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# Empowerment and reproductive health status of women in urban slums in Tamil Nadu

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**Abstract**

Empowerment of women and reproductive health status of women in India is not satisfactory though government of India and Tamil Nadu have taken various measures to improve the empowerment and reproductive health status of women. The objective of this paper is to estimate the empowerment status and reproductive health status of women in urban slums in Tamil Nadu. Women living in urban slums aged 15-49 years were interviewed; probability proportional to size sampling method was adopted in the urban slum areas of Madurai and Dindigul districts of Tamil Nadu.

Empowerment of women and the socio economic and demographic variables namely, education of wife, occupation of wife, type of family, age of wife, age at marriage, Mass media exposure and health seeking behavior of women are significantly associated at 5 % level ($p<0.05$). Women living in urban slums suffered due to various reproductive health problems and it ranges from 11 per cent to 69 per cent. Women with low empowerment status suffer from various reproductive health problems at higher level. Treatment seeking behavior of women for their reproductive health problems increases as empowerment of women increases. Women belonging to low socio economic conditions, low decision making power, low empowerment status and low mass media exposure are less likely got treated for their reproductive health problems than their counterparts.

**Keywords:** Empowerment of women, Reproductive health status, Urban slum, Health seeking behaviour

## Introduction

Women's empowerment is defined as a process of women gain greater share of control over resources, human and intellectual like knowledge, information, ideas and financial resources like and control over decision-making in the home, community, society and nation, and to gain `power'. The United Nations declared 1975-1985 as International women's decade. Various countries in the world have taken steps to eliminate gender discrimination and to achieve gender equality at all levels. In 1992, women were given 33 per cent reservation in local bodies in India and a national policy for the empowerment of women was formed in 2001. In Tamil Nadu 30 per cent of seats for women in education and employment reserved since 1989. Mahalir thittam has been established in

Tamil Nadu for the poor and disadvantaged women for providing social, economic empowerment and capacity building.

Though government has introduced various measures for the empowerment of women, but still there exist disparity and gender inequality prevailing in most of the places. This paper highlighted the empowerment status of women living in urban slums and reproductive health status of women and treatment seeking behavior.

**Review of literature**

Health is an important factor which contributes to human well being and economic growth (Shiva M. 1993). Reproductive health of women will be protected if the government failed to give information and reproductive health services. (ICRW, 2007) A significant proportion of women in rural areas (47 per cent) affected with BMI <18.5 kg/m2, gender discrimination prevailing in intake of energetic food (Srinivasan. R). Women who married below 18 years were less empowered and affected with more reproductive health complications. (Bruce et.al., 2004). The government has to ensure provision of health education including family planning, personal hygiene, menstrual hygiene, sanitation and prevention of communicable and non communicable diseases (Monica Panchani, 2014).

**General objective**

The objective of this paper is to estimate the empowerment status and reproductive health status of women in urban slums in Tamil Nadu.

**Specific objective**

- To find out the effect of socio-economic and demographic factors on empowerment of women.
- To examine the Reproductive health status among women in urban slums in Tamil Nadu.

**Methodology**

This study adopted an analytical study design. Municipal Corporation areas of Dindigul and Madurai urban slum areas were selected as study area. Probability proportional to size sampling method was adopted and the sample size was fixed as 460. Data was collected from women living in urban slums in the reproductive age group of 15-44 years. The data collection was done by trained investigators, data edited, entered in M. S. Access, data cleaning and analysis of data was done through SPSS 16. Tabular, Percentage and Chi square analysis was carried out. Empowerment of women is considered as dependent variable and the socio economic, demographic and other variables like Religion, Caste, Education of wife, Occupation of wife, type of family, standard of living index, age of mother, age at marriage, mass media exposure are considered as independent variables.

**Development of index**

Empowerment of women index was developed by scoring the variables like, working in last 12 months, decision on spending their earned money, husband earned money, decision on health care seeking, purchasing household items, permission to go to shop, health facility, outside the village, having bank account, freedom to be a member of SHG/NGO and vote in an election etc., The responses were coded and the total scores obtained was divided in to low, medium and high and used for further analysis. Similarly, mass media exposure index and health seeking behavior index were calculated and analyzed.

**Results and discussion**

Empowerment of women is affected with various socio economic, demographic and cultural factors. A higher proportion of women (45 per cent) living in urban slums are less empowered, 30.7 per cent of women

are in medium empowerment status and only 24.3 per cent of women are high empowered. A higher per cent of Muslim women (46 per cent) are with low empowerment status and a higher per cent of Christian women (26.8 per cent) are living with high empowerment status. Regarding caste women belonging to Scheduled caste (45 per cent) are having low empowerment status and women belonging to backward caste are having high empowerment status (27.8 per cent). Women who are housewives (54.6 per cent) are with low empowerment status and women working as labourer/sanitary work (48.3 per cent) are high empowered. Women living in joint family system (55.6 per cent) are less empowered and who follow nuclear family system (25.9 per cent) are high empowered.

