

2-23-2009

Understanding the relationship between women;s participation and health in Uttar Pradesh, India

Candace Hillary Feldman
Yale University

Follow this and additional works at: <http://elischolar.library.yale.edu/ymtdl>

Recommended Citation

Feldman, Candace Hillary, "Understanding the relationship between women;s participation and health in Uttar Pradesh, India" (2009). *Yale Medicine Thesis Digital Library*. 406.
<http://elischolar.library.yale.edu/ymtdl/406>

This Open Access Thesis is brought to you for free and open access by the School of Medicine at EliScholar – A Digital Platform for Scholarly Publishing at Yale. It has been accepted for inclusion in Yale Medicine Thesis Digital Library by an authorized administrator of EliScholar – A Digital Platform for Scholarly Publishing at Yale. For more information, please contact elischolar@yale.edu.

Understanding the relationship between women's participation and health in Uttar
Pradesh, India

A Thesis Submitted to the
Yale University School of Medicine
in Partial Fulfillment of the Requirements for the
Degree of Doctor of Medicine

by

Candace Hillary Feldman

2008

Abstract

UNDERSTANDING THE RELATIONSHIP BETWEEN WOMEN'S PARTICIPATION AND HEALTH IN UTTAR PRADESH, INDIA

Candace H. Feldman, Gary L. Darmstadt, Vishwajeet Kumar, and Jennifer P. Ruger (Sponsored by Michael Cappello). Departments of Pediatrics and Epidemiology and Public Health, Yale University School of Medicine, New Haven, CT.

The purpose of this qualitative research study was to better understand perceptions of the limitations, motivations and influence of women's political participation on the health of a community in northern India. This study was nested within a larger community-based participatory neonatal health intervention led by the *Saksham* study group. Eighteen small focus groups were held in the rural villages of Shivgarh, separated based on gender, age category, and parent study intervention status. Scenarios were presented on culturally sensitive, locally relevant topics surrounding the concept of women's health agency, defined generally as a woman's ability to advocate for better health. Qualitative results were analyzed based on four key discussion themes: participation, autonomy, agency/self-efficacy and health systems. Elder women were found to demonstrate the greatest sense of self-efficacy and as a group, cited the largest number of successful health advocacy efforts. Women consistently prioritized issues relating to education, child health and familial well-being. Male concerns included infrastructure repair, village development and need for business opportunities. Caste was a significant factor in that the greatest political party participation, and sense of self-efficacy were seen among the highest and lowest caste members, and the strictest limitations to autonomy were among members of the warrior caste. Participation in the community-based intervention had varying effects, showing some differences in self-efficacy, but rare improvements in participation, autonomy and the functioning of the

health system. Conclusions include the need to keenly understand the local infrastructure and health system, cultural norms surrounding autonomy, and male and female perceptions of participation and self-efficacy to appropriately define and ultimately improve women's health agency. In addition, in order for a community-based participatory health intervention to truly improve women's empowerment, explicit strategies in keeping with this aim must be as central as the health-related goals.

Acknowledgements

This research was made possible by a short-term research grant from Yale University School of Medicine, and was sponsored and supported by Dr. Michael Cappello. In the development of the study, the assistance of medical anthropologists Dr. Elli Leontsini and Dr. Peter Winch, and of health and human rights expert Dr. Robert Lawrence, were invaluable. In the field, the authors are grateful to the *Saksham* study group, and particularly Ratnesh Srivastava and Vivek Singh, for their assistance. Translator S. M. Talha and community organizer Alok Awasthi facilitated the data collection process. The support of Dr. Shally Awasthi at King George Medical University was also appreciated. We further recognize the assistance of the Department of International Health at Johns Hopkins Bloomberg School of Public Health, and the Departments of Pediatrics and Epidemiology and Public Health at Yale University School of Medicine. Institution Review Board approval was obtained from Yale School of Medicine (HIC#0707002895), Johns Hopkins Bloomberg School of Public Health (IRB#00000545) and King George Medical University in Lucknow, India.

Table of Contents

Introduction	2
Review of the Literature	5
Statement of Purpose, Hypothesis and Specific Aims	43
Methods	48
Field Notes and Limitations	59
Results	64
Discussion	95
Conclusions and Recommendations	108
Figures	
Figure 1: Behavior Change Model	112
Figure 2: Impact Model	113
Figure 3: Map	114
Figure 4: Cause/Impact Diagram (Participation)	115
Figure 5: Cause/Impact Diagram (Lack of Participation)	116
Appendices	
Appendix 1: Focus Group Scenarios for Women	117
Appendix 2: Focus Group Scenarios for Men	118
References	119

Introduction

A woman's ability to participate politically is shown in the literature to be intrinsic to her progressive empowerment. Further, a relationship between this participation and health has been alluded to in a number of studies. However, the motivations, perceptions and limitations surrounding women's participation at the local level, and largely, the concept of women's health agency, have never been formally studied in a qualitative manner. Prior studies suggest a potential synergistic effect when a health intervention is coupled with efforts to improve women's political advocacy and involvement. Therefore, this study aims to provide a realistic, comprehensive understanding of women's health agency, defined generally as woman's ability to advocate on her own behalf and for her family for better health, in the context of a preexisting community-based health intervention. Further, this study also investigates the male perspective on women's health agency which has largely been overlooked in the past. The knowledge obtained through this formative research will provide a framework to improve future community health interventions and, ultimately aims to contribute to the greater realization of women's empowerment.

The first section consists of a review of the literature relating to political participation as a human right and as an aspect of empowerment and the specific studies that evaluate the relationship between this and varying measures of health. Incorporated in this review are past studies that took place in India, justifying the chosen location for this research. Certain gaps in prior research, most notably the lack of understanding of male perceptions, inadequate representation of informal means of women's participation particularly at the household and community level, and lack of follow-up on the influence

of health-related community based interventions on individual advocacy, will be addressed by this study.

The subsequent section delves into the specific justification for this study both through theoretical models and the literature review, and proposes the purpose, objectives and hypothesis for this research. The parent community-based health intervention, led by the *Saksham* study group, will also be described here in terms of its role in the development and analysis of this study. The focus group methodology will then be explained suggesting why this was chosen as the best way to obtain somewhat sensitive qualitative data in the subset of villages in northern India. Four central themes found to be intrinsic to women's health agency were incorporated into the focus group methodology and the qualitative analysis. These include participation, autonomy, agency/self-efficacy and health systems. These themes stem from gaps in past studies and the goal to achieve a more comprehensive understanding of the concept of women's health agency in this community context.

The final sections include a description of limitations based on field notes from the study, thematic analysis of the qualitative results, and a discussion of the relevance and applicability of these results to future studies. Results were categorized by the aforementioned themes and compared across intervention and non-intervention villages, between young and elder age groups and between women and men. Certain issues relating to caste and poor infrastructure were anticipated, but their impact was underestimated. The importance of elders in village traditions was pervasive and possibly more striking than the distinction between men and women. Differences in the reliance of villagers on external organizations and on political structures were particularly profound.

Overall, both formal and informal channels of women's local participation are described and perceptions, obstacles, and realities of advocacy and its impact on the local health system are addressed. Finally, a set of recommendations are offered to respond to the findings of this study by providing goals for future community-based health interventions.

A review of the literature

A woman's ability to advocate on her own behalf, and on behalf of her family, is a fundamental human right. If a woman cannot represent her own needs and those of her children in a political setting that permits positive change, she is not truly empowered. Therefore, the progressive realization of this right to political participation, formally and informally, and at all levels—individually, nationally and internationally—is central to the process of women's empowerment.

However, women's political participation is not a straightforward concept, nor does it lend itself to solely quantitative measures. Across the world, women are underrepresented, and oftentimes, descriptive representation does not correlate with substantive power.¹ A quantitative characterization of the social, cultural, religious, and political obstacles facing women through national survey data is limited. The role of personal motivations, or perceptions of self-efficacy among women who do choose to participate politically, is also frequently overlooked. Furthermore, studies of the impact of women's participation on health often ignore informal channels of participation, as well as advocacy at the household and community levels. However, it is argued that these routes are not only more accessible to women, but also that they have a more direct, measurable effect on health processes and outcomes.

This section provides a review of the literature on women's political participation, with a particular focus on the developing world, and the relationship between participation and health. Both human rights-based and operational definitions of empowerment and of political participation will be presented and evaluated in terms of applicability to women. Subsequently, the motivations, obstacles, perceptions and

realities of women's participation as described in the existing literature, will be addressed. The influence of women's participation on the allocation of public goods, and on child and women's health outcomes, and the limitations in current methodology to study this concept will also be described. Ultimately, this section aims to provide the framework and justification for this study and to demonstrate the centrality of a woman's ability to participate politically to the improvement of the health of her community.

What is women's empowerment?

The Fourth World Conference on Women in 1995, and the Beijing plus Five Conference in 2000 both focused on gender equity, stimulating an increased call to action to understand, measure, and improve women's empowerment.² Empowerment is extremely difficult to quantify, and may differ in both actuality and perception across cultures, political systems and societies. However, the strongest measures of empowerment rely on the framework of universal human rights which transcend local structures of gender inequality. When looking at empowerment from a public health standpoint, one aims to analyze it in terms of a measure, a process, or an outcome. The following section will describe these operational approaches to the definition of empowerment, specifically with respect to women.

Empowerment is more often used to advocate for a policy or an intervention rather than as a term to define, or as a tool for analysis. Most broadly, empowerment is described by the World Bank as "the freedom of choice and action," as it applies to women or any other disadvantaged group, socially, economically or otherwise.³ There is some difficulty in the application of this definition to women. The World Bank document considers empowerment in terms of the poor, or a disadvantaged group with a designated

place in society. Women, however, transcend these group boundaries, and the focal points of disempowerment occur across societal levels from the household to formal institutions.⁴

One frequently cited definition of empowerment is “the expansion in people's ability to make strategic life choices in a context where this ability was previously denied to them.”⁵ This is often explained as having two components: the change from a prior situation of disempowerment, and existence of human agency to choose amongst real alternatives that do not bear unreasonably high costs.⁴ The role of accountability may be added, such as in this alternative World Bank definition: “the enhancement of assets and capabilities of diverse individuals and groups to engage, influence and hold accountable the institutions which affect them.”⁶

In a United Nations document, women's empowerment was described as having five components: women's sense of self-worth; their right to have and to determine choices; their right to have access to opportunities and resources; their right to have the power to control their own lives, both within and outside the home; and their ability to influence the direction of social change to create a more just social and economic order, nationally and internationally.⁷ This, in addition to the World Bank definition, has a clear institutional, policy component. However, here too “institution” may be multi-faceted starting with the individual, the household and the community, and then moving to more widespread national and international levels.

When discussing the policy implications of empowerment, the definition has also been extended to include power, decision-making and control. In this context, it has been described as “women's actual exercise of power over the allocation of resources, her

level of control in decision making positions, and her ability to control and determine public policy, regulations and laws.”⁸ Other definitions relate to a woman’s self-reliance, her individual capacity to advance, and overall, to her autonomy. One interesting definition includes self-indulgence, or the ability for a woman to be “unproductively free.”⁹ This implies that true women’s empowerment enables a woman to experience leisure, or for example, allows her to put aside money freely for her own use. It may not be possible, however, to generalize this definition across socioeconomic classes.

A number of definitions approach empowerment from the viewpoint of “bottom-up” development. This involves the concept of agency, or self-efficacy, whereby individual women are charged with the responsibility of being the agents of change in their lives.⁴ However, two important caveats to this definition include access to resources and structural support. Alone, agency, resources and structural support each are not sufficient to explain empowerment. For example, pure access to resources may not actually lead to greater control over resources especially in places where legal statutes do not significantly influence practice. Similarly, structural support, such as seats reserved for women, may not actually matter if women do not have the agency or the resources to get elected to office, or if the system will not permit them to have any real effect once elected to a position. Alternatively, patriarchal structures may serve as obstacles even with ample resources and strong self-efficacy.

Therefore, an operational definition of empowerment that combines these concepts of agency, structure and resources in terms of women’s status may be the most appropriate. For the purposes of this paper, women’s empowerment will therefore be defined as the degree of women’s personal access to, and control and influence over

material and social resources within the household, in the community and in the society.^{10, 11} Here, material resources may include food, income, land, and other forms of personal and family wealth, and social resources include education, power, class, and prestige.¹² This personal access, control and influence stem from a woman's agency and may relate equally to her perceived power to effect change as it does to her tangible wealth of resources.

Women's empowerment as a human right

While the goal is often to operationally define women's empowerment, it is necessary to understand the human rights framework that transcends socio-cultural distinctions and provides the basis and motivation for this concept. The United Nations (UN) Declaration of Human Rights explicitly states in Article 2 that "everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."¹³ The remaining articles spell out these rights and freedoms including, but not limited to, the right to education, the right to security, the right to recognition under law, the right to a standard of living compatible with good health and well-being, the freedom of movement, the freedom to willfully consent to marriage, freedom of thought and religion, and the freedom to assemble peacefully.¹³ Women's empowerment, essentially, is women's progressive realization of these universal human rights set forth by this declaration.

Women's rights as human rights have come to the forefront of international discussion particularly since the UN General Assembly adopted the Convention on All

Forms of Discrimination Against Women (CEDAW) in 1979. CEDAW specifies that women and men are entitled to “equal enjoyment and exercise of human rights and fundamental freedoms in civil, cultural, economic, political and social fields.”¹⁴

Furthermore, it goes beyond other human rights treaties by requiring states that ratify the Convention to take all appropriate measures to “eliminate discrimination against women by any person, organization or enterprise.”¹⁵ It also provides an international legal framework for women’s empowerment in the development process and specifically addresses issues of primary concern to women. Since the International Conference on Human Rights, held in June 1993 in Vienna, political will and international support for women’s human rights has increased substantially.¹⁵ As a result, the UN Commission on Human Rights appointed a Special Rapporteur on violence against women, and pledged its support to integrate the rights of women into the human rights mechanisms of the United Nations.¹⁴ Subsequent global conferences, including the 1994 Cairo Conference on Population and Development, the 1995 Beijing Women’s World Conference, and the 2000 Beijing Plus Five Conference on Gender Equality, Development and Peace for the 21st Century have offered reviews of international policies and programs and have re-examined their impact from a gender perspective.²

Overall, while it is important to note that the semantics of an operational definition of women’s empowerment may differ across cultures, the fundamental premise of empowerment is the achievement of these universal human rights to which all individuals are entitled. The movement by international institutions such as the UN to create a gender perspective to development programs through empowerment recognizes that women’s rights as a whole have yet to be realized. Therefore, it seems necessary to

operationalize empowerment to some degree in order to delineate specific barriers for women at the individual, family, community, national and international levels. By addressing these obstacles, the international community can tangibly and directly focus efforts to achieve these universal human rights.

What is the relationship between women's empowerment and health?

While the topic of women's holistic empowerment is not the specific focus of this paper, it must be noted that its relationship to health has been documented extensively in medical, public health, and social science literature. One might even argue that "women's empowerment" and "community empowerment" have become catch phrases for international programmatic efforts. It is necessary therefore, to discuss in brief, a few of the many studies that point to this relationship between the empowerment of women and health outcomes in part to justify the decision to narrow the subsequent study's focus to one of many elements.

One of the most notable contributions to our understanding of the relationship between women's empowerment and health stems from analysis of Demographic and Health Surveys (DHS). The data derived from DHS questionnaires are used to develop a number of indicators that measure women's status and empowerment.¹⁶ Most DHS data relating to empowerment are collected at the individual or household level and are often aggregated to obtain community-level indicators. Gender-related categories that are frequently analyzed in terms of empowerment include women's participation in household decision-making, hurdles to accessing health care, gender-role norms that

justify men's control over women, women's financial autonomy, marriage, employment and contraceptive use decisions, and encounters with domestic violence.¹⁷

A number of surrogate indicators have been combined in the attempt to assess empowerment. Demographic and health surveys, for example, use the age gap between a woman and her partner, whether a woman reads a newspaper/magazine at least once a week, whether she listens to the radio once a week, whether she is allowed to visit family and friends (with or without permission), whether she has decision-making control over health care issues, whether she has money set aside to use as she wishes, and whether she thinks domestic violence is justified, as the "empowerment variables."¹⁸ Other proxies such as health, education level, knowledge and employment are often used to demonstrate the process of empowerment. The distance between these surrogate measures and true empowerment, however, is one limitation of this method. In addition, the weight placed on any one indicator or combination of indicators varies depending on location and socio-cultural norms.

One specific study examines the relationship between women's decision-making and child health in twelve countries across the world. The authors, Desai and Johnson, defined empowerment in terms of whether women were making household decisions independently or not. The child health outcomes measured includes children's vaccination status, nutritional status, and child mortality. Desai and Johnson claim that empowered women, notably those with household power, will allocate more to child-oriented resources and health-enhancing behaviors. The study found that women's empowerment had a consistent positive effect on children's height-for-age and less of an effect on child immunization and child mortality.¹² The authors concluded that household

empowerment of women may have the greatest effect on day-to-day nutritional status of the children. In terms of other outcomes such as vaccinations and mortality, even empowered women would likely have to involve other household members in preventative measures, and therefore less of a direct effect may be observed. Additionally, this study found different strengths of the relationship between empowerment and child health by region with the weakest in sub-Saharan Africa and the strongest in South Asia. This validates the hypothesis that there are a number of factors that play into empowerment, including socio-cultural factors and political structures, which may account for these distinctions.

An additional study uses India National Family Health Survey data for Mumbai and Maharashtra, India and the Mumbai Safe Motherhood Survey to study the relationship between women's autonomy and use of maternal health care services.¹⁹ The study also made comparisons between slum and non-slum populations in the city of Mumbai and between urban and rural populations in the entire state of Maharashtra (where Mumbai is located). There were a number of important findings. Primarily, the study found that women who recently migrated to Mumbai's slums from rural areas have higher autonomy and better access to maternal care than women in non-Mumbai urban areas. Specifically, the authors found that direct individual measures of autonomy, as opposed to proxy indicators such as education, were positively correlated with maternal care. Interestingly, it was also shown that women's autonomy was a much stronger indicator of use and access to maternal health care when women were offered health care choices. The paper also emphasizes the need to look at individual-level factors when measuring empowerment, as opposed to relying purely on community-level indicators.¹⁹

A clear commonality in all of the literature that addresses this relationship between empowerment and health is the difficulty in defining and measuring empowerment and autonomy. Many studies tend to look to several categories of empowerment including economic, socio-cultural, familial/interpersonal, legal, political and psychological, and may further divide each by level—household, community, and broader arenas.⁴ However, this is frequently complicated by the fact that empowerment in one of the dimensions does not imply empowerment in another, and similarly, overlap both in the positive and negative direction can skew the independent effects of each. Further, the outcome of interest in each paper, beyond those discussed, varies significantly, ranging from child health, nutrition and mortality, to maternal care, nutrition and reproductive health. Thus, it is clear that while the definition and analysis of empowerment as a variable related to health varies across studies, the fundamental tenet that empowering women will directly or indirectly improve maternal and child health remains constant.

Studying Women's Empowerment through Political Participation: An Operational and Human Rights Based Justification

As demonstrated by the previous sections, women's empowerment is multi-faceted and difficult to define. It is undeniable however that the concept of agency, or the ability to participate in and advocate for change, if provided with the necessary social and material resources and structures, is essential to its realization. The ability to participate politically can be viewed as a reflection of decision-making and control at the household level, as freedom and empowerment at the community level, and as true achievement of the right to advocate for one's beliefs at the national and international

levels. Through both formal and informal channels, the ability to participate politically is intrinsic to holistic empowerment.

A human rights approach leads first to the aforementioned Universal Declaration of Human Rights, but also to the International Covenant on Women's Civil and Political Rights. The Covenant declares in Article 3:

“The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all civil and political rights set forth in the present Covenant.”

In addition, Article 25 states:

“Every citizen shall have the right and the opportunity, without any of the distinctions mentioned in article 2 and without unreasonable restrictions: (a) To take part in the conduct of public affairs, directly or through freely chosen representatives; (b) To vote and to be elected at genuine periodic elections which shall be by universal and equal suffrage and shall be held by secret ballot, guaranteeing the free expression of the will of the electors; (c) To have access, on general terms of equality, to public service in his country.”²⁰

The Convention on the Political Rights of Women, ratified in 1952, first explicitly conferred this right of political participation to women. CEDAW then restated this right in Article 7:

“States Parties shall take all appropriate measures to eliminate discrimination against women in the political and public life of the country and, in particular, shall ensure to women, on equal terms with men, the right: (a) To vote in all elections and public referenda and to be eligible for election to all publicly elected bodies; (b) To participate in the formulation of government policy and the implementation thereof and to hold public office and perform all public functions at all levels of government; (c) To participate in non-governmental organizations and associations concerned with the public and political life of the country.”

In Article 8, this right is further extended to the international level:

“States Parties shall take all appropriate measures to ensure to women, on equal terms with men and without any discrimination, the opportunity to represent their Governments at the international level and to participate in the work of international organizations.”²¹

The right of women to participate in the public, political sphere and to formally and informally exercise power and control over the allocation of resources seems central

both to basic doctrines of human rights, and to the roots of empowerment. Thus, a woman's ability to aid directly in the determination of policies that affect her and her family is fundamental to any definition of empowerment. One can also extend this interpretation to the relationship between empowerment and health. Specifically, the Alma-Ata Declaration of 1978 states that "the people have the right and duty to participate individually and collectively in the planning and implementation of their health care."²² This unequivocally confers this right to women as individuals in society, and guarantees their ability to advocate for better health. Moreover, it provides a basis through which women should be empowered politically, economically and socio-culturally to achieve this right. In addition, the People's Charter for Health reiterates the importance of empowerment in this domain by stating that "the participation of people and people's organizations is essential to the formulation, implementation and evaluation of all health and social policies and programs."²³ Therefore, for the purpose of this paper, the focus will be on this particular element of empowerment—political participation—in terms of its contribution to holistic empowerment and its relationship to health processes and outcomes. This paper will not argue for the use of political participation as a proxy for empowerment, nor will it aim to provide a comprehensive strategy to understand the process of empowerment through participation. Rather, political participation will be described as a critically important component of multiple elements of women's empowerment, from both an operational and a human rights perspective. Varying definitions and measurements of women's political participation, and its relationship to health will be discussed. Overall, the goal here is to demonstrate the intricacies and implications involved in empowering women to be advocates of individual, community,

national and international health-related change, rather than simply as the targets of policies and programmatic endeavors. Further, the need to better understand this concept from a qualitative perspective will be proposed.

What is political participation and how is it measured?

Political participation may be defined broadly by including knowledge of the political system and means of access to it, the right to vote, involvement in local campaigns and governing structures, representation in bodies of local and national government, and the ability to represent interests as a lobbying and voting bloc. When narrowing the definition to women, it is important to consider informal political participation, particularly at the community-level, where women may be especially involved.²⁴ This participation includes women's role in social networks, women's organizations and civil society, and may be equally as important in promoting change in communities where formal political channels are less open to women. Therefore, a more applicable definition of women's political participation may actually closely resemble political expression. This includes the rights women possess, formally and informally, to express dissatisfaction within their political and social culture, and their ability to be involved in all levels of the political process.²⁵

Political and civil rights are capabilities necessary to reach a high-level of well-being.²⁶ In terms of empowerment, political participation may be described from the individual, the household, the community, the national and the international levels. Individual and household participation refer to knowledge of the political system, domestic/spousal support for political engagement, participation in household economic,

reproductive and health-related decision-making, personal motivation for engagement in community level organization and civil society, and the desire to exercise the right to vote in elections. Community involvement includes participation in village meetings and local campaigns, advocacy efforts for specific issues or legislation, and actual representation and leadership in local government. National participation may include women's strength as a voting bloc, the ability to represent and transform women's interests and women's issues into effective legislation and simply, women's numerical representation as legislators. On the international level, as stated in CEDAW, participation includes the woman's ability to represent her country, to engage in the work of international institutions, and to rally for the rights and interests of women beyond the boundaries of her home-country.

