a view to study demographic profile of respondents and to find out women's autonomy in decision making regarding utilization of reproductive health care services among rural women. Descriptive Design was adopted in the present study. The primary data is collected with the help of self designed interview schedule from 300 married women residing in selected villages of Anand Taluka. Stratified Proportionate Sampling method is adopted for selecting respondents. The data were analyzed by using SPSS software.

RESULTS & DISCUSSION

This section is further divided into two sections according to the objectives- demographic factors, and women's say in utilization of reproductive health care services. The main idea with which the research was initiated was to study women's say in utilization of reproductive health care services among married rural women.

Demographic Factors of the Respondents

The socio-economic characteristics of 300 respondents are that majority of the respondents i.e. 81 percent are of the age group of 19-29 years and the education level of the respondents shows that 40.3 percent women have taken primary education. Majority (74.7%) of the respondents are house wives while their husbands are involved in labour work. Majority (32 percent) of the respondents have an income of Rs. 1501-3000. Regarding religion of the respondents, majority (82%) of the respondents follow Hindu religion. Similarly, caste classification shows that most (40%) of the respondents belong to Other Backward Caste. 44.3 percent have family size of 1-5 members.

Women's say in Reproductive Health Care Service Utilization:

Variables	Women's Say in deciding Place of Delivery (N=300)		p Value
	Yes	No	
Age Group			
19-29 Years	130	113	**.513**
30-39 Years	29	24	
40-49 years	1	3	
Education			
Illiterate	22	37	
Primary	64	57	
Secondary	36	32	**.012**
Higher Secondary	26	11	
Graduate	7	2	
More than Graduation	5	1	
Respondents' Occupation			
Housewife	124	100	
Farmer	4	7	
Labour Work	22	30	**.104**
Business	2	2	
Govt. Service	4	1	
Private Job	4	0	
Respondents' Husbands' Occupation			
Farmer	27	21	
Labour Work	70	78	
Govt. Service	1	0	**.216**
Private Job	33	24	
Business	29	16	
Any Other	0	1	
Family Income			
≤ Rs. 1500	34	34	
Rs. 1501-3000	45	51	
Rs. 3001-5000	35	33	**.055**
Rs. 5001-8000	17	12	
≥ Rs. 8001	29	10	
Religion			
Hindu	132	114	
Christian	4	3	**.769**
Muslim	23	23	
Any Other	1	0	
Caste			
SC	30	23	
ST	11	6	
OBC	54	66	**.103**
General	47	27	
Minority	18	18	

The above table shows women's say in deciding place of delivery and its association with demographic factors of the respondents. It is found from the above table that out of 300 respondents, majority of the women have their say in deciding the place of delivery. While those who do not have say in deciding the place of delivery, decision regarding the place of delivery was taken by their mother-in-law and husbands. The findings reveal that education has a significant association ($p \leq .05$) with women's say in deciding place of delivery. While other demographic factors namely, maternal age, respondents' and their husbands' occupation, family income, religion and caste have statistically non significant association ($p \geq .05$) with women's say in deciding place of delivery.

Women's Say in Family Planning

Variables	Women's Say in Family Planning (N=300)		p Value
	Yes	No	
Age Group			
19-29 Years	136	107	**.030**
30-39 Years	40	13	
40-49 years	2	2	
Education			
Illiterate	24	35	**.000**
Primary	64	57	
Secondary	46	22	
Higher Secondary	31	6	
Graduate	7	2	
More than Graduation	6	0	
Respondents' Occupation			
Housewife	141	83	**.025**
Farmer	6	5	
Labour Work	21	31	
Business	2	2	
Govt. Service	4	1	
Private Job	4	0	
Respondents' Husbands' Occupation			
Farmer	26	22	**.002**
Labour Work	74	74	
Govt. Service	1	0	
Private Job	43	14	
Business	34	11	
Any Other	0	1	
Family Income			
≤ Rs. 1500	35	33	**.001**
Rs. 1501-3000	45	51	
Rs. 3001-5000	45	23	
Rs. 5001-8000	23	6	
≥ Rs. 8001	30	9	
Religion			
Hindu	150	96	**.282**
Christian	5	2	
Muslim	23	23	
Any Other	0	1	
Caste			
SC	34	19	**.005**
ST	10	7	
OBC	62	58	
General	56	18	
Minority	16	20	

From the above table it is evident that out of 300 women, majority of them have say in Family Planning. Findings also reveal that there is a statistically significant association ($p \leq .05$) between independent variables namely, age, education, respondents' occupation, husbands' occupation, family income and caste while a non significant association ($p \geq .05$) is found between religion and women's say in family Planning.

CONCLUSION

The socio-economic and demographic variables are highly significant and consistent predictors of health seeking behaviour of women in

India. It is evident from the results that women who have some education are more likely to have their say in utilizing maternal health care services than women who have no education. The most important result from this analysis is that several socio-economic characteristics, particularly education of the women has strong positive association with women's say in deciding place of delivery and their say in Family Planning.

Literature indicated that autonomy of women in a society is largely influenced by their socio-economic characteristics. A woman with higher socio-economic status in terms of better education and employment has more autonomy than illiterate and unemployed women.

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