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Is Women's Empowerment Retrenching Reproductive Health Vulnerabilities: A Study among Urban Poor Women in India

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Abstract

The expression of empowerment regarding reproductive health among Indian women is often misunderstood with various indicators of autonomy. The assumption that educated and working non-poor women in urban areas have better empowerment compared to urban poor women; this paper aims to diagnose the magnitude of the problem of the urban poor women in the context of their autonomy addressing reproductive health vulnerabilities. The data is extracted from Health of the Urban Poor (HUP), collected from ever married women age 15-49 in both Slum and Non-Slum across three cities, Bhubaneswar, Jaipur and Pune in 2012-13. Bi-variate and multivariate techniques are used to analyse the association between dimensions of women's empowerment and their reproductive vulnerabilities. Study reveals that empowerment of women do not contribute significantly to reducing their reproductive vulnerabilities.

Rather, women having higher level of empowerment reported a lack of control over own sexuality, which is evident from a substantially higher prevalence of STIs in each of three cities included in the analysis. Adjusted effects of factors affecting sexual rights of women portray that woman's educational attainment; husband's alcoholism and freedom of mobility have emerged as the most significant predictors of woman's control over their own sexuality, which is deep-rooted in socio-cultural factors operating within lives of these women. Despite a recent wave of woman's empowerment in India, the socio-cultural barriers existing in ensuring bodily rights of women has not broken, creating a challenge to address woman's reproductive vulnerabilities, especially for urban poor, despite a tremendous progress in education, health and political empowerment of women. Therefore, health care planners and health educators should not only focus at the macro level of empowerment, especially regarding developing entrepreneurship for women, implementing micro-credit and adult literacy programs, rather they should also focus on their reproductive and sexual rights.

Keywords: *Health; Urban Poor; Autonomy; Decision making; Reproductive health; Lack of control over own sexuality; Sexual rights; STIs*

Abbreviations: STIs: Sexually Transmitted Diseases; HUP: Health of Urban Poor; ICPD: International Conference on Population Development; HIV: Human Immunodeficiency Virus; RTI: Reproductive Tract Infections; UFS: Urban Frame Sample; PPS: Probability Proportional to size; NSSO: National Sample Survey Organization

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Introduction

Poverty in urban India has been deeply influenced by growing urbanization and industrialization. Certain aspects of urban poverty are associated with the deteriorating health status of the urban poor. According to the Planning Commission of India "*… urban poverty manifests in the form of inadequate provision of housing and shelter, water, sanitation, health, education, social security and livelihoods along with special needs of vulnerable groups like women, children, differently-abled and aged people. Most of the poor are involved in informal sector activities where there is the constant threat of eviction, removal, confiscation of goods and almost non-existent social security cover*" [1]. With increasing migration to cities, moving tides of population to cities, they bring along avenues which provides working environment for both the genders, specifically unorganized sectors for urban poor. In a patriarchal society, where women's role is limited to bearing of children and caring for them, these avenues help to expand the horizons of poor women in urban areas. These have the potential to empower them.

Upper-class women with relatively higher educational attainments have better access to healthcare, educational and economic opportunities, while women from poor families, who are less educated or not at all, are particularly disadvantaged in these respects. Poor migrants are unable to adapt to urban living. Rapid urbanization has resulted in creation of large slums in which these migrants mostly live. These, usually informal, settlements lack basic facilities and services [2].

Additionally, an overwhelming majority of these people depend on the unorganized and informal sector for livelihood opportunities. Irregular employment and fluctuating incomes makes them a particularly vulnerable group. The problems are further compounded by high levels of alcoholism among male migrants, which not only erodes their already fragile finances, but also exposes the women and children to violence and abuse.

Numerous studies have documented that poverty, together with various socio-economic factors such as age, gender, class, caste and ethnicity within households influences the food security and life choices of the population. The burden is especially heavy on women, the elderly and disabled, and young children [3,8 and 9]. Girls in this segment are even more severely affected. The earnings of women engaged in informal work are, on average, considerably less than that of men.

