# A Gender Sensitive Approach in Reproductive Health among Poor Women: Findings from Health of the Urban Poor (HUP) Project

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***Introduction***

The past decade has seen a growing concern with women's health in developing countries as evidenced by the safe-motherhood initiatives. Reproductive morbidity was considered a first priority on the research agenda set by the programmers about reproductive health in Indian society. This paper is the first of a series of papers presenting work undertaken by the Health of the Urban Poor (HUP) group to diagnose the magnitude of the problem of reproductive morbidity and by the adoption of reproductive health perspectives in strategies addressing child survival, family planning and women's autonomy issues. A growing literature links poverty to adverse reproductive health outcomes. Evidence from health facilities suggests that abused women's reproductive health is compromised through much higher rates of gynecological problems, HIV and sexually transmitted infections (STIs), miscarriages, abortions, low birth weight, and unwanted pregnancy (Campbell 2002). However, there is dearth of research on whether women who are both poor and have experienced violence have more disadvantaged reproductive health outcomes than women who are not poor and have experienced violence. Gender norms which give women lesser control over her own sexuality and sexual rights stipulating that girls should remain modest, chaste or innocent about sexual matters may limit adolescent girls' access to information on sexually transmitted infections. Limited women's autonomy also put's women's at risk of intimate partner violence often related to increased risk for poor reproductive health outcomes, STI and chronic pelvic pain. It is also associated with decreased use of antenatal care and cervical screening.

Hence there is and urgent need to understand the gender role perspective in context of psycho-social vulnerabilities and its linkages with reproductive morbidities which would go a long way in helping the program manager to design an appropriate intervention, keeping in view women's need. Information about incidences of sexually transmitted infections (STIs) is not only useful as a maker of unprotected sexual intercourse, but also as a co-factor of HIV transmission.

***Need for the study***

It is right time for reviewing and debating gaps in existing literatures to improve statistics on prevalence of reproductive morbidities, and with this in mind to develop a clear picture of its nature and prevalence, to permit the identification of those sections of population which are often hidden and hard to reach. The main research question which guided this empirical investigation have been to study women's involvement is the household decision making process in relation with gender role attitude and risk of reproductive morbidity which is of particular relevance in designing reproductive health programs in the

country . There is an urgent need to determine the extent to which women the main target of such programs are empowered enough to have control over their own behaviour, body and sexuality. In developing evident based research it is important to envisage the contemporary situation of the study population. Therefore, the purpose of this research is two-fold: to provide the status of women's autonomy in low income slums and to present a conceptualization of women's control over own sexuality as a means of understanding its causes and consequences on reproductive health vulnerabilities.

**Data and Methods**

The data extracted from Health of the Urban Poor (HUP) Project, recently collected from both Slum and Non Sum across three cities of India, Jaipur, Bhubaneswar and Pune in year 2011-12. The respondents were female aged 15-49. Some household characteristics were assumed as depend variable that lead us to capture the role of decision making power of women on the home front. Some factors like educational qualification, occupational standard, caste, religion, mass media exposure, age-group, mobility, husband's education and alcoholism may have influence on decision making factors. The choices of specific decisions to ask women about in the HUP questionnaire was guided by the need to ensure that the decision areas included are relevant to currently married women. Accordingly, HUP asked respondent who have ever had sex weather they had a genital sore and/or ulcer, or had experienced at bad smelling abnormal genital discharge during last 12 months prior to the survey. If the women has responded any on of the above symptoms she is reported having STIs.

The presumption behind these questions is that truly empowered women would not except such gender inequalities in power, empowered women would not except any justification for a husband beating his wife and would believe that a wife should have the right to decide when to have sex with husband which may prevent women's from the risk of reproductive morbidities. Bi variate techniques has been used to see the association between predictor variable and response variables.

**Results and Discussions**

From the present study it is evident that through all the three study cities the overall status of women living in low income slums is not very impressive. Overall 19 percent of women lives in slums in Bhubaneswar the corresponding figures for Jaipur and Pune are 26 and 24 respectively. Women all-round have almost no power to carry out any decision of their own, like final say on own health care, final say on major household purchase or final say to visit family or relatives. Even though the figures pertaining to women's autonomy is low, women living in slums are more empowered than their counterparts which is found universal across all the three study cities. Data depicts that over all just 9 percent women can make decision about their mobility of their own in Bhubaneswar where as the corresponding figures for Jaipur and Pune are 37 percent and 55 percent respectively. Findings also shows that just one percent of women have full autonomy (based on results of Autonomy index) in Bhubaneswar

where as in Jaipur 4 percent of women have full autonomy and in Pune it is 11 percent which shows the pathetic situation of women in low income slums.

