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Dynamics Governing Women's Decision on Reproductive Health Matters Reflections from a Qualitative Study in Central India

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Abstract:

One of the major challenges of Reproductive and Child Health Programme in India is addressing the barriers in communication and improve dialogue between diverse stakeholders, particularly women in the community. Through a qualitative study conducted in one of the rural districts of India, it was attempted to understand the factors affecting women's decision-making process. It is observed that most of the factors are affected by strong intrinsic environment and hence it becomes important for programme managers to understand the environment first in order to design an acceptable and effective

communication strategy. In this study, knowledge, tradition, stigma and accessibility of services are identified as the key primary factors affecting decision making of women in the community, particularly on their health related issues. These in turn are governed by various supporting factors. Finally, it is observed that communication strategies can achieve their desired objective only when the local intrinsic environment is taken into cognisance.

Key Words: Reproductive health, Knowledge, Stigma

Introduction

The centrality of women's decision making towards success of reproductive health programme was recognised for the first time in the 1997 ICPD Conference in Cairo¹, while the lack of it resulting in their increasing vulnerability towards several reproductive infections including HIV/AIDS was pointed in the UNAIDS 2004 report on Global AIDS epidemic.² Following the recommendation of the ICPD, at Cairo, the Government of India undertook a major initiative, the Reproductive and Child Health (RCH) Programme, to reorient the family planning programme towards reproductive health. The RCH programme, among other things, envisages addressing communication barriers and improved dialogue between diverse stakeholders of reproductive and child health programme.

However, proper communication through adequate dialogue process has been a major challenge for the programme managers. One of the barriers in designing an effective communication strategy is that often the programme managers tend to develop communication strategy with a preconceived notion or set guidelines without trying to assess the dynamics governing women's decision-making process. Women's decision making is governed by strong intrinsic environment, which is difficult to change through external environment alone. Often programme managers tend to ignore these intrinsic factors while planning for an intervention, resulting in outcomes which are less than satisfactory.

Research Objective and Methodology

The major objective was to study the factors that affect the decision-making process of women in Indian community and identify areas which need to be considered in designing an effective communication strategy. The primary data was collected through a qualitative research carried out in one of the rural district of Central India.

The key research tool used for the study was Focus Group Discussion (FGD), supplemented by natural group interviews with the target population. FGD technique was used to elucidate information about group process and practices. A check-list was developed to elucidate information about general social and education status of the group, their work pattern, knowledge, attitude and practices on their own reproductive health problems, behaviour and customs during pregnancy, antenatal care services available in their community, customs followed in the society after childbirth, family planning options and practices and sources of information in the community. Additionally an important component of decision-making in the family and community was part of the FGD check-list.

The group participants were chosen to cover a wide range of different populations in the district under study, including those whose decisions play a major role in the family. They were 'natural groups' in that they pre-existed the research, such as adolescent girls, newly married women (marital duration less than 2 years) and women above 30 years of age. The three different groups were chosen for obvious reasons. While adolescents started experiencing various reproductive changes in their body, newly married women have most probably undergone pregnancy episodes and the knowledge and beliefs of elder women play an influencing role for the younger generations. That they were natural groups was important, as similar age structure and social settings are the ones in which we come to know about issues which govern their decision making process about reproductive health matters. The intention was to maximise the interaction between participants in the groups to see how social knowledge was developed. The second method for encouraging interaction was the use of facilitator's skills in actively managing the discussion, pushing participants into accounting for their views, or exploring disagreements. Maximising interaction allowed access to not only what

people thought, but also to the cultural contexts in which the views were held.

Sample-Size:

One hundred and sixty (160) women of the different age-groups participated in twenty three (23) focus group discussion sessions. The study was conducted in a rural district of Central India. Some of the key statistical indicators for the district are: sex ratio - 932 females per 1000 males, literacy rate - 61.04 per cent with female literacy rate of 34.5 per cent, couple protection rate - 58.2 and unmet need is 23.9 per cent. 35.7 per cent of the delivery in the district is institutional and 31.1 per cent female reported symptoms of RTI/STD.³

Although the sample size of the study is not large enough to generalize the findings, the very nature of the tools used for the study gives a definitive direction for programme planners in planning for an intervention in