In addition to these problems, increasing urbanization also exposes family ties to deep stress from exposure to unhealthy influences-which is, directly or indirectly, encouraged by mass media-such as gambling clubs, video-parlours, sex work, etc., leading to deviant behaviour [4,5]. Co-occurrence of alcohol, violence and sexual abuse adds to the worsening condition of deprivation of women making them more vulnerable [6].

Whether poor or otherwise, a woman's status affects her personal and reproductive health. The rights of women, as provided by International Conference on Population and Development (ICPD), in terms of their reproductive and sexual life have enhanced their decision-making powers which, consequently, empower them [7]. This empowerment allows women to make decisions about livelihood choices, the place where they want to stay, whom to marry, the number of children they want to have, and the freedom of movement.

In the present context, empowerment is defined as the expansion of women's ability, and the freedom, to make strategic life choices. Empowerment is a process that occurs over time and makes women the agents who can formulate choices, exercise control over resources, and take decisions affecting important life outcomes [8-11]. For Indian women, the expressions 'Reproductive Health (RH)' and 'empowerment' are often misunderstood in the context of the country's healthcare system. Some studies have shown that women may be empowered in one area of life, while not so in others [8,11 and 12]. Supporting this finding is the Gender Gap report by the World Economic Forum (WEF).The report focuses on the four dimensions of gender gap: economic participation, educational attainment, health and survival, and political empowerment. It reveals the poor condition of women in the context of health in which India ranks a poor 143rd out of 145 countries. India's ranking is higher for the other three dimensions [13].

To address this concern, India's healthcare system has been structured in such a way that the services can reach the lowest levels of the population. Most of the programmers are designed in a way that they address the health concerns and needs of women who are not only prone to certain infections and diseases, but also are victims of ill-treatment and violence. It needs mention here that the state of a woman's health is also significantly affected by her lack of control over her own sexuality. Though the ICPD has increased awareness in many countries, including at policy levels, that women have the right to be free from all the kinds of violence (including sexual harassment and abuse, coercion into engaging in unlawful sexual activities, etc.),there is constant threat to women's sexual autonomy [14].

The impact of urbanization and industrialization has had a profound effect on the overall status of India's women. Though urban women today are more empowered in economic, political and social terms, they are considerably less so but in terms of health. Women remain largely unable to take decisions on matters relating to health with adverse consequences for their reproductive health. Lack of control over own sexuality, experience of coercion and sexual violence not only affect women's physical and mental health, but it also leaves a woman at a substantial risk of acquiring HIV, or other Reproductive Tract and Sexually Transmitted Infections. These situations pose a challenge of decoding linkages between women's empowerment and their reproductive health vulnerabilities. It is within this context this paper aims to explore the relationship between women's empowerment and their reproductive vulnerabilities with special focus at urban poor. This paper aims to understand the influence of women's (urban poor and non-poor) vulnerability to reproductive health issues.

Materials and Methods

The data is extracted from Health of the Urban Poor (HUP), collected from ever married women age 15-49 in both Slum and Non-Slum across three cities, Bhubaneswar, Jaipur and Pune in 2012-13. For the appropriateness in the study many variables had to be computed which is defined below

Variables used in the study: To study the vulnerabilities among urban poor women, the data was first divided into poor and non-poor women. The variable was computed by merging standard of living index and place of residence.

Non-poor: Non-slum women with the moderate and high standard of living and slum women with high standard of living are considered non-poor in the study.

Poor: Slum women with low and moderate living standard and non-slum women with low standard of living are considered poor in the study.

Autonomy in women's decision-making

This variable is computed into three categories 'low' 'moderate' and 'high' by merging five questions related to the say of women in different decisions taken at the household level. Accordingly, the questions asked to women are

Who in your family usually has the final say on following decisions?
Your own health care?
Children's health care?
Making large household Purchase?
Making Household purchase for Daily need?
Visit to family and/or relatives/friends?

