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Identifying the Decision Makers of Women Particularly in Child Bearing and Sterilization among the Rural Women in the Villages of Kangpokpi District, Manipur, India

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Abstract:

In order to identify decision makers of women particularly in child bearing and sterilization among the rural women, 213 women from four rural villages of Kangpokpi district in Manipur, India was selected. Questionnaire method was used for collection of data and descriptive statistics is used in analysis of the data collected from the 213 respondents. The study found that the women take the decision of the family members more than the medical doctors' advice on matters regarding child bearing and sterilization.

Keywords: Women's Health, Rural Women, Women Health Information, Rural Women Health Information, Health Decision Making, Women's Health Decision Making.

Introduction

Women's health refers to the health issues relating to, or specific to human female anatomy such as menstruation, contraception, child birth, menopause, and breast cancer. It also includes proper nutrition, especially during pregnancy, child birth and during child

nursing (Devi, 2011). The World Health Organisation WHO (2018) defines reproductive health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and its functions and processes”. Women including girls have particular health needs that most health systems are failing to provide. These are conditions that only women experienced with negative health impacts and that only women suffered. Some of these conditions, such as pregnancy and childbirth, are not in by themselves diseases, but normal physiological and social processes that carry health risks and require health care (Ogi, 2016).

In a country like India, women’s health can be understood through certain indicators based on two sources such as, (a) Demographic trends, and (b) Access to Health Services. The Demographic trend generally includes indicators of women’s health like the Sex Ratio, Maternal Mortality Rate, and Infant Mortality Rate. There is an adverse declining sex ratio and the life expectancy of women is lower than that of men’s. When compared to availability of basic medical facilities, India’s position is even backward than some of the developing countries of the world (Devi, 2017).The reproductive health of women is also, to a great extent, influenced by their social, cultural, and economic status. A variety of factors combine to make rural life unfavourable for women living rurally creates geographic and socio-economic challenges for women, which negatively affect their health and well-being. “Gender ideologies, expectations and practices that assign domestic and familial unpaid care work as ‘women's work’ serve also to disadvantage women” (Dolan & Thien, 2008).Many studies have also confirmed the uneven distribution of health services with urban areas given more priorities than the rural areas, which make people in the rural areas more vulnerable to diseases. The limited acceptance of health interventions can be attributed to existing social beliefs and inefficient infrastructure in rural areas. Women’s experience within the health care system reflected their place in society, with men’s experience being viewed as the norm

and women's experience as being deviant from this (Lagro, Liche, Mumba, Ntebeka, & Roosmalen, 2003). The low status of women in India can be attributed to social problems like male child preferences, and cultural forces such as patriarchy, hierarchy, and multigenerational families which in turn contributed to Indian gender roles. Gender inequalities are directly related to poor health outcomes for women.

Statement of the problem

The health of women is of great concern because, in many societies, especially in the rural areas, women are disadvantaged by discrimination rooted in socio cultural factors. Some of the socio cultural factors that prevent women to benefit from quality health services and include unequal power relationships between men and women; social norms that decrease education and paid employment opportunities, etc. Many studies in rural areas found that when it comes to women's health in general and in matters of women's fertility and reproductive behaviour in particular, women usually have very less power to exercise their decision-making authority in the family. It is usually the mother in law and husband who decide on their behalf (Das, 2003; Ngom, Debpuur, Akweongo, Adongo, & Binka. 2003; Parveen, 2003). Therefore, it will be worthwhile to study and find out the decision makers of women's health in the selected rural villages of Kangpokpi district in Manipur and also find out the impact of education on women's independence in seeking of health information and their decision making.

Literature Review

Das (2003) conducted a study on Women's Decision-making Power in Reproductive Health in Orissa and found that when it comes to reproductive behaviour, women usually have very less power to exercise their decision-making authority in the family. It was found

that the mother in law and husband were the ones who decide on the women's behalf. Even on matters related to family size or fertility preferences, use of contraception and reproductive health, the husbands are the decision makers.

A total of 2,856 women were interviewed in the 1994 Kassena-Nankana district Birth History Survey and who had at least one birth recorded by the Navrongo Demographic Surveillance System by the end of 1995. Compound gate-keeping systems characterised the nature of constraints on women's seeking of modern health treatment for themselves and their children. Only 14.5% said they do not require authorisation from any man in their compound before attending a hospital for their health care needs. The rest 85.5% needed authorisation from either their husband or compound head for seeking their health needs (Ngom, Debpuur, Akweongo, Adongo, & Binka. 2003).