Empowerment of women and the variables education of wife, occupation of wife, age of wife, age at marriage and health seeking behavior of women are significantly associated at 1 % level ($p<0.01$). Mass media exposure and type of family are statistically significant at 5% level ($p<0.05$). Women living in medium standard of living (49.3 per cent) are low empowered and who are living in high standard of living (27.8 per cent) are high empowered. Regarding demographic characteristics, women who are aged below 24 years (68.4 per cent) are less empowered and women aged 40 years and above are high empowered and it is observed that as the age increases the empowerment status of women increased. Women married below 18 years (56.9 per cent) are less empowered and whose age at marriage above 22 years (22.5 per cent) is high empowered. Regarding mass media exposure, women who are having low mass media exposure (45.9 per cent) are less empowered and who are having high mass media exposure (27.5 per cent) are high empowered.

**Table 1: Per cent distribution of empowerment with background characteristics of women**

| Socio economic and demographic Characteristics | No. | Empowerment of women Index | | | Chi square | p value |
|---|---|---|---|---|---|---|
| | | Low | Medium | High | | |
| **Religion** | | | | | | |
| Hindu | 354 | 45.8 | 30.2 | 24.0 | | |
| Muslim | 50 | 46.0 | 30.0 | 24.0 | 0.843 | 0.933 |
| Christian | 56 | 39.3 | 33.9 | 26.8 | | |
| **Caste** | | | | | | |
| SC | 229 | 45.0 | 33.6 | 21.4 | | |
| MBC | 37 | 35.1 | 40.5 | 24.3 | 6.427 | 0.169 |
| BC | 194 | 46.9 | 25.3 | 27.8 | | |
| **Education of wife** | | | | | | |
| Illiterate | 58 | 36.2 | 20.7 | 43.1 | | |
| Primary | 95 | 31.6 | 37.9 | 30.5 | 25.813 | 0.000** |
| High school | 228 | 51.3 | 28.5 | 20.2 | | |
| Higher secondary and higher | 79 | 49.4 | 35.4 | 15.2 | | |

| Socio economic and demographic Characteristics | No. | Empowerment of women Index | | | Chi square | p value |
|---|---|---|---|---|---|---|
| | | Low | Medium | High | | |
| **Occupation of wife** | | | | | | |
| House wife | 335 | 54.6 | 29.9 | 15.5 | | |
| Labourer /Sanitory work | 58 | 20.7 | 31.0 | 48.3 | 65.251 | 0.000** |
| Company/Other work | 67 | 17.9 | 34.3 | 47.8 | | |
| **Type of family** | | | | | | |
| Nuclear family | 336 | 41.1 | 33.0 | 25.9 | | |
| Joint family | 124 | 55.6 | 24.2 | 20.2 | 7.807 | 0.020* |
| **Standard of living Index** | | | | | | |
| Low | 201 | 45.8 | 28.4 | 25.9 | | |
| Medium | 146 | 49.3 | 28.1 | 22.6 | 4.905 | 0.297 |
| High | 113 | 38.1 | 38.1 | 23.9 | | |
| **Age of mother (years)** | | | | | | |
| <=24 | 79 | 68.4 | 21.5 | 10.1 | | |
| 25-29 | 116 | 49.1 | 40.5 | 10.3 | | |
| 30-34 | 100 | 35.0 | 34.0 | 31.0 | 51.825 | 0.000** |
| 35-39 | 96 | 36.5 | 29.2 | 34.4 | | |
| 40+ | 69 | 37.7 | 21.7 | 40.6 | | |
| **Age at marriage (years)** | | | | | | |
| <18 | 103 | 36.9 | 29.1 | 34.0 | | |
| 18-21 | 228 | 52.2 | 26.8 | 21.1 | 14.344 | 0.006** |
| 22+ | 129 | 38.8 | 38.8 | 22.5 | | |
| **Mass media exposure** | | | | | | |
| Low | 219 | 40.6 | 30.1 | 29.2 | | |
| Medium | 144 | 49.3 | 27.1 | 23.6 | 9.801 | 0.044* |
| High | 97 | 48.5 | 37.1 | 14.4 | | |
| **Health seeking behavior of RH problems** | | | | | | |
| Low | 268 | 45.9 | 31.7 | 22.4 | | |
| Medium | 112 | 48.2 | 25.0 | 26.8 | 24.087 | 0.000** |
| High | 80 | 37.5 | 35.0 | 27.5 | | |
| **Total** | **460** | **45.0** | **30.7** | **24.3** | | |

Note: ** Significant at 1%, * significant at 5%

Chi square analysis is used to assess the significant association between empowerment of women and socio economic and demographic characteristics and the result is presented in Table 1. The null hypothesis that, "Empowerment of women and Socio economic and demographic characteristics are not associated".

Empowerment of women and the variables education of wife, occupation of wife, age of wife, age at marriage and health seeking behavior of women are significantly associated at 1 % level ($p<0.01$). Mass media exposure and type of family are

statistically significant at 5% level ($p<0.05$). So the null hypothesis is rejected and we can conclude that Empowerment of women and education, occupation, age, age at marriage of women, mass media exposure, type of family, health seeking behavior of reproductive health problems are significantly associated. The other variables Religion, Caste and Standard of living index are not significant with empowerment of women ($p>0.05$).