Past studies examining political expression and participation tend to focus on the national level. Few investigate these issues at the individual or household level, or at the community level. Further, there are few if any systematic examinations of the interaction between domains. The most traditional measures of political participation have been quantitative and include the percentage of female seats in parliament, in government at ministerial level and sub-ministerial level, and the percent of female legislators, senior officials and managers (of total).²⁵ Some also include the number of women who voted in the last election. The UN Development Program's Gender Empowerment Measure (GEM) specifically ranks countries by women's access to political power and economic resources, particularly emphasizing the female share of parliamentary seats.²⁷ A comprehensive study of women's participation in Africa measured political participation in terms of a gender gap in leadership positions including government and legislature

seats, members of the judiciary, senior officers in the armed forces, and top managerial positions in media and in business domains.⁸

It is frequently noted that these measures do not account for women's participation in local or community politics where women across the world tend to be the most active, and specifically where their presence makes a definite, direct contribution.²⁵ It could be argued that the number of women in parliament for example, does not represent true participation of women, or the actualization of women's empowerment. Rather, these numbers may be more of a benchmark than a measure of empowerment. Also, there is no way to distinguish whether these women have the position in name only, as is often the case in India where women, under law, occupy one-third of government seats, but their actual power is often limited by social, cultural and political factors.²⁸ One particular study examined domestic violence against women in 36 countries and found no linear relationship between the number of women in parliament and antiviolence policies.²⁴ This too demonstrates that sheer numerical measurements of participation may not be sufficient for either empowerment or policy changes. Similarly, one might also argue that national-level measurements of female leadership may not have any direct bearing on the level of empowerment of women in the society.

Increasingly, there has been a call for more research examining community or local level participation of women. A quantitative human rights framework was proposed in one study that assessed community-level participation specifically in health through the question: "I am able to influence laws and regulations which regard health."²⁹ Additional questions looking at the equity and justice aspects were: "I am able to protest successfully against unfair laws and regulations" and, "I have the same rights as other

citizens in this country.²⁹ Priorities of women legislators have also been examined to some degree, specifically through a 1999 survey by the Inter-parliamentary Union of 187 women parliamentarians from 65 countries. This survey investigated women's perceived political power once in office, the motivations for leadership and the ability to have an immediate impact on women and children, particularly in health and education.²⁴ On the individual level, studies have attempted to link household decision-making power and education of both the woman and her husband with the ability of a woman to participate in community-level politics.³⁰ The intersection between individual and local politics can be seen in a study of village *panchayats*, or local Councils, in West Bengal. Here, the researchers examined women's participation in local politics by counting the number of questions, complaints and requests made by women at village council meetings.³¹ Further, a comparison was made between a village council with a woman *pradhan*, or leader, versus and male *pradhan* and there was a significant increase in attendance and participation by women at the former.³¹ The study also looked at women's engagement and understanding of the local political system and their perceived freedom to be involved as their measure of political participation.

As suggested, there are a number of limitations inherent in these measures of political participation both within a country and between countries. First, women's participation is often measured as representation in higher level decision-making positions. The problem here is three-fold. First, it assumes that participation is purely on the national level and that actual occupation of a seat is necessary for participation. Second, it implies that women who take political office have some level of decision-making power. There are a number of countries that require women to fill seats but these

women often serve as puppets, or play no role at all. Third, it ignores positions that women may more informally hold through which they may actually wield more political influence.⁸ In the end, quantitative measures of political participation at the national level provide only baseline measures to very broadly compare countries against each other. In terms of narrower measures of political participation, particularly as they relate to the community and local-level government, similar difficulties arise when trying to quantify the concept. Here especially, women participate through both formal and informal channels and by measuring the number of women who vote in a local election, or the number of women who attend a village council meeting, one ignores the influence of local women's groups and the role they play in political expression. Further, the intricacies of political participation may be more individual than community-based. Therefore, aggregates of individual measures may not actually be representative of true political participation and they may ignore key personal differences and influences. Overall, despite the inherent difficulties, by broadly defining women's political participation to encompass political expression at multiple levels, it may be possible to capture the critical features of involvement.

The Current State of Women's Political Participation: Statistics, Obstacles and Perceptions

Political participation of women through formal channels, for example, as representatives in governing bodies, is often measured as a basis for comparison across countries, and as a baseline figure to demonstrate the gender gap and encourage greater equity. As of July 2006, women account for less than 17 percent of parliamentarians, 14 percent of ministers and 6 percent of heads of government worldwide.²⁴ Ten countries

have no women parliamentarians and in more than 40 other countries, women account for less than 10 percent of legislators. Nordic countries rank the highest with women comprising 40 percent of parliamentarians, and Arab states rank the lowest with an average of less than 8 percent.²⁴ Annual growth rates in the proportion of women members of national parliament is estimated at 0.5 percent worldwide, meaning that if the rate remains constant, gender parity will not be achieved until 2068.³²

As mentioned in the prior section, in 1999, the Inter-Parliamentary Union (IPU) conducted a survey of 187 women parliamentarians from 65 countries. The results indicated that four out of five respondents believed that women held different conceptions of society and politics. More than 90 percent stated that women's greater participation would lead to change, and nine out of ten women believed that women's participation in the political process significantly altered political outcomes.³² A US-based study found that women feel a strong responsibility to represent other women and in turn, consider themselves more capable of representing their interests.³³ In general, women in political positions have proven to be advocates for women and children and have been shown to be more responsive to the concerns of all citizens.³³ At the national level women push for more gender and child-sensitive legislation. At the local level, studies indicate that greater investment is made in public goods and services, and in resources that benefit women and children.³⁴ One notable study in India showed that female leaders invest more in the public goods more closely linked to women's concerns such a drinking water and roads, and less in public goods more relating to men.³¹ In an analysis of women legislators in Latin America, female legislators were more likely than their male counterparts to sponsor bills on women, children and family issues, and have

worked to get these issues to the top of the policy agenda. However, it was noted that this effort was not exclusive to women and that men also prioritized these issues.¹

It has also been argued that women's representation can have an indirect influence by heightening the attention male leaders pay to policies geared towards women and children. This has been called the "critical mass argument" which is described as when an underrepresented group increases its presence in an organization, other groups begin to take on the concerns of the underrepresented groups until they become indistinguishable from traditional issues."³⁵ Along these lines, a study conducted by the Center for American Women and Politics found that the presence of women lawmakers made legislators of both genders more likely to consider how laws affect women, racial and ethnic minority groups, and the economically disadvantaged.³⁶ Similarly, it has been shown that if the policymaker is a woman, other women may be more likely to participate in the political process, and to raise issues and express concerns.³⁷

One must note however, that it is difficult to make accurate estimates of the true impact of women's participation on national politics. This in part is due to the fact that there are still so few women in political positions, and many have only recently been elected.²⁴ In addition, those in established positions may not actually wield true power if the dynamics of the existing political system are not welcoming to women. In keeping with this, it is difficult to quantitatively measure the impact of women legislators as an isolated good without also investigating the local social, cultural and political norms that are closely intertwined. Clearly, the understanding of national political participation must include better measures of local mechanisms.

As an extension of this, given the low percentages of women in political positions, one must address the obstacles that exist for women in this domain. Interestingly, most studies do not seem to examine this question qualitatively or otherwise. In India, there have been attempts to better understand whether the problem is structural, or rooted in socio-cultural norms. The country's policy as of 1992 (Constitutional Amendment Act 73 and 74), of reserving one-third of the seats in the *panchayats* (local Councils) for women has, to some degree, fostered this research. Despite this law, women still do not fill many of their reserved seats and still represent only 5.8 percent of all parliamentary seats in the country.³⁸ There are a number of reasons that have been suggested to explain this. One article cites difficult entry into the field, lack of training, and institutional hierarchies as the key obstacles. Specifically, the article describes lack of orientation and training, no prior experience or knowledge of the rules/municipal acts, no technical knowledge, lack of support from both male and female senior colleagues, less budgetary understanding, poor organizational structure of the party system, discrimination at the decision-making level, and lack of resources to sustain a political campaign.³⁸ Personal reasons such as fear and insecurity, lack of confidence in public speaking and family responsibilities were also mentioned. Overall, the analysis emphasized the critical point that constitutional provisions guarantee neither effective participation nor political equality.³⁸ Critiques also extend to the women's movement itself, stating that it created an organizational strength of women and increased the focus on women's issues, but never pushed for active participation in politics or real structural changes that would enable this.⁴

Other obstacles that are discussed, particularly in the countries where political participation of women is particularly low, include issues of women's status, religious factors, education level and socio-cultural concerns. While one may argue that women's lack of access to education and low literacy rates may be a primary limitation of participation, a study comparing women's participation in Africa with the rest of the world, found that the level of women's education is not a predictor of political participation.⁸ However, this does not mean that a base level of literacy and education are not necessary for participation. It refers to the fact that countries with higher aggregate levels of women's education do not necessarily have higher rates of political participation. Therefore, while a woman's education level may give her an individual advantage over a less educated woman, the collective level of women's education did not appear to improve political representation.⁸ Similarly, in India, it has been shown that even in the regions where women have better access to education and higher life expectancy, such as in Kerala where the proportion of women in the local legislative body does not differ significantly from regions with less favorable statistics.²⁸ This emphasizes the importance of the interplay between many factors, both individual and societal, that together serve as obstacles to realization of this right.

It has also been suggested that women's participation politically is intrinsically related to their position in the household. Specifically, if a woman is able to create independent space in the household, she is more likely to participate in political life.²⁸ In India, caste also plays a significant role in both household independence and in political participation. Age, household economic status, and women's perception of ability and

influence are also factors that have been shown to contribute to both formal and informal political participation in India.²⁸

One might also consider that there may be a fundamental difference in interest in political participation between men and women across the globe. The 2000 World Values Survey, looked at political participation, here defined as “any activity that has the intent or effect of influencing government activity” such as petition signing or participation in a demonstration. The results indicated that 39 percent of women demonstrated interest in politics whereas 52 percent of men did.³⁹ There were however, some countries, including Argentina, Philippines and Tanzania where men and women showed equal interest. In terms of participation, again, men were statistically more likely than women to participate, with a few notable exceptions including the US, Canada, Sweden, Argentina, South Korea, Israel, Tanzania, Vietnam and Egypt. However, noting the exceptions, again one must wonder if the difference is not an inherent, genetic difference between men and women, but rather a product of environmental circumstances that instills this participatory discrepancy. This need for a so-called “enabling environment” that promotes political, economic, socio-cultural, religious and educational equality is clearly fundamental to improving women’s political participation.⁴⁰

It is also important to understand the perceptions of women political leaders, by both men and women, as a contributing obstacle to their participation. There has been little qualitative research done on the subject, but preliminary survey-based studies do show some significant discrepancies in opinion and support of female versus male leaders. While both men and women tend to agree that women may be more in tune with maternal and child-related issues, when the leadership role is more typically male, bias

against women, by both genders, tends to be more pronounced.³⁰ Furthermore, a survey conducted in the US and in Western Europe demonstrated that overall women leaders are evaluated more negatively than male leaders with performance held constant.⁴¹ However, there are also studies that indicate the opposite opinion. A survey conducted in East Africa by the British Council in 2002, for example, found that more than 70 percent of people thought women performed better or as well as men, and more than 50 percent of people thought that women were less corrupt and were more interested in the basic needs of the community than their male counterparts.⁴² In a study looking at perceptions of leadership in villages in India with reservations for women, it was found that while women leaders were considered to be less likely to be corrupt, their overall performance was thought to be worse than men in terms of satisfaction with specific public goods.³⁰

This variation in perception may be due to a number of factors. First, there is little data on this specific subject, likely stemming from the fact that there are still very few women elected as political leaders compared to men. Second, one must consider that the women who do get elected have overcome many obstacles and may be extremely effective leaders and therefore are perceived as such.³⁰ Finally, it is possible that the countries where women's participation is substantial are overall more liberal and progressive and thus more accepting of the ability of a woman to lead as successfully as a man.

In addition, while primarily this section discussed women's participation in national-level, formal, political structures, women's involvement in local politics, both formally and informally, must not be ignored as a significant measure of political participation. However, there has been little research in this area, in part because it may

be more difficult to quantitatively assess in terms of both involvement and outcome. In reality, it is at this local level where women's greatest impact can be seen likely because many of the aforementioned structural obstacles may exist to a lesser extent.²⁴ Across the world women's groups have formed to both support women who have been elected to political office, and to conduct advocacy efforts on behalf of women, children and families. These women's groups provide valuable networking opportunities, and serve to advance the human rights of women in economic, legal, political, and socio-cultural domains. While most studies on local, formal leadership have taken place in India given their policy of reserving seats for women, research into informal women's groups has been more widespread investigating organizations in Afghanistan, Australia, Morocco, Mozambique Rwanda and Tajikistan.²⁴ However, it has also been argued that while these groups give women organizational strength, most do not have the explicit goal of increasing women's participation in formal political structures or making the political environment more accessible to women.³⁸

What is the relationship between women's political participation and health?

As mentioned, past research has shown that women's participation in politics, both formally and informally, tends to be geared towards advocacy for women, children and families. Evidence proves that women tend to support more liberal policies and greater spending on child care, education, health, nutrition and other child-related expenses.⁴³ However, this does not necessarily imply that because men and women have different policy preferences, that increased female representation will affect policy decisions. Therefore, a few studies have been conducted, with varying results that

specifically examine the relationship between women's political participation and health indicators, most often relating to women's reproductive health, child health or, to health-related public goods. This section will describe these studies and their outcomes in brief to provide the foundation for this research.

One particular study by Susanne Gleason, examined this link from a macro-perspective in India by investigating whether poor health outcomes have an impact on female political participation and conversely, if female participation in elections has an impact on health outcomes.⁴⁴ The study used a multiple non-linear regression model to determine that income, acceptance of females in office and education of women all had statistically significant influences on participation. Interestingly, the study also found that areas with higher numbers of teachers had a negative impact on participation, while areas with higher numbers of doctors per capita had a positive effect. In terms of impact of political participation on health, Gleason chose to look specifically at child survival as her basic measure of health outcomes. She assumed that female literacy, female labor force participation, income distribution and the presence of minority groups all affect child survival. Three indicators of political participation were used: the proportion of district constituencies that had a female member of the legislative assembly divided by the proportion of the voting age population that is female, the ratio of female to male votes, and the ratio of female to male candidates. The data used were from the 1977-78 election and from the 1981 census data. The results from regression modeling failed to show a statistically significant relationship between political participation and child survival. However, Gleason points out a number of limitations of her study including the overall low representation of women in state legislatures and the fact that the district-

level analysis may be too aggregated to see an impact on this specific health indicator. Further, she emphasizes that these results should stimulate greater research into the subject, particularly at the local, community level.⁴⁴

Also in India, a study conducted by Beaman, Duflo, Pande, and Topalova, looks at this relationship between participation and health by focusing specifically on the allocation of public health-related goods by female politicians.³⁴ The study uses data from an all-India survey to compare villages reserved for women *pradhans* with those that are non-reserved, and examines specifically two Indian states in West Bengal and in Rajasthan, in terms of public goods and child-health outcomes. An additional arm, a survey in West Bengal specifically examining child health and development at the household level, is ongoing. The study focused on the lowest level of local governance in rural India, the *Gram Panchayat*. The results thus far show that villages reserved for women *pradhans* have more public goods, and the quality of these goods is at least as high as in the non-reserved villages. Comparing the two Indian states, in villages led by female *pradhans*, child immunization rates were higher, there was better access to drinking water, and girls had improved school attendance.³⁴ In West Bengal, female *pradhans* invested more in goods directly relevant to the priorities of women and children, notably, water and sanitation infrastructure. This is particularly significant, considering that water-borne and diarrheal diseases account for more than 1.8 million deaths of children under five each year.⁴⁵ In addition, according to the most recent National Family Health Survey, India's version of the Demographic and Health Survey, full immunization rates vary from 30 to 35 percent in rural areas and from 53 to 57 percent in urban areas.⁴⁶ Therefore, the authors emphasize that it is particularly striking,

given these inadequate rates, that women leaders tend to increase the likelihood of complete immunization. The results of this study, specifically the increased allocation of health-related public goods in villages with female *pradhans*, were consistent with the findings of an earlier study also conducted in West Bengal and Rajasthan, by Chattopadhyay and Duflo.³¹ The Chattopadhyay and Duflo study also demonstrated that in West Bengal, women *pradhans* invested more time and effort into duties relating to health such as organizing public health campaigns and monitoring providers at public health facilities.³¹

However, another study, also in India, looking primarily at local level political participation and comparing all-women to all-male *panchayats*, demonstrated a variation on these aforementioned findings. Similarly, they found that women leaders successfully allocated resources towards improved drinking water and water for agriculture. In addition, as a whole they showed that women tend to view women's issues as closely intertwined with community issues and therefore automatically link their community's interests to women's interests.^{47, 48} But the study also found that while all-women *panchayats* were successful at addressing women's "practical" needs, they were not successful with respect to so-called strategic, more paternalistic issues. Specifically, the women's *panchayats* were largely unsuccessful at addressing rape, unequal wages between men and women, dowry, and alcoholism.⁴⁹ These issues challenge male authority more directly, and are more linked to gender-interests than to community interests. This emphasizes the reality that the influence of women's political participation on improved health and social goods cannot be examined in a political, social or cultural

vacuum and that there are other environmental and institutional factors that directly confound this relationship.

Another study, conducted in the US looked indirectly at political participation as one of four measures of women's status in terms of its relationship with child well-being. In this ecologic analysis of the 50 United States, women's status was measured using women's political participation, economic autonomy, employment and earnings and reproductive rights. Child well-being was assessed through five outcomes: percent of low birth weight babies, infant mortality, teen mortality, high school dropout rate, and teen birth weight.⁵⁰ Women's political participation was associated with a statistically significant lower percentage of low birth weight babies and of teen birth rates. Overall, higher state-level women's status across all indicators was associated with better state-level child well-being.⁵⁰

In addition to child health or public good outcomes, there are a few articles that examine the relationship of women's political participation to family planning and women's reproductive health. A systematic review, written by Dixon-Mueller and Germain, looked at the role of "feminist political action" in the formation of population policy in Brazil, Nigeria and the Philippines.⁵¹ The authors examined the feminist movement in these three countries in terms of its ability to successfully influence policies on integrated women's health and family planning. Here, the interplay between formal and informal political participation, particularly through women's organizations and civil society, is particularly apparent. The institutional contrasts between the three countries, particularly with respect to the stage and strength of the feminist movement and the socio-political environment, clearly influenced the extent to which the women's voice

was heard in the development of the national population programs. Brazil proved to have the most successful movement in terms of specific health-related influence on government policies, in part attributed to the political atmosphere of the country, and the coherence of the women's movement. In the 1980s, Brazil's women's political advocacy movement was organized around four central health-related issues: the quality of primary health care for rural women, informed choice for women regarding family planning, the availability of contraceptives, and the legality of abortion services.⁵¹ The government's response included the appointment of a number of Brazilian feminists to high-level national councils, the development of the Integrated Women's Health Program and the Policy on Women's Health and Family Planning offering a range of birth control methods through social security services. In addition, the National Council for Women's Rights was established to write a new Brazilian constitution, and 26 of the 559 members were women who used their role to explicitly advance a feminist agenda on reproductive rights. While there were still many obstacles to the implementation of the women's agenda, notably the Catholic Church's position on reproductive rights, the dialogue between feminists and the formal political infrastructure of Brazil did lead to the institutionalization of a woman's perspective on women's health and rights in the country. This provides further evidence of women's political contribution to health, in a historical context.

The link between women's empowerment in reproductive health and in the political domain has also been examined in a programmatic context in Plateau State, Nigeria. Here, a collaborative effort between the Center for Development and Population Activities (CEDPA) and the Enable Project ("Enabling Change for Women's

Reproductive Health”) examined the relationship between women’s participation in a reproductive health project and their involvement in democracy and governance (DG) activities. The project defined DG activities as women’s rights, party membership, participation to protest and registration to vote. The study also looked at women’s empowerment (defined here as mobility, household decision-making, right to refuse sexual activity, household socioeconomic status, and husband-justified beating), and the husband’s influence on women’s empowerment, reproductive health and DG activities. The goal of the reproductive health component of the study was to promote an “enabling environment that strengthens women’s informed and autonomous decision making” through an integrated package of reproductive health services, the training of community health workers, and encouraging community participation and coalition building for women’s reproductive rights.⁵² The authors hypothesized that women who were exposed both to DG and reproductive health activities would have more favorable reproductive health practices than those who were unexposed, especially among those women with supportive spouses.⁵³ The study findings validated this hypothesis demonstrating that intention to use family planning was 56 percent greater among those women exposed to DG activities, and DG participation was 79 percent higher if a woman was visited by a community health worker. The study also showed that women’s intention to use family planning was almost twice as high for women with husband-permitted high freedom of mobility.

The findings of this study support the idea of linking interventions that improve women’s health with those that improve political participation. In addition, the authors demonstrate the importance of male support for female participation, at both leadership

and household levels, to achieve health-related goals. Further the study affirms that increased political participation may lead to greater decision-making autonomy for women that in turn, may translate into greater reproductive health equity with her spouse.⁵³ The authors did note however, that further investigation into this link between women's political participation and reproductive health should be conducted, preferably in a region that is more politically stable than Nigeria.⁵²

Finally, in addition to child health indicators, health-related public goods, and reproductive health, political participation of women has been associated with psychological health and well-being. One particular study used data from the US-based National Longitudinal Study organized by the Bureau for Labor Statistics of the Department of Justice to determine the relationship between a number of health and political involvement variables among a cohort of young women between 1983 and 1993.⁵⁴ Specifically, the author looks at how political engagement may affect individual-level mental health outcomes. The author emphasizes that this relationship between psychological health and participation is rooted in efficacy theories, specifically those espoused by Albert Bandura. Bandura states that “the inability to influence events and social conditions that significant affect one's life can give rise to feelings of futility and despondency as well as anxiety.” Furthermore, he involves political participation by arguing that people are proactive beings, and should “have a hand in shaping their own lives and social systems that organize, guide and regulate the affairs of their society.”⁵⁵

In this study, the author focuses on the relationship between measures of participation – participation in voluntary associations and participation in activities to address workplace discrimination – and measures of mental health – psychological

distress and depression. The longitudinal nature of the data allowed for a demonstration of mental status both prior to and post- political engagement. Statistical analysis conducted provided support for the claim that political participation assists psychological well-being. However, while participation in voluntary associations was not among the most significant predictors of freedom from psychological distress, the ability to “fight back” did prove to be significant in this respect.⁵⁴ Despite the limited external validity of this study, the author concludes, possibly most importantly, that political activity may be a resource that will offset the negative psychological impact associated with disadvantaged social status. Therefore, one could extrapolate that in countries where women still suffer from oppression, improved political participation may provide one avenue to improve that, and simultaneously, may reduce the psychological harm.

It is evident from the aforementioned examples that there has been some effort internationally to investigate this relationship between political participation and health. However, data remain scarce and somewhat conflicting outcomes and numerous confounders of this relationship are obvious limitations. Across the board though, the motivation to continue to investigate this link remains and the desire to both examine and improve women and child’s health through women’s empowerment appears unanimous.

Focusing on the household and the community: Can the link between political participation and health be better examined here?

