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Women's empowerment and its differential impact on health in low income communities in Mumbai, India

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Abstract

This paper examines the relationship of empowerment to women's self-reported general health status and women's self-reported health during pregnancy in low-income communities in Mumbai. The data on which this paper is based were collected in three study communities located in a marginalized area of Mumbai. We draw on two data sources: in-depth qualitative interviews conducted with 66 married women and a survey sample of 260 married women. Our analysis shows that empowerment functions differently in relation to women's reproductive status. Non-pregnant women with higher levels of empowerment experience greater general health problems, while pregnant women with higher levels of empowerment are less likely to experience pregnancy related health problems. We explain this non-intuitive finding and suggest that a globally defined empowerment measure for women may be less useful that one that is contextually and situationally defined.

Keywords

Empowerment; women; health; pregnancy; India

Introduction

The development efforts of the 1950s and 1960s that targeted low and middle-income countries (LMICs) sought to enhance the lives of both men and women, but it quickly became clear that in patriarchal contexts, women were not sharing equally in the benefits of these programmes (Cohn, Woodand, and Haag 1981; Escobar 1995; Sen 1988). Programmes initiated in the 1960s focused more on women as child bearers and nurturers but did little to enhance women's status, development and access to development initiatives (Leslie 1992;

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Marieskind 1975). In the 1980s, activists challenged the male-dominated, pro-natal orientation of many health and development programmes for their failure to incorporate women's rights, voices and participation (Eisenstein, 2009; Elliott 2008) and stressed the need for women's empowerment.

The literature proposes a variety of definitions of empowerment including control over decision making (Gollub 2000; Kabeer 1999); ability (agency) to formulate strategic choices and to control resources required to achieve a desired outcome (Alsop and Heinsohn 2005; Kabeer 1999; Malhotra et al. 2002; Sen 1990); and having the power to be able to attain desired outcomes (Grown, Gupta, and Pande 2005; Laverack 2006; Sen 1988). Empowerment is also seen as the ability, based on education and skills development, to advocate for improved quality of life (Sen 1990). One element of improved quality of life is the ability of a woman to make decisions about and to control her body, thereby increasing positive health outcomes (Gollub 2000). Empowerment is also a process that occurs over time (Carr 2003; Conger and Kanungo 1988; Kabeer 2000). A woman's level of empowerment may change over the course of her life as a natural process of advancing age, improved income generation, or as a response to familial, social, political and other contextual challenges and life changes (Kabeer 1999).

The concept of empowerment has been criticised for several reasons including its multiple and sometimes contradictory definitions; its focus on individual level approaches to implementing empowerment interventions and its failure to address the issues associated with the power of patriarchy. Nonetheless, regardless of the critiques, the implementation of empowerment programmes and interventions became widespread as the concept of empowerment became inextricability linked to women's well-being and has been accepted as a necessary pathway to women's overall development (Grown, Gupta, and Pande 2005; Sen 1988).

While most research associates higher levels of empowerment with better health and social outcomes, critical scholars have re-examined this widely held position (Parpart, Rai, and Staudt 2002; Rocca et al. 2009). In this paper we use a case study, drawn from a low-income community in Mumbai, to address this question. We explore whether, and to what extent, context and situation shape women's expressions of empowerment and under what circumstances empowerment leads to positive or negative health and other consequences and outcomes for women. We argue that a globally defined empowerment measure for women may be less useful that one that is contextually defined.

Empowerment and health among Indian women

Several factors contribute to Indian women's relative lack of empowerment including the patriarchal nature of Indian society, constrained mobility, limited work opportunities, and low levels of social, political and economic participation (Hashemi, Schuler, and Riley 1996; Kantor 2003). Lack of empowerment results in negative consequences, such as poor health, disparities in allocation of household resources, medical care and education, and increased burden of strenuous physical tasks (Velkokk and Adlakha 1998). According to

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Patel et al. (2006), gender disadvantage is the main determinant of the poor health status of many Indian women.