The responses are coded into three categories: if the "Respondent alone" has right to make decision on the following questions than it is considered as "high autonomy in decision-making power", if the decision is taken by "Husband" and "Husband and Wife jointly" then "moderate decision-making power" and if the decision is taken by "Other family members" then it is considered as "low decision-making power".

Freedom of Mobility

To see if the women have freedom of mobility; the following questions were taken into considerations.

If she was

Allowed to go the market places alone
Allowed to visit the health care facility
Allowed to visit the places outside village/community.

The responses are coded in three categories: if the "Respondent alone" visits all the mentioned places then it is considered as "high freedom of mobility", if the respondent is allowed to visit the mentioned place "With someone else" then it is considered as "moderate freedom of mobility" and if the respondent is "Not at all" allowed to visit outside then "low freedom of mobility".

Control over money use

The control of women over the use of money was taken from the question *who decides how to spend money earned by you?* If the response was "Respondent herself" then it is considered "high control over own money use", if it was decided by her "Husband" and "Jointly by Husband and Respondent" then it is considered as "moderate control over own money use" and if it was decided by "Husband's family" and "Others" then it is considered as "low control over own money use".

Women's empowerment

The empowerment of women was computed by combining all the three variables *"Autonomy in decision-making power", Freedom of Mobility"* and *"Control over money use"* and it was categorized into three response categories,where in all cases if the "Respondent herself" was the response then it is considered as "high women's empowerment", if the response was "Husband" and "Jointly by Husband and Respondent" then it is considered as "moderate women's empowerment" and if it was decided by "Husband's family" and "Others" then it is considered as "low women's empowerment".

Lack of control over own sexuality

The following set of questions that explore women's acceptance of norms that subordinate women's bodily integrity and sexuality. If the women have responded "yes" in any one of the following categories, then she is reported that she has control over her own sexuality.

To assess control over women' own sexuality question asked to the women's that whether
She can refuse to have sex with husband if
Has her husband affected by sexually transmitted disease
She knows her husband has sex with other women.
She is tired or not in a mood to have sex.

In our study we are considering the negative effect i.e. lack of control over own sexuality. Hence, whoever has reported "no" in the above question, those are taken into consideration.

Prevalence of Sexually Transmitted Infection

The respondents who have ever had sex were asked whether they had these symptoms during last 12 months prior to the survey. If the women have responded any one of the above symptoms, she is reported having STIs.

The questions asked to women are

If she has genital sore

If she has genital ulcer

If she suffered with bad smelling, abnormal genital discharge

Results

Women's Empowerment

The results show that, overall, the level of women's empowerment varies significantly across the three cities that were considered in the analysis (Table 1). Nearly 70% of the respondents from Pune claimed an elevated level of empowerment. The corresponding percentages for Jaipur and Bhubaneswar were 39 and 17 respectively. The ranking was higher for Pune than the other cities for all indicators of empowerment-decision-making powers (16%), freedom of mobility (66%) and control over finances (47%).

	Bhubaneswar			Jaipur			Pune		
	Non-Poor	**Poor**	**Total**	**Non-Poor**	**Poor**	**Total**	**Non-Poor**	**Poor**	**Total**
Decision-making power									
Low	9.1	7.7	8.6	14.5	11.3	13.2	9.4	9.2	9.3
Medium	87.9	86.5	87.4	83.2	84.7	83.8	74.2	76.2	75.0
High	3.0	5.8	4.0	2.3	4.0	3.0	16.5	14.6	15.7
Freedom of mobility									
Low	9.4	18.1	12.4	12.3	15.9	13.8	8.6	15.2	11.3
Medium	75.4	72.1	74.3	48.4	51.7	49.8	18.6	28.7	22.7
High	15.2	9.7	13.3	39.2	32.4	36.4	72.8	56.1	66.1
Control over money use									
Low	2.0	11.7	6.1	6.0	8.3	7.3	4.1	6.4	5.1
Medium	78.4	66.2	73.2	67.3	61.7	64.1	49.1	46.3	47.8
High	19.6	22.1	20.7	26.7	30.1	28.6	46.8	47.3	47.1
Women's empowerment									
Low	2.9	2.7	2.8	2.6	1.7	2.2	2.0	1.9	2.0
Medium	79.0	83.2	80.5	56.8	61.6	58.8	23.2	37.7	29.0
High	18.1	14.2	16.7	40.6	36.7	39.0	74.8	60.4	69.0
Total	851	471	100.0	943	670	100.0	818	598	100.0