From the discussed studies regarding both health and non-health related measures of political participation, it is evident that nation-wide markers and aggregate data may not accurately reflect the individual limitations, perceptions and influence of women’s

political expression. Rather, assessing both formal and informal channels of political participation at the community level and even in the household may better reflect the influence that women's advocacy could have on health. This is particularly important as women's specific contributions to health both in the household and in the community frequently go unmeasured since most often they are unremunerated and therefore not counted in national level data.⁵⁶ However, studies have shown that female headed households benefit children, particularly girls, with respect to health and education.²⁴ A study in rural Bangladesh demonstrated that enhanced household autonomy and authority for women significantly decreases both post-neonatal and child mortality.⁵⁷ Furthermore, Demographic and Health Survey data reflected by studies measuring women's empowerment, show that much of the impact of women's overall decision-making power is concentrated at the community level.²⁴ Again, this power can be expressed through formal channels such as election to local office, or through informal channels such as participation in town meetings and women's groups. One may hypothesize that at this local level, informal participation may be more accessible to women in part because it is less restricted by economic boundaries, education level, and socio-cultural norms.

Women's community participation is often described as the central avenue through which women engage in political and service work to improve their own lives, their families and their communities.⁵⁸ From a sociological perspective, this participation is described as a reflection of a woman's ability to negotiate power in the household and in the community.⁵⁸ Similarly, research suggests that women are more drawn to "connectivity, collectivity and community consciousness" as their form of political participation, while men are more focused on political office or political organizations.⁵⁸

It has even been suggested that participating in the community, formally or informally, often becomes an extension of a woman's identity as the caretaker in the private sphere.

While preliminary efforts have been made internationally to study community and household participation of women, published studies that look at women's specific health influence in this domain have primarily occurred in India. This is likely due to a number of factors. First, India's government structure has been a stable, parliamentary democracy for over 50 years and therefore participation can be easily studied. Second, while women have had the right to vote since the ratification of the Constitution in 1950, true socio-cultural, political and economic equality have been slow to follow.⁵⁹ Thus, progress over time, especially following specific interventions, is possible. Third, in 1992, the Indian Parliament passed the 73rd and 74th Constitutional Amendments that reserved 33 percent of seats for women at the local government level. As a result, it is estimated that 5 million women have entered local politics directly or indirectly since the passage of this law.⁶⁰ In addition, women have also joined informal channels of politics, particularly women's groups, in part to help create an enabling environment to promote formal election to local political office. However, as discussed earlier in this paper, one must recognize that women still face many obstacles to full participation, despite these amendments and the nature of India's liberal democracy. Regardless, the existence of a structural, legal mechanism for women's participation in the community has provided the impetus for a number of preliminary investigations into its impact on health, rural development, poverty alleviation and gender equality.⁶⁰

Specifically, studies have looked at women's individual perceptions towards participation, the impact of local women leaders on public goods allocation, the influence

of local leadership on child mortality, and the interplay between civil society, feminist groups, and formal government structures in enacting change. In addition, household level surveys throughout India have considered the positive influence of women's decision-making power on child health.⁴⁴ Increased participation of the entire community, particularly women, in planning, advocating and meeting health care needs has also been suggested to be central to reducing neonatal morbidity and mortality.⁶¹

Other studies also in South Asia have indirectly examined participation through the formation of women's groups and their influence on health outcomes. In Nepal for example, participatory women's groups were found to reduce maternal and newborn mortality and to improve perinatal care practices.^{62, 63} The formation of women's groups and specifically, the empowerment of women in the community through economic and educational opportunities, are also prevalent in Bangladesh. One particular study demonstrated that children of women who participated in women-focused development programs had a statistically significant reduction of hazard of death during infancy compared with women who did not participate.⁶⁴ Also in Bangladesh, a study investigated whether women's participation in rural credit programs influenced their demand for formal health care. The findings showed that women's participation in these programs did result in increased control over resources for their demand for and use of formal health care.⁶⁵

Overall, it is apparent that women's participation should be measured both formally and informally, and that the household and the community serve as key avenues for political expression. Studies remain rather limited in this area, particularly those that look at these channels qualitatively to understand why and how some women choose to

participate and others do not. In addition, the interplay and overlap between community empowerment, informal women's groups, civil society, local representation and national participation has yet to be studied formally. Similarly, the role of self-efficacy and perception by both women and men, in terms of decision-making capability and health advocacy in the home and in the community has not been a focus of past research in this field. In order to fully empower women by encouraging them to participate politically to advocate for their own health and the health of their families, it seems imperative that we have a more comprehensive understanding of these issues.

Defining women's health agency: the bridge between women's participation and health

One could argue that the link between women's political expression and both personal and community health is best studied and understood through the concept of women's health agency. Agency, as described earlier, can be interpreted in many ways. In this context, one might rely on a simplification of Amartya Sen's definition of agency as "voice," and here, critical agency as critical voice.⁶⁶ He specifies that the realization of women's agency "relates not only to the freedom to act but also to the freedom to question and reassess," which he deems central to development.⁶⁶ Health agency, as defined by Jennifer Ruger, refers to "individuals' ability to work towards health goals they value."⁶⁷ Here we aim to incorporate these interpretations into the study of women's health agency, or the self-efficacy, freedom, and ability of a woman to question, participate and act to improve her own health and that of her family.

There are a number of external factors that also must be considered in order to appropriately assess women's health agency. These fall into two main categories- the

health norms of the society and the level of functioning of the existing health system.⁶⁷

The former refers to the culture of the society and its view of health and well-being, the political environment that either promotes or restrains women's agency, and the degree to which the existing structures facilitate healthy functioning. The latter refers to the structure of the health system, the level and quality of the resources provided, and the accessibility of healthcare to the community. Here, resources include not only health care services, but also the infrastructure intricately tied to the ability to access the services, the financial resources that enable a family to afford the services and the overall availability of proper sanitation, electricity and clean water that are essential for healthy living. The key here is the need to sufficiently appreciate the functioning of the health system and the political and health-related norms of the community, in order to both understand and encourage women's health agency.

In the current literature there is no evidence of any specific formative study examining this concept of women's health agency. Therefore, the following study attempts to fill the gaps described throughout this literature review by examining this idea in the context of women's political participation and its influence on the health of the local community. To understand women's health agency in general, an appreciation of both male and female perceptions of women's self-efficacy and autonomy are central. As described in this section, one must also have an understanding of the norms and expectations of participation in the community, politically and otherwise, to improve health.⁶⁸ Finally, an appreciation of the existing health resources, both relating to general infrastructure and the health system itself, is intrinsic to truly defining and understanding and assessing women's health agency.⁶⁹ Therefore, the following study will be guided by

the themes of participation, autonomy, agency/self-efficacy, and health systems, as the framework to examine the complex relationship between women's participation and health.

Statement of purpose, hypothesis and objectives of this study

The purpose of this formative research study is to better understand both female and male perceptions of the role of women's political participation in the improvement of health at the household and community levels. To achieve this, the specific components of health agency, as defined in the prior section as autonomy, self-efficacy, local health-related norms and health systems, will be addressed. Additionally, the influence of a local neonatal health project on these aspects of women's health agency will be studied by comparing qualitative data from villages that were randomized to intervention and non-intervention groups. Ultimately, the goal of this research is to propose recommendations for future empowerment interventions to better understand and directly promote political participation of women. It is the hope that this will have a synergistic effect, improving both women's participation and the project's health-related goals.

Public health problem to be addressed

To broadly and comprehensively understand public health problems, one must consider the issues in all spheres— social, cultural, political, and economic—and at all levels—individual, household, community, national and international. The concept of female empowerment as it relates to health pervades each of these spheres and crosses all of these levels. The definition of women's empowerment often varies by the project or program goal. Underlying all definitions is the fundamental tenet that women's rights are human rights, and the progressive realization of these rights is the process of empowerment. However, looking at empowerment from a public health standpoint, one aims to analyze it in terms of a measure, a process, or an outcome. The most

comprehensive operational definitions of empowerment include three central concepts: agency, resources and structure.^{4,5} Integrating these, empowerment will here be defined as “the degree of women’s personal access to, and control and influence over material and social resources within the household, in the community and in the society.”^{10, 11} Here, material resources may include food, income, land, and other forms of personal and family wealth, and social resources include education, power, class, and prestige.¹² This personal access, control and influence stem from a woman’s agency and may relate equally to her perceived power to effect change as it does to her tangible wealth of resources. This definition also implies that the structures, both formal and informal, create an enabling environment for women’s empowerment.

Numerous studies, many using questions elicited through the women’s empowerment component of Demographic and Health Surveys (DHS), have demonstrated clear relationships between improved women’s empowerment and improvement of child health and women’s reproductive health.¹⁸ Some studies have specifically considered women’s political participation and expression, both formally and informally, to understand how enhancement of this critical aspect of empowerment could similarly improve the health of both women and children.³⁴ The ability, or inability of a woman to advocate on her behalf, and for her family, both formally and informally, and at all levels, will be the focus of this study. The hypothesis is that if women are empowered in this way, not only will they be able to directly advocate for the health of their children, but they will heighten the awareness and attentiveness of the entire community to child health concerns. In so doing, both men and women will be

empowered and the threshold for care-seeking will be lowered, in turn improving processes and health outcomes.⁷⁰

Interventions used to date

There have been a number of examples of women and child health-related projects that have aimed to empower women in all domains with the goal of improving health outcomes. The formation of women's groups to encourage informal and formal participation in health decisions has been central to these interventions. Possibly the seminal example is the Warmi Project in Bolivia consisting of two projects—La Casa de la Mujer in Santa Cruz and the Kumar Warmi (Health Woman) clinic operated by the Centro de Informacion y Desarrollo de la Mujer (CIDEM) in El Alto— both of which rely on women's groups to improve reproductive health.⁷¹ These projects incorporate women in all levels of decision-making, and emphasize participation in health care as one critical aspect of empowerment. Moreover, the missions of both groups include the achievement of women's political, social, legal and economic rights and affirm the reciprocal relationship between this and women's reproductive and sexual health.⁷¹

Another key example of the success of women's groups, particularly as they relate to maternal/child health, stems from interventions in Nepal where participatory women's groups were found to reduce maternal and newborn mortality and to improve perinatal care practices.^{62, 63, 72} Examples of women's group formation and specifically, the empowerment of women in the community through economic and educational opportunities, are also prevalent in Bangladesh. One particular study demonstrated that children of women who participated in women-focused development programs had a

statistically significant reduction in hazard of death during infancy compared with women who did not participate.⁶⁴ Also in Bangladesh, a study investigated whether women's participation in rural credit programs influenced their demand for formal health care. The findings showed that women's participation in these programs did result in increased control over resources for their demand for and use of formal health care.⁷³

An additional, relevant past intervention took place in Plateau State, Nigeria as a collaborative effort between the Center for Development and Population Activities (CEDPA) and the Enable Project ("Enabling Change for Women's Reproductive Health"). This project, as discussed in the prior section, explored the relationship between women's participation in a reproductive health project and their involvement in democracy and governance activities. The authors of this study suggested that "the teaching of civic responsibility and duties within a women's empowerment environment of advocacy and social mobilization should be incorporated into all women's reproductive health programs."⁵² This potentially synergistic effect between women's empowerment through political participation and a community health intervention will provide the foundation for this qualitative research study.

Impact and behavioral models

To understand the relationship between the study itself and its ultimate goals, both behavioral and impact models were developed (Figures 1 and 2). The behavioral model (Figure 1) is a variation on the Health Belief Model.⁷⁴ This model was chosen as a guide to link individual perceptions of self-efficacy with the ultimate goal of increased political participation of women in the community. Here, it is shown that a greater understanding

of women's individual perceptions of barriers and motivations to political participation and expression will increase their likelihood to advocate for the improved health of their family. This advocacy in turn will increase the entire community's attentiveness and awareness of health issues in particular, and will lower the threshold to action thus improving health outcomes. The impact model (Figure 2), demonstrates the relationship between community health needs and community participation, and the hypothesized impact that this participation and empowerment may have on health outcomes.

Study Objectives

- 1) To qualitatively assess male and female perceptions of motivations, limitations, opportunities and efficacy regarding women's formal and informal political participation at the community level.
- 2) To determine the key components necessary to evaluate, define and improve women's health agency.
- 3) To understand the relationship between a preexisting community-based participatory health intervention and the central themes behind women's health agency.

Methods

Site and population

This study took place between October and December 2007 in the Shivgarh Block of the Rae Bareilly District in Uttar Pradesh, India (Figure 3). The population of Shivgarh is approximately 104,100 over an area of approximately 200 square kilometers. Shivgarh is entirely rural and resource poor with an economy that is mostly agrarian-based.⁷⁵ The caste and religious distribution is similar to the national statistics. Caste structures in Uttar Pradesh (UP) are particularly prominent when considering both formal and informal interactions both among women and between women and men. It has been argued that the preservation of this caste system is in part the attempt to maintain male status and political and economic control over women.⁷⁶ In addition, despite some political reservations by caste, women who have participated politically through formal structures are mostly from the highest caste.⁷⁷ Thus, a true understanding of women's political empowerment among the lower castes may be difficult given the structural traditions of this specific region.

In terms of Shivgarh's health infrastructure, a government-run Community Health Center and three Primary Health Centers serve the entire population. Community health workers, or Asha workers, are also government sponsored and recently, have become increasingly active in the area. Hindi is the regional and official language of UP and is spoken by approximately 90 percent of the population. Awadhi, a dialect of Hindi, Urdu and Bengali, are also spoken in parts of UP. In Shivgarh, villagers speak a mix of Hindi and Awadhi, but those that speak Awadhi understand Hindi. From an international perspective, over 20 percent of child mortality worldwide occurs in India. Over 70

percent of child mortality occurs during infancy, and, neonatal and perinatal mortality are responsible for 60 percent of infant mortality.⁷⁸ UP is the most populous region in India, and also has one of the highest rates of infant mortality with 74.7 deaths per 1000 live births.⁷⁹

A general understanding of India's broader political system and the rural governance structure at the local level is also significant. India gained its independence from British rule in 1947 and was declared a republic in 1950. The country has a federal government system consisting of 25 states and 7 union (central) territories.³⁸ Each state has its own government and state activity is divided between the union and state governments. Both have parliamentary forms of government with executive power held by a Council of Ministers led by the Prime Minister. This structure is the same in each state. There is a head of state as well who is an indirectly elected President. India also has a bicameral parliament with a Lower House (directly elected by the people) and an Upper House (permanent with one-third of members retiring every two years).³⁸

The local government structure differs for urban and rural communities. Urban bodies consist of three levels- municipal corporations for cities with population greater than 0.3 million, municipal councils for towns smaller than this, and *panchayats*, or local councils, for villages that are transitioning to townships. Rural bodies, which are especially relevant to this study, have three tiers- village *panchayat* at the village level, block *panchayat samiti* for 100 villages and a district council for an area of approximately 1000 villages. These rural bodies do not have many of their own resources and thus are dependent on state funds and serve more as implementation arms.³⁸ In only two states, Kerala and West Bengal, have local governments been given control over

their own budgets.⁸⁰ In addition, India supports a closed, extensive and hierarchical civil service. Attempts at reform have included a recent freeze on vacant civil service posts, and a 16-year campaign to decentralize power moving it to *panchayats* and decreasing the bureaucratic center.⁸⁰ However, there has been little success thus far. Testimonies from individuals in northern Indian communities have shown the civil service, and particularly the elite Indian Administrative Service, to be extremely powerful, but also inefficient, unaccountable, corrupt, and in need of reform.⁸⁰

Political parties are also significant players in the political structure of India. There are both national parties (those recognized by four or more states) and small regional parties. Identities of the parties are organized along a number of lines ranging from caste affiliation, to historical ties to political figures, to religious ideology, to economic philosophy. There are frequent and shifting alliances between smaller, local parties and the four main national parties- Bahujan Samaj Party (BSP), Bharatiya Janata Party (BJP), Indian National Congress (INC), and Nationalist Congress Party (NCP).

The role of women in Indian government has both historical and current relevance. Historically, India has been home to strong female leaders, most notably Indira Gandhi. Despite this, female representation in Parliament's Lower House has ranged from 3.4 percent to 8.1 percent, with a current 7.4 percent. In the Upper House, women representatives ranged from 5.8 to 11.8 percent.⁸¹ Women also make up a low percentage of the civil service (7.5 percent in 1997).³⁸ In 1992, India ratified the Constitutional Amendment Act 73 and 74 which reserved one-third of *panchayat* seats for women. However, despite this institutional provision, women still do not fill many of their reserved seats and still represent only 5.8 percent of all parliamentary seats in the

country.³⁸ In the 1998 general election, the region of Uttar Pradesh had the largest number of women candidates (56) and the largest number of women elected (9).³⁸ Currently, Rae Bareilly (where the villages of Shivgarh are located), is the constituency of female National Congress Party leader Sonia Gandhi, and Uttar Pradesh is led by Mayawati Kumari, who is notably the first female, *dalit*, Chief Minister of the Bahujan Samaj Party (BSP). Both women are strong yet controversial figures and it is hypothesized that their leadership role in the region of this study has a significant influence on local perceptions and norms.

Programmatic and community context

This study was nested within a community-based cluster-randomized controlled trial established to examine the effects of home-based essential preventive newborn care. The original trial was conducted by the *Saksham* (“Empower”) study group, a collaboration between Johns Hopkins Bloomberg School of Public Health and King George Medical University, Lucknow. The parent study consisted of three intervention arms: (1) a comparison group which received the usual government services and was engaged to some degree by a number of international and local NGOs including CARE and PATH, (2) an essential newborn care intervention including the introduction of skin-to-skin care through community mobilization and behavior change and (3) the intervention in group (2) with the addition of Thermospott to understand hypothermia in the newborn.⁸² This study only involved individuals living in villages that were randomized to either the first comparison arm, or the second intervention arm. Additionally, one village engaged in this study was originally a comparison village

however recently the community-based essential newborn intervention has been introduced.

This community-based project that examines birth preparedness and essential newborn care also served to mobilize both male and female community leaders who were dedicated to promoting newborn health. Thus far, a significant number of both women and men have emerged as leaders and participate on a project-specific community health advisory board. Moreover, there is significant overlap between both the women and men who are health leaders and those who are in elected district-level political positions.

Qualitative team, IRB approval and consent process

The data collection team consisted of the study coordinator/focus group leader, a community organizer from Shivgarh who worked previously for the *Saksham* study group, and an independent Hindi and Awadhi-to-English translator. The community organizer and the translator were both male, and given the traditions of the villages, they both accompanied the female study coordinator at all times.

Institutional Review Board approval for this study was obtained from Yale University School of Medicine (HIC#0707002895), Johns Hopkins Bloomberg School of Public Health (IRB#00000545), and King George Medical University, Lucknow. All consent forms were translated and back-translated into Hindi. Once recruited, each individual was read the entirety of the consent form in Hindi. Ample opportunity was given to ask questions after each section. Each person was asked to make marks in the designated boxes, and to sign the final pages of the consent form. Most participants asked to have the interviewer or the community organizer make the mark on their behalf. There

was always, at minimum, one witness to this procedure, and more often 2-3 witnesses.

All individuals who were recruited consented with the exception of two men who decided against participating and thus were not included in the focus groups. One man stated that he did not have the time to participate and the second man noted that he had participated in groups like this in the past and never saw any changes come to his village and thus did not want to participate.

Data collection procedures and sample

Villages chosen at random from a list of intervention and non-intervention villages (pre-randomized by the parent study) were visited by the data collection team and the community organizer, and with the help of a village elder in each specific hamlet, participants were recruited for this study and gathered together at the hamlet's center. All data collection began at 11am to accommodate the women and men who spent their mornings in the field, and ended around 5pm as the villages had no electricity. Recruitment was based on approximate age and gender and a brief conversation between the village elder, the community organizer and the individual regarding the extent of their participation in the *Saksham* study group, and in the non-intervention villages, the extent of their participation in local government or in another NGO's community-based intervention.

Prior studies that involved women in rural India and addressed sensitive issues suggested that the most effective strategy to stimulate discussion were focus groups with between three to five participants.⁸³ In addition, one goal of this study was to provoke discussion both among men and women on issues such as autonomy and self-efficacy,

which are rarely discussed openly in the traditional villages. Therefore, small groups were chosen over one-on-one interviews to introduce these topics publicly and to potentially fuel future spontaneous conversations. Further, reviews of the literature suggest that women's groups tend to be the most accessible means of political participation and advocacy for women at the community level. It was assumed that in some of the villages where this study was taking place, this concept of women's groups would be new. Therefore, by creating this group structure and promoting discussion about advocacy, there was a hope for some potential sustainability and natural future extension of this method by the villagers themselves.

A total of 78 individuals participated in the 18 focus groups. Each group had between three and five participants. There were eight focus groups conducted in non-intervention villages and eight in intervention villages. Two additional focus groups were conducted in one village that was formerly a non-intervention village but recently received the intervention. In both the intervention and non-intervention villages, there were an equal number of male and female focus groups, and an equal number of young (age 18-36) and elder (age 40-78) groups. The age division between the "young" and "elder" groups was largely made by the villagers themselves. The elder women's groups included women who were now mother-in-laws and chose to categorize themselves as the village elders. Similarly, the elder male groups largely consisted of men with grandchildren who categorized themselves as elders. Many of the participants did not know their exact age. In addition, attempts were made to separate groups of women who were deemed to be active participants either in *Saksham* or other community-based interventions from those who were less active, and to have similar numbers of both

groups. However, oftentimes this distinction was not clear-cut, and did not become apparent until deep into the discussion. Initial questions were also asked regarding each individual's literacy, education level completed, marital status and number of children of each sex, however there was no inclusion or exclusion criteria based on this information.

Depending on the village, the focus groups were either held in a room of the home of a village elder, or right outside a home. Women's groups were most often held inside a hut, when available, given the traditions of the villages, whereas the men's groups were often held outside. Attempts were made to have each group be as private as possible.

The structure of each focus group consisted of an introduction and brief description of the study after which the ground rules were set for the group. Following this, eleven scenarios that differed slightly for the male and female groups were presented and discussed (Appendices 1 and 2). Discussion was facilitated by the study coordinator and the translator. Each focus group lasted for approximately one hour. Thorough notes were taken during each group and every session was tape recorded and transcribed the same day. The tapes were erased each day following transcription.

Specific focus group scenarios were developed based on knowledge obtained from *Saksham* study group ethnographies, past study tools found in the literature, and research of local politics, customs, and current health conditions. The scenarios for both men and women addressed the four themes described in the previous section to be central to an understanding of women's health agency- participation, autonomy, agency/self-efficacy, and health systems. Within each theme, the following key issues were both directly and indirectly discussed:

Participation

- General attendance at village council meetings
- Difference in attendance and participation with a female versus a male *pradhan*
- Difference in attendance and participation if other women are present and participating
- Priorities at the meeting and differences in issues raised and supported by women and men
- Differences in issues prioritized by a female versus a male *pradhan*
- Participation in NGO projects and governing boards
- Past and present participation in women's groups
- Specific actions of these women's groups
- Perceived efficacy of women's groups, motivation for participation and priorities of the groups
- Support by village elders and husbands for women's formal and informal participation
- Perceived differences between women and men who actively participate and those who do not
- Obstacles to participation for women and men
- Perceived influence of participation
- Perceived relationship between participation and health goals for women and children
- Overall priorities and goals of participation
- Relationship between education and participation
- Relationship between poverty and participation
- Relationship between caste and religion and participation

Autonomy

- The freedom to attend and participate in village council meetings with/without permission
- The ability to go to the doctor, or take children to the doctor with/without permission
- The ability to seek medical care for oneself or family unaccompanied
- The ability to learn about candidates and make independent issue-based decisions
- The ability to vote in elections for a different person than husband/elder
- The ability to participate in women's groups without permission.
- The right to keep money for leisure
- The ability to learn about a candidate independently
- The ability to protest without permission
- The ability to move freely in the village unaccompanied
- The ability to pay for medication and to make medical decisions for children without permission
- The ability to make decisions in the household independently

Self-efficacy/ agency

- The perceived effect of participation in an international research project
- The perceived influence of participating on the governing board of an international research project.
- The perceived ability of men/women to obtain a vaccination for their children that is not readily available in the village, and the strategy developed and predicted obstacles encountered.
- Recognition of inadequate health services at the local health post and perceived ability and channels to improve this.
- Perceived ability to ensure that women and children have access to the health services they need.
- Understanding of channels to effect change, and ability and freedom to easily participate in these ways.
- Perceived effect of women's group formation and ability to accurately prioritize and address key health concerns.
- Ability to represent family and community interests at village council meetings or in women's groups
- Ability to assert oneself as the primary decision-making regarding the children's health and well-being in the household.
- Ability to address issues relating to public goods and health (clean drinking water, sanitation), knowledge about these issues and the channels for advocacy and change.
- Ability to obtain health education services and perceived relationship between this education and better health of the family.
- Perceived differences in women's issues versus men's issues and the ability to raise awareness of these women's issues
- Understanding of general education/literary, differences between boys and girls access to education and role of this in advocacy
- Ability to independently decide to take a child or a pregnant woman for medical care and to perceived ability to appropriately assess the need for higher level care outside the home.
- Ability to vote independently in an election and to assess whether a candidate will appropriately represent and advocate for their needs and the needs of the village.