While examining the gender role attitude, in terms of ""Wife beating Justification" it is found that (Table 1) 14 percent women's in Bhubaneswar has justified wife beating, the corresponding figures for Jaipur and Pune is 42 percent and 48 percent respectively. To assess the control over own sexuality in order to identify gender role attitude among women's in slums across three cities. It is encouraging that women's have in all the three cities to a certain extent have control over their own sexuality.

Analyzing the level of STIs, Prevalence of any STIs (which is considered as an important indicator to measure reproductive morbidity) found to be highest in Jaipur (10 %) to lowest in Bhubaneswar (6%). Conceiving thus, though the status of women as a whole is lower in all the three cities, but there are some spheres where women's household decision making autonomy supersedes in Jaipur than Pune and Bhubaneswar. The analysis presented in paper points to one over reaching conclusion: although the four sets of question on GBV are theorized by through their gender role attitude, many explanatory variable that have positive relationship in one city have negative relationship in other. Results form HPU data illustrates the incidences of reproductive morbidities across all cities which is captured STIs. Therefore, health care planners and health educators need to empower women and also stress the specific relationship between women's control over their own bodily rights, Sexuality and risk of reproductive morbidity.

**Table 1: Percentage Distribution of Women Who Justified Husband Wife Beating by Selected Background Characteristics**

| **Background Characteristics** | Bhubaneswar | | Jaipur | | Pune | |
|---|---|---|---|---|---|---|
| **Wife beating justified** | Yes | No | Yes | No | Yes | No |
| **Age of women** | | | | | | |
| 15-24 | 7.5 | 92.5 | 38.5 | 61.5 | 49.1 | 50.9 |
| 25-34 | 12.8 | 87.2 | 39.8 | 60.2 | 44.7 | 55.3 |
| 35+ | 20.0 | 80.0 | 44.9 | 55.1 | 50.5 | 49.5 |
| **Education of women** | | | | | | |
| < 5 years | 20.3 | 79.7 | 48.5 | 51.5 | 63.5 | 36.5 |
| 5-9 years | 12.8 | 87.2 | 32.6 | 67.4 | 44.4 | 55.6 |
| 10 years & above | 11.7 | 88.3 | 34.6 | 65.4 | 35.7 | 64.3 |
| **Caste of household** | | | | | | |
| SC/ST | 14.5 | 85.5 | 43.7 | 56.3 | 55.1 | 44.9 |
| OBC | 17.0 | 83.0 | 47.5 | 52.5 | 34.7 | 65.3 |
| Others | 10.4 | 89.6 | 32.2 | 67.8 | 49.5 | 50.5 |
| **Religion of head of HH** | | | | | | |
| Hindu | 14.4 | 85.6 | 43.4 | 56.6 | 45.9 | 54.1 |
| Muslim | 0.0 | 100.0 | 32.7 | 67.3 | 55.6 | 44.4 |
| Christian | 0.0 | 100.0 | 0.0 | 100.0 | 66.7 | 33.3 |
| **Husband consume alcohol** | | | | | | |
| Yes | 17.6 | 82.4 | 50.5 | 49.5 | 53.8 | 46.2 |
| No | 13.6 | 86.4 | 39.3 | 60.7 | 45.5 | 54.5 |
| **Husband's Education** | | | | | | |
| < 5 years | 6.3 | 93.8 | 27.3 | 72.7 | 65.0 | 35.0 |
| 5-9 years | 21.8 | 78.2 | 39.4 | 6.6 | 45.7 | 54.3 |
| 10 years & above | 3.3 | 96.7 | 35.9 | 64.1 | 43.8 | 56.3 |
| **Media exposure** | | | | | | |
| No | 20.0 | 80.0 | 41.7 | 58.3 | 66.7 | 33.3 |
| Partial | 13.5 | 86..5 | 38.6 | 61.4 | 47.4 | 52.6 |