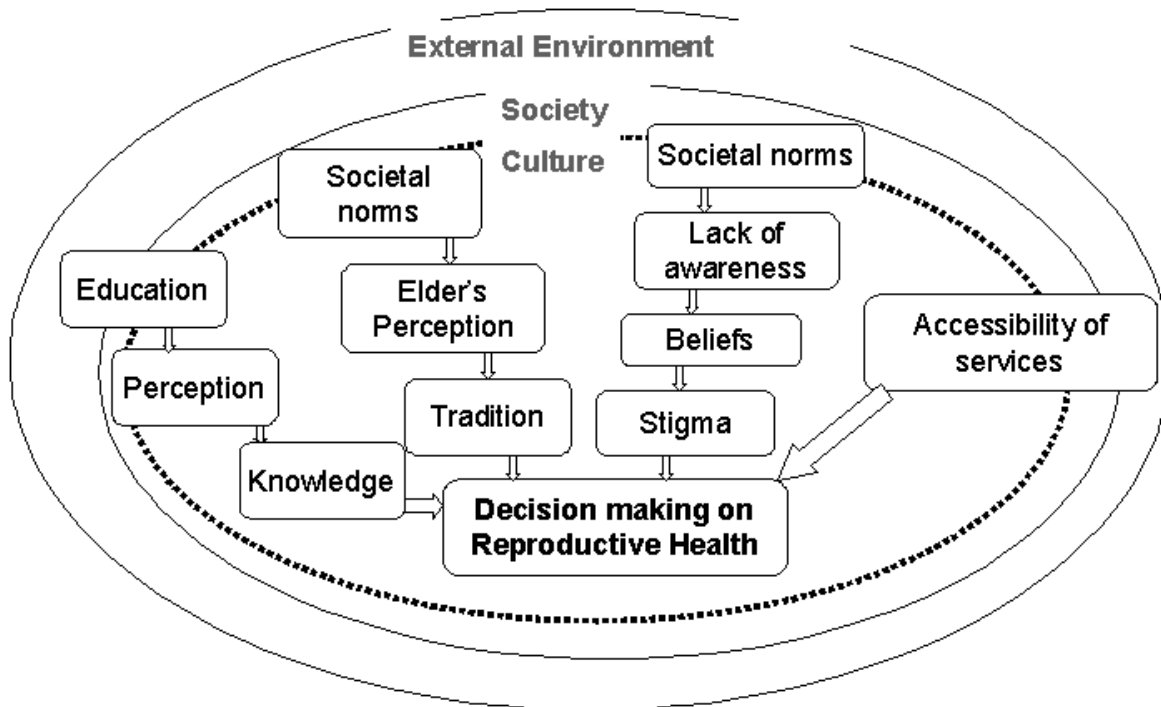
the community involving women of reproductive age group.

Results

Factors affecting women's decision-making in reproductive health matters

Although decision-making in reproductive health of a woman is her individual attribute, it is governed by interplay of the environments in which she lives. The immediate environment after her own family is the society she is living in, which is governed by the culture prevailing in the society. The society in turn is affected by the external environment comprising of public health machinery of government, non-government organisations, private for-profit and traditional health practitioners and other local bodies in the society. This is depicted in Figure 1. Table 1 classifies the primary, supporting and governing factors that affect the decision-making process.

Figure 1: Social perspective for analysing women's decision-making on their health



Women's decision-making typically is affected by three levels of her interaction with the world outside. The farthest is the external environment which provides her the services. The next is the society of which she is a part. This society has its own culture which governs the concepts of right or wrong. The society and the culture it professes and practices are too close to be made distinct such that they seem interwoven (hence depicted here by broken lines). This cultural environment with its societal norms interacts/affects her in ways more than one. First, these norms go on to shape her elders' perceptions which she is expected to follow unquestioningly. Second, these norms, on account of lack of awareness, become strong beliefs and stay as stigmas until the veil of ignorance is removed. Education (or the lack of it) influences the women's perceptions and affects her knowledge regarding the dos and don'ts of reproductive health and her health in total. Education is partly governed by the external environment with regard to

accessibility and availability of schools/colleges. The last but definitely not the least important factor is the women's access to health services. Here however it must be remembered that it is not just the accessibility of health services alone but the quality of the services offered which will go a long way in determining the woman's choice of reproductive health. If the quality of the services is not up to the mark it will in all probability be a deterrent for the other women in the community.