Health systems

- The availability of vaccines for children
- The availability of medications of reasonable cost
- Access to health posts (distance, transportation) and obstacles to getting care
- Facilities at the health post
- Cost of health services
- Cost of getting to the health post
- Availability of emergency services at the local health post
- Access to community health workers

- Access to health education
- Availability of doctors at the health post during the day and at night
- Access to maternal health services and delivery services
- Availability of female health workers
- Responsiveness of the health system to recommendations for improvement
- Relationship between the health post and the local government leaders
- Differences in treatment/care/access for the rich versus poor
- Differences in treatment/care/access for the different castes or religions
- Differences in treatment/care/access for the educated/literate versus the illiterate

Qualitative Analysis

Transcripts of the data were interpreted using thematic analysis following the structure of the aforementioned categories, themes, and sub-themes. Similarities and differences were noted across gender, age, education level, and intervention versus non-intervention villages. Direct comparisons were made between *Saksham* intervention and non-intervention villages, between men and women, and between individuals categorized as young versus elder. Key, particularly emblematic quotations were preserved and documented. Topics that strayed from the designated themes were also noted. Coding of specific words and expressions was not included given the language barrier and the risk of loss during translation, and the goal of understanding perceptions of and connections between central issues rather than definitions of terms.

Field notes and limitations

There were a number of field observations and limitations to the administration of this study that must be addressed. Overall structural difficulties, such as access to resources, means of communication, paper, tape recorders, photocopiers, and computers, were encountered, as expected when conducting research in rural communities in the developing world. Similarly, transportation in and out of the hamlets was challenging given the lack of paved roads. There was a narrow window of time each day to hold focus groups because it was rice paddy season and all of the villagers were in the field for the majority of the morning. Data collection also had to end before sundown because there was no electricity available in the villages and because women were busy with household chores in the early evening. Interruptions were frequent and noise levels, even in semi-enclosed spaces, were high making tape recordings challenging to transcribe. Certain adaptations had to be made to the original study plan, particularly relating to the amount of time considered reasonable for participants to be engaged in the study, how the focus groups were organized and where they were held.

Ideally, this study would have organized focus groups of individuals who were entirely unknown to each other. However, given the small size of the specific hamlets visited, nearly all of the groups consisted of individuals who knew each other to some degree. Given the lack of link roads, street lights, transportation and central meeting places, it was difficult to bring together villagers from different hamlets to create focus groups of entirely independent individuals. In addition, this study was conducted during rice paddy season and women in particular, were unable to take more than one hour out of their field work and the decision was made that that time was better spent in discussion

than in travel. In addition, it seemed that both the women and men, because of their level of comfort with each other in their respective groups, did not hesitate to express their opinion, or in most groups, to vocalize their differences.

Relating in part to this, selection bias likely existed on a number of levels. First, the villages that were visited were those that were previously randomized as intervention and non-intervention villages three years ago by the *Saksham* study group. Over the course of the three years, one of the non-intervention villages was transformed into an intervention village, and there was some degree of spillover into the villages that remained non-intervention villages due largely to their close proximity, shared resources, and continuous communication with the intervention villages. Thus, even those that were blind to the specific neonatal health intervention still likely received more involvement from the international community than other villages just by virtue of baseline surveys and knowledge that they were enrolled in a study. In addition, the Rae Bareilly district is the constituency of Sonia Gandhi which may contribute to an overall level of the increased political awareness in this area.

Second, this study in part evaluated perspectives on participation, but there was likely some degree of volunteer bias, or a difference between those individuals who joined the focus groups and those who did not. This bias could have represented a few different things. Those that joined may have been slightly more secure financially and thus able to take more time out of their field work. They also may have been a bias towards those individuals who participate more readily in the community, and even attempts to enroll those who said they had never attended a council meeting or an international study group meeting, may not have been entirely representative of those

who never participate. There were definitely more elder women eager to participate than young women. This may have been in part because they have less field responsibilities and more time for this type of activities, or because of the elder-dominated culture of this community.

In addition, the translator and the community organizer were both male which may have limited the willingness of the women's groups to express their opinions entirely openly. Most did not seem to hesitate though, and having one female study member present may have provided the necessary balance. Along these lines, the female study coordinator may have restricted the openness of the male groups. Occasionally, a member of a male group would ask that his statement not be translated into English. However, they did know that all of their responses were being recorded and that the tapes would be fully transcribed. Due to the organization of the study, it was necessary for the study coordinator to moderate each of the focus groups and thus to be present during all of the group sessions. Given the traditions of the village, she would have had to be accompanied by a man at all times regardless, and having a male translator made the presence of an additional male unnecessary which was important particularly for the young women's groups. There is the reality however, that given the disclosure of her background as an American medical student, there was an element of response bias that resulted. This bias may have presented itself in three ways. First, there may have been the desire on the part of the villagers to describe their current situation as even worse than it is, especially when engaging an individual they perceived as able and willing to help their plight. Second, they may also have thought that the study wanted them to have participated more than they actually do, or utilized the formal government run health care

system more than they do. Only a few groups for example, expressed their reliance on “fake doctors” despite prior studies in the area that demonstrated this fact. Third, the villagers associated this study with *Saksham* which was highly regarded by the intervention villages and both admired and resented to varying degrees by the non-intervention villages. This may have affected not only responses, but also the desire to participate in this study. One individual actually refused to participate during the consent process because he felt he had participated in studies like this one and saw no improvement in his village. Efforts were made to distinguish this study from *Saksham*, and also to enroll a sampling of individuals who did not participate or know of *Saksham*'s work in the area. In addition, in the focus groups, different themes were addressed through multiple scenarios which allowed for verification of consistency in the responses, improving the study's internal validity.

A further limitation was the setting of the focus groups. All of the men's groups were conducted outside along with the majority of the elder women's groups. The young women's groups were held inside when possible given the customs of the village and also to ensure greater privacy. Most often however, the places were semi-public. Occasionally, the husbands of the young women were hesitant to allow their wives to participate without them being present. Similarly, sometimes the elder women felt it was their duty to help guide the answers of the young women. In every situation however, when the nature of the focus groups was explained by the community organizer, the men and the village elders left willingly. There were a few groups that had some lingering onlookers which may have limited the openness of the responses, but again, when asked to leave each time, they readily complied. Some of the young women were also tending

to their young children (for example, breastfeeding) during the groups which posed some logistical difficulties.

Another consideration was the extent of diversity within the villages chosen. All were in the *Saksham* study's area, in the Shivgarh block of the Rae Bareilly district. Each of the hamlets visited were chosen at random- approximately half from the intervention villages and half from the non-intervention villages- allowing for variation of distances from the main road, proximity to the health post, and accessibility of facilities. In addition, it allowed for differences in caste as the hamlets seemed to be organized more or less along caste lines. Within each hamlet, attempts were made to represent individuals with a range of literacy levels, ages, and number of children, and with different degrees of involvement in the community. However, the socioeconomic and religious diversity in the villages was lacking. Only one individual identified herself as Muslim while all others were Hindu. In addition, with one or two exceptions, every participant was a farmer at roughly the same poverty level. Therefore, it is clear that the study findings may be primarily generalizable to other rural underserved districts of northern India.

Results

Despite the aforementioned limitations and field obstacles, the focus group structure stimulated lively, detailed discussions in all of the villages visited. The thematic goals guided the scenarios and also allowed for insight into the issues surrounding participation, autonomy, agency/self-efficacy and health systems, among women and men in both intervention and non-intervention villages. Attention was paid specifically to the discussion of strategies used by villagers to advocate for improved health services at local level.

Focus group participants were predominately Hindu and belonged to a range of castes. Members of the *dalit* (the lowest) caste, the warrior caste, and the *brahmin* (the highest) caste comprised the majority of participants but were also the most willing to reveal their affiliation. Individuals were of diverse education levels, with participants who ranged in grade level completed from zero to twelve, and with two having begun graduate work. The majority of the elder participants were illiterate. The socioeconomic status- rural poor- was largely the same for all individuals within each of the groups and across all of the villages included in this study. The majority of participants were married, however a few of the elder women were widowers and a few of the young women and men were single. No single focus group had greater than one widower or single individual. Every married participant had between one and eight children. All participants spoke a mix of Awadhi and Hindi.

To address each of the central discussion topics, the pre-determined scenarios were presented, and group-specific follow-up questions were asked. Thematic analysis, stemming from the general premises of participation, autonomy, agency and health

systems, was used in this interpretation of the focus group transcripts. Sub-themes within each category were also explored. When appropriate, comparisons were made between elder and young women, elder and young men, and overall between men and women. In addition, differences and similarities between *Saksham*'s intervention and non-intervention villages were noted within each theme. The analysis also incorporates certain key issues that were universally raised beyond the specific scope of the four themes.

Participation

The aim of this theme was to understand the channels available for formal and informal participation, the goals of participation and the perceived obstacles and impacts of involvement. First, differences in the eagerness of villagers to participate in these focus groups is of primary importance as it is likely representative of a more general level of community mobilization. Elder women, regardless of whether they were from an intervention or non-intervention village, were the easiest to recruit. Every elder woman who was approached quickly joined a group and, occasionally, asked if she could participate in other groups as well. Elder men were similarly willing to participate, however a few were skeptical of the study's motivations and felt that they were frequently visited by international groups and have yet to see any tangible benefits. Young men and women, in general, were the least eager to participate. Once involved, most often the young women at first sat huddled on the floor with their faces covered, avoiding eye-contact with the focus group leader and the translator. For young women, scenarios involving children's health and education seemed to invoke the greatest

participation in the discussion. For young men, issues of local business development and infrastructure repair precipitated their increased involvement.

Across all groups, individuals voiced their recognition of the importance of participation at all levels- household, community and national- and at all meetings held by governmental and non-governmental organizations. In this domain, there were no overt distinctions drawn between elder women and men and young women and men, and similarly, no notable differences between men and women. In both intervention and non-intervention villages, all individuals stressed the advantages and the importance of participation by both genders and the differences in abilities between those who participate and those who do not. Access was a particularly important issue raised by nearly all of the groups. In varying ways, a number of individuals felt that they would have greater access not only to health services, medications and specific community development programs, but also to government officials. Similarly, access to information and greater knowledge were the key benefits that most groups highlighted.

“Those who participate have better access to services and more information. Those who do not participate don’t know what to do in a time of crisis...All women must participate so they can bring up their families and their children in good condition.”

“Those who participate help other women have better access. They will be better informed than those who do not go. The others have to get only secondhand information. The women who are active feel comfortable dealing with the government officials who hold the meetings. Those who do not go to the meetings don’t know how to talk to the officials and cannot tell them what is actually going on.”

“Women who participate will be informed. If they don’t participate how will they get information? How will they know how to bring good things to their families? How can they be quality women if they sit in the house? There is a big difference between those who participate and those who do not.”

“There is definitely a difference between those who participate and those who don’t...Some women who participate can even identify the diseases their children have and know how to handle them. Women who go to these meetings can better look after the health and education of their children. They have proper knowledge of everything.”

Largely, both men and women of all ages in all of the villages stated that there would be no difference in their participation in meetings or in government if the leader

was female. Most stated that they would raise the same issues and concerns and willingly attend in either case. However, there were groups of women who described feeling more comfortable raising certain issues with a female *pradhan*. In some groups there was also the sentiment that while a woman *pradhan* would be easier to talk to about certain problems, a male *pradhan* would be better able to respond to the concerns and take action.

“We would like to have a woman *pradhan* in the village. We would be better able to raise our issues because it is easier to talk to a woman leader.”

“I would feel more comfortable conveying our children’s issues to a woman leader. If there were a male leader though, it would be easier to take these issues to higher authorities.”

One male group set forth criteria for female *pradhans*, stating that their participation in a meeting with a women *pradhan*, and her success as a leader, would be dependent on whether or not she was educated. A second male group described obstacles that a female *pradhan* would disproportionately face. It is necessary to note, however, that regardless of gender, there was a blatant skepticism among the villagers that a *pradhan* of either gender would have the ability and willingness to appropriately respond to their grievances.

“A woman *pradhan* should be well educated. Unless women are aware and educated, they cannot lead.”

“Women cannot approach the officers the way a male *pradhan* can...It would be harder for a woman to travel to proceedings and to maintain her family at the same time. A man can reach any place at anytime of the day but a woman cannot. He has the ability to interact with the authorities all the time.”

“Women’s issues we can raise better with a female *pradhan*. But our grievances would be the same if there were a male or female *pradhan*. No one would listen to our issues, whether it is a male or female.”

“We always participate in village council meetings and give applications for the issues that are most important to us, but they are never addressed.”

“I don’t think the *pradhan* could do anything. We would go to the *pradhan*, but we don’t even know who to write to or what to write.”

Issues raised by the villagers most broadly included the need for significant infrastructure development, improved children’s health and education, and the desire for

improved economic opportunities. All of the villagers stated that they would raise these issues regardless of whether there was a male or female *pradhan*. Nearly every group cited the need for improved infrastructure- roads, electricity, sanitation, water supply. Every female focus group also raised the issue of education particularly for their children, and oftentimes discussed infrastructure in this context. A number of women also discussed the desire for small cottage industries for women to provide an additional source of income. The male groups emphasized rural development above all, although many also raised issues of education and the desire for other forms of industry beyond farming. Both men and women also raised issues of health, particularly child health, and the need for better, more accessible health facilities.

“Whatever problems we have, we will raise. Children’s health and education are very important to us...If it is a male or female leader, we would attend the meetings and participate, and raise the same issues. We will advocate for the needs of the village...We need better transportation in order to send our children to a good school. We need better roads for them to travel on.”

Men for the most part seemed very supportive of women’s participation in these meetings. Similarly, most women believed that if their husbands felt the content of the meetings would help them better care for their families, they would encourage their participation. Additionally, groups of elder men pointed to changes over time stating that in the past they were more reluctant to have their wives and daughters attend meetings but now, due to a number of factors, they are more encouraging of their participation.

“We would like our women to join these meetings. Getting information would help our families. It would have a good effect on our entire family and we want them to take part.”

“In the past meetings were so far away and we would not want to send the girls on the road by themselves. Now there are more shops and it is more developed so we have no problem sending our women. We also used to be hesitant to send our women because of social issues, but this is changing. We are starting to accept their role and send the women to the meetings. Now we feel that if we get our girls educated and to the meetings, it is good for the village and for us. Those who do not participate will be backward.”

“We do not stop them from going. If it is for their betterment, they must go. It is good for the family, the village and the community if the women go and get information.”

Participants did point to a number of obstacles that either prevented participation in the community in general, or influenced who did or did not decide to participate in specific meetings. Location and timing of meetings were of particular concern- further distances limited women’s ability and freedom to attend these meetings. Lack of transportation and paved roads made it difficult especially during monsoon season to participate. In addition, both women and men stated that while education level or literacy should not be a limiting factor, individuals without education tended to be more reluctant to attend and actively participate in these meetings. Others stated that they could not attend meetings because they were too busy doing work, and they did not feel they would be appropriately remunerated nor that their concerns would be properly addressed. A few young women stated that their husbands did not allow them to attend meetings.

“Sometimes there is no common call for the meetings so we do not know about them. If there are meetings here in our village and we know it will benefit the villagers, we will go. Sometimes if we think only a few will benefit monetarily, we will only want a few to go.”

“I am only allowed to go to meetings if they are held in some places, but not in others.”

“Those who don’t participant are hesitant and shy. Some believe what they learn but others are not accepting of information. Some women do not go because they are busy doing work. Some don’t go because they won’t be paid for their participation and therefore it is a waste of time. The women who do not go are not well informed.”

“Some women’s husbands don’t let them participate. They are not as progressive or as educated. Some of these men are drunk and always involved in gambling. They blame their women. These men don’t want women to go and participate in meetings. There are only 3 or 4 households in the village that are like this.”

Caste and religion were not cited as reasons for lack of participation or as obstacles to participation. Villages that were predominately *dalit* actually demonstrated increased involvement in BSP party politics and repeatedly noted that the *dalit* leader of UP, Mayawati would facilitate their ability to voice their concerns. The focus groups

were predominately Hindu and therefore accurate understanding of participation by the Muslim minority could not be assessed.

Dividing the results based on gender, it seemed that both men and women strongly encouraged participation by both genders and felt that it led to the betterment of the entire family. Superior access to knowledge, education and health services for their children was the key motivator for women. Potential for village development and improved infrastructure seemed to drive male participation. Both men and women were similarly skeptical of the ability of a *pradhan* to respond effectively to complaints however all recognized the importance of vocalizing their concerns at council meetings. Both elder women and elder men seemed to be more wary, in general, of the village leadership and felt that they could appropriately advocate for their needs however due to corruption, the hierarchical nature of the government and the overall lack of allocated resources, the *pradhan* would never be able to fully enact change. Younger men and women, while also concerned about the ability of local government to respond to their needs, seemed fundamentally unsure of their own ability to voice their concerns in a meaningful way. They were able to name the available channels for advocacy, for the most part, as readily as their elders, however they were far more hesitant to participate in this way for fear that no one would listen to or care about their needs. They felt that they would not have access to the higher officials who might be able to make a real difference and seemed, for the most part, to be far more resigned to their current plight than their elders. Their participation in community politics, meetings, NGO groups and women's groups was viewed more as a forum to accrue information rather than as a place to advocate for the betterment of their families. Both elder men and elder women saw

participation both as a way to get better access to available programs and facilities and as a way to fight for the services their families require.

There was some difference noted in perceived effect of participation among individuals from villages that were randomized to the *Saksham* community empowerment intervention compared with those that were not. While both groups recognized the importance of their participation, the intervention villagers could cite tangible benefits, particularly relating to the health of their children. They seemed to feel that their voices mattered more and that *Saksham* would listen, respond to their complaints and convey their needs to higher authorities. Non-intervention groups did not have a similar sense of access to the government, felt that their voice mattered less, and were less inclined to list specific examples that reflected the benefits of participation. Cause/impact diagrams were also constructed to formally demonstrate the results of this theme (Figures 4 and 5). The figures outline the perceived causes and impacts described by male and females villagers of participation (Figure 4) and lack of participation (Figure 5).

Autonomy

The aim of this theme was to understand the autonomy, particularly of young women, to make individual decisions and to participate freely in the community and the household, both formally and informally. Given the goal of understanding political participation on multiple levels, decisions of who to vote for and how to vote are particularly relevant both to the overall objective of this study and to this theme.

There was a significant range in responses regarding how individuals obtain information about candidates, how they choose who they will vote for, and the varying degrees of freedom women have to decide how they will vote. A number of individuals, especially male members of the *dalit* caste, stated that they vote for a candidate based on party. Nearly all women indicated that they voted for the person their family supported. Younger women voted according to their husbands or the elder males in their family (usually their father-in-law). Elder women said that they voted according to their sons and husbands.

“I vote with the consent of my family. Usually I vote according to my husband. Like if my husband favors the Congress party, I will too.”

Only a few groups of women indicated that their vote would be predicated on a certain issue. Most women stated that they did not feel that their goals would be achieved by the candidate once they were elected so voting for an issue was not productive. Young women were more hesitant than elder women to respond in depth to this topic. For the most part, it was the character of the candidate, and certain personal qualities rather than a specific issue that determined who the women voted for. Some women did acknowledge that caste was also a consideration for them, or that they knew it was for other women in their village. Overall, most women did not vote for female leaders over male leaders, or vice versa. However, nearly every group pointed to Sonia Gandhi and Mayawati as examples of strong, effective women leaders.

“The vote should be cast on an issue and be given to the person who actually addresses this issue. Politicians promise they will get the road constructed and make other similar promises but are never true to them. They always come and talk handsomely and convince us that everything will be okay once they are elected- ‘I will get the whole road constructed’- but they never keep their promises. We know the issues, but they are never properly met. That is the problem.”

“We usually vote for the person who promises to help develop our village, but often these promises are not met. I never met a candidate that promised and kept his promise. He sometimes will respond partially but he never returns to our village once he is elected. He sits in the assembly and doesn’t do anything.”

“I voted on the issues of road construction, electricity and water- all infrastructure development. He has helped partially, it has been slow.”

“I voted for Sonia Gandhi because she is an honest lady. I am not always aware of the positions of candidates. I see who the people of the village vote for and I vote for him. If a candidate doesn't address the issues, I will vote for someone else in the next election.”

“We want a young- no more than 40 year old- candidate who is an energetic, enthusiastic man of character. If he is young he will think of new things and do them with zeal. He must have the sense to understand the agony of the villagers and their needs.”

“The candidate needs to be very humble and soft-spoken. Sometimes when a candidate comes, he bends down to our feet and makes promises and appears to be so humble. He is full of these promises but never keeps them.”

“I voted for Sonia Gandhi because of her name, her honesty and because she is a big leader of the party. I think it is an honor to vote for her. She will care for the development of our village. But we know she is spending a lot of money but the poor people living here are not getting it. The middlemen are embezzling the money.”

“I would prefer a local person. His personality must be good. I want to vote for someone I am familiar, can talk easily too and have easy access to.”

“At the *pradhan* level election, we always vote for our group, or the party of the village, usually according to religion or to caste.”

“I am not *dalit*. But most *dalits* for for BSP, for Mayawati. They vote on the basis of caste.”

“Women can be good, effective leaders like Mayawati and Sonia Gandhi as long as she is a woman of character. Now women participate in every sphere and in every post and they are working more effectively, not less, than their male counterparts.”

“Women can be as effective as leaders. We need strong women. If these women do not come forward, how will we progress?”

The responses of men seemed to span a wider range likely because they have greater access to information about the candidates, and because they appear to be the main decision-makers in the political sphere. Men also relied on their sense of the character of the candidates but seemed more inclined than women overall to vote on a particular issue. This issue for nearly all men was the development of the village. However, many also noted that while they do vote on these issues, promises made by campaigning candidates were rarely kept once elected. Men also seemed to emphasize voting by party. Men from higher caste villages consistently voiced their support for candidates from the Congress party and men from the *dalit* villages supported BSP.

“At the time of elections we know about all the candidates. All of them criticize each other so we know their strengths and weaknesses. We learn who the man of character is from this.”

“The candidate should be a public servant fighting for the interests of the common people. Party, caste and religion do not matter.”

“Sometimes a candidate is a manifestation of the party, sometimes the candidate is an honest individual. Sonia Gandhi is an honest lady and our leader. She will help us with development...I always vote for a candidate I know well. Sometimes I vote for a party, but not always. The candidate must have good character and be sensible. Caste and religion do not matter to me but they do matter for some people, especially in Uttar Pradesh.”

“We vote at the party level. We all voted for Sonia Gandhi because of her party. If the candidate is good, we will vote for them. Sonia Gandhi would give funds to us but it is the lower representatives who do not give us the funds she allocates.”

“At the time of election, issues are raised. But after the election, the issues are over- they are never properly addressed. The leader promises to solve them but after he is elected, it never happens.”