Table 1: *Percent distribution of poor and non-poor women according to the dimensions of women's empowerment.*

However, when the data was disaggregated for the poor and the non-poor respondents, it was found that decision-making powers are the highest for the non-poor of Pune. In comparison, poor women of Bhubaneswar and Jaipur had more decision-making powers than those of Pune. A noteworthy observation here is that that a relatively higher proportion of urban poor women reported they had control over the use of money (22% in Bhubaneswar, 30% in Jaipur and 47% in Pune) as compared to non-poor women (19%, 27% and 46% respectively) in three cities.

The rich-poor gap in woman's empowerment is more pronounced in Pune and Bhubaneswar, where the difference is more than 25%. Even accepting that a certain amount of gender inequality will continue to exist in the near future, it is essential to acknowledge that upliftment of the women is crucial to development. This is possible only by empowering the women in all aspects. Empowerment should encompass both the financial and decision-making aspects.

Women's autonomy is also determined by the interactions of the social and economic aspects of life [15]. When considered by the background characteristics, the indicators show a higher level of empowerment among the respondents from Pune than the other two cities (Table 2). Irrespective of economic status they enjoy, the percentage of women respondents who claimed decision-making powers was the highest for Pune (16%) as compared to Bhubaneswar (4%) and Jaipur (3%). It is important to mention here that with increasing level of female education, the gap between poor and non-poor in decision-making power is found to be narrow in all the three cities. The result also revealed that those women whose husbands are alcoholic have high decision-making power as compared to those women whose husbands are not alcoholic across all three cities.

Decision-making power									
	Bhubaneswar			**Jaipur**			**Pune**		
Background Characteristics	**Non-Poor**	**Poor**	**Total**	**Non-Poor**	**Poor**	**Total**	**Non-Poor**	**Poor**	**Total**
Age group									
15 to 24 years	0.0	5.4	3.6	1.9	2.3	2.1	6.0	6.5	6.3
25 to 34 years	3.5	3.7	3.6	1.4	2.5	1.9	16.0	12.0	14.3
35 + years	3.0	7.9	4.3	3.1	6.7	4.3	18.5	22.7	19.9
Women's education (years)									
Less than 5 years	0.0	8.7	7.6	2.1	4.2	3.5	20.9	22.8	22.3
5 to 9 years	3.8	4.4	4.2	3.8	4.5	4.2	15.3	11.0	12.6
10 Years and Above	3.0	5.0	3.3	1.5	2.0	1.6	16.4	13.4	15.7
Husband Education (years)									
Less than 5 years	50.0	12.5	14.7	0.0	3.8	2.4	11.1	22.2	20.0
5 to 9 years	3.8	5.3	5	3.3	4.4	4.0	11.9	15.2	14.1
10 Years and Above	2.7	5.1	3.1	2.0	2.1	2.0	16.8	13.2	15.7
Husbands alcohol behavior									
No	2.6	4.2	3.1	2.3	2.5	2.4	15.6	12.2	14.3
yes	8.6	11.6	10.5	2.1	9.2	6.1	23.8	23.5	23.6
Exposure of Media									
No Exposure	0.0	13.2	12.1	0.0	4.2	4.0	50.0	23.5	26.3
Partial Exposure	2.8	4.8	3.5	2.2	3.7	2.8	15.6	14.6	15.2
Full Exposure	10.5	0.0	9.5	2.8	0.0	2.4	25.8	0.0	24.6
Total	3.0	5.8	4.0	2.3	4.0	3.0	16.5	14.6	15.7
Control over money use									
	Bhubaneswar			**Jaipur**			**Pune**		
Background Characteristics	**Non-Poor**	**Poor**	**Total**	**Non-Poor**	**Poor**	**Total**	**Non-Poor**	**Poor**	**Total**
Age group									
15 to 24 years	0.0	20.0	16.7	22.2	10.7	13.5	33.3	46.2	40.0
25 to 34 years	23.8	16.7	20.5	26.2	34.1	30.6	46.9	48.1	47.5
35 + years	16.9	27.8	21.1	27.6	32.1	29.9	48.2	46.8	47.6
Women's education (years)									