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|---|---|---|---|---|---|---|
| Full | 0.0 | 0.0 | 42.9 | 57.1 | 50.0 | 50.0 |
| **Standard of living index** | | | | | | |
| Low | 14.7 | 85.3 | 50.3 | 49.7 | 49.7 | 50.3 |
| Medium | 19.0 | 81.0 | 28.1 | 71.9 | 46.8 | 53.2 |
| High | 0.0 | 100.0 | 34.5 | 65.5 | 28.6 | 71.4 |
| **Women's Autonomy** | | | | | | |
| Full | 0.0 | 100.0 | 15.4 | 84.6 | 45.2 | 54.8 |
| Partial | 14.2 | 85.8 | 38.5 | 61.5 | 57.9 | 52.1 |
| No | 11.7 | 88.3 | 58.4 | 41.6 | 41.7 | 58.3 |
| **Total** | **14.3** | **85.7** | **41.6** | **58.4** | **47.5** | **52.5** |

**Table 2: Percentage Distribution of Women Having Control Over Own Sexuality by Selected Background Characteristics**

| **Background Characteristics** | Bhubaneswar | | Jaipur | | Pune | |
|---|---|---|---|---|---|---|
| **Wife beating justified** | Yes | No | Yes | No | Yes | No |
| **Age of women** | | | | | | |
| 15-24 | 65.0 | 35.0 | 83.7 | 16.3 | 74.1 | 25.9 |
| 25-34 | 64.0 | 36.0 | 82.7 | 17.3 | 75.4 | 24.6 |
| 35+ | 61.8 | 38.2 | 83.0 | 17.0 | 73.1 | 26.9 |
| **Education of women** | | | | | | |
| < 5 years | 55.2 | 44.8 | 80.8 | 19.2 | 65.9 | 34.1 |
| 5-9 years | 61.5 | 38.5 | 81.8 | 18.2 | 73.0 | 27.0 |
| 10 years & above | 73.3 | 26.7 | 96.3 | 3.7 | 84.3 | 15.7 |
| **Caste of household** | | | | | | |
| SC/ST | 74.1 | 25.9 | 80.7 | 19.3 | 64.7 | 35.3 |
| OBC | 62.4 | 37.6 | 83.3 | 16.7 | 89.0 | 11.0 |
| Others | 52.1 | 47.9 | 87.4 | 12.6 | 74.1 | 25.9 |
| **Religion of head of HH** | | | | | | |
| Hindu | 64.2 | 35.8 | 82.9 | 17.1 | 77.5 | 22.5 |
| Muslim | 0.0 | 100.0 | 84.1 | 15.9 | 75.0 | 25.0 |
| Christian | 0.0 | 100.0 | 100.0 | 0.0 | 50.0 | 50.0 |
| **Husband consume alcohol** | | | | | | |
| Yes | 61.8 | 38.2 | 77.1 | 22.9 | 72.7 | 27.3 |
| No | 63.6 | 64.4 | 84.4 | 15.6 | 75.0 | 25.0 |
| **Media exposure** | | | | | | |
| No | 64.0 | 36.0 | 62.9 | 30.8 | 50.0 | 50.0 |
| Partial | 63.2 | 36.8 | 85.5 | 14.5 | 74.6 | 25.4 |
| Full | 100.0 | 0.0 | 100.0 | 0.0 | 100.0 | 0.0 |
| **Standard of living index** | | | | | | |
| Low | 63.3 | 36.7 | 78.4 | 21.6 | 72.7 | 27.3 |
| Medium | 57.1 | 42.9 | 90.2 | 9.8 | 76.2 | 23.8 |
| High | 83.3 | 16.7 | 85.7 | 14.3 | 85.7 | 14.3 |
| **Women's Autonomy** | | | | | | |
| Full | 50.0 | 50.0 | 75.0 | 25.0 | 84.4 | 15.6 |
| Partial | 62.5 | 37.5 | 84.7 | 15.3 | 72.1 | 27.9 |
| No | 71.7 | 28.3 | 76.7 | 23.3 | 82.6 | 17.4 |
| **Justified wife beating** | | | | | | |
| Yes | 82.8 | 17.2 | 71.6 | 28.2 | 62.6 | 37.4 |
| No | 59.9 | 40.1 | 92.9 | 7.1 | 86.2 | 13.8 |
| **Total** | **63.4** | **36.6** | **83.0** | **17.0** | **75.0** | **25.0** |