EXTENDED ABSTRACT

Women's Autonomy and Utilization of Maternal and Child Health Care Services in India

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Introduction

In recent times, women's autonomy and its association with reproductive health and behavior have appeared as a central point of investigations and interventions around the world. Particularly, Since the Cairo International Conference on Population and Development (ICPD) in 1994, women's role has been a priority area not only for sustainable development, but also in reproductive health (United Nations, 1994). At the ICPD, a general harmony was reached to revolutionize women's status, along with the related goals of improving women's reproductive health and securing their reproductive rights, which represents a paradigm shift that emphasizes the reproductive autonomy of individuals. Following the ICPD, there have been a number of recent studies that examine women's autonomy and its relationship with reproductive health and health outcomes (Bloom et. al, 2001,).

Concept of Women's Autonomy

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).

The description of the stages of the women life cycle in Rampur and in other studies of Northern India varies over the life cycle. Briefly stated, it is low in early childhood, rises during adolescence drops sharply upon marriage and remains low during early reproductive years; and rises during the later reproductive years to a high in older ages when women becomes a mother-in-law and grandmother, followed by a small drop at

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extremely old ages (Vatuk 1987; Jeffery, and Lyon 1989; Wadley 1994 Quoted in Das Gupta 1996).

Objectives

The specific objectives of the study are…

- To examine the level and differential in the women's autonomy and utilization of maternal and child health care services.
- To examine the association between women autonomy and utilization of maternal and child health care services in India.

Hypothesis

- The core hypothesis behind the paper is that, women with low autonomy and status will be less likely to use maternal and child health care services.

Data and Methods

National Family Health Survey-3 (NFHS-3), which has been conducted by International Institute for Population Sciences in 2005-06, is the main data source for this study. NFHS-3 has collected information from a nationally representative sample of 124,385 women aged 15-49 years. For analysis purpose kids file has been used, the present study is based on the sample of currently married women who have at least one birth in the preceding five years of the date of survey. This analysis is based on latest birth and also to imprison the child health care children age 12-23 months have been taken for analysis. The study variables can be grouped into four categories, utilization of antenatal and delivery care, indicators of women decision making autonomy, child immunization and social and demographic characteristics.

Use of Maternal and Child Health care

Utilization of antenatal care services (at least once during the pregnancy), institutional delivery, women autonomy and child immunization 12-23 months children are considered as dependent variables in this study.

Women Decision Making Autonomy

The National Family Health survey, 2005-06 posed several questions to women regarding decision making and control over resources. To capture two dimension of women autonomy (Decision Making and Economic Security) a composite index of women autonomy (CIWA) has been constructed (Singh, et al 2005) in their study of child mortality and women autonomy have also been constructed CIWA in similar way. Two categories of CIWA viz. lower and higher have been made on the basis of average value of index taking all states together. The women receiving less than the average score are put in the lower autonomy category. The remaining women are treated as having relatively higher autonomy. The indicators of the two dimensions of women autonomy along with questions that were posed to women in the survey are:

1. **Involvement in decision making**

"Who makes the decision about health care for yourself?"
"Who makes the decision on purchasing household daily needs?"
"Who makes the decision on purchasing household?"
"Who makes the decision on visits to your family or relatives?"

2. **Economic Security**

"Who decides how the money you earn will be used?"
"Who decides how your husband's earning will be used?"

Statistical Analysis

The bi-variate relationship of women's social and demographic variables with the composite index of women autonomy, antenatal care, institutional delivery and child immunization are examined using X^2 test. Binary logistic regression models are used to identify the association between different social and demographic variables with maternal health care services. Further multinomial logistic regression model has been applied to examine the effect of selected socio-economic variables on child immunization.

Description of Dependent Variables

1) Antenatal Care (ANC) Visit is categorized as follows:
   (i) No ANC visit (ii) At least one
2) Place of Delivery is also categorized into two categories:
   (i) Home (ii) Institutional
3) Child Immunization
   (i) **Full Immunization:** Received all 6 doses of immunization (BCG + 3 doses of DPT + 3 doses of Polio + Measles)
   (ii) **Partial Immunization:** Received at least any one of the vaccination
   (iii) **No Immunization:** did not receive any immunization

Social and Demographic Characteristics

A number of social and demographic characteristics are considered in the analysis including Place of residence, women age, children ever born, Caste, Religion, Wealth index, Sex of the child, Children ever born and to capture the regional variation in terms of health outcomes and autonomy region variable has also been used.

Findings

In this study, women's autonomy, as measured by the extent of women's sole final say in decisions on making large and daily household purchases and of visiting families or relatives and their association with maternal health care utilization are examined. The primary aim is to determine whether there is a link between women's autonomy and utilization of maternal and child health care and if so how such relationships depend on socio-economic factors such as educational attainment of women and husband, women'

age, wealth quintile, children ever born and place of residence. After describing the concept of autonomy indicated above, we explored the evidence regarding the level of women's autonomy and we then looked at the relationship between socio-economic characteristics and autonomy indices of women. Finally, we examined our hypothesis on whether women's autonomy increases maternal care seeking behavior.

The results of our study show that most of our specified socio-economic factors and impact of women autonomy on antenatal care and institutional delivery have significant influence which shows the impact of women autonomy on maternal and child health care in which women's rural-urban residence, women education, region factor being the most important predictors for autonomy.

The most important result from our analyses on health-seeking behavior during pregnancy, childbirth, and child immunization is that several socio-economic characteristics, particularly women's and husband's education and place of residence, wealth index, women autonomy, regional variation have strong positive association with health-care utilization, implying that these variables have direct effects on the use of health care facilities. For instance, the impact of women autonomy is not much on antenatal visit but very much effect on institution delivery and child immunization. Finally it may be concluded that women with higher autonomy are more likely to use maternal and child health care services as compare to women with lower autonomy.