The typical decision-making process in the family is exemplified in a case developed from natural group interview in the district studied (See Box and Figure 2).

Natural group interview is a qualitative technique to maximise interaction between participants, as well as between the facilitator and participants with some access to shared group culture in a naturalistic setting⁴. This resembles in some ways the kinds of interaction people might have in their everyday lives.

Illustration: Decision-making process in the community on seeking a place for child delivery

(The case discussed here describes the typical process of decision-making in an Indian family. The case is designed using natural group interview in the district under study.)

Pramila Devi is 22 years old and married for the past two years. She has been educated till eighth standard and has one child. She had experienced complications during her first delivery because it was pre-term and baby was underweight. The delivery was conducted through an untrained traditional birth attendant in the village. On hearing about her delivery complication, the ANM visiting her village suggested her to go for institutional delivery on her subsequent pregnancy. Pramila Devi is now expecting a second child within a span of 1 year and is thinking of going for institutional delivery this time. However, she was not empowered to take her own decision in her reproductive choice. She consulted her husband regarding her wish to go for institutional delivery. However, due to his education and lack of knowledge about complications expected during her subsequent delivery, he asked his mother and other senior members in the family for advice.

A lot of factors govern their decision-making process as to the traditions followed in case of child birth, beliefs in the community and experiences of others regarding the service provider at government health institutions. The stigmas surrounding the newer practices, willingness to break away from traditions will then determine their chosen course of action.

Once the family decides to opt for institutional delivery, the next question in their mind: Are the services accessible/ available in the community? Remote accessibility of the service provider affects decision-making of the community towards seeking health services. A positive response will make the family take a decision on seeking institutional delivery, or else they would be going for traditional delivery options of their community.

However, the process will not end here - any negative experience of the family with service provider will create a negative environment not only within the family, but also among the community about institutional delivery. Communication without proper service delivery will be disastrous for the health system. Figure 2 depicts a decision tree discussing the typical process involved in decision-making on seeking institutional method for delivery or seeks the help of traditional birth attendant.

Figure 2: Decision tree depicting decision-making process on choosing type of service delivery