A variety of symptoms and syndromes among Indian women in low-income rural and urban communities have been described in the literature as contributing to women's negative health status. *Tenshun* (derived from the English word “tension”) for example, is a culturally defined health problem associated with high levels of poverty, low education, excessive household chores, husband's alcoholism, low empowerment, domestic violence and marital difficulties (Patel and Oomman 1999; Ramasubban and Rishyasringa 2001). A similar syndrome is *kamjori*, which includes a wide range of general bodily complaints such as pain related to menses, pain in joints (hands and legs), dizziness, loss of appetite and chronic fatigue (Nichter 1989; Kostick et al. 2010). The most common physical symptom that women present to health care providers is *safed pani* (“white water”) or vaginal discharge, which has been associated with psychosocial problems and negative life situations (Patel et al. 2002; Kostick et al. 2010). *Tenshun, kamjori* and *safed pani* are associated with gender-based inequalities, social burdens and pressures, and related low self-esteem and are associated with low levels of empowerment (Jejeebhoy and Koenig 2003; Patel and Oomman 1999).

Many studies have associated higher levels of empowerment with positive reproductive health outcomes (Beegle, Frankenberg, and Thomas 1998; Hindin 2000; Wolff, Blanc and Gage 2000; Tuladhar et al. 2013). Women's greater degree of autonomy and gender equity are seen as playing an important role in shaping their ability to manage fertility as well as the health and development of children (Bloom, Wypij and Gupta 2001; Shroff et al. 2009). The social status of Indian women is, in part, determined by the ability to have children (Mehta and Kapadia 2008). Married women are defined and judged in relation to dominant family norms and associated gender ideologies, especially the ability to become mothers. A woman's pregnancy affords her an opportunity to gain status within the household and thus may contribute to higher levels of empowerment through the duration of her pregnancy.

On the other hand, higher levels of empowerment can also be associated with negative outcomes. For example, in examining domestic violence and its relationship to empowerment, Rocca et al (2009) found that women in south India that participated more actively in social groups, vocational training or employment opportunities were more likely to experience domestic violence. They argue that efforts to empower women may have unintended negative consequences, such as domestic violence (Rocca et al. 2009) which in turn has negative implications for the health of women (Tuladhar et al. 2013).

This paper will examine the relationship between empowerment, women's self-reported general health status and women's self-reported health during pregnancy in low-income communities in Mumbai. General health refers to health problems and health status that occur outside of pregnancy or delivery. Pregnancy related health refers to women's self-reported problems during the perinatal period. We propose that level of empowerment will vary with respect to general versus perinatal health. We hypothesise that empowerment will be higher and reported health problems lower during pregnancy and that the converse will be true for women who are not pregnant.

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Methods

The study communities

The data on which this paper is based were collected in three study communities located in north-eastern Mumbai and technically labelled as "slums" and characterised by high population density, limited sanitation and access to clean water and residential instability. The majority of the population (66%) residing in the study communities are migrants from impoverished rural and urban areas of north India and rural areas of southern states. Households consist primarily of one room (81.3%) and average household size is 6.4 people. Nuclear households are most common (47.0%), followed by joint and extended households (37.1%). Men are the primary income earners in this community with only 4% of wives working for cash income either inside (40.6%) or outside (59.4%) the home. On average, women who generate cash income earn significantly less than men per month (mean of Rs 1353 ($31) for women versus Rs 3272 ($72) for men).

Data collection procedures

The data were collected as part of a National Institute of Mental Health (NIMH)-funded intervention study entitled "Assessing risk for HIV/STD among married women in urban India" (2002 to 2006) (RO1 MH064875); a part of the programme, *Research and Intervention in Sexual Health: Theory to Action* (RISHTA, an acronym meaning "relationship" in Hindi and Urdu). Data collection consisted of formative research on women's issues related to risk of HIV infection, leading to the development of a pilot intervention to reduce the risk of HIV/STI transmission within marriage. For this paper we draw on two formative data sources collected between 2004 and 2005: a quantitative baseline survey of 260 women and in-depth interviews with a sample of 66 women.