**Experience of reproductive health problems of women**

Reproductive health status of women living in urban slums is analyzed in this section. Women who suffered due to various reproductive health problems and the health seeking behavior of women are analyzed. A majority of 68.5 per cent of women experienced pregnancy complications, 36.7 per cent of women suffered due to delivery problems, 45 per cent of women experienced post delivery problems, 17.4 per cent of women suffered due to complications due to family planning methods, 43.2 per cent of women experienced menstrual problems, 24.8 per cent of women experienced RTI/STI problems, 11.3 per cent of women suffered due to infertility problems and 15.4 per cent of women experienced anemic problems.

A majority of 45.4 per cent of women with low empowerment status suffered due to pregnancy problems 39.6 per cent of women with low empowerment status suffered due to delivery complications, a majority of 44.7 per cent of women with low empowerment status suffered due to post-delivery complications, 38.8 per cent of women with low empowerment status suffered due to complications after the use of family planning methods. A majority of 39.2 per cent of women with low empowerment status suffered due to menstrual problems, 37.6 per cent of women with low empowerment status suffered due to RTI/STI problems, a majority of 46.2 per cent of women suffered due to Infertility problems and a majority of 53.5 per cent of women with low empowerment status suffered due to anemic problems and is presented in Table 2. It is observed from the Table 2 that the women suffered due to various reproductive health problems is low for those who are high empowered.

Health seeking behaviour of women is considered as dependent variable and is analyzed with empowerment status of women. Chi square analysis is used to assess the significant association between health seeking behavior of women with empowerment of women and is presented in Table 3. The null hypothesis that, "health seeking behaviour of women and empowerment of women are not associated".

**Table 2: Per cent distribution of empowerment with RH problems of women.**

| Reproductive Health Problems | Empowerment of women | | | Total |
|---|---|---|---|---|
| | Low | Medium | High | |
| Pregnancy complications | 45.4 | 31.7 | 22.9 | 315 |
| Delivery complications | 39.6 | 32.0 | 28.4 | 169 |
| Post-delivery complications | 44.7 | 28.6 | 26.7 | 206 |
| Problems due to FP methods | 38.8 | 30.0 | 31.2 | 80 |
| Menstrual Problems | 39.2 | 36.6 | 24.2 | 186 |
| RTI/STI Problems | 37.6 | 38.7 | 23.7 | 93 |
| Infertility problem | 46.2 | 21.2 | 32.7 | 52 |
| Anemic problem | 53.5 | 33.8 | 12.7 | 71 |

**Table 3: Per cent distribution of Health Seeking Behaviour of women by Empowerment of women**

| Empowerment of women | Health Seeking Behaviour of women | | | Total |
|---|---|---|---|---|
| | Low | Medium | High | |
| **Low** | 58.6 | 56.6 | 16.3 | **210** |
| **Medium** | 25.7 | 25.0 | 22.4 | **152** |
| **High** | 15.7 | 18.4 | 61.2 | **98** |
| **Total** | **58.3** | **24.3** | **17.4** | **460** |
| **Chi square: 24.087, p value: 0.000** | | | | |

It is observed from Chi square analysis that the hypothesis is rejected implying that empowerment of women is significantly associated with health seeking behavior ($p < 0.01$). A higher percentage of respondents (61.2 per cent) who have high level of empowerment treated at high level for all RH problems and a higher percentage (58.6 per cent) of respondents having low level of empowerment treated at low level of all reproductive health problems.

Logistic regression analysis was carried out to assess the determinants of health seeking behavior of women for their reproductive health problems. Respondents who treated for the RH problems are coded as 1 and not treated for the problem is coded as 0. Logistic regression analysis resulted that women belonging to scheduled caste, illiterate women, women in low standard of living, women with more number of living children, women with low awareness about health facility, low decision making power and low empowerment status and low mass media exposure are less likely got treated for their reproductive health problems than their counterparts.

## Conclusion and suggestions

Women living in urban slums suffered due to various reproductive health problems and it ranges from 11 per cent to 69 per cent. Women with low empowerment status suffer from various reproductive health problems at higher level and the proportion of women suffering from reproductive health problem decreases as empowerment status increases. Treatment seeking behavior of women for their reproductive health problems increases as empowerment of women increases. Women belonging to low socio economic conditions, low decision making power, low empowerment status and low mass media exposure are less likely got treated for their reproductive health problems than their counterparts.

The awareness creation and health education on reproductive health issues through IEC and mass media exposure is needed urgently for improving health seeking behavior of women in urban slums. Ensuring availability of infrastructure and equipments along with availability of female medical officers at the government health facilities will help women to avail free services at the public health facilities. Personal and menstrual hygiene, use of Condom and partner treatment will help women to avoid infections and complete cure of reproductive heath problems of women living in urban slums.

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