Less than 5 years	0.0	22.6	21.9	20.7	23.1	22.7	54.5	42.9	44.6
5 to 9 years	50.0	16.7	20.6	41.2	40.9	41.0	56.3	50.8	52.7
10 Years and Above	18.6	31.3	20.4	23.0	42.9	27.8	44.7	48.4	45.7
Husband Education (years)									
Less than 5 years	0.0	11.1	11.1	0.0	0.0	0.0	33.3	47.8	46.2
5 to 9 years	20.0	20.0	20.0	30.0	34.2	33.3	47.8	54.2	52.4
10 Years and Above	18.8	35.0	21.6	26.9	34.6	29.4	46.1	46.3	46.2
Husbands alcohol behavior									
No	15.9	19.1	17.0	25.7	24.6	25.2	45.9	45.3	45.6
yes	42.9	26.7	31.8	35.7	43.4	41.8	53.6	52.9	53.2
Exposure of Media									
No Exposure	0.0	28.6	28.6	0.0	28.6	28.6	0.0	40.0	40.0
Partial Exposure	20.2	20.6	20.4	27.3	29.8	28.7	46.0	48.6	47.2
Full Exposure	0.0	0.0	0.0	18.2	66.7	28.6	55.0	0.0	52.4
Total	19.6	22.1	20.7	26.7	29.8	28.7	46.8	47.3	47.1
Freedom of mobility									
	Bhubaneswar			**Jaipur**			**Pune**		
Background Characteristics	**Non-Poor**	**Poor**	**Total**	**Non-Poor**	**Poor**	**Total**	**Non-Poor**	**Poor**	**Total**
Age group									
15 to 24 years	2.6	2.7	2.7	19.4	21.4	20.5	56.7	38.3	45.4
25 to 34 years	13.5	10.2	12.2	37.0	26.3	32.3	70.7	57.3	65.0
35 + years	17.2	12.0	15.8	45.7	45.4	45.6	77.2	64.9	73.3
Women's education (years)									
Less than 5 years	11.1	8.7	9.0	31.9	29.6	30.4	55.8	54.5	54.8
5 to 9 years	10.4	8.3	9.0	36.5	31.2	34.1	61.3	50.2	54.4
10 Years and Above	16.1	13.3	15.7	43.6	44.1	43.7	76.2	63.2	73.1
Husband Education (years)									
Less than 5 years	50.0	9.4	11.8	12.5	38.5	28.6	55.6	77.8	73.3
5 to 9 years	9.4	8.3	8.5	34.3	27.4	30.3	58.3	48.8	52.0
10 Years and Above	15.6	12.0	15.0	41.4	34.5	39.7	74.7	56.6	69.4
Husbands alcohol behavior									
No	14.7	8.4	12.8	38.2	31.4	35.5	72.5	55.5	66.2
Yes	22.4	14.7	17.6	48.4	35.3	41.1	75.0	58.3	65.3
Exposure of Media									
No Exposure	20.0	11.3	12.1	0.0	8.3	8.0	100.0	52.9	57.9
Partial Exposure	15.3	9.6	13.4	38.7	34.8	37.2	72.3	57.1	66.1
Full Exposure	10.5	0.0	9.5	47.2	25.0	44.0	79.0	66.7	78.5
Total	15.2	9.7	13.3	39.2	32.4	36.4	72.8	56.1	66.1