The quantitative sample of 260 women was derived from a 2003 baseline survey utilising a systematic random sample of 2408 married men between the ages of 21-40, drawn from the three study communities. A random sub-sample of the 2408 men were administered STI testing (*n*=641). A further random sub-sample of men (n = 311) whose wives were living in the household was selected, and men were asked for their verbal consent to have their wives interviewed for the women's project. When these men agreed, their wives were asked for written consent. Of the 311 women who were contacted, 9.3% refused to be interviewed, and 7.1% had family members who refused to allow them to be interviewed. As a result, the women's project survey instrument was administered from February–June 2004 by female RISHTA staff to a final sample of 260 married women. Women were administered the survey in Mumbai in Hindi by female RISHTA staff in their homes at times when husband and children were not present, to maintain privacy.

In-depth interviews were conducted in Hindi and focused on women's health issues, life situations and marital/family dynamics. Women were interviewed by female interviewers over three or four visits lasting about one to one and a half hours for each visit. Interviews were transcribed and translated into English, entered into Atlas.ti (Muir, 2004), a text management programme, and coded.

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Sample characteristics

Women in both the survey and in-depth interview sample were married and between the ages of 18 and 48, with a mean age of 30 for the interviews and 28 for the survey sample. The mean age of education was five years (range from 0 – 12). Ethno-religious membership was approximately evenly divided in the survey sample between Muslims (50%) and Hindu (48%). All but one of the women in the qualitative sample had at least one child at the time of the interview. The average number of pregnancies in both samples was three (range 0 – 11). The survey sample data analyses for this paper were limited to the 244 women who had had at least one pregnancy.

Measures

The *general health* scale is a composite of seven symptoms that women reported experiencing in the previous three months including: low backache, headache, giddiness (dizziness), pain in body, loss of appetite, chest pain and palpitations (alpha = .71). The distribution of the responses had a slightly positive skew (mean = .33, S.D = .29, skew = .72, S.E=.16). The *pregnancy-related health* scale consists of eight items (alpha = .83) including excessive bleeding, backache, dizziness, white discharge, lack of sexual desire, anaemia, nausea and pain during intercourse during their last pregnancy. The distribution of the responses had a slightly positive skew (mean =.37, S.D =.31, skew =.31, S.E=.16).

To account for the time difference between general health (within the past three months) and last pregnancy-related health, we calculated the number of years between the last pregnancy and the time of the interview; the range for women in the sample was from 0 to 23 years. We created a variable of “age at last pregnancy” and included it in the analysis to control for the time difference between the two scales. The covariates of age, education, and religion were also included in the analysis.

A *Women's Empowerment Scale* was constructed that included 23 questions regarding various domains of women's empowerment (alpha = .82). The scale was derived from the Mason and Smith (2000) Measures of Women's Empowerment and Couples Communication questions and modified with additional questions drawn from our ethnographic interviews. The measures of empowerment included questions on participation in domestic decision-making, control over sexual relations and freedom of movement/mobility. Women responded to the statements with a three point Likert-type scale: “not at all true of me, somewhat true of me, or very true of me”, coded from 0 to 2. The distribution of responses was relatively normal with a slight positive skew (mean= .98, S.D. = .30 skew =.02, S.E=. 16) indicating somewhat greater levels of empowerment reported among women in the overall sample.

Analysis

We first examined the relationship between the two dependent variables: General Health and Pregnancy Related Health. The association was low (Pearson Correlation = .108, Two-Tailed Significance Level = .096), confirming that the two measures were separate and independent. We then examined the relationships of empowerment (the primary independent

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variable) to general health and pregnancy related health in two separate regression analyses with the survey sample of 244 women using PASW (v16.0 2010). Analysis of the in-depth interviews was guided by a theoretical model and was analysed inductively, using a grounded approach that involved the progressive abstraction of themes from raw data (LeCompte and Schensul 2013). Interviewers were transcribed directly into English and entered into Atlas.ti (v. 7; Muir 2010) for coding.

Results

Empowerment

Three themes related to empowerment were evident in both the qualitative and quantitative data. The first theme, *control over body*, included several questions related to ability to refuse sex, their duty to have sex, and if they would fight back or seek help in the event they were being physically beaten by their husband. The second, *control over decisions/finances*, included women's participation in terms of saving money or purchasing goods for the household. The third, *access to community/mobility*, included statements on ability to access resources and services outside of her home.