“At the time of election everyone claims to be a good person. I vote for whoever says he is in factor of farmers, not a capitalist and from the socialist party. He must support the cause of farmers. He must speak for the development of the village.”

Also intrinsic to this theme of autonomy is women’s freedom to vote independently and to express separate political opinions from their husbands. Most women stated that they never vote independently. Some said they would express their opinions but in the end, felt that their vote would be wasted if they were not united with their husband.

“We never differentiate from the opinion of our husband. We cannot surpass his opinion.”

“I would not raise an issue on my own. I raise issues only with the consent of my husband.”

“The elder of the family, my father-in-law, instructs me who to vote for. When there is common support in the village, we vote for that candidate. I don’t know who the good or the bad candidate is. It is the men who decide who is best. Some of the husbands in the village say that if you don’t think their choice is the appropriate candidate, then you can just sit in the home and don’t vote.”

“Some of us vote differently. Some do not. If I feel that a person is right, I will vote for him. We vote in a unified way.”

While in most groups, both elder and young women stated they must vote according to their husbands or the village’s elder males, occasionally one or two women stood apart. Among the younger women, in two groups, it was the best educated woman in the group who stated she would consider voting independently. Among the elder women, it was most often a widow, or a member of the village council who stated this. A

few women said that while they did not necessarily have to vote according to their husbands, they did need their consent if they wanted to vote differently.

“We don’t necessarily have to vote according to our husband. If we think our candidate is the best one, we vote for him or her, but we do get consent to vote this way. We make the decisions with our husbands.”

“Sometimes I vote differently if I think my husband’s candidate is not fit. I am educated and I can see if my husband is not supporting the right candidate. I vote according to who I think is best. I stand apart when necessary.”

Among all women, there was also a sense that the community as a whole limits individual autonomy particularly with respect to individual voting. While this does appear to be a cultural norm in these villages, women also seem to feel that it is a choice that they are obligated to make. Nearly all women stress that their personal issues are also the village’s issues and they believe that voting according to other members of their village is the only way to achieve change. Therefore, autonomy may sooner be viewed as community autonomy as opposed to individual autonomy, meaning that they perceive their ability to work as a village to bring change as a key freedom they have achieved.

“If a group of women decides to vote for a certain candidate and he is the best, I will vote for him.”

“Sometimes we are divided as a village, but if we are divided, then we waste our vote.”

The majority of men agreed that women could not vote independently. Many, particularly the elder males, seemed shocked that the question was even raised. A number of men either outright stated or implied that it was illogical that women would vote separately because they are not as informed about local politics and therefore cannot judge who would lead best. There were some elder and young men however, who did grant this freedom to their wives. Two elder men felt that they no longer had the ability to tell their wives that they must vote accordingly to them. It did not seem overall that younger men, even those with higher education, were any more willing to grant this

freedom than the elder males and if anything, the elder men felt they had less control over their wives' decisions than the younger men.

“She cannot vote differently. Women vote according to the men. We are more capable of deciding who to vote for than women. Therefore we should influence them.”

“Women always vote with the consent of the family. Since the elder man is the master of the house, the woman votes according to him.”

“Sometimes women favor women candidates. Men do not do this. We don't vote according to our wives. Women vote according to their husbands and their elders.”

“It is difficult for them to vote differently. Usually they will vote according to the head of the family, the elder man, not the husband, because he has the greatest vision and the most experience.”

“If we agree on a candidate, we vote for the same. If we disagree, we vote differently.”

“Sometimes women may accept our opinion about who to vote for but in the end, they do whatever they want to do because I don't see who they vote for.”

“A woman may have a better understanding of the candidate so sometimes I will vote according to how my wife feels, but not always. I don't force my wife to vote with me but she might ask for my consent.”

“Sometimes, I can be convinced by my wife to vote differently. Once I agreed with the person my wife wanted to vote for. If the candidate is from the village where my wife comes from and she wants him, I will have to vote for him because I need my wife to cook the food or else I will go hungry.”

Beyond political freedom, other aspects of autonomy including freedom of movement, ability to seek medical care without permission, and control over finances were also addressed. In terms of freedom of movement, there were differences noted primarily between young and elder women, and between villages of disparate castes. Young women were limited in their ability to move independently around the village, other than to work in the field and tend to their children near their homes. This was also observed by focus group locations that were designated by the village elders. Focus groups with young women, particularly in the more traditional warrior caste villages, had to take place inside of a house. Similarly, husbands of the young women tended to lurk close to the focus group at all times, and often had to be asked to leave. Elder women on the other hand, were free to meet in groups outside of the homes and their husbands willingly removed themselves when asked. Young women from the more traditional villages also refused to sit in chairs or on tables and only would sit on the ground. Elder

women did not have to follow such procedures. Neither young nor elder men sat on the ground, and all male groups were held outside.

Women were asked about their freedom of movement as it relates to their ability to take their children to the doctor. In every group, all women, both young and elder, indicated that they could take their child to the doctor in an emergency without permission. However, most women, particularly the young women, stated that they would not go alone, especially to a district hospital. Most said they would ask neighbors or anyone they could find quickly to accompany them. Nearly all women voiced their reliance on their community to help them get care for their children.

“We normally ask for permission, but in an emergency, we will get neighbors and community members to help us.”

“Women manage with help from their neighbors. We all will go to the hospital together. No permission is needed. With the help of the community we will get the child treated and take them to the hospital.”

Similarly, men indicated that in the case of an emergency, no permission would be needed. However, the caveat was that nearly all men felt that women should always be accompanied. In some cases this seemed to stem from traditional, cultural constructs, but in most cases it seemed to be more of a logistical or safety issue since the health facilities are so far from the village. Some men did state that in the case of health, emergency or not, no permission would be needed, and she could go alone.

“A man should go with a woman but in an emergency, she is free to go. Women have difficulty going to the hospital since it is so far away. She has to go with a man because it is so far.”

“In an emergency, anyone, man or woman, can take the child. If there is no emergency, she must wait to discuss it with the family elders and wait for someone to come to take them to the hospital. It is a family matter. Sometimes they ask, but it is a mutual understanding if it is not an emergency.”

“A woman can take her sick child to the hospital without anyone’s permission in an emergency. If we are there, we will accompany her. She will take someone with her, like a neighbor, or another woman, because the health post is very far away (5-6 km) and she will not go alone. Someone from the community will go with her.”

Having money to spend, both on specific needs, and also for leisure, has been shown to be central to autonomy, and ultimately to female empowerment. It was very difficult to get a true understanding of this freedom because most men and women in the villages responded that they had no money in general and anything the family had, they used on basic needs such as healthcare or education for their children. Women indicated that they had no money to spend on leisure, but that in general, their family had no extra money from which they could even imagine setting aside for their own wishes. A few elder women said they had a little extra money set aside, but of the most part, neither young nor elder women had access to financial resources. Similarly, men stated that women were allowed to have some money for themselves, but depending on circumstances such as profitability of the crop, they may or may not have any.

“We are poor farmers, we have no money and no savings. How can our husband give us extra money that we don’t have? To save our children’s lives we will sell anything. We are working class. What we make every day, we spend at night. We have to earn for each day.”

“At night, a child was sick and I only had 200 Rs in my house so I had to manage. Sometimes women have some money for themselves, sometimes they do not. If our husbands were in government jobs, we would have much more money. But we are farmers and we have to spend a lot of money on farming. We have very little saved. We spend all the money we have on our family’s education.”

“I am the shared owner of the house. I have access to money.”

Women and men were also asked about freedom of education, particularly for their girls compared with their boys. Every individual in every group agreed that both girls and boys should have equal access to education. However, one group of young women pointed out that elders oftentimes encourage girls to stop school after 7th or 8th grade because they feel that it is not necessary for their futures or for the betterment of their families.

“In ancient times, it was the custom of our fathers to not care about the education of girls. We now think they should be equally treated in education and healthcare and in other facilities. Girls and boys should be equally provided for...If a girl is brought up in Lucknow, it is different. When we come after marriage to our

husband's house, we are brought up in another district with different thoughts and obstacles. Girls in Lucknow are freer to get education than here in Rae Bareilly. Here we cannot change customs in our husband's house immediately. It takes time to accommodate. Elders here say that after 7th or 8th grade, girls have studied enough. They don't need to study anymore to go to their husband's house. Sometimes we protest to change this. Sometimes we are successful, sometimes we are not."

"If you educate a girl, she can better maintain and look after her family. It is not like it was in the past. We are educating them equally."

"We don't differentiate between girls and boys. I love my girl more. We will take both to the doctor and we will make sure both get educated."

"Both should equally be sent to school. Previously, the family wasn't balanced unless the boy went to school and the girl stayed at home. Now everyone has started thinking that families would be better if everyone was educated. There will only be halfway development if there is only half of the house educated. Boys and girls should both be educated."

Women were asked specifically if they had concerns that they felt were more female by nature than male, and that they might be better able to articulate. Young women in particular, stated that they had no issues that they would independently raise and that their issues were shared issues with their husbands. They consistently felt that men were more equipped to raise and act on their joint concerns. Nearly every group, in some context, brought up children's education as the primary concern for women. Others suggested that household needs and child health were more women's issues than they were men's concerns.

"Women are more involved in household issues. We need water to cook food and lighting to cook at night. We also need wood and fuel to make the food. Men are indifferent to these things. They want the food cooked for them but how we do this is up to the women. External issues like agriculture, money and making businesses are men's issues."

"Mothers are concerned for their children's health and education. Sometimes men force children to work in the field and they are not as concerned with their education. Women are more sensible. We want all of our children to be educated."

"At large, the issues for men and women are the same- health and education of children and betterment of the family. Men's main issue is unemployment. After the men are finished with their agriculture work, they are jobless and just sitting around the house."

Overall, it seemed that women were satisfied with the degree of autonomy they had in their households and in their village. Most did not seem to think that they should have the rights that they do not have- such as voting differently from their husbands, or

having complete freedom of movement in the village. In the domains they found to be most important- education and health- they seemed to have the autonomy they desired and had achieved some degree of equality for boys and girls. There were definitely villages where the men consistently did not feel that women should gain equality or increased autonomy. These distinctions were seen largely between villages rather than between elder and young men. Largely, villages were not divided along intervention/non-intervention lines but rather along caste lines, where villages that were dominated by the more traditional castes granted less autonomy to women.

Agency/Self-efficacy

The aim of this theme was to understand the concept of women's agency, both more broadly, and as it relates to health. Here, discussions addressed women's perceived ability to participate politically and to advocate- in the household, in the community, and at the state/national level- to achieve specific goals, particularly better health. Parallel issues were similarly addressed with male villagers both in terms of their own perceived abilities and their views on women's capabilities. This section is divided into three interrelated and complementary parts- health agency, political agency and health education. The final theme, health systems, is also central to health agency, but will be discussed separately.

Health agency

Health agency encompasses a number of issues including the availability of resources and the adequacy of those resources to provide medical care, the concept of self-efficacy, or the perceived ability of individuals to make the changes to their health

system they deem necessary and ultimately, the level to which the society supports this notion.⁶⁷ In addition, the extent to which individuals have access to health information and education and the health and political norms and infrastructure of the society that facilitate or hinder an individual's ability to advocate for better health also come into play.⁶⁷ These concepts were addressed through scenarios and different means of participation were assessed to see which had the greatest perceived efficacy.

There were a number of channels that women felt they could employ to advocate for better health. Elder women consistently needed less prompting and many eagerly responded with lists of methods and past evidence of successes. Young women, overall, seemed more resigned to their current health system and did not feel it was their place to advocate for better services, or when they did, they did not seem to think others would be receptive, or that they would achieve their goals. Many women, especially the elders, felt that the formation of women's groups was the only way to get their grievances addressed. Others felt that they needed to channel their complaints through either an official, or through a more educated person, usually a male member of their family. Many in the intervention villages, particularly the young women, cited *Saksham* as their best intermediary. Others pointed to specific village council members who would help bring the health services to them directly.

The importance of the *pradhan* was evident in all of the villages. Individually, the women had differing degrees of confidence in their respective *pradhans'* ability to actually bring change. A significant number also questioned the honesty of their *pradhan* and noted dubious interactions with members of the civil service. Regardless, the women saw the *pradhan* as their direct representative and as the person who would best convey

their needs to the authorities who could make a difference. It also became clear that many groups viewed their participation in this study as a form of their advocacy and as part of their fight to improve their village. A number of women stated their explicit hope that this study would help advertise their current plight and help get their complaints addressed by the higher officials.

“We are not educated enough to voice our grievances in a proper way, so we will find some right person who actually can accomplish our grievances. We will complain again and again to other people.”

“We would ask questions and send the leader of the community, and then Sonia Gandhi letters. We would submit an application to the *pradhan* at the next big meeting. We would petition for proper hospitals, better infrastructure and better schools. If we don't have direct access to the right channels, we can find someone who does.”

“A women's group is better than one woman alone. An organized group will hold more weight and have more say than if we go individually.”

“Vaccinations are very important to us. If a vaccination program happens in another village, we will complain to get it and go in groups to the village chief and the higher authorities if we need. *Saksham* will help us and tell us what we need to do.”

“We rely on *Saksham* or other organizations in the area to help us. We hope they will collect our grievances and convey them to the higher authorities.”

“Our village council member would go door to door and tell all women about a new vaccination if one exists so they altogether could make sure it would be brought to the village.”

“We would ask our *pradhan*, our doctors and every authority to put antibacterial spray in our water and to make sure the water supply/pump is hygienic. If the *pradhan* doesn't listen to us individually, if we go as a group of women, they will listen to us better. They listen to groups of women.”

“We need a better hand pump- an India Marka hand pump. It broke and no one has fixed it. We have one pump for 50-60 houses. The *pradhan* could help us. Sometimes our grievances are addressed, sometimes they are not. He is capable, but it is not up to him- it is up to the higher authorities... The water right now is not in order. IT is yellow and tastes bad. We women villagers do not know who to approach. We always go through the *pradhan*. We need help from a proper water corporation that would work for us.”

“We have many priorities. Medications, technical support, road construction drainage, street construction, vaccinations that are on time, health workers who come to our villages regularly and give medications properly, health care for pregnant women, better roofs for our houses and better living conditions. Rae Bareilly is a backward district. This report should reach Sonia Gandhi. They are not properly distributing essential commodities like food grains and kerosene to the poor rural people. A quota of commodities is supposed to reach us but the distributors sell the goods on the black market instead so we don't get it. Corruption is at the level of distribution. Ration cards never reach the poorest people.”

A number of women were eager to cite examples of their successful health advocacy, particularly through women's groups. Interestingly, two of the most vocal focus groups on this subject- one of young women and one of elder women- took place a

village that was a non-intervention village that recently began to receive some degree of *Saksham* involvement. These young and elder women were the most excited about the prospect of participating in women's groups and had a number of success stories to share.

"We can express ourselves better if we go in a group. Groups will have a say. Sometimes the *pradhan* even takes our group of women before the higher authorities to demand more efforts to develop the village. We were brought by the *pradhan* to face the higher authorities to say that we need a proper drainage system that takes the dirty water to a sewer system away from the village. By using us the *pradhan* was able to get more funds allocated to the development of the village."

"I already have a group of eleven women and we started a program of saving money by depositing an amount every month and saving the money. By saving it, in a time of emergency, anyone can use that money to help their family, like to take their child to the doctor. I think we are more effective if we work as a group."

"As a group we fought for road construction- that was accomplished 50%- and for a drainage system- also partially constructed...Over there you see new bricks forming a street. A group of women told the *pradhan* they would vote for him if he did this and when he was elected this is what he did. Because we were a group we got him to be true to his word. The new *pradhan* is working to solve our problems. We got him to do some things already."

"We go as a group to the *pradhan* and speak to the council. Last year our villagers got encephalitis and we heard there was a vaccine and we got this. We also had filariasis and heard there were pills and we went and got them. Sometimes the government does provide us with these services. We go to the hospitals and we talk to the officials. From last year we became more aware about how to get the vaccines and medicines we need."

There were also accounts of attempts that were unsuccessful and descriptions of failed women's groups that were ineffective or corrupt. A number of women also felt they were too uneducated to be part of a group and stated they would not know how to make them work effectively. A few young women requested outside help to facilitate this.

"When five people in our village died, all of the villagers complained to the *pradhan*. We never heard back because no one cared. Then we went to the higher officials with the *pradhan* but no one cared about that either. The problem is no clean drinking water and everyone turns their back."

"There was a [women's] group in the past that formed to save money but a woman embezzled from the group. A group must be led only by an educated woman so she can work for our interests."

"Here there are no groups so women don't have anything they could join. Women are not going to form such groups here. Most of us are uneducated. Time in a group would hurt our work in the field. If a group could bring us money or help us with financial issues, we would join."

"There are no government schemes that help women's groups. We want more of these. We also want guidance and how these work. If we were better educated, maybe it would be easier for us to work as a group...Our groups wouldn't have money so we wouldn't get things to work. Without money we can't do anything. We would have to offer a bribe to the officers to get a favor but we don't have money. We don't know how

to establish these groups and we don't know how to work effectively. We want to learn. We think these groups will bring a change if we could join them."

Among many women in non-intervention villages, there was a poor sense of self-efficacy. Women were oftentimes aware of the appropriate channels to action but felt that no one really cared about their needs or would truly commit the resources necessary to help them. Similarly, examples of corrupt behavior, particularly among local officials, permeated nearly all of the focus groups and were mentioned equally as often by young and elder women and in intervention and non-intervention villages.

"Either you are satisfied with the available services or you will die."

"We go to the *pradhan* and ask for services but things stay mostly the same. Sometimes we are cared for and sometimes we are not. At large, the situation remains the same."

"The *pradhan* doesn't care about the dirtiness of the village or about fixing the drainage system so the children won't get diseases. We still hold a sanitation drive once a year, or once every 2 years. There is no proper sanitation. Once the *pradhan* is elected, he doesn't care. He gets some money from the government but the amount he allocates doesn't fix this... We go back to the *pradhan* but sometimes he is indifferent to our problems and doesn't care. The *pradhans* get very rich and strong, they get a lot of money and then they take half of it. The poor people can't stand against him."

"There are schemes for women in India that are provided by the government but never get them. We know there are things that are supposed to help empower women and give them work but we don't get them. Blankets are distributed by the government through the district magistrate to the *pradhan* but the poor people never get them."

"We ask the higher authorities, from the health department too to come and check the water. Our children repeatedly suffer from diarrhea. They need to come and check our water and give us better sanitation. There are only 3 hand pumps in this big village and the water supply system is very poor. The wells are contaminated and there has been no effort to clean them. The government should take better care of this. There is no proper water supply. We keep telling this to the authorities but they don't care to hear about it. When children keep getting sick we just take them to doctors. What can we do other than this? Maybe I can send a male member of my family to the authorities to tell them to fix this."

"We should have better services provided at our health post. Nobody turns back once elected to respond to our grievances. It is all about getting the vote. We are unable to put pressure on them. Nobody appears at the time when the actual problems happen. It is up to us to make things better. We are helpless and rely on the machinery of the government."

Male focus groups were similarly presented with scenarios to better understand both their own concepts of health agency, and their views of women's health agency.

There were a number of similarities between the men and women's health and

development related complaints and their respective criticisms of the obstacles to advocacy. However, while men had a greater sense of self-efficacy, they were able to cite far fewer actual examples of instances when their efforts got better health services for their villages. The men were far more critical of the current government and nearly every group expressed a sense that their needs had been abandoned by the local officials. Overall, regardless of intervention village status, men were very encouraging of women's participation in groups and in health-related advocacy.

The men pointed to a number of channels for advocacy for both men and women. They also emphasized their specific complaints regarding obstacles they have encountered particularly relating to health. There was a sense, among both young and elder men, of resignation to their current plight and to the will or lack thereof, of the current leadership.

“We complain to higher authorities but no one listens to us. We would either go by ourselves or in a group of four or five. If women complained, they wouldn't listen to them either.”

“There was an anti-malaria drive and they sprayed this area but only covered half of the village. We depend on the administration. We don't think we can get the other half sprayed. Our complaints are never addressed. We will make an effort sometimes. Now, we just wait for them to come and spray the other half.”

“We talk about better facilities that we need in the hospitals. At the local level we need the health workers to come to look after women and children to give us information. We keep writing to the higher authorities for better facilities to be made available. Our grievances and applications are put in the garbage. They tell us they feel harassed and tell us to stop writing to them like this.”

“The local health post does not have proper services. It is the duty of the government to fix this. Sometimes we complain to government representatives but they don't care about our grievances. We say them through newspapers too but they are not always heard and addressed. Largely, the situation is the same.”

“For 50-60 houses there is only one pump at the end of the village. Many *pradhans* were elected and were told about this but no one cares. What can we do? We have gone to the block office to complain but no one cares. We also do not have direct access to the higher officials. We know where to do but nothing happens. No one addresses our complaints.”

“Diarrhea from the water is the epidemic of this area. We go to the hospital and to the authorities who look after the water supply. We will keep writing to the *pradhan*. This year we wrote to the district officer at the Tehsil and asked for a survey of our town to look at who is affected by the diarrhea and who is not, and who is most affected by the dirty water and who is not. We kept writing to the *pradhan*. We did meet with the higher authorities and asked for medicine and antibacterial spray for our wells. They

came and inspected the village. We think our actions made a difference. The diarrhea has stopped a little.”

“We complain to the *pradhan*, to the chief medical officer, to the MLA, but the conditions for the most part remain unchanged. Our complaints are not addressed properly.”

Nearly every male group stressed the importance of women’s group formation.

Some questioned their ability to actually achieve their goals, but for the most part, they vocalized their support both in principle and in practice.

“There are no women’s groups here but they would be good. They could pressure doctors to improve health services. Groups would be much more successful than individuals. Together they could pressure doctors to take better care of our children. Individually, this will not work. If the women are well educated, they can work efficiently.”

“Women can form a group. It would be very beneficial to the community. They can share information with each other and have greater say. But all women don’t think the same. Some are educated and some are not. If they work with a mutual understanding, it could help and they could have a say.”

“We strongly encourage our women to participate in women’s groups. They are free to join without permission and we help take them to groups that are working. These groups are good for the family and for the village... They would be effective sometimes. They have to work for all the issues- health, children’s issues and the development of the village. They do this sometimes, but things are not going to change because the higher authorities do not listen to these women.”

“It is good for women to participate in women’s groups especially those that advocate for their children’s health. These women’s groups can be more effective. At the beginning there may be more of a hassle but ultimately they will have sure success. If they complain to the higher authorities as a group, they will be more successful. Women may be better advocates for everything.”

Similar to the responses of many of the women’s groups, a number of the men also pointed to the central role of the *pradhan* in both relaying their needs to higher authorities and addressing complaints. Depending on the village, the men had varying levels of faith in their respective *pradhans* to actually achieve their goals. Compared with women in the same intervention villages, the men seemed to rely less on *Saksham* or other international groups to help them.

“We would go through the *pradhan*. He would send grievances to a higher level of government He would continue our effort and get us success. We continue to make efforts [to get better health posts] but doctors are not available, sometimes medicines aren’t available, sometimes there aren’t machines or no technicians to run the machines. We hope the *pradhan* conveys our needs to the authorities. If central government works, there will be change. Now we get background services provided for us and we keep

complaining and writing letters. One day our grievances will be addressed and we will get the services at our post.”

“I would go to the *pradhan* or directly to the health post. I would be successful. The *pradhan* is always capable of bringing facilities here. Sometimes, we go individually. If the *pradhan* needs our help, we would go with him.”

“*Saksham* is helping us some. They come and inspect the health conditions of the village and help us report our complaints to the authorities. But this doesn’t completely change the scenario. *Saksham* doesn’t have enough money to actually help us.”

Political Agency

Intertwined with this theme of health agency is the concept of political agency, or the ability of both men and women to make their voices heard and to change their current situation, health and otherwise. Women were asked to address this directly whereas men were asked it in terms of a woman’s ability to participate in the political process in a meaningful way. Here the goal was to understand whether the villagers feel that their votes make a difference and more generally, that their participation in the political process matters.