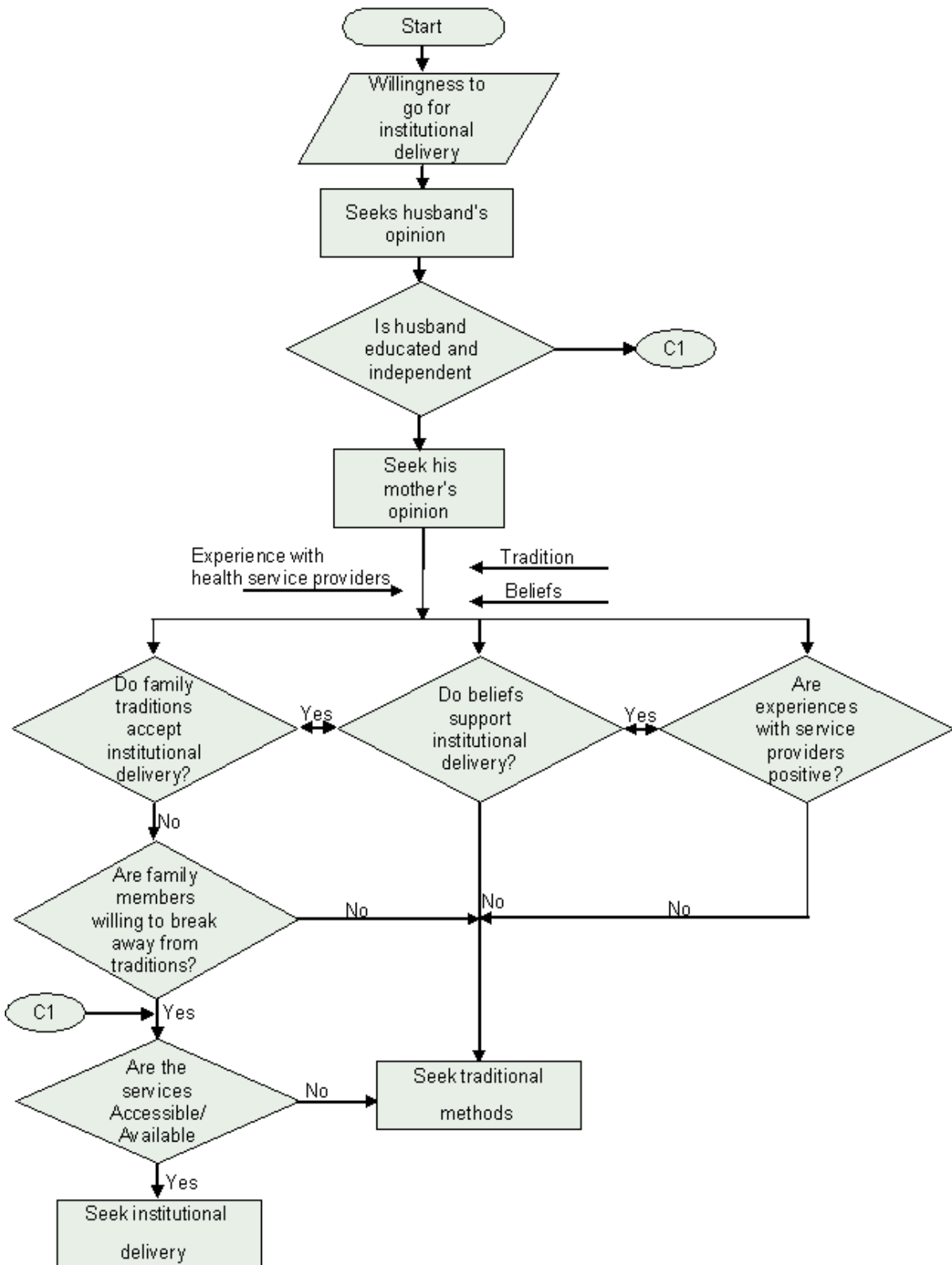


Table 1: Factors affecting Women's decision-making

Primary Factors	Supporting Factors	Governing Factors
Knowledge	<ul style="list-style-type: none"> • Education • Perception 	Interplay of External Environment, Society and Culture
Tradition	<ul style="list-style-type: none"> • Elder's perception • Societal norms 	Interplay of Society and Culture
Stigma	<ul style="list-style-type: none"> • Beliefs • Lack of Awareness • Societal Norms 	Interplay of External Environment, Society and Culture
Accessibility of services	<ul style="list-style-type: none"> • Availability • Affordability • Trust in service providers 	External Environment

Knowledge

Knowledge, perception and behaviour related to reproductive health and sexual matter underlie virtually all conditions that Family Welfare programmes address; hence these are important issues for any service providers. To achieve significant levels of fertility or decline in mortality, it is essential that the community should participate in the programme and the programme understands and addresses the knowledge and prejudices of the community. Knowledge in a society is supported by interplay of perception and education. While perception is governed by intrinsic environment, education, particularly in its modern form, is governed by extrinsic environment. Various myths and customs prevalent in the community like what will a girl do by getting educated, family preference towards a male child receiving education, fears that girls will 'get spoiled if sent outside the village', monetary pressure etc. are the major factors keeping girls away from school. Perception on the other hand denotes attitude of the community and their level of adaptability to change. Hence it is of utmost importance to judge the perception

of the community about a particular issue and then move towards designing intervention which can address the local/community concern.

Situation Analysis

The result of the field work generated a wealth of information on how the community relate their knowledge level towards various health problems.

Around 40 per cent of adolescents do not know about the problems that the adolescent girls face in the community. These may be attributed to the social taboos prevalent in the community regarding their health problems. The major problems reported by the adolescents are dizziness, headache and weakness as symptoms of anaemia.

Reproductive tract infection is perceived to be caused by personal, social and biological factors and seems to be interlinked. The interplay of these causes needs to be understood and strategized accordingly. There is a high degree of ignorance about symptoms of reproductive tract infections in the community. Majority of women consider

changes like itching in vagina, foul smelling white discharge and irregular menstruation as a routine event and not a health problem. Interestingly the knowledge level about reproductive tract infection does not vary significantly across ages. Moreover, certain misconceptions about reproductive tract infection and menstruation are evident among older age groups.

Self-Care: Almost half of the respondents could not recognise proper ways of personal hygiene and almost two-third of the adolescents do not know about any precautions to be taken during menstruation. Two-third of the newly married women are not aware about proper care and precautions during pregnancy. Knowledge about the need for iron-folic acid (IFA) tablets during pregnancy is found to be very low. Although mass campaign made them aware about importance of breastfeeding, knowledge about period of exclusive breastfeeding and immunisation schedule is lacking in the study group.