Factors such as poor socio-economic status, lack of physical accessibility, cultural beliefs and perceptions, women's autonomy and low literacy level play important role in seeking women health information (Parveen, 2003).

In examining the factors that influence the utilisation of health services by women in the rural and urban areas in Ghana,Buor (2004) found in the study that, in the rural areas in Ghana, male dominance in decision-making is more pronounced than in the urban areas. Therefore, the study made some recommendations to improve utilisation of health services by women of the rural Ghana through the location of maternal and child health services within easy reach, intensification of family planning education, the empowerment of women through access to formal education and vocational training for income generation activities and the full implementation of the National Health Insurance Scheme (NHIS).

Jacob, et al (2006) found that autonomy in decision-making rarely exists for women, such that even decisions related to reproductive and contraceptive choices are not under their own control. In situations where there is no male child, decisions of whether or not to use

contraception are often forced on women. Evidence from the region also suggests that despite the high rates of reproductive tract infection among young married women, there is a low rate of treatment-seeking, and assumes that the failure to seek treatment is related to the women's low social status.

Methodology

Field Site

Four villages, namely, Haijang, South Changoubung, Chaljang, and Wakotphai villages were selected from Kangpokpi district of Manipur for the study. For ease of communication, these villages will be those inhabited by the Thadou-Kuki speaking community.

Population of the study

All married women of childbearing age in the four villages formed the population. The whole population was covered in the study. The survey reveals that the total population of married women of child bearing age was about 213 (Two hundred thirteen). Since there is no official government census available, the total population, total number of households and the total number of women of child bearing age from each village is taken from the respective village chief from the four villages. The same is tabulated along with the household and total population of each village as follows:

Table 1: Demographic profile of the respondents

Sl. No.	Village	Total Household	Total Population	Total population of married women of child bearing age
1.	Haijang	50	353	51
2.	South Changoubung	72	670	55
3.	Chaljang	130	875	61
4.	Wakotphai	124	700	46
5.	Total	376	2598	213

(Source: Study Area/Villages Chiefs)

The questionnaires are constructed using a point 5 scale ranking system, where 1 is the least (never) and 5 the most (most frequently). The questionnaires were distributed randomly among the women for response. Descriptive Statistics will be used for the analysis of the study.

Analysis and Interpretation

The number and percentage of respondents and their educational qualifications are worked out and displayed in the table below:

Table 2: Background information of all the respondents

Sl. No.	Age Group (in years)	No. of persons	Percent (%)	Education	No. of persons	Percent (%)
1.	<17	00	00	None	67	31
2.	18-25	90	42	Class-VI	104	49
3.	26-32	94	44	Class-X	30	14
4.	33-40	25	12	Class-XII	11	05
5.	>40	04	02	Graduate	01	01
6.	Total	213	100	Total	213	100

From the above table it is seen that about half of the respondents, that is, 104 (49%) of them have completed just the primary level (class vi) of education. And 67 (31%) of the respondents reported that they have no formal education. This means that about 80% of the women are either illiterates or semi literates. 30 (14%) of the respondents have completed their matriculation. 11 (5%) completed higher secondary and just one (01) respondent out of the 213 is a graduate.

To find out decision makers in child bearing and sterilization, the scores are tabulated and analysed using Descriptive Statistics. The average frequencies of reliability of each village are calculated and the results are shown in the table below.

Table 3: Decision makers of Women Health in Child Bearing and Sterilization

	Frequency of Decision making										
Sl. No.	Opinion	Village 1		Village 2		Village 3		Village 4		Average Frequency	
		Childbearing	Sterilization	Childbearing	Sterilization	Childbearing	Sterilization	Childbearing	Sterilization	Childbearing	Sterilization
1.	Self	5	5	5	5	5	5	4	5	5	5
2.	Husband's	5	5	5	5	5	5	5	5	5	5
3.	Father-in-law's	4	4	5	5	5	5	5	5	5	5
4.	Mother-in-law's	4	4	5	5	5	5	5	4	5	5
5.	Parents'	3	3	3	3	3	3	4	2	3	3
6.	Doctor's	3	3	2	2	2	2	2	2	2	2