Among the majority of the elder women in both intervention and non-intervention villages, there was definitely the sentiment that it was their duty to voice their grievances and to participate in the political process. Despite this impetus to participate, many expressed significant disillusionment with the system.

“It is our duty to say our grievances and it is up to him [village *pradhan*] if he addresses them or not. We will talk to an elected person with the help of a person who has access. It will not always change the scenario. There may be some change if there is help from a person with access and if we are part of an organized group.”

“When five people died, all of us complained to the *pradhan*. I went to the *pradhan* but never heard back because no one cared. Then we went to a higher government official along with the *pradhan* but no one cared about that either... We need someone to do something about this.”

“The village council does not heed our call for help... No one cares if we complain to the authorities. They make promises to get elected but once elected there is no improvement. Political leaders only care about the vote. Our village is the same as it was in the ancient time.”

Younger women, as a whole, felt less effective in the political sphere, and seemed to have less faith in their village leaders. They also seemed to have more difficulty articulating their priorities and their grievances.

“We don’t think the *pradhan* could do anything. We would go to the *pradhan* but we don’t know who to write to or what we would write.”

“Sometimes the *pradhan* cares, sometimes he does not. Mostly men will go to the *pradhan* and to the higher authorities. Women don’t really go. A woman cannot go and look after her children at the same time. I would send my husband to make the complaint.”

In every group, women felt that their best means of political expression were through women’s groups. They felt that their top priorities- better health and education for their children and infrastructure development- were best addressed through their cooperative advocacy.

“A group of 20 of our women went to the district minister in a group and got the junior high school built in a nearby place even though it had been shifted to be built somewhere else. Even the *pradhan* could not do that. We brought that school here to our village. Our women’s group also got us that little bridge and part of the road leading to the village. Before it was a dusty road. This is the group working. There must be a group. If the men don’t bother to fight for it, women must go. A women’s group- all women- both old and young- this is how we bring change to the village.”

The nature of the scenarios presented to men on this topic was slightly different. Here, this theme was addressed both through support for their wives’ political expression and their perspective on a woman’s ability to lead. For the most part, men felt that women could be effective leaders so long as they were properly educated. One group actually decided that a woman would be a better leader than a man because she would be less easily influenced, financially and otherwise, by men in the community. The most frequently cited limitation for women as leaders and for women as active political participants was their inability to travel safely and freely by themselves. The men also felt that most often the women leaders are not as educated as they should be and end up serving as their husband’s puppets. Otherwise, men felt that women would prioritize

health and education in particular, and care for children and the elderly, more than their male counterparts. There was no clear split between young and elder males on these issues.

“A woman leader can be effective if she is educated. Here in our area women are puppets. Sometimes, women cannot go to the district headquarters. If she is pregnant for example, she cannot go for a long time and men have to look after all the work. Men have much more access than women do. If women are educated, intelligent and aware, they can work better on health issues than men and they could be successful leaders.”

“A woman *pradhan* depends on her husband. Only a small number of women here are educated. A woman *pradhan* cannot make a decision independently. If she is educated, she can work better. Women think about children’s health and education more than men. It is not that women cannot do anything- If they are educated, they can help the interests of the people- especially the women and children.”

“Women leaders are more effective than male leaders. They don’t get as influenced as men do by other men in the community. She will think more of the women in the community. She can make a difference this way.”

“Women cannot go to every place anytime. A male leader can work effectively in areas where women cannot go and can access these places and people better than women can.”

“Women are busy in the house and they don’t have as much capacity to work as men. They are not as exposed to the outside world. They can’t be as effective with the issues. Male members are capable of raising every issue. Women may better represent the health and education of their children because women are more involved with their children. Men are always outside working and they cannot care for them as well.”

“Women will have a much better effect and be more influential than men. Higher authorities have a soft spot for women... A woman’s group will be handled more delicately and get a good reception. A male group would not be treated as well. Higher authorities cannot behave rudely to women. They are bound to respond and behave decently. India is a nation that prioritizes women... There are women chief ministers, of UP of the country. We vote for women. There are reserved seats for them too.”

Education

Both women and men clearly felt that education was central to political agency and, similarly, that health education was critical to health agency. Among elder women who were less educated as a whole than any other group, the importance of better access to information and education for their children and grandchildren was paramount. Many men and women expressed disappointment with the school system and felt that children in rural communities did not have the same access to teachers or learning materials as those in the main cities. Men in particular were critical of their current access to education. Nearly every group also affirmed the importance of educating boys and girls

equally. With respect to health education, women in particular felt their current level of health knowledge was inadequate and believed that they would be significantly better able to care for their family if they were provided with more information.

“Education of mothers is most important and will help them better care for their babies. We need to learn English. More than anything we need more knowledge, information and education. Everyone needs this. These things will bring the change.”

“The students do not get fellowships anymore from the central government to go to better schools. Girls who finished high school used to get 20,000 Rs but now the government stopped this. They also have done away with mid-day nutritious meals even though it is still promised.”

“Women want to get children good schooling and good education. The schools are in poor condition and the standard of education in this village is very poor. Sometimes there are no teachers because they are all local farmers who are busy with their own work at home. We want teachers from the outside to come and teach our children appropriately.”

“We send both our boys and girls to school with the same affection. What I spent for my boy, I spent for my girl. I sent them to the same schools we thought were good.”

“We want to be provided with the information we require to improve the health of our families. Health education would help us better care of our children. We don’t want our children to face the same things we face. We want to see them well placed. If we receive proper education and they receive proper education, maybe they will take care of us in our old age.”

“At the time of delivery, if women received better education, they could better help themselves. If they were better educated they could deal with their children’s health issues. We are all illiterate so we understand the importance of education. If we were educated, we could handle children’s health problems much better.”

“If people had good health education we would not need doctors. Already health education here has really improved the health our pregnant women and children... We need help from other organizations to help provide and fight for these services.”

Health Systems

Intrinsic to an understanding of health agency is an appreciation of the existing health system that serves the villages. A number of issues relating to health infrastructure and obstacles to services were examined through scenarios presented in the focus groups.

Infrastructure

Complaints relating to infrastructure were the most common among both men and women. It became overwhelmingly apparent that basic issues of sanitation, access to clean water, lack of electricity and street lights and poor road development were the most

important to the villagers. The reality of the poor conditions of the health posts, the lack of doctors, the inadequate medications, the lack of pathological services, and the costs of services were all secondary to their fundamental inability to actually reach these facilities, especially at night. Only one group acknowledged their reliance on traditional healers or *jholachap* doctors- untrained men with bags of medication- due largely to their inability to get to the health posts. Primarily, the unpaved roads, the lack of link roads, the lack of transportation and the absence of nearby health posts made access to health services nearly impossible for the majority of the villagers, particularly during monsoon season. There was no distinction by age or gender in the responses to these issues.

“No one responds to grievance so far as cleanliness or sanitation is concerned. Doctors can only give the medications but they cannot improve the living conditions. General living conditions must be improved. All the other things are secondary to a healthy atmosphere... We are rural people without proper infrastructure- with not even a road. Maybe if we had this basic infrastructure we would be able to participate better and get better care.”

“We need laboratories, electricity and proper water supply. We have no light at night and the students cannot study. The light comes after 11 at night. There is dirty drainage. We need a link road. We can’t do anything during rainy season.”

“We need new hand pumps. The India Marka pump broke and has never been repairs. Our top issues are the lack of infrastructure here, the lack of roads, no sanitation and poor water supply.”

“The water is pale yellow in color and tastes salty. We do not know how to get clean water. We want it supplied better. We need a submersible and a deep well to get us clean water. The water corporation needs to work more here. If a person drinks the dirty water, he will get sick”

“Our priorities are cleanliness, especially at the time of childbirth, health, education, better care for our children and improved living standards and sanitation. A proper sanitation system, better drains and a sewage system would benefit the health of the children. Street lights, electricity and clean water are our other priorities.”

“Our priorities are roads and easy access to the hospital. We go to fake doctors, or *jholachap* doctors who have little knowledge because we can’t get to the real doctors. Hospitals must be in reach. When a family member gets ill, we want a nearby facility”

Community Health Workers

A critical component of the health system in rural UP is the community health workers, or the Asha workers. Given the poor infrastructure, the ability for health care and education to be brought directly to their homes is central to the way services are

obtained. However, it is clear from descriptions provided by both men and women that while these health workers are extremely important to their village, there are also definite flaws in the services they provide.

“Health workers are supposed to come on a fixed date. We don’t have proper health education but they do come regularly to the village and to the health center. If the midwife does come at the time of delivery, she often doesn’t give us the medicine properly and is always demanding money. We pay them only if the newborn is healthy. They don’t work like they should and take advantage of us. The government is not providing enough for pregnant women. We think we have been informed about 50 percent. If we were educated better we would have better awareness and better health.”

“Sometimes the health workers come to vaccinate our children but they don’t make sure that every child has been vaccinated.”

“Health workers should come more and visit the villages properly. Vaccination programs should be conducted on time and regularly.”

“Asha workers come here. Now all deliveries are with the help of the Asha workers and our maternal death rate is lower and things are better. The Asha worker in our village is very good at efficient.”

“Health workers come once a week or twice a month and they find us and vaccinate us. If the women are busy in the field, they write on the door and tell them to come to the hospital to get the vaccine. There should be a common call for the entire village to get the vaccine so everyone actually receives it. The health workers just want to complete their quota on paper. They are not concerned with making sure every single child has received the vaccine. When the higher authorities come to check that everyone is vaccinated, they see a number on the door and think everything is okay. The higher authorities should make a common call to the village, or arrange for a camp so that we all can get the vaccine.”

Health posts

The conditions and services of the local Shivgarh health post among the villagers who had actually visited it were consistently described as inadequate. Not only was the health post far away (on average approximately 4-7 km from the different villages) and there were no roads, transportation or street lights to help them reach it, but once they did get there, most were unable to obtain the services they felt they required. Many, particularly the elder males, stated that they have complained numerous times to their *pradhan* and to district level health officials about the problems with the health post but they have seen no change. Both women and men seemed most concerned about women during childbirth. They consistently felt that in an emergency, they had no ability to get

adequate life-saving care for the young women. Many expressed skepticism with the medications and diagnoses they were given. Most did not have faith in the government doctors assigned to their post. They felt they were bureaucratic and poorly trained, and had very limited resources to work with. Others believed that the medicines and the equipment did exist at the health post but because they were poor farmers, they did not have access to them. A few groups also mentioned the rise of a black market where government drugs are sold which makes it even harder for villagers without money to obtain the medications they need.

“Sometimes they give us the same medicines for different diseases. The health post does not have the facilities we need. And what the health post has, we don’t get. In Shivgarh, the doctor isn’t even there all the time. At nighttime there is no doctor in the health post. If we take our women there in an emergency, there is no one there and we have to go further to the hospital. During summertime we were more prone to diarrhea and cholera and dehydration but at the health post, there was only a man with an injection, not the doctor and they referred us to the district hospital which costs more money and takes so long to reach- its 50 km away.”

“The reality is that there are no resources at our local health post. We have to go to the big hospitals in Lucknow and pay a lot of money that we don’t have. It is very expensive to get a car to take a person to the hospital and it takes a lot of time. In emergencies we always have to take the patient to the big hospitals in Lucknow.”

“We need a health post that is less than one kilometer away, not more than five like the Shivgarh health post. When we take a patient there, there is no laboratory and no pathologic testing. Everything has to be sent out to be checked. There is no blood bank. People have to go to Lucknow if they need these things. We don’t have the money to do this and we have to sell our food, animals, anything in our homes to get there.”

“We wait for a long time queuing and by the time we make it in, the doctor isn’t there... There is an inadequate supply of medications especially in the case of emergency or at the time of delivery. If we need blood, syringes, medicine, or gloves, they send us to buy them outside. How do we do that if we don’t have the money?”

“There are resources at the health post, not all, but some, but we are poor so we don’t get them. People who deserve these services don’t get them. Only those who are influential can get medications and prescriptions they need. Some doctors have private practices and if we pay them, then they will take proper care of us. There are good medicines but they are sold illegally on the black market. We never receive medicine from the doctors at the health post. We have to go to the chemist. The medicine is supposed to be given to us by the government but instead it is sold on the black market and we have to buy it from the chemist’s shop instead.”

“Last year my daughter-in-law had a problem during delivery. She got shaking chills and did not recover after 3-4 days. We took her to the local health post but the treatment was not proper. We had to take her to another hospital in Lucknow. We need better services at the local health post. Since *Saksham* came to our area there have been more doctors present and the performance has improved. We still have to go other places to have our blood tested and also to get transfusions... Doctors never listen to us because we are poor. They charge us their fees no matter what.”

It is necessary to note how central the villagers felt the poor infrastructure and inadequate health system was to their ability to advocate for better health. This finding emphasizes the importance of understanding the local health system in the conceptualization of women's health agency.

Overall, the four main themes presented here- participation, autonomy, agency/self-efficacy and health systems- incorporate the majority of responses provided by the male and female participants. Together they provide an adequate representation of the villagers' perceptions surrounding the complexity of women's health agency. A few central issues did arise multiple times that did not fit clearly into these themes. These predominately included descriptions and specific examples of local corruption and personal beliefs relating to traditional practices, including widow burning and dowry.

Discussion

The focus group scenarios clearly engaged a number of villagers in discussions about formal and informal channels of local participation, the relationship between advocacy and community health, and the concept of women's health agency. Many individuals expressed their belief that participation in this study was an example of their advocacy to improve the conditions of their villages and their lives. A number of limitations were recognized, however overall, individuals appeared to be largely uninhibited in their responses and eager to discuss the given topics. In addition, it seemed as though certain subjects, such as autonomy and self-efficacy, were, to our knowledge, not previously discussed by the men or women. Thus, the introduction of these issues into public conversation was clearly significant as well.

The following discussion section will summarize the findings within each of the four themes deemed relevant to an understanding of women's health agency. Rationale for the specific results will be proposed and similarities and differences to findings in the current literature will be highlighted.

Participation

Overall, it became evident that the villages' culture encouraged elders, particularly elder women, to actively engage in their communities. While few outlined outright restrictions to the participation of young women, obvious limitations existed. In the majority of the villages, the elder women were especially protective of the young women and permission from the mother-in-law was clearly necessary and possibly more important for day-to-day activities than permission from the husband. Like the young

women, young men exhibited less impetus to involve themselves in advocacy efforts. However, the young men, more than the young women, were keenly aware of the obstacles they would likely encounter.

Elder men, like the elder women, were more eager to be extensively engaged, particularly in discussion of the problems that exist in their community and the limitations to their ability to change their current plight. The elder men, however, seemed to be able to provide fewer examples of their actual efforts and accomplishments than the elder women. One reason for this may have been the overall sentiment that men had less to prove to us than the women, as it was made clear that the study was primarily about women's health agency and political participation. Another reason may be that elder women are simply more involved in actual health advocacy efforts than elder men. Both men and women believed that women were more in tune to health, education and concerns of the family than men and therefore it may be more their societal role to work to improve these aspects. Findings from past studies in India similarly emphasized greater female presence in the areas of education, health, and familial well-being which would affirm this justification.³¹

An additional explanation suggests that men are more intertwined with both the traditional channels of participation and the obstacles of hierarchy and corruption such that they are more hesitant to involve themselves in more innovative means of advocacy. Among women however, informal means of participation, most notably women's groups, were their primary way of organizing and accomplishing their goals. It has been shown in the literature that women's groups are oftentimes the most accessible channel for women to mobilize and participate politically. In other studies discussed, that took place in rural

communities with similar demographics, an outside organization most often was influential in starting these groups, training women, and promoting goals.^{62, 63}

Interestingly, the most energetic, determined women's groups uncovered by this study were those that formed in villages that had limited outside interventions. These women had clear priorities and goals and formed these groups spontaneously to achieve them. A number of women however, did mention that they wanted better training and financial support for their groups and felt that these aspects would make the groups more successful and sustainable.

Attempts were also made to understand potential differences in participation by caste. Interestingly, it seemed that individuals belonging to the lowest, *dalit* caste and individuals belonging to the highest, *brahmin* caste, seemed to be the most knowledgeable about the avenues of participation. In addition, they seemed to be the most active participants. Members of the *dalit* caste were closely tied to the BSP party, and felt well represented by Mayawati, the leader of Uttar Pradesh who is also a member of the *dalit* caste. Members of the *brahmin* caste were the most active in the village council and frequently served as the village *pradhan*. They also tended to be the wealthiest in the villages and thus had the greatest access to educational opportunities. In part, their higher level of education may have also facilitated their increased participation. Further, because of the recent ties between Mayawati and the *brahmin* caste through a number of political appointments, both the *dalits* and the *brahmins* feel well represented by their regional government. Therefore they seem more eager to participate locally since they feel that their requests will be supported by the Uttar Pradesh leadership.

Importantly, no individual seemed to feel that his/her caste was a limiting factor in terms of participation.

It was more challenging than anticipated to extract true differences in participation between villages that were deemed intervention and non-intervention villages by the *Saksham* study. One expectation, based on an aforementioned study in Nigeria, was that participation would be significantly higher in villages that experienced a community-based health and empowerment intervention.^{52, 53} Here, members of intervention villages did seem to be more aware of the channels of advocacy and more in tune to their role as active participants. They also pointed to *Saksham* as the organization that will ensure that their voices are conveyed to the higher government leaders. Likely secondary to this, they were less disillusioned as a whole with the local government and with their access to health care. However, one village that was formerly a non-intervention village and was recently transitioned to an intervention village was noticeably different from both the intervention and the non-intervention villages. Unexpectedly, the women in this village seemed to be even more knowledgeable, engaged in the community and aggressive with respect to their goals than those in the standard intervention villages. Moreover, their advocacy efforts were more creative, independent and overall, more successful than those described by women in other villages. This may suggest that international interventions might be better served teaching and promoting informal, less traditional means of participation, as opposed to council meetings or community board structures. By enabling grassroots formation with outside support and encouragement, the women could take greater control over their participation, contribute their own goals, and foster its sustainability.

Greater understanding of men's perception of women's participation and their potential efficacy as community leaders was also central to this study. Thoughts on this varied, and for the most part were not split evenly by age or education level or between intervention and non-intervention villages. Most of the hesitancy towards women's participation and leadership from the men's perspective was logistical. The men, in general, seemed to think that educated women were capable of political leadership and advocacy however were limited by certain external circumstances such as distance to meetings and safety with unaccompanied travel. Most men thought that women would prioritize issues of child care, health and education and would be as successful as men at improving conditions in those domains, and possibly less corrupt or easily influenced than male leaders. There were certain other areas such as infrastructure improvement and economic development that the men felt they would be more successful at achieving. This divide was similar to that shown in past studies. However, in this study there were more groups that seemed to think that all issues were both male and female issues, and more broadly, community issues, than those that aligned certain issues with one gender.

Autonomy

Distinctions between men and women, and possibly more dramatically, between young and elder individuals were apparent in the discussions surrounding autonomy. There were a few different dominant structures that seemed to especially limit the autonomy of young women. The first, and most prominent, is the mother-in-law. As soon as young women were married, they moved into their husband's home. In terms of daily functions including movement around the village, participation in community activities

and ability to seek health care in the middle of the day, permission from the mother-in-law must always be obtained. This was clear in all villages, but was especially vocalized in hamlets where the majority of participants belonged to the warrior caste. This central role of mother-in-laws was emphasized in all focus groups regardless of age and gender and it was clear from observations of body language and facial expressions, the dominant role the mother-in-law plays in this community.

The second limiting figure is the husband. For young women, permission was traditionally granted by the husband and the mother-in-law, however, if the husband was not available, the consent of the mother-in-law was sufficient. Decisions relating to household functions, care of the children, and the family health were more in the domain of the mother-in-law than the husband. However, issues of money, business, and politics were controlled by the husband, and in some households, the elder male or the father-in-law. The young men seemed to emphasize their requirement that women obtain permission for most things whereas elder men seemed less concerned with this formality.

The third structure in these villages that was found to influence autonomy was the community. Both men and women expressed the importance of their village community in making decisions, and elder women in particular emphasized that their individual voices must be unified as a community or else they would not matter. Individuals conformed to the norms of their hamlet and their issues, concerns and priorities were most often shared. This can be explained by a number of factors. Most villagers within a single hamlet were of similar socioeconomic status and caste. They shared the same poor infrastructure, relied on the same wells, and the same faulty electricity wiring. Their children went to the same schools and they relied on the same health post in Shivgarh.

Individual women and men of all ages felt that the only way they could bring change to their village was if they worked as a unit. Therefore, when specific questions were asked for example regarding individual autonomy to vote for whichever candidate they choose, many deferred to the village as a whole and said that it was more important to vote for the same person as the other community members than to vote for the person they thought might be best. These findings confirmed prior studies also in India that showed that women are more likely to link their issues and priorities to those of the entire community than to express individual priorities.^{47, 48, 49}

It is also noteworthy to examine those women who stood apart and stated for example that they would vote for a different candidate from their husbands, or their neighbors. These women, in general, tended to be literate, better educated and in their mid-30s or early 40s. One might anticipate this to have been the case, however, past studies have varied in their descriptions of the relationship between education and participation and autonomy. There were also a few men who felt that women had the right to decide on their own who to vote for. However here, there was no relationship between age or education level. Most often, these men stated that because ultimately they do not know exactly who their wife votes for, they cannot have complete control over it. The rationale of many of the men was that women were not as well informed about the candidates. Interestingly, while many of the women similarly felt that they did not have as much access to this information as men, when asked for concrete thoughts on specific local candidates, both women and men responded with about equal awareness and proficiency.

Along these lines, both women and men fairly universally seemed to say that men should be the ones to raise important issues and concerns in council meetings or in the community. The rationale was that men are simply more aware of these issues and are able to better represent them. However, here too, when asked explicitly, women described in equal detail and eloquence, the issues that most significantly affected their families. Thus, it seems that while women's knowledge and fluency is perceived to be inferior to men's, their autonomy is more significantly restricted by cultural norms than by their actual awareness of the issues and access to information.

Autonomy was also assessed in other respects, particularly in terms of a woman's access to education, health care and control over household finances. Fairly universally, men and women believed that girls should have equal access to education and health care as boys. Similarly, all men emphasized the need for better prenatal and postnatal care for their wives. In terms of money, it seemed that the men had control over whatever money was available, but for health needs, either the man or the woman could readily access it. Most women said they did not have money to spend for leisure, but this was not because their husbands would not allow it but rather because their family did not have it to begin with. According to DHS studies, this caveat is deemed central to the realization of women's empowerment. However, it is clear that given the circumstances of the village, that either other more achievable indicators must be established to better ascertain this, or that the villagers are far from realizing true empowerment given their financial and structural limitations.

Responses in general for these issues relating to autonomy did not differ significantly between intervention and non-intervention villages. This finding was

somewhat inconsistent with past literature of its kind and to some degree refutes part of this study's hypothesis. Based on past studies, this study hypothesized that through a community-based intervention, all of the villagers would be raised to a higher level of awareness both to health-related goals, and to the importance of participation. By encouraging both men and women to participate both in the administration of the *Saksham* intervention and on its community governing board, one would have thought that men's perceptions of women's autonomy may have been changed to some degree. However, the findings of this study show that responses did not vary significantly for either men or women between intervention and non-intervention villages. One reason may be that the study had clear goals that were specifically focused on neonatal health. The purpose of the community board was to mobilize male and female community members' efforts to improve this, rather than explicitly to improve women's participation and autonomy. Without the actual, formal discussion and education about these topics, the strong cultural norms may not be readily displaced. Alternatively, this study may have taken place too soon after the *Saksham* intervention to truly appreciate its long-term effects on participation and autonomy.