Control over her body—Women expressed a lack of control over their bodies when they had to give into their husbands' demands for sex in spite of their desire not to have sex.

> But I cannot say no to my husband if he wants to have sex…if I say no to him sometimes, then he really forces me to do sex. I also understand that if I say no to him then he might get involved into some other activities [going to be with another woman] (25-year-old woman, 3 children)

Women described contextual factors that allowed them to have more control over their bodies regarding when and how often to have sex including being pregnant, menstruating, and the presence of children and/or family members (frequently in the same room). Privacy also played a role in the frequency and nature of sex.

> As long as we were sharing a room with one family, my husband never forced me to have sex due to lack of privacy. Once we shifted [to a private room] I used to refuse and my husband forced me to have sex … he started abusing me. (30-year-old woman, 1 Child)

Women who stated that they were able to say no to their husbands desires, described their husbands as being ‘good’ if they did not force them to have sex. Some women also stated that with time, sex became something that they enjoyed especially in cases where their husbands did not force them.

> He is such a nice person that he never forced me to have it. I also realised that woman can also take initiation and can enjoy it. (25-year-old woman, 8 Children-Married at age 13)

Women in this sample exhibited great variation in terms of the control over their bodies, their exposure to forced sex and their enjoyment of sex.

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Control over decisions/finances—Women's control over decision-making varied depending on the matter discussed. In many cases, women were able to make decisions with regard to household matters such as what food to prepare, what types of groceries to buy, or matters concerning children's day-to-day wellbeing.

> My husband gives his salary to me. The usual day-to-day shopping (purchasing vegetables, buying something for household or kitchen), I manage to do. But…. we take the major decision jointly… (22-year-old woman, 2 children)

Women were less involved in major financial decisions where the mother-in-law and other members of the extended family were present. In these cases there were several individuals who had 'seniority' over the woman and limited her decision making ability. Moreover, limited finances, or lack of access to personal income by the women also played a role in limiting women's decision-making abilities.

> My husband takes all the decisions. As he is the eldest son in the family, his advice is always welcomed in every occasion or matter. All the financial matters were looked by my mother-in-law and husband…a household matter decision like what to cook, shopping and so on was taken care by my mother-in-law and me. (30-year-old woman, 5 Children)

Yet, in cases where men are less able to generate household resources, women take control of a wider range of decisions as exemplified by the following quote,

> We have quarrels only because of his idleness. Sometimes after drinking alcohol, he gives me bad words, but never says anything bad about my character. He trusts me very much. He knows I can take proper care of my responsibilities and family so he is not much bothered… He never interferes in my decision-making matters. (35-year-old woman, 3 Children)

Women in the study community show wide variation in their control over and participation in decision-making, undermining the stereotype, at least for a subgroup, of women's roles in a patriarchal society.

Mobility/access to the community—Most women reported that they were able to move freely within their communities without seeking permission from their husbands. These movements were primarily to run errands such as taking the children to and from school or going to the market for groceries and other household supplies. Although some women did exhibit relatively high levels of mobility, this mobility may still be constrained and controlled by husband and other family members.

> I have a lot of freedom inside the house, meaning I can do anything within the four walls. I don't have to ask my husband what to cook and what clothes to wear. But if I have to go out somewhere then I either have to inform him or need to take his permission. (24-year-old woman, 1 child)

A few women reported greater amounts of freedom regarding their mobility and were able to move freely without seeking permission. These women also faced limited restrictions from their husbands in terms of visitation of friends and family and participation in events or outings.

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> I am having one friend in the neighbourhood that runs a grocery shop; with her, I used to go out and have food outside. My husband was also saying if you feel [like it] go with her. From his side no restriction is there. (24-year-old woman, 2 children)

On the other hand, some women were very restricted, and were not able to move freely within the community and were often times not allowed to leave the home; however, some of these women viewed this restriction positively, accepting and endorsing patriarchal cultural norms.