Scale 1: Never, 2: Sometimes, 3: Occasionally, 4: Often, 5: Always

Village1: Haijang, Village 2: South Changoubung, Village 3: Chaljang, Village 4: Wakotphai

The average frequencies of reliability of each village on child bearing and sterilization are calculated and the results are shown in the table above. The above table clearly shows that on both child bearing and Sterilization the women ranked their own decision and their husbands' as the most reliable with the average rank of 5 (always). The women then ranked their Fathers-in-law and Mothers-in-law's decision on Child bearing and Sterilization at 4 (Often) each, which means that the women find the decision of their parents-in-law often reliable. The women only take the decision of their parents and the Doctors' occasionally on

Child bearing and Sterilization. This also means that on Child bearing and Sterilization matters the women chose the opinions of themselves, their husbands', and their in-laws' more than that of the Medical Doctors'. The women do not make decisions based upon their sole interest alone but give equal importance to the decisions of their husband and their parents-in-law.

In order to find out how much role does the Doctor's advice play regarding Child bearing and Sterilization of the women, a descriptive statistical analysis was used to find out whether the decisions of the family members are more acceptable than the medical doctor's advice on child bearing and sterilization matters, and the analysis is shown in the tables below.

Table 4: Frequencies of preference of Doctor's advice and Family Decision

Sl. No.	**Doctor's Advice**			**Family Decision**		
	Scale	Frequency	Percent (%)	Scale	Frequency	Percent (%)
1.	Strongly Disagree	26	12	Strongly Disagree	Nil	00
2.	Disagree	89	42	Disagree	Nil	00
3.	Total	115	54	Total	00	00
4.	Undecided	64	30	Undecided	07	03
5.	Agree	21	10	Agree	119	56
6.	Strongly Agree	13	06	Strongly Agree	87	41
7.	Total	34	16	Total	206	97

The result in the above table on Doctor's advice shows that only 13 (06%) respondents strongly agreed and 21 (10%) respondents out of the total 213 respondents agreed to Doctor's advice on Child bearing and Sterilization. So, the total number of respondents who prefer the doctor's advice on Child bearing and Sterilization matters is 34 (16%). 26 (12%) of the respondents strongly disagree and 89 (42%) disagree to the Doctor's advice on Child bearing and Sterilization. the total number of respondents who do not prefer

the doctor's advice on Child bearing and Sterilization matters is 115 (54%). The remaining 64 (30%) respondents were undecided.

On the other hand, the table on Family's decision shows that 87 (41%) respondents strongly agreed, and 119 (56%) respondents agreed to Family's decision on Child bearing and Sterilization matters. This means that a total number of 206 (97%) respondents prefer family's decision on Child bearing and Sterilization matters. The remaining 07 (03%) respondents were undecided.

Findings and Suggestions

Findings

The findings of the study show that, the women of the study area take the decision of themselves, their husband's, and parents-in-law on matters regarding child bearing. The findings show that women take collective decisions in childbearing and sterilization. Similar finding is seen in the works of Bogale, Wondafrash, Tilahun, and Girma in 2011. According to them, "Women in developing countries are either under collective decision making with their partners or completely rely on the male partner's decision on issues that affect their reproductive lives. Identifying the major barriers of married women's decision making power on contraceptive use has significant relevance for planning contextually appropriate family planning interventions."The study also found that almost 90% of the women chose the decisions of the family members than the medical doctors' advice on matters regarding child bearing and sterilization.

Suggestions

- In a number of studies, it is found that women's failure to seek treatment and inability to take their health decision are related to the women's low social status. Therefore,

empowerment of women through access to formal education and vocational training for income generation activities.

- Community education is needed on all aspects of maternity care, unsafe abortion and treatment for obstetric complications so that the women are confident enough in taking their own health decisions.

Conclusion

The systems of Compound gate-keeping which characterised the nature of constraints on women's prompt seeking of modern health treatment for themselves and their children are still common among many rural communities in the developing countries. In a country like India, Male child preference is still prevalent. In most cases, education a son is considered an investment, however, spending on the education of a daughter is considered a loss. Women in rural areas are mostly illiterates or semi literates (Ogi, 2016). Even in the present study, 31% of the women are illiterates and 49% percent are semi literates. The study shows that the women trusted the advice and decision of the family members in matters regarding child bearing and sterilization than the medical doctors'. It is believed that if the women were properly educated, they are likely to make better choices in their health matters in general and on matters regarding child bearing and sterilization in particular.

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