Agency/Self-efficacy

The goal of the scenarios that addressed agency was to better understand both women and men's ability to advocate for themselves and their families in general, and for improved health and health-related services. Here, perceptions of both women and men were especially important as numerous behavioral studies have shown that the extent to which an individual believes he/she is capable of change relates directly to his/her success.⁵⁵ In this study, individuals with the greatest sense of self-efficacy tended to be

elder women living in the intervention villages. A number of these women were able to cite examples of groups of women staging protests, speaking with higher officials or launching advocacy campaigns to obtain better services for their village. Most of the examples resulted in some degree of success whether it was part of a link road created, electricity for a few hours each day, the administration of the Japanese encephalitis vaccination to children in the village, or the inspection of the broken water well by the local water corporation.

One village, already discussed in the participation section, that was, until recently, a non-intervention village but now is receiving some degree of early intervention by *Saksham*, seemed to have women with the greatest sense of self-efficacy, and with examples of concrete achievements. There are a few hypotheses that may explain this. It is possible that there was significant spillover from neighboring intervention villages and thus, these individuals were potentially more empowered than a non-intervention village in another region. Alternatively, they may have been aware to some degree, of the interventions in the nearby village and recognized that they had to create their own channels to achieve the same successes. Therefore, they had to fight even harder than the intervention villages for their achievements and could not rely on *Saksham* to aid them in the same way. This may actually have resulted in more sustainable, successful women's groups as they truly were formed from the bottom-up. Now that the intervention has been introduced, these women have a more direct channel for advocacy and seem very eager to utilize it. Possibly, these women may have also been more eager to share their accomplishments than other villagers, even in the intervention villages, because of their largely autonomous success.

A key factor ascertained was the degree to which the community, and the society as a whole, supports and encourages individual health agency. Overall, the majority of individuals, regardless of age, gender, education level and intervention status, were disillusioned with the current governing system and found it corrupt, inaccessible and excessively hierarchical. Individuals who had received some degree of higher education seemed to be the most in tune to the obstacles of the current political and health system and therefore were also the most hesitant to fight for change. A minority of individuals, usually elder women, did feel that their voice could make a real difference by working through the existing structures and were able to cite examples of this. Most young men and women felt that the village leaders would not be receptive to their complaints and their efforts would not be effective. Elder men consistently described an environment that does not facilitate their real participation or advocacy, except in the time of elections where everyone makes promises for improved infrastructure and better health systems and then no one acts once elected. Thus, it seemed that the structures of the society and the governing system actually serve as barriers to advocacy and in turn limit individual health agency significantly regardless of gender, literacy status and age. These findings affirm the importance, as stated in definitions throughout the literature, of understanding the structures and norms of the society in order to appropriately assess the potential for women's agency.

In this domain, there was a notable difference, as anticipated, between intervention and non-intervention villages. The villages that had *Saksham* as a resource, felt that their environment was more supportive of their voice for change than the villages without this additional channel. Intervention villages in general felt more favorably

towards their village leadership and believed that *Saksham* was a helpful intermediary that rendered the governing structures more accessible and receptive to their needs. However, in this spirit, villagers seemed to be more eager to have *Saksham* function as their proxy health advocate than to work on their own to achieve their village's goals.

Health Systems

The functioning of the health system, access to health education, and the receptivity of health leaders to improve access, resources and affordability of the health post, also contribute to an understanding of women's health agency. In addition, the overarching infrastructure that determines ability or inability to access health care in the first place is a significant consideration. Consistently, in every focus group, villagers provided extensive critiques of their local health post. Specifically, inadequate facilities, far distances, no medications, no laboratory for tests, no doctors after the mid-afternoon, no emergency services and unaffordable care were the most frequent criticisms. In addition, basic infrastructure issues including no paved roads, no street lights or electricity and no transportation made the health post inaccessible to most. Lack of sanitation and clean water wells in the villages were also thought to be intertwined with the inadequate health system. It became clear that the persistence of these problems, despite repeated complaints, and the lack of receptivity by the local government leaders and local health leaders to fix these problems contributed significantly to the poor self-efficacy felt by many villagers.

However, female focus groups did speak favorably about the Asha workers, or the community health workers. They felt that although they were unable to reach everyone

with prenatal care and vaccines, the situation was significantly better than what they had before. In addition, both women and men felt that they required more health education and felt that some of it was coming from these community health workers. From the responses provided, it did seem that the government health system would be utilized if it was perceived to be effective. However, currently, some of the villagers stated that they either have to rely on private doctors or *jolachobs* (“quack” doctors) to receive affordable, accessible care.

Overall, the villagers felt that even if they fought for better health services, the health posts would be ill-equipped to provide them, here again affirming the importance of understanding the health system in order to gauge women’s health agency. Focus groups in both the intervention and non-intervention villages both were equally disappointed by the health posts however it seemed that those in the intervention village were still more likely to seek care at the posts possibly because they had more knowledge of the services offered. It was apparent that the obstacles to reaching the health posts and affording the care if they did arrive were the most significant, especially in emergencies. These were also the difficulties that the villagers thought to be the most insurmountable. It became clear that even the groups that demonstrated the greatest participation, the most significant autonomy and the best sense of self-efficacy, felt that they could not achieve their health goals because the health system was so inadequate and for the most part, resistant to change.

Conclusions

This study gathered a significant amount of qualitative data which highlighted a number of key points, and met the study's objectives. A greater understanding of perceptions and obstacles of women's political participation was grasped through the focus group structure. Targeting both men and women in the discussions was found to be crucial both to a comprehensive understanding of the cultural norms of the village and to an understanding of the true opportunities afforded to women and the limitations they face. It became clear that informal channels of participation, and specifically, spontaneously forming women's groups, were thought, by both men and women, to be the best way women could become involved in the political culture and promote health-related goals. However, the need for greater education and financial support for these groups, either from the local government or from international organizations, was affirmed.

The study hoped to show an added benefit of improved women's health agency among individuals who participated in a community-based participatory health intervention. Here, data was quite varied. In some intervention villages, women were clearly more aware of the channels for participation and the possibility of taking control over their own health and the health of their children, compared with women in non-intervention villages. However, overall, there was little difference in overall participation, autonomy, or the functioning of the health system between the two groups of villages. The most interesting finding here was a village that had a newly introduced partial intervention in which women demonstrated the greatest self-efficacy and, actual achievements in health infrastructure improvement. It is clear from these findings that

community-based health interventions must have explicit women's empowerment goals in order for this to be a byproduct of the study. Further, it is also evident that bottom-up mobilization is optimal and most sustainable, especially when supported and nurtured by an international study group with a record of a positive presence in the community.

Another key finding of this study was the central role of elders, and particularly of elder women, in the community. Their role spans that of caretaker, community spokesperson, advocate, and family advisor. Given the crucial importance of their place in the society, it is clear that efforts to improve the autonomy, participation, and self-efficacy of young women must include, and likely prioritize elder women.

Possibly the most significant finding of this study was the recognition of the crucial role that poor infrastructure and the inadequate health system play in limiting women's health agency. An elder woman clearly captured this: "*All other things are secondary to a healthy atmosphere. We are rural people without proper infrastructure, with not even a road. Maybe if we had this basic infrastructure, we would be able to participate better and get better care.*" This information is particularly important because it emphasizes that regardless of the intervention, health or otherwise, if fundamental improvements are not made to the living conditions, sanitation system, water supply, road structures, and health facilities, neither empowerment nor health related goals can truly be obtained in a real, sustainable way.

Finally, this study reaffirmed the knowledge that an operational definition of agency and women's health agency in particular, is complex. This study connected an understanding of the channels of participation, the cultural norms relating to autonomy in the home and the community, self-efficacy and past accomplishments, and the workings

of the health system, to provide a multifaceted appreciation of the obstacles and opportunities to improve women's health agency in this community in Uttar Pradesh, India. The introduction of these topics into this community's public discourse was a significant beginning to the process of achieving greater empowerment for women.

Recommendations

The findings from this qualitative research contributed to the following proposed recommendations for future community-based participatory health work in rural northern India.

- 1) Awareness of the potential channels of advocacy must be heightened particularly focusing on young women and young men.
- 2) Local groups, NGOs, and international projects must open the channels of advocacy and serve as a link for less accessible government structures, but they must also transition this role to the villagers to allow for sustainability.
- 3) Women's group formation should be encouraged with specific goals and strategies.
- 4) Education and literacy efforts should be emphasized and adult education particularly for elder women should be encouraged.
- 5) Attention must be paid to infrastructure development. True ability to achieve health goals and to advocate successfully can only happen if appropriate infrastructure (paved roads, electricity, sanitation, clean water) exists.

- 6) Village council meetings, NGO meetings and international project meetings must occur closer to the villages. Women especially cannot attend if they are any sizable distance away.
- 7) Health post resources must be improved. Villagers must feel that they are getting the services they require once they reach the post (affordable care, available doctors, tests, medication, transport to other facilities if necessary.)
- 8) Involvement of young women in health education efforts, in local village council meetings and in women's groups is central to their sustainable participation in their community and their confidence to engage in effective advocacy efforts.
- 9) Success stories particularly relating to the achievement of health and development goals (increased village vaccination rates, improvement of water pumps, road pavement), should be publicized to show other women and men that they are capable of similar accomplishments.
- 10) Transparency and accountability of local government must be improved. Villagers who do choose to vote for candidates that promise to focus on their interests must have some degree recourse if this does not occur.
- 11) Efforts must be increased to educate young men in particular, about the importance of women's participation in government and in health decisions.
- 12) Women and men should be encouraged to speak openly and publicly about issues relating to women's political participation and autonomy.
- 13) In order to facilitate sustainability, health projects must have an explicit component that encourages women's advocacy, participation and empowerment.

Figure 1: BEHAVIOR CHANGE MODEL TO IMPROVE POLITICAL PARTICIPATION AMONG WOMEN IN SHIVGARH, UTTAR PRADESH

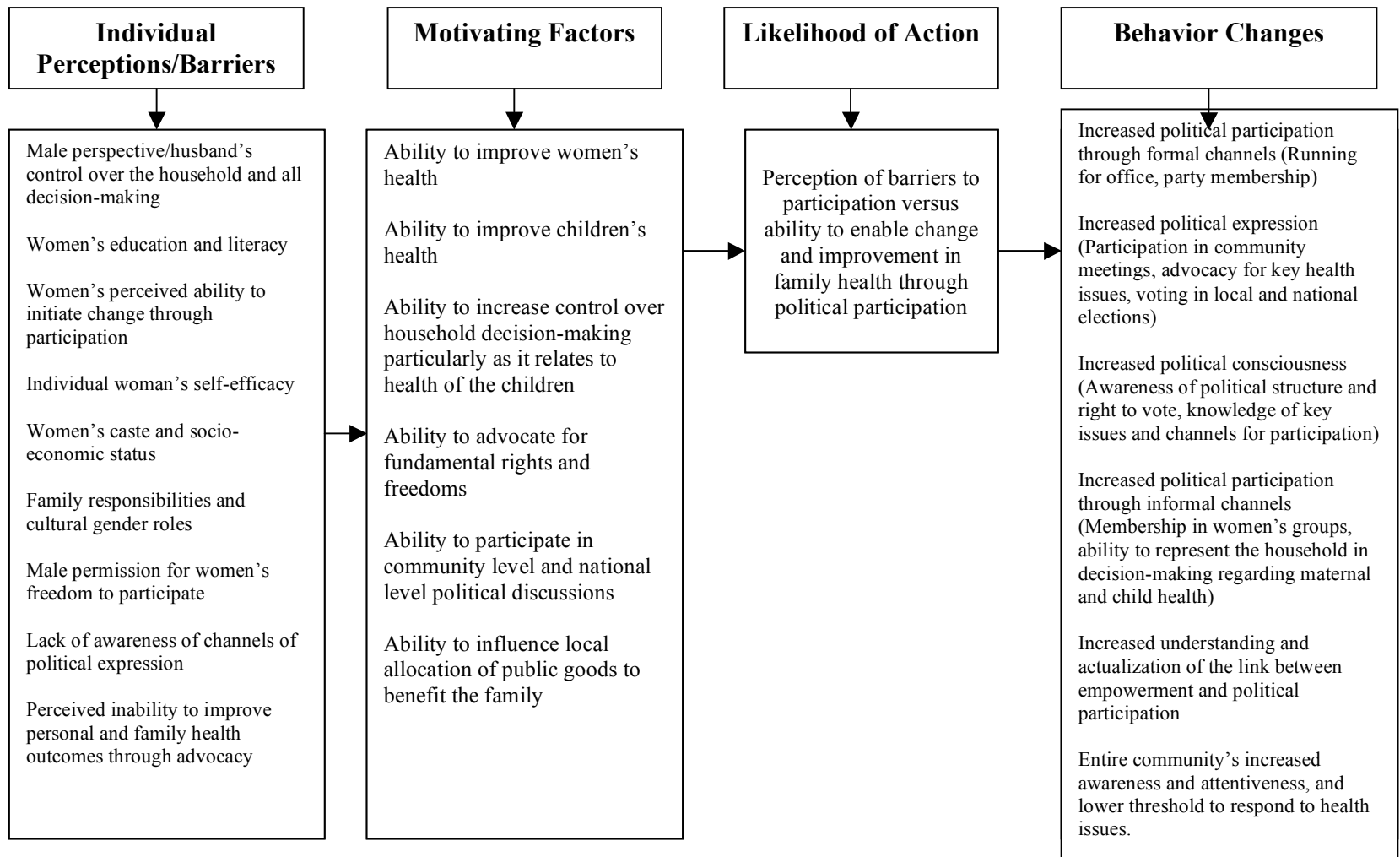


Figure 2: IMPACT MODEL: COMMUNITY EMPOWERMENT AND POLITICAL PARTICIPATION OF WOMEN TO IMPROVE NEONATAL, CHILD AND COMMUNITY HEALTH

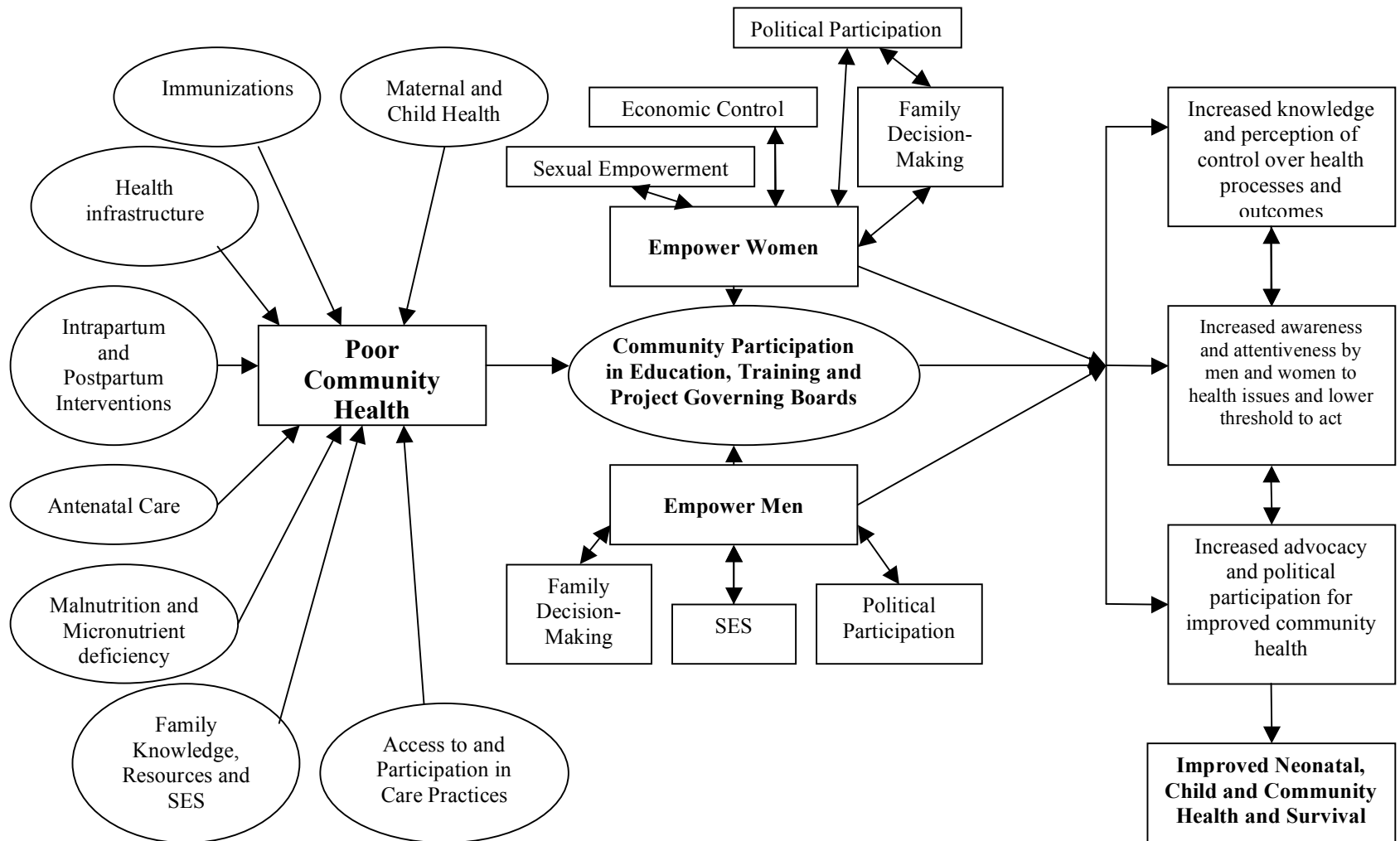


Figure 3: Map of Uttar Pradesh⁸⁴



Figure 4: CAUSE/IMPACT DIAGRAM FOR PARTICIPATION AMONG WOMEN AND MEN

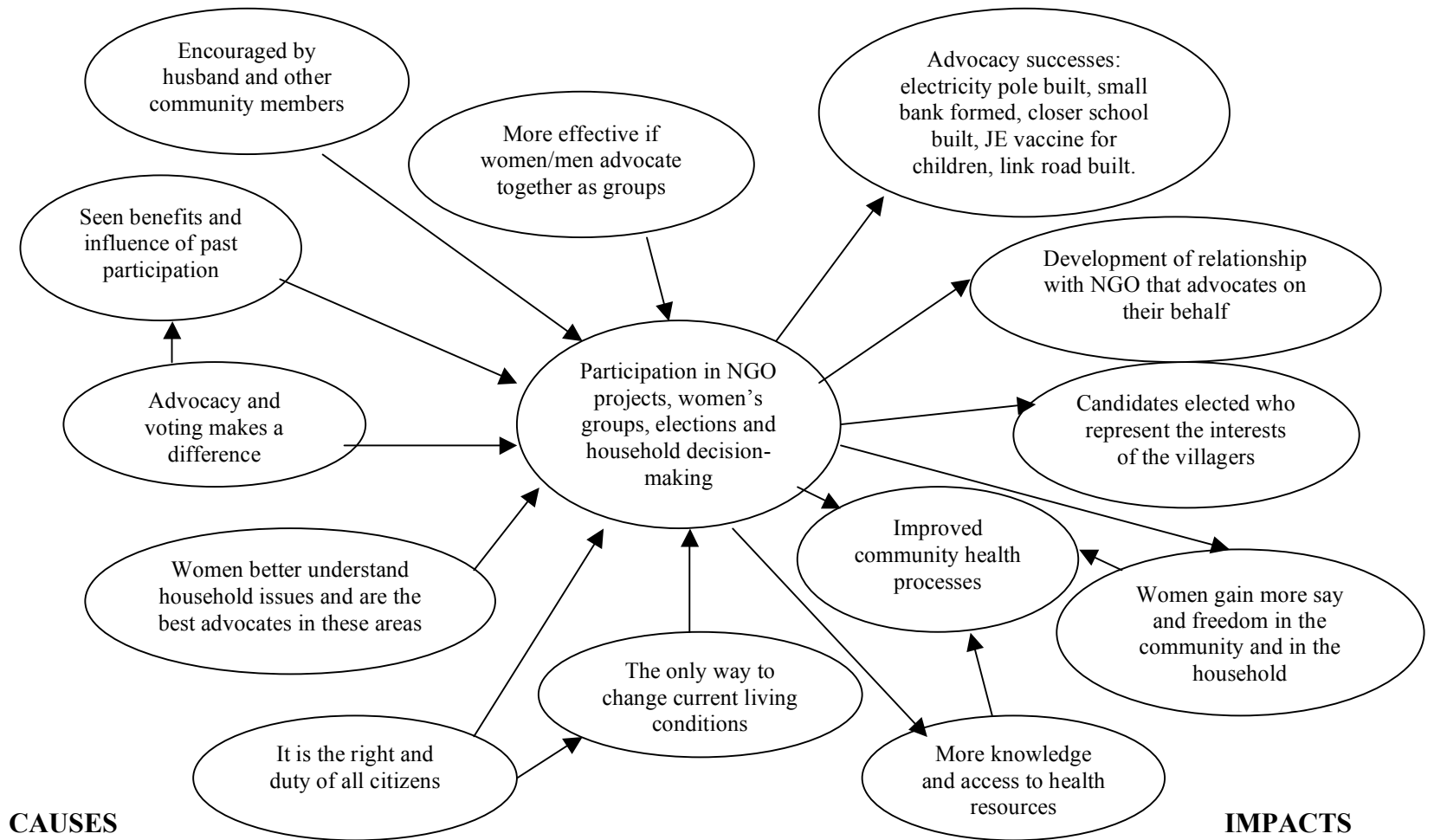
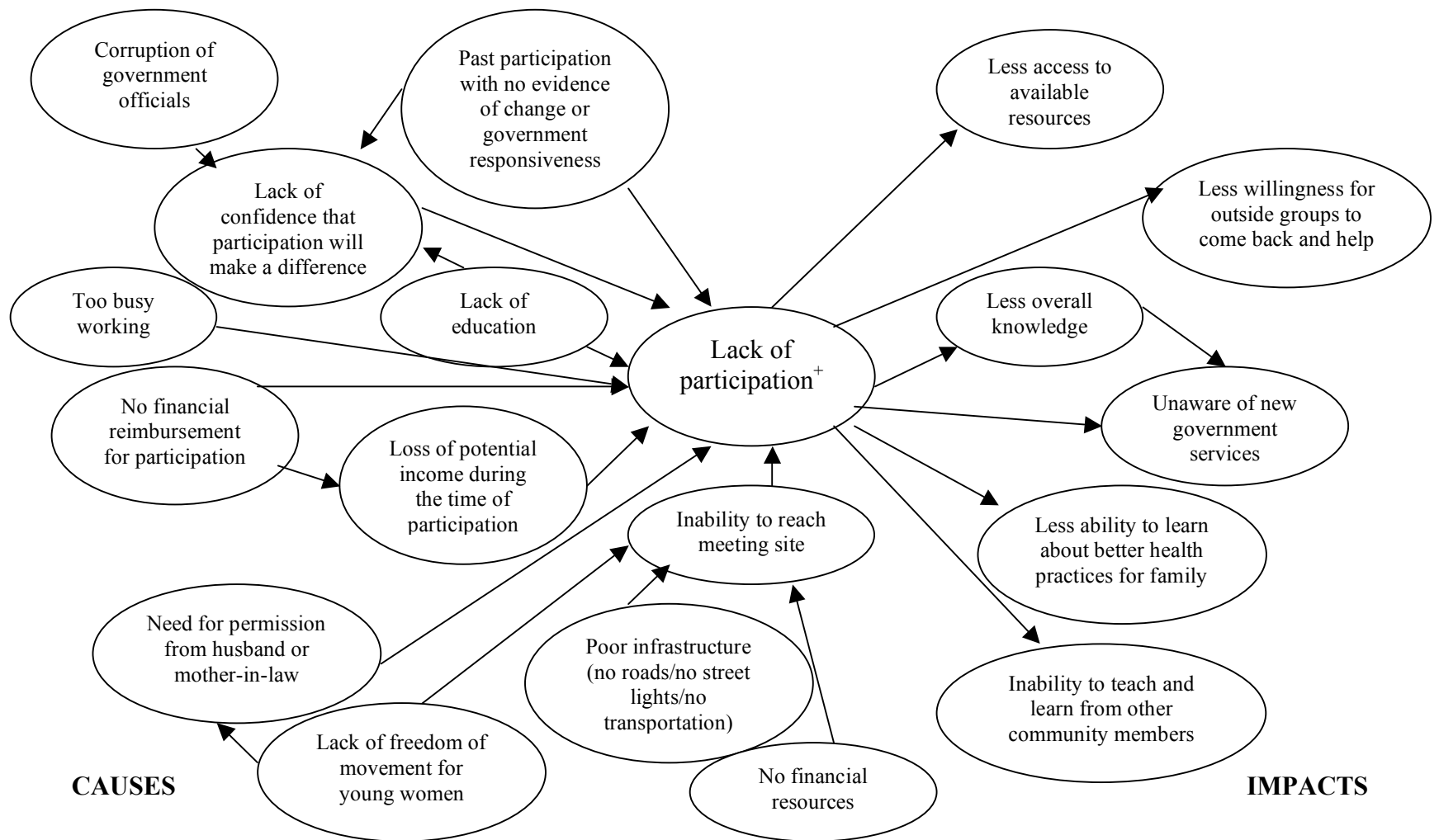


Figure 5: CAUSE/IMPACT DIAGRAM FOR LACK OF PARTICIPATION AMONG WOMEN AND MEN



⁺Participation includes but is not limited to village council meetings, women's groups and NGO board meetings.