> Even if I get [permission], I do not go out of the house because my mother-in-law does not like. We do not have purdah system as such in the house; still I prefer to avoid any misunderstandings. (35-year-old woman, 2 children)

Women with access to the community were able to join organisations and women's groups, which helped them to address some of their problems. Participation in such organisations is indicative of greater freedom of movement and access to information. Women's degree of mobility showed great variation with some women moving in and outside of the community without the permission of husbands and senior household members, while other women were required to seek permission, sometimes granted and other times not. Mobility can be an asset since women with high levels of mobility had opportunities to participate in various organisations or access information, resources and services.

General health

The survey data indicated that the most common general health problems were lower backache and headache, experienced by almost half of the sample. Women also frequently reported pain in the body and dizziness. Loss of appetite, palpitations and chest pain were the least reported problems. Table 1 provides the frequencies and percentages of women's reports of general health problems.

Many of the women interviewed also described a variety of general health problems ranging in severity and duration. Women's explained that these problems were associated with difficult situations in their lives. Women in the sample faced constant pressure in terms of fulfilling household duties, the needs of their husbands, children and in-laws and financial constraints. Lack of adequate financial or social support from a woman's husband exacerbated this pressure. General health problems were also associated with limited support that women were receiving from their husbands. A 28-year-old Muslim woman with three children stated: “as husband and father his love and affection towards us is lacking. This is the main reason of my ill health.”

Another woman describes her husband in the following way:

> He doesn't help in any household work, everything I have to manage. Even if I am sick, I have to do everything. I don't have daughters, it would have been a great help. (35-year-old woman, 2 Children)

Further, attention to women's general health often waited until other household expenses were met. A significant subset of women placed a low priority on their own health. In

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addition, some women complained that their husbands or in-laws were reluctant to spend money on their health needs and they expressed resentment that husbands placed less priority on their personal needs and health issues.

> My health was going down. I could not eat or sleep. Many times I would stand at my in-law's doorstep with my kids. They would be having their food inside but they would never ask me or my kids to have food. (25-year-old woman, 2 Children)

Level of stress or tension in the home also led women to exhibit behaviour that was harmful in terms of their physical health, mainly gambling and chewing tobacco.

> To keep myself away from tension and worries I started going for gambling in the nearby locality. I thought I could earn a lot to repay the debts, I also got used to chewing tobacco it helps me to be away from anxieties. (30-year-old, woman, 2 children)

On the other hand, there were a few examples in which women received support or encouragement to seek treatment from their husband or extended family, even in cases where the woman did not want to spend the money on treatment.

> Nowadays I am not keeping well. I have either a cold and cough or some other problem. I really avoid spending on it…But my husband doesn't like all these things; he forces me to buy the medicine prescribed by the doctor (37-year-old woman, 5 children).

Pregnancy related health

The survey asked women about which problems they experienced during their last pregnancy. The most commonly experienced problems were anaemia, dizziness lack of sexual desire and backaches. Nausea and white discharge and pain during intercourse were less frequently experienced pregnancy-related problems. The least commonly reported pregnancy related health problem was excessive bleeding, with 30 women reporting experiencing this problem during their last pregnancy. Table 2 presents the frequencies of reported pregnancy-related health problems.

Women feel pressure to have a child early in their marriage and most women in the sample became pregnant soon after their wedding.

> I was only about 15 years when I got married. It was only after two-three years that I could conceive a child…So my husband took me to the hospital, the doctor told me I was young and my body was not yet capable for the pregnancy…then at the age of 18 we got our first baby. (25-year-old woman, 3 children)

Having a pregnancy with limited complications, which results in a healthy child (in particular a male child), is greatly desired by not only the woman, but also her husband, natal family and in-laws.

> Everything went on well and after two days of labour pain, I delivered a baby boy. After the birth of our first child, my life totally changed. I was so happy with the baby. Everybody in the family was happy to see a baby boy. (37-year-old woman, 5 Children)

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Women report that the period during which they are pregnant is also a time when they received the most support from their relatives and husband.

> For my deliveries I was with my parents, they bore the delivery expenses…. In our community we celebrate the naming ceremony of the child, for that also my parents paid, it was a grand celebration (29-year-old woman, 2 children).

Further, the amount of money and effort spent when a woman is unable to become pregnant illustrates the high value placed on pregnancy and childbirth.