Knowledge about birth spacing: Oral contraceptive pills is the preferred spacing method among newly married women, while older women prefer terminal method. However women in the community are grossly unaware about the options in case of missed pills. We found evidence of female infanticide among the community members although validation of the facts was not possible in the research tool used.

Traditions

Traditions in a closely knit community of rural India are governed by perception of senior members of the family and societal norms. The traditions followed in the community play an important role in the decision-making process of women. These traditions date back to early age and are inherited through generations in the community. These practices have become a part of our culture and evolved through years of experience.

Communities have a traditional system of healing which caters to a wide range of

conditions covering promotive, preventive and curative aspects of health. The general practitioners or local healers deal with a range of problems like gynaecological conditions, paediatric disorders, eye disorders and also spiritual curing. There are some traditions that are related to the lifestyle, occupations etc of particular communities. The system has a holistic approach towards health care. Traditional birth attendants in villages are older women in the community who take care of antenatal and post natal care and also attend to deliveries. Recognising the lack of human resource for attending to deliveries in rural areas of India, Government of India has trained the *dais* for conducting aseptic deliveries. However, this study found that they were not given high credibility in the community. Local health traditions are time-tested practices in the community and any effort to influence or affect the tradition can be counter-productive, a phenomenon depicted in Figure 3.

Stigma

Stigma is a major barrier to positive attitude and behaviour towards reproductive health in the community. The negative attitude and behaviour needs to be changed in order to achieve a positive impact of any programme in the community. Stigma governs nearly all aspects of practices in India specifically in rural societies. An insight on the study on stigma prevalent in the community reveals the following useful insight⁵.

Need to deal with stigma first: Although public health communication strategies have identified the need for behavioural interaction between the community and the user, the need to de-stigmatise the family members and community is considered important. De-stigmatisation as a necessary precondition for effective public health intervention has been quite a recent development.

Stigma is amenable to communication management: Evidence of various health programmes has shown that relation

between knowledge and attitude on the one hand and knowledge and behaviour on the other may not be high and positive. This has two clear implications for communication planning. One, campaign managers can not rely on mass media alone to bring about a significant gain in knowledge among the different segments of population. Two, campaign managers also need to examine the characteristics of source (expertise versus attractiveness), message (one-sided versus two-sided presentation of arguments) and media (media mix strategies) in order to strengthen knowledge-attitude and knowledge-behaviour linkages. High knowledge with no significant change in attitude and behaviour is the least effective situation from a practical standpoint. Hence it is the degree of attitude-behaviour relationship which plays a major role in the process.

Stigma in the community regarding reproductive health: In this study, a host of stigma relating to reproductive health and health-seeking behaviour prevalent in the community were found. These decide to a very large extent the attitudes and behaviour of average rural Indian. There are not many ways through which these stigmas could be challenged and mitigated. For example there are stigmas related to girl education, menstruation, reproductive tract infection, hygiene and delivery practices. Often older members of the family - mothers, mother-in-laws - create barrier in education of their children, especially girls. Added to this are rumours against sending girls outside the village for education. Knowledge about importance of education does not remove the stigma. There seems to be a weak link between attitude and cognition. Similarly, stigmas related to menstruation are a result of lack of awareness among the community. The lack of awareness is again related to lack of education which is governed by external environment. This shows that existing communication strategy did not percolate well in the society. There is a high degree of myths and misconceptions about causes of menstruation and related customs prevalent

in the community. It was found that even among adolescent groups, traditions related to menstruation are considered as an old tradition which can not be changed and have to accepted.

Accessibility of Services and Practices

Private health facilities in villages are characterised by local practitioners practicing in the village or touring the community from a nearby village. They are accessible to the larger community and poor patients visiting the facility often have options to avail services on credit or through barter system. However, more than these, it was observed that patients often visit them due to perceived quality, confidentiality and lack of taboos attached with visiting these facilities, especially in case of sexually transmitted diseases.