Appendix 1: Focus Group Scenarios for Women

- 1) There is a woman leader of your village council and the topic of discussion is the health of children in the community. Would you attend the meeting? What would you say? What would your priorities be? What if there was a male leader? Would any of these answers change? (*Participation/autonomy*)
- 2) An international research project is taking place in your community trying to improve the health of your newborns. Will you volunteer to sit on the project governing board? What will your priorities be? (*Participation/agency*)
- 3) Your child has diarrhea for the 4th time this month. You know that one of the problems is the lack of clean drinking water in the community. What do you do? Who do you talk to? (*Agency*)
- 4) The health post closest to your home does not have the resources to provide the best care for your family. What do you do? How do you make sure your children have access to the health services they need? (*Health systems/agency*)
- 5) You need to ask permission to take your child to the doctor. You notice your child is sick but your husband (or mother-in-law) is unreachable. What do you do? Can you pay for the services and medication your child may need without help from your husband (or mother-in-law)? (*Autonomy*)
- 6) You and your neighbors decide to start a women's group because you think that your voice will be better heard if it comes from an organized group. What is the group's priority? What will you most want to advocate for in your community? How do you think you can make the greatest difference? (*Participation/agency*)
- 7) You notice that there are some women in the community who always go to town meetings and are actively engaged in the debates. Many women in your community however are not like this. What makes the women who do participate different? (*Participation*)
- 8) You hear rumors of a new vaccination that will prevent a disease in your child. You learn that some neighboring villages have it but yours does not. What do you do? (*Health systems/agency*)
- 9) A new election is coming up. You would like to vote but you do not know anything about the candidates. How do you find out? What issue in the election is the most important to you and will most influence who you vote for? Can you vote for a different person than your husband? (*Participation/Autonomy*)
- 10) You are at a town meeting with your husband. You can raise one issue that is important to you and he can raise one that is important to him. What do you think the issues would be? Would they be different? (*Autonomy/agency*)
- 11) A health education campaign teaches you all about prenatal care and need for better access to health facilities during childbirth. Now that you know that this will improve your own health and the health of your baby, what will you do to obtain these services? (*Agency/Health systems*)

Appendix 2: Focus Group Scenarios for Men

- 1) There is a woman leader of your village council and the topic of discussion is the health of children in the community. Would you attend the meeting? What would you say? What would your priorities be? What if there was a male leader? Would any of these answers change? (*Participation/autonomy*)
- 2) An international research project is taking place in your community trying to improve the health of your newborns. Will you volunteer to sit on the project governing board? What will your priorities be? (*Participation/agency*)
- 3) Your child has diarrhea for the 4th time this month. You know that one of the problems is the lack of clean drinking water in the community. What do you do? Who do you talk to? (*Agency*)
- 4) The health post closest to your home does not have the resources to provide the best care for your family. What do you do? How do you make sure your children have access to the health services they need? (*Health systems/agency*)
- 5) You are away from the home and your wife thinks your child is sick. She takes him to the doctor. The doctor tells her to get medicine for the child. She does not ask permission from you or from her mother-in-law to take him to the doctor and to buy the medicine he needs. What do you do? How would you react? (*Autonomy*)
- 6) Your wife wants to become a member of a women's group to advocate for better health for your children. Can she do this? Should she do this? Will you encourage her to do this? Do you think this group will be effective? What kinds of things would they be able to do most successfully? (*Autonomy/agency*)
- 7) You notice that there are some women in the community who always go to town meetings and are actively engaged in the debates. Many women in your community however are not like this. What makes the women who do participate different? (*Participation*)
- 8) You hear rumors of a new vaccination that will prevent a disease in your child. You learn that some neighboring villages have it but yours does not. What do you do? (*Health systems/agency*)
- 9) A new election is coming up. You would like to vote but you do not know anything about the candidates. How do you find out? What issue in the election is the most important to you and will most influence who you vote for? Can your wife vote for a different person than you? (*Participation/Autonomy*)
- 10) You are at a town meeting with your wife. You can raise one issue that is important to you and she can raise one that is important to her. What do you think the issues would be? Would they be different? (*Autonomy/agency*)
- 11) A woman has been elected to represent your village. Can she be an effective leader? Will she represent your interests? Do you think she will prioritize health issues more than a male leader? What do you think she will prioritize less? (*Agency/Health system*)

References

- ¹ Schwindt-Bayer, L. "Female Legislators and the Promotion of Women, Children, and Family Policies in Latin America." *Background Paper of The State of The World's Children 2007*. UNICEF 2006.
- ² "Beijing Plus Five Process and Beyond. Gender Equity Development and Peace for the 21st Century. *Division for the Advancement of Women*. (Accessed via Internet: <http://www.un.org/womenwatch/daw/followup/beijing+5.htm>).
- ³ Empowerment and Poverty Reduction: A Sourcebook, Poverty Reduction and Economic Management (PREM), World Bank. 2002. (Accessed via Internet: <http://www1.worldbank.org/prem/poverty/empowerment/sourcebook/index.htm>)
- ⁴ Malhotra A, Schuler S, Boender C. "Measuring women's empowerment as a Variable in International Development." *Background Paper Prepared for the World Bank Workshop of Poverty and Gender: New Perspectives*. June 2002. (Accessed via Internet: <http://www.aed.org/LeadershipandDemocracy/upload/MeasuringWomen.pdf>)
- ⁵ Kabeer, N. "Reflections on the measurement of women's empowerment." *In Discussing Women's Empowerment-Theory and Practice*. Sida Studies No. 3. Novum Grafiska AB: Stockholm, 2001.
- ⁶ Bennett L. "Using Empowerment and Social Inclusion for Pro-poor Growth: A Theory of Social Change" *Working Draft of Background Paper for the Social Development Strategy Paper*. Washington, DC: World Bank. 2002.
- ⁷ "Guidelines on Women's Empowerment. United Nations Population Information Network." *UN Population Division, Department of Economic and Social Affairs, with support from the UN Population Fund*. (Accessed via Internet: <http://www.un.org/popin/unfpa/taskforce/guide/iatfwemp.gdl.html>)
- ⁸ Longwe S., Clarke R. "Towards Improved Leadership for Women's Empowerment in Africa: Measuring Progress and Improving Strategy" *Africa Leadership Forum*. April 1999. (Access via Internet: <http://www.africaleadership.org/Finreports/ISWA.pdf>)
- ⁹ Basu AM, Koowal GB. "Two Concepts of Female Empowerment: Some Leads from DHS Data on Women's Status and Reproductive Health. *A Focus on Gender*. USAID. August 2005.
- ¹⁰ Dixon-Mueller, RB. *Rural women at work: strategies for development in South Asia*. Baltimore, MD. Johns Hopkins University Press. 1978.
- ¹¹ Mason KO. "The status of women: conceptual and methodological issues in demographic studies." *Sociological Forum*. 1(2), 1986.
- ¹² Desai, S, Johnson K. "Women's Decision-making and Child Health: Familial and Social Hierarchies." *A Focus on Gender: Collected Papers Using DHS Data*. August 2005.
- ¹³ "Universal Declaration of Human Rights." *United Nations General Assembly Resolution 217 A (III)*. 10 December 1948. (Accessed via Internet: <http://www.un.org/Overview/rights.html>)
- ¹⁴ "Women's Rights Are Human Rights." *Office of the High Commissioner for Human Rights*. Spring 2000. (Accessed via Internet: <http://www.unhchr.ch/html/menu2/womenpub2000.htm>)
- ¹⁵ Guidelines on Women's Empowerment. United Nations Population Information Network. *UN Population Division, Department of Economic and Social Affairs, with support from the UN Population Fund*. <http://www.un.org/popin/unfpa/taskforce/guide/iatfwemp.gdl.html>
- ¹⁶ Kishor S., Neitzel K. "The Status of Women: Indicators for Twenty-Five Countries." *DHS Comparative Studies* No. 21. Maryland, USA: Macro International, Inc. 1996.
- ¹⁷ "Introduction: A Focus on Gender." *Collected papers on Gender Using DHS Data*. USAID. August 2005.
- ¹⁸ "The Context of Comparative Reports: Women's Health Results from Demographic and Health Surveys 1994-2005." *USAID*. ORC Macro Publishers: Maryland, December 2005.
- ¹⁹ Mathews et al. "Village in the City: Autonomy and Maternal Health-seeking among Slum Populations of Mumbai." *A Focus on Gender: Collected Papers Using DHS Data*. August 2005.
- ²⁰ "International Covenant on Civil and Political Rights." *Office of the United Nations High Commissioner for Human Rights*. December 1966. (Accessed via Internet: <http://www.ohchr.org/english/law/ccpr.htm>)

- ²¹ “Convention on the Elimination of All Forms of Discrimination Against Women” *United Nations General Assembly*. December 1979. (Accessed via Internet: <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm#part2>)
- ²² International Conference on Primary Health Care. *Declaration of Alma-Ata*. September 6-12, 1978. (Accessed by Internet: http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf)
- ²³ Marks, Stephen. “Peoples Charter on Human Rights” *Health and Human Rights: Basic International Documents*. Harvard University Press. Cambridge, US. 2004.
- ²⁴ “Women and Children: The Double Dividend of Gender Equality.” *The State of the World’s Children 2007* UNICEF. New York. 2006.
- ²⁵ Moghadam V. Senftova L. “Measuring women’s empowerment: participation and rights in civil, political social, economic and cultural domains.” *UNESCO*. 2005.
- ²⁶ Sen, G, Grown C. *Development, Crises, and Alternative Visions: Third World Women’s Perspectives*. New York: Monthly Review Press, 1987.
- ²⁷ Pillarisetti JR, McGillivray, M. “Human Development and Gender Empowerment: Methodological and Measurement Issues.” *Development Policy Review* 16 (1998) 197-203. (Accessed via Internet: <http://www.blackwell-synergy.com/doi/pdf/10.1111/1467-7679.00059?cookieSet=1>)
- ²⁸ Chhibber, P. “Why are some women politically active? The Household, public space and political participation in India.” *IJCS* 43(3-5): 409-429. (Accessed via Internet: <http://cos.sagepub.com/cgi/reprint/43/3-5/409>)
- ²⁹ Wildner M, Fisher R, Brunner A. “Development of a questionnaire for quantitative assessment in the field of health and human rights.” *Social Science and Medicine*. 55, 1725-1744, 2002.
- ³⁰ Duflo E, Topalova P. “Unappreciated Service: Performance, Perception and Women Leaders in India.” *Poverty Action Lab Paper, MIT* 2004. (Accessed via Internet: <http://www.povertyactionlab.com/papers/Duflo%20Topalova%20Unappreciated%20Services.pdf>)
- ³¹ Chattopadhyay, Raghavendra, and Esther Duflo (2004) ‘Women as policy makers: Evidence from a randomized policy experiment in India.’ *Econometrica* 72(5), 1409–1443.
- ³² “Women in Politics.” *Inter-Parliamentary Union*. March 2007. (Accessed via Internet: <http://www.ipu.org/wmn-e/world.htm>)
- ³³ UNICEF calculations based on data from the Inter-Parliamentary Union database (Accessed via Internet: www.ipu.org/wmn-e/world.htm).
- ³⁴ Beaman L, Duflo E., Pande R., Petia T. “Women Politicians, Gender Bias, and Policy-Making in Rural India. *Background Paper for the State of the World’s Children 2007*. UNICEF. New York. December 2006
- ³⁵ Kanter, Rosabeth M. Some Effects of Proportion on Group Life: Skewed Sex Ratios and Response to Token Women. *American Journal of Sociology* 82:965-990, 1977.
- ³⁶ “Women State Legislators: Past, Present and Future” *Presented at CAWP’s fifth national Forum for Women State Legislators*. California, US. Nov. 15-17, 2001. (Accessed via Internet: <http://urwebsrv.rutgers.edu/focus/article/Women%20lawmakers/859/>)
- ³⁷ Banerjee A. and Somanathan R. “A Simple Model of Voice.” *Quarterly Journal of Economics* 116. 189-227. 2001.
- ³⁸ “State of women in urban local government in India: A Description of the Country.” *UN ESCAP India Report*. (Accessed via Internet: <http://www.unescap.org/huset/women/reports/india.pdf>)
- ³⁹ World Values Survey 2000 (Accessed via Internet: www.worldvaluessurvey.org)
- ⁴⁰ Bari, F. Women’s Political Participation: Issues and Challenges. *Division for the Advancement of Women (DAW) Expert Group Meeting Enhancing Participation of Women in Development through an Enabling Environment for Achieving Gender Equality and the Advancement of Women*. Bangkok, Thailand, 8-11 November 2005.
- ⁴¹ Eagly A, Karau SJ. “Role congruity theory of prejudice toward female leaders.” *Psychological Review*. 109. 2002. (Accessed via Internet: http://econ-www.mit.edu/faculty/download_pdf.php?id=1070, 2002.)
- ⁴² British Council. “Effective leaders, view from Central and East Africa.” Mimeo, London, 2002.
- ⁴³ Lott and Kenny. “Did Women’s Suffrage Change the Size and Scope of Government?” *Journal of Political Economy*, 107. 77-95, 1999.
- ⁴⁴ Gleason, S. “Female Political Participation and Health in India. *Annals, AAPSS*. 573, January 2001.

- ⁴⁵ Bryce J, Boschi-Pinto C, Shibuya K, Black RE, WHO Child Health Epidemiology Reference Group. "WHO estimates of the causes of death in children." *Lancet* 365:1147-52. 2005.
- ⁴⁶ Gaudin S, Abdo, Yazbeck. "Immunization in India: An Equity Adjusted Assessment." *HNP Discussion Paper*. World Bank. March 2006. (Accessed via Internet: <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/GaudinYazbeckImmunizationinIndiaFinal.pdf>)
- ⁴⁷ Naples N. *Grassroots Warriors: Activist Mothering, Community Work, and the War on Poverty*. New York: Routledge, 1998.
- ⁴⁸ Bystydzienski, J, Sekhon, J. *Democratization and Women's Grassroots Movements*. Bloomington: Indiana University Press, 1999.
- ⁴⁹ Engendering grassroots democracy: research, training, and networking for women in local self-governance in India. *Contemporary Women's Issues, NWSA Journal*. Indiana University Press. June 2006.
- ⁵⁰ Karestan KC, Lincoln A, Appleton A. "Women's status and child well-being: A state-level analysis." *Social Science and Medicine*. 63:12, 2006.
- ⁵¹ Dixon-Mueller R. Germain A. "Population Policy and Feminist Political Action in Three Developing Countries" *Population and Development Review*, Vol. 20, Supplement: The New Politics of Population: Conflict and Consensus in Family Planning. (1994), pp. 197-219. (Accessed via Internet: <http://links.jstor.org/sici?sici=0098-7921%281994%2920%3C197%3APPAPFA%3E2.0.CO%3B2-Q>)
- ⁵² Teller C., Oyediran. "Linkages Between Women's Participation in Democratic Activities and Reproductive Health Reproductive Health Behaviors: Case Study of Plateau State, Nigeria." *CEDPA and the Enable Project Formal Report*. August 2003.
- ⁵³ Teller C., Oyediran. "Linkages Between Women's Political Participation and Reproductive Health and the Male Influence: Case Study of Plateau State, Nigeria." *CEDPA and the Enable Project Presentation*. September 2003.
- ⁵⁴ Sanders L. "They Psychological benefits of Political Participation" *Prepared for presentation at the Annual Meeting of the American Political Science Association*, San Francisco, August 30 - September 2, 2001.
- ⁵⁵ Bandura, A.. *Self-efficacy: the exercise of control*. New York: W.H. Freeman, 1997.
- ⁵⁶ "Twenty-first Session of the Subcommittee on Women, Health and Development of the Executive Committee." *PAHO*. Washington, DC. February 2005. (Accessed via Internet: <http://www.paho.org/English/GOV/CE/MSD/msd21-04-e.pdf>)
- ⁵⁷ Hossain M, Phillips J. Pence B. "The Effect of women's status on infant and child mortality in four rural areas of Bangladesh." *J. Biosoc Sci*. 2006.
- ⁵⁸ Abrahams, N. "Negotiating Power Identity Family and Community: Women's Community Participation." *Gender and Society*. Vol. 10 No. 6 December 1996. 768-796.
- ⁵⁹ "Women's Suffrage in Asia." *OneWomen Website*. (Accessed via Internet: http://www.onlinewomeninpolitics.org/suffr_asia.htm)
- ⁶⁰ "Women's Empowerment in the Context of Local Government in India" *Report from the Conference held at Institute of Social Sciences*, New Delhi, India. 2003. (Access http://www.issin.org/institute-social-science_2.asp?id_lvl_1=17&id_lvl_2=314)
- ⁶¹ Bhutta ZA, Darmstadt GL, Hasan BS, Haws RA. Community-based interventions for improving perinatal and neonatal health outcomes in developing countries: a review of the evidence. *Pediatrics* 2005 Feb; 115(2 Suppl): 519-617.
- ⁶² Manandhar DS, Osrin D, Shrestha BP, Mesko N, Morrison J, Tumbahangphe, KM, Tamang S, Thapa S, Shrestha D, Thapa B, Shrestha JR, Wade A, Borghi J, Standing H, Manandhar M, Costello A M de L. "Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomized controlled trial." *The Lancet*, 364:970-79, 2004.
- ⁶³ Wade A, Osrin D, Shrestha BP, Sen A, Morrison J, Man A, Tumbahangphe, Dharma S, Manandhar, and Costello A. "Behaviour change in perinatal care practices among rural women exposed to a women's group intervention in Nepal" *BMC Pregnancy and Childbirth*. 6:20. 2006
- ⁶⁴ Bhuiya A, Chowdhury M. "Beneficial effects of a woman-focused development programme on child survival: evidence from rural Bangladesh." *Social Science & Medicine* 55 (2002) 1553-1560.

- ⁶⁵ Nanda P. "Women's Participation in Rural Credit Programmes in Bangladesh and Their Demand for Formal Health Care: Is there a positive impact?" *Health Economics* 8. 415-428.
- ⁶⁶ Sen A and Drèze J, *India: Development and Participation*. Oxford Uni. Press, 2002;
- ⁶⁷ Ruger, JP, "Rethinking Equal Access: Agency, Quality, and Norms," *Global Public Health*, Vol. 2, No. 1, pp. 78-96, 2007 (Accessed via SSRN: <http://ssrn.com/abstract=957973>).
- ⁶⁸ Ruger, JP, "Democracy and Health." *QJM: Medical Journal*, Vol. 98, pp. 299-304, 2005 (Accessed via SSRN: <http://ssrn.com/abstract=950879>).
- ⁶⁹ Ruger, JP, "Health, Capability, and Justice: Toward a New Paradigm of Health Ethics, Policy and Law." *Cornell Journal of Law and Public Policy*, Vol. 15, No. 2, 2006 (Accessed via SSRN: <http://ssrn.com/abstract=931703>)
- ⁷⁰ Winch, P. "How Neonatal Care Interventions Work" *Unpublished Powerpoint Presentation delivered at Johns Hopkins Bloomberg School of Public Health*. 2007.
- ⁷¹ "Case Studies of Two Women's Health Projects in Bolivia." *Family Health International*. 2007. (Accessed via Internet: <http://www.fhi.org/en/rh/pubs/wsp/casestudies/boliviacs.htm#Overview>)
- ⁷² Morrison, J., Tamang, S., Mesko, N., Osrin, D., Shrestha, B., et.al. "Women's health groups to improve perinatal care in rural Nepal." *BMC Pregnancy Childbirth*, 5(1), 6, 2005.
- ⁷³ Nanda P. "Women's Participation in Rural Credit Programmes in Bangladesh and Their Demand for Formal Health Care: Is there a positive impact?" *Health Economics*, 415-428, 1999.
- ⁷⁴ Glanz, K.; Lewis, F. M.; and Rimer, B. K. "Linking Theory, Research, and Practice." *Health Behavior and Health Education: Theory, Research, and Practice*. San Francisco: Jossey-Bass, 1997.
- ⁷⁵ Darmstadt, GL, Kumar V., Shearer, JC, Misra, R., Mohanty, S., et.al. "Validation of accuracy and community acceptance of the BIRTHweigh III scale for categorizing newborn weight in rural India." *Journal of Perinatology*. 27, 602-608, 2007. (Accessed via Internet: <http://www.nature.com/jp/journal/v27/n10/pdf/7211797a.pdf>)
- ⁷⁶ Liddle, J. and Joshi R. *Daughters of Independence: Gender Caste and Class in India*. London: Zen Books, 1986.
- ⁷⁷ Rai, S. "Class, Caste and Gender- Women in Parliament in India." *International IDEA: Update to International IDEA's Handbook*. 2002. (Accessed via Internet: http://www.idea.int/publications/wip/upload/CS_India.pdf)
- ⁷⁸ "Strategy 2003-2007: Improved Health and Reduced Fertility in Targeted Areas of India." *USAID India*. (Accessed Via Internet: http://www.usaid.gov/in/our_work/strategy/strategy5.htm)
- ⁷⁹ Singh SP, Reddy DC, Mohapatra SC, Gaur SD. "Study of infant and childhood mortality in an ICDS block of eastern UP." *Indian J Public Health*. Apr-Jun; 37(2): 61-5, 1993.
- ⁸⁰ "India's Civil Service: Battling the Babu Raj." *The Economist*. March 6, 2008.
- ⁸¹ Sooryamoorthy, R, D, Renjini. "Political participation of women: the case of women Councilors in Kerala, India." *Journal of Third World Studies*. Spring 2000. (Accessed via Internet: http://findarticles.com/p/articles/mi_qa3821/is_200004/ai_n8889412/pg_1)
- ⁸² Darmstadt GL, Kumar V, Yadav R, Singh V, Singh P. "Introduction of community-based skin-to-skin care in rural Uttar Pradesh, India." *Journal of Perinatology*. 26, 597-604. 2006. (Accessed via Internet: <http://www.nature.com/jp/journal/v26/n10/abs/7211569a.html>).
- ⁸³ Go V., Johnson S., Bentley M. "When HIV-Prevention Messages and Gender Norms Clash: The Impact of Domestic Violence on Women's HIV Risk in Slums of Chennai, India" *AIDS Behav*. 7(3): 263-72. September 2003.
- ⁸⁴ "Uttar Pradesh Map" (Accessed via Internet: <http://travels.talash.com/india-map/uttar-pradesh-map/img/map-1.jpg>).