> Three years of married life…I was not able to conceive again…I took Allopathic and Ayurvedic treatment, after one month of Ayurvedic treatment, I conceived…. over 50,000 Rupees (US$1,000) - we spent for treatment. (33-year-old woman, 1 child)

Several women described the process of becoming mothers as one that improved their relationship with both their husband and husband's family.

> After the birth of the child, we were really happy, in the sense that the relationship between my husband and me also became strong, and I could say to people, "Look, I also became a mother." (25 year-old Muslim Woman, 3 Children).

During the pregnancy period, women often are able to obtain better health care and are more likely to acquire more power within the household. Having a child also increased the responsibilities felt by both the woman and her husband. Although the social context in which these women are situated is generally disempowering for women, the time during pregnancy and fulfilling the role of mother provides women with more opportunities to exercise elements of empowerment.

Empowerment and health

We utilised linear regression analysis to examine the relationship between empowerment and the two domains of health: general health and health during pregnancy. In our analysis, we sought to determine whether the relationship between empowerment and general health differs from the relationship between empowerment and pregnancy-related health. The first regression (Table 3) examined the relationship between general health and empowerment and the second regression (Table 4) examined the relationship between pregnancy related health and empowerment.

The results show that women's reports of more general health problems were associated with *higher* levels of empowerment (Table 3). Thus, women who were more empowered were significantly more likely to report having general health problems (β=.204, $t_{(5)}$=2.89, p=. 004). There was no significant relationship for the covariates of age, education, and religion. Table 4 presents the standardised and unstandardised coefficients for pregnancy related health.

Table 4 shows that higher levels of empowerment were associated with *fewer* reports of pregnancy-related health problems. Thus, women that were more empowered were less likely to report having pregnancy-related health problems (β= -.212, $t_{(5)}$= -3.05, p=.003). As

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with general health, the demographic variables of age, education and religion did not have a significant impact on pregnancy-related health.

Discussion

The results of our analysis show that empowerment functions differently in relation to women's general health situation and their pregnancy health status. We have shown that women who are more empowered are more likely to experience general health problems, and less likely to experience pregnancy related health problems. We look to our qualitative data to try to explain these differences.

The qualitative data illustrated the importance of childbirth in establishing the status of young married women in their husband's family. The period of time in which a woman is pregnant and in the immediate post-partum period is highly valued by mother and father, as well as the members of the extended family. Pregnancy gives women special status and privilege and during this liminal time, they can claim greater attention to their bodily health and wellbeing. Pregnancy enables women to increase their power, control and decision-making over their own bodies and provides women other benefits such as increased access to the community, greater agency, more financial support, greater levels of respect and more support from husband and his family. However, this is a temporary situation. When women are not pregnant, husbands and families see women's health problems as a potential interference with the maintenance of the household.

Our data supports the notion that empowered, non-pregnant women in a predominantly patriarchal society constantly battle gender inequalities, which results in greater somatic symptoms. Husbands and members of the extended family view women's general health problems as further reducing the households' limited financial resources, especially if the cost of treatment is high. Women themselves are raised with the cultural norm that their health problems (and other aspects of their lives) are less important, and thus tend to minimise them.

We argue, based on the ethnographic data, that women with higher levels of empowerment have better pregnancy related health for several reasons. During pregnancy women have more control over their own bodies, and are able to respond more readily to their physical needs. Pregnant women can gain more mobility, which gives them access to more effective treatment and health care remedies. Since children are highly valued in Indian society, pregnant women have greater freedom and flexibility to pursue matters that ensure the best birth outcomes and to express opinions and needs in a family context. While the period of pregnancy affords women with a higher status in the household and is associated with greater levels of empowerment, once the baby is born and her household status shifts from pregnant to new mother, her junior status in the household is again affirmed. Empowerment may be further reduced if a woman has an unsuccessful delivery, if her first child is female, or if she has given birth to several female children.

In general, the negative consequences of empowerment are especially evident where women's independent choice, voice, agency and income conflict with the social and cultural

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norms of patriarchal societies. In the context of shifts in women's status across the lifespan and during specific periods in their lives such as pregnancy, empowerment status may also vary. However, high levels of empowerment in one domain, such as mobility, do not necessarily correlate with higher levels of empowerment in other domains such control over one's body or decision-making.

