

## **Implication of women's autonomy and socio-economic status on Maternal and child health in Karnataka: Evidence from NFHS-3**

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### **Extended Abstract:**

From time immemorial Indian society is patriarchal one implies that the culture of India is highly gender stratified. Women's position is subordinate to man in various household decision making matters. The low status of women in the household indicating the health seeking behaviour of women in such a traditional society is greatly depends on the decision of partner or other elder household members. However, women's autonomy and its association with reproductive health and behaviour have emerged as a focal point of investigations and interventions around the world.

A number of studies examine women's autonomy and its relationship with reproductive health outcomes. Increase in women's autonomy will lead to mortality decline and improve health outcomes for women and their children (Caldwell,1986).A study in Uttar Pradesh in North India shows that women's autonomy is the major determinant of maternal health care utilization (Bloom et al 2001). The study shows that women with greater freedom of movement are more likely to receive antenatal care and to use delivery care. A study made by Kishor (2000) found women's autonomy to be an important explanatory factor in child survival. Another study in India has shown that women who score greater autonomy are more likely to use antenatal and delivery care for their last birth than women with lower autonomy (Basu 1992). Better health care utilization rates reflected in south Indian women as they have greater autonomy as compared to north Indian ( Dyson and Moore,1983).

At the outset, some of the studies used the socio-economic status of women i.e. education and employment as the best predictors of women's autonomy. Safilos-Rothschild (1990) uses women's income as a key indicator of women's status to examine fertility in rural Kenya. Still others (Balk 1994; Tfaily 2004) have used both socio-economic factors and decision-making autonomy indicators and suggest that socio-economic indicators have direct effects as well. It is stated in various literature that the autonomy of women in a society is largely influenced by their socio-

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economic characteristics. A woman with higher socio-economic status in terms of better education and employment has more autonomy than illiterate and unemployed women (Rammu, 1988; Basu, 2001). Where as Presser and Sen(2000) argue that women's socio-economic indicators such as education and employment are often not sensitive enough to capture the nuances of gender power relations and the ways in which they influence women's and men's reproductive behaviour.

By addressing this paradox, whether the direct indicators of decision making or the indirect indicators are the better predictors of maternal and child health care utilization, an effort is made in this paper to examine the various determinants of women's autonomy and its relation to utilisation of maternal and child health care in the state of Karnataka.

**Objectives:**

1. To examine the determinants of women's autonomy.
2. To examine the influence of women's decision making indicators on maternal and child health care utilization
3. To examine whether the direct measures of women's autonomy are important predictors of maternal and child health care.

**Data and Methodology:**

**Data Source:** To fulfill the above stated objectives National Family Health Survey-3 is used here. The NFHS-3 covered a sample of over 109,041 sample households, 124,385 women age 15-49. It provides estimates for the country as a whole and all the 29 states. The survey was conducted with the primary objective of providing reliable and comparable estimates of fertility, infant mortality, contraceptive use, reproductive health, family size etc. for different states of India.

The survey also provides information on Women's Status in terms of their socio-economic position. Apart from this NFHS-3 collects data on a large number of indicators of women's empowerment. Information was collected on the magnitude of a wife's earnings relative to her husband's earning, control over the use of one's earning, women's control over resources, wife's participation in household decision making etc.

**Methodology:**

**Bivariate analysis** is used to carry out the extent of differential in maternal and child health indicators by different dimensions of autonomy and by their socio-economic status.

**Logistic regression** models are used to quantify relationships between different aspects of autonomy and maternal care seeking. Logistic regression models were first fitted to investigate the influence of socio-economic factors on women's autonomy. We subsequently, fitted two logistic regression models for each of the maternal and child health variables of our study to investigate the effect of women's autonomy on maternal health care seeking behaviour. The first of these latter models includes women's autonomy indicators only, while the second model adds the socio-economic indicators.

**Findings of the study:**

Women's autonomy in this study measured by their economic decision making indicator and mobility indicator where the socio-economic indices include, maternal and husband's education, current work status of women and place of residence. The study shows that in large household purchases and in visiting friends and relatives women's autonomy is relatively higher in the state than national average. In the state of Karnataka, large number of women takes decision in daily household purchases as compared to other indices.

The socio-economic factors have significant influence on women's autonomy where women's education, current employment and rural-urban residence being the most important predictors for each dimension of autonomy. These findings are consistent with those of recent studies focusing on the influence of women's socio-economic status on autonomy outcomes (Woldemicael, 2007).

The effects of women's autonomy varied by the health outcomes and some of them lost their significance after the socioeconomic indicators are controlled. The most important result from our analyses on health-seeking behaviour is that several socio-economic characteristics, particularly women's and husband's education and place of residence have strong positive association with health-care utilization. Highly educated women are more aware and more concern about their health of their own and their children. This motivation increases the utilisation of such service among the educated women. The utilisation of health services is less in rural area compared to urban area because of the lower accessibility of modern health care services near their

homes, lack of transportation, costs of transport, and difficulty of walking for hours to the health facilities.

One of the interesting finding is that women who are currently employed does not have any significant impact on use of MCH services. This implies that women though become the earning member but not have financial autonomy because financial empowerment also requires control over the use of one's own earning. But, it is not correct to hypothesize that financial independence does not have significant impact on using the MCH service. The reason may be that most of the working women are from different socio-economic background and it is expected that majority are from poorer sections of the society. Women from lower socio-economic strata are more likely to lag behind those from the higher socio-economic strata in the utilization of services. They have less exposure to the outside world, and they have consequently more traditional complacency about their health conditions, as well as lack of knowledge about illnesses. The poor are also more likely to encounter other constraints, such as apathy and lack of concern from health care providers and corrupt practitioners, inhibiting their access to, and utilization of services. So, one should really look in to the circumstances in which most of the women join in work force. Then it is possible to find out the exact relation between employment and use of MCH services.

The most relevant conclusion from this study is that in Karnataka though women's autonomy indicators in some cases influence the utilisation of maternal and child health care but health-care seeking behaviours are more strongly affected by socio-economic factors - like education of women and place of residence. Lack of awareness and geographical distance should be the possible reasons for less utilisation of services among the uneducated and rural people. The effects of autonomy indicators are statistically significant in some cases, but most after controlling the socioeconomic indicators, the statistical significance is attenuated or becomes weaker. Hence, in nutshell it can be said that health seeking behaviour of women not only explained by autonomy indices, socio-economic factors play a significant role in utilising Maternal and Child Health services. An analysis that integrates both the socio-economic factors and women's autonomy is the most appropriate in a study on maternal and child health care utilization than one that includes only the socio-economic or autonomy indices.