The growing preponderance of private health facilities attract maximum number of patients in the community; however, majority of them are not satisfied with the services available over there. Although there are an extensive network of public health delivery system in place, overcrowding, unavailability of doctors, lack of confidentiality, lack of empathy showed towards poor patients, indifferent staff behaviour, distance from community and longer waiting time in the facility are some of the major reasons that lead to people losing trust in the public health delivery system.

Discussion

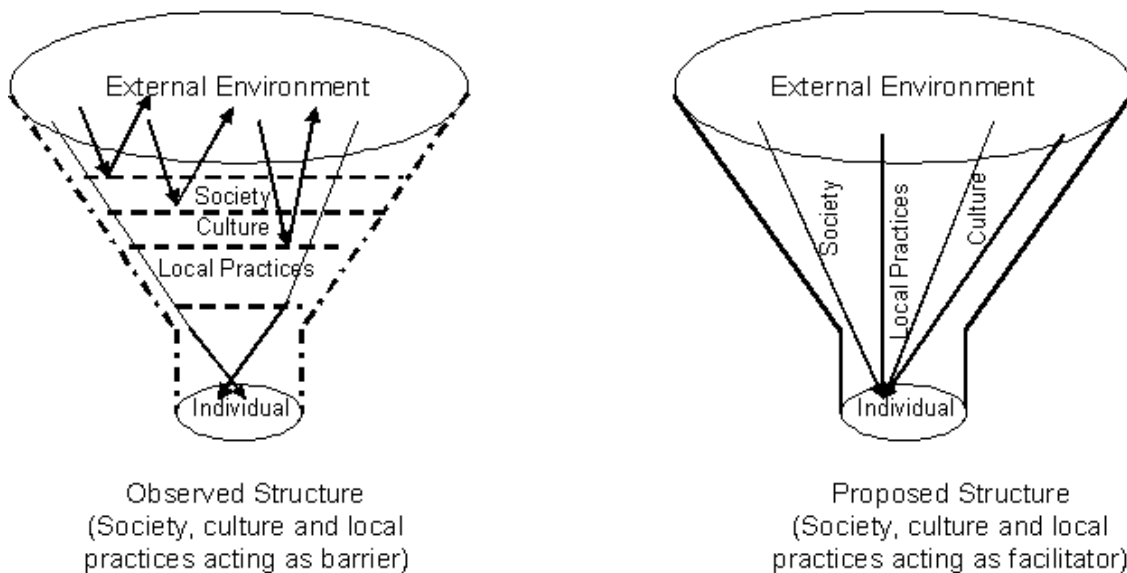
Getting the communication process work

In order to inculcate positive and empowered decision-making among women in the community, particularly on their reproductive health matters, there is a felt-need to create an enabling environment in the system. As mentioned in Figure 1 and Table 1 above, there are three different environments: External Environment, Society and Culture, with the latter two forming part of the internal environment in the system. However, it appears that the

present system lacks co-ordination between the different environments due to the lack of enabling communication channel. There are serious inherent rigidities in the system. The experiences suggest that the communication process between the environments has some serious flaws. These are characterised by:

- Fragmentation of health care delivery system by creating operating islands without any mechanism of coordination and information sharing between the existing culture and norms of the community; and
- Structural rigidities in the system leading to the lack of enabling environment for communication process

Figure 3: Observed and proposed structure to address communication barriers



In Figure 3, the observed structure depicting the factors contributing to communication barrier in the community are summarised. As mentioned earlier, society has its own culture which governs the concept of right or wrong. The cultural environment with its societal norms and traditions are governed by elders' perception and beliefs prevalent in the community. Local practices are inherited through generations in the community and these practices become a part of the culture in the community. Over a period of time, the community developed trust and confidence in the system and hence any effort to bring about a radical change in the system will result in strong resistance to change. Bringing about a sustained and durable change in the system

requires continuous engagement with the community, identifying areas of willingness to change and then designing strategies to make the change process work. And this requires creating a supportive environment from among the community.

Communication strategy must make efforts to identify the change agent and design culturally adaptable campaign strategies. The alternative structure proposed here aims to convert these intrinsic environments into a supporting change agent leading to attaining the desired objective of the communication strategy and intended behaviour change in the community. This ultimately will lead to positive and informed decision-making among women in

the community. The task is not simple and is a continuous process of understanding the community and acting upon the same to make the communication process work effectively. What may work well in one community or set-up, may not work in another and hence the strategy needs to be fine tuned accordingly.

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