This paper raises several key points concerning the concept of empowerment and its outcomes. We argue that a globally defined empowerment measure for women is less useful than one that is contextually and situationally defined. We have seen that greater empowerment does not necessarily equate to positive outcomes. As a result, the social context and life situation of women mediates the relationship between empowerment and health. There are situations in which woman can manifest behaviours that indicate increased empowerment and others where they is cannot or, if they do, the consequences may be negative.

Empowerment programmes are likely to prove unsuccessful by focusing only on the development of the woman since an individual level focus has the potential for creating conflict with the normative attitudes and beliefs of husbands, family members, and the general community. The potential outcome of individual level empowerment efforts may be conflict between women's new capacities for independent control and decision-making and the patriarchal cultural norms of their families and societies. Thus, if community and cultural norms are not changed, targeted empowerment interventions and programmes at the individual level could result in negative or unintended outcomes for women (Dalal 2011; Rajendran and Raya 2011).

One of the areas that several empowerment interventions have targeted is women's health since it is a key factor in ensuring both the health of new and expectant children and the family as a whole. Yet findings on the outcomes of empowerment interventions on health outcomes presented in the literature are inconclusive. The varying results on the relationship between empowerment and women's health presented in the literature may have more to do with women's changing contexts and different periods in their lives than contradictory results. In the case presented here, women's empowerment increases or is more accepted when she is performing the traditional role of producing a child. Therefore, her status and agency improve temporarily only when she is assumes the role of producing children.

Interventions must consider the multi-dimensionality of empowerment as a means for specific changes in aspects of women's lives as they cope with violence, sexual risk, and perinatal and general health. Empowerment intervention requires a clear understanding of the social context, the specific outcomes sought and a greater understanding of change in a patriarchal community. Both researchers and interventionists should acknowledge the complicated nature of the concept of empowerment. More studies are needed that combine an understanding of context and stage in a women's life with her relative empowerment to examine in greater depth the ways in which the cultural and social context both influence and are influenced by the concept of empowerment.

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Table 1

General Health Frequencies and Percentages (N=244)

General Health Problem	N	Percentage
Lower Backache	118	48%
Headache	109	45%
Pain in Body	89	36%
Dizziness	66	27%
Loss of Appetite	41	17%
Palpitations	38	16%
Chest Pain	34	14%

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Table 2
Pregnancy-Related Health Frequencies and Percentages (N=244)

Pregnancy-Related Health Problem	N	Percentage
Anemia	132	54%
Dizziness	129	53%
Lack of Sexual Desire	127	52%
Backache	106	43%
Nausea	79	32%
White Discharge	64	26%
Pain During Intercourse	59	24%
Excessive Bleeding	30	12%

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Table 3

Linear Regression Coefficients- General Health

	Unstandardized Coefficients		Standardized Coefficients		
	Beta	**Std. Error**	**Beta**	**t**	**Sig**
(Constant)	0.290	0.139		2.089	0.038
Empowerment	0.202	0.070	0.204	2.889	0.004
Age	0.005	0.005	-0.097	-1.023	0.307
Education	-0.008	0.005	-0.107	-1.562	0.120
Muslim vs. Non-Muslim	-0.014	0.039	-0.023	-0.348	0.728
Time Since Last Pregnancy	0.009	0.006	0.130	1.431	0.154

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Table 4

Linear Regression Coefficients- Pregnancy Related Health

	Unstandardized Coefficients		Standardized Coefficients		
	Beta	**Std. Error**	**Beta**	**t**	**Sig**
(Constant)	0.613	0.146		4.210	>.000
Empowerment	-0.223	0.073	-0.212	-3.047	0.003
Age	0.001	0.005	-0.013	0.138	0.890
Education	0.001	0.005	-0.015	0.226	0.821
Muslim vs. Non-Muslim	0.042	0.041	0.067	1.022	0.308
Time Since Last Pregnancy	0.003	0.006	-0.042	-0.473	0.637