Women's Empowerment									
	Bhubaneshwar			Jaipur			Pune		
Background Characteristics	**Non-Poor**	**Poor**	**Total**	**Non-Poor**	**Poor**	**Total**	**Non-Poor**	**Poor**	**Total**
Age group									
15 to 24 years	2.6	6.8	5.4	20.4	22.9	21.8	58.2	41.1	47.7
25 to 34 years	17.7	11.2	15.2	38.1	32.0	35.5	72.5	62.2	68.1
35 + years	19.5	19.9	19.6	47.4	49.6	48.1	79.4	69.2	76.2
Women's education (years)									
Less than 5 years	11.1	16.7	16.0	32.3	33.8	33.3	58.1	61.8	60.8
5 to 9 years	11.3	10.7	10.9	38.5	35.7	37.2	64.5	54.5	58.3
10 Years and Above	19.3	17.5	19.0	45.1	48.0	45.6	78.0	65.7	75.0
Husband Education (years)									
Less than 5 years	50.0	18.8	20.6	12.5	38.5	28.6	55.6	77.8	73.3
5 to 9 years	11.3	12.7	12.5	35.9	33.9	34.7	60.7	53.0	55.6
10 Years and Above	18.6	15.2	18.0	42.7	37.9	41.5	76.7	61.8	72.3
Husbands alcohol behavior									
No	17.5	12.1	15.8	39.7	34.2	37.5	74.5	59.3	68.9
yes	27.6	22.1	24.2	49.5	46.2	47.7	77.4	64.3	69.8
Exposure of Media									
No Exposure	20.0	15.1	15.5	0.0	16.7	16.0	100.0	52.9	57.9
Partial Exposure	18.1	14.1	16.8	40.2	38.6	39.6	74.1	61.5	69.0
Full Exposure	15.8	0.0	14.3	47.2	33.3	45.2	83.9	66.7	83.1
Total	18.1	14.2	16.7	40.6	36.7	39.0	74.8	60.4	69.0

Table 2: *Percent of women having empowerment according to some selected background characteristics.*

Analysis shows that women from Pune (47%) are twice as likely to have control over money as women living in Jaipur (29%) and Bhubaneswar (21%). On examining the variation between the poor and non-poor from each city, it is found that the poor are in more advantageous situation as a much lower proportion of them exercise control over the use of money as compared to the non-poor women in the three cities. It is also seen that with increasing educational level, the women's control over money decreases. Results also show that a greater proportion of women, whose husbands consume alcohol regularly, reported control over money use (32%, 42% and 53% respectively) than those women whose husbands did not (17%, 25% and 45%) in Bhubaneswar, Jaipur and Pune.

Women living in Bhubaneswar had the least (13%) freedom of mobility. In comparison, 36 percent of the respondent women in Jaipur and 66 Pune said that they enjoyed the freedom of mobility. Freedom of mobility increases with increasing level of educational attainment. Analysis shows that a lower proportion of urban poor women have freedom of mobility in comparison to the non-poor in all three cities. Overall, woman's empowerment was found tobe higher in Pune (69%) than women in Jaipur (39%) and Bhubaneswar (17%). But women among the urban poor are at a disadvantage in all three cities. Interestingly, analysis showed that the increasing level of their husbands' education negatively affectsthe empowerment of poor women.Another noteworthy finding is that women with alcoholic husbands are more likely to have a high level of empowerment in Bhubaneswar and Jaipur, but not significantly so in Pune.

Reproductive Health Vulnerabilities

Reproductive health vulnerabilities are the results of restricting women's right to exercise control over their reproductive health. Sexual and reproductive rights are fundamental human rights, which mean that everyone has equal right to express and enjoy their sexuality, be free from interference in making decisions about sexuality and reproductive matters, and to access sexual and reproductive health information, education, services and support. It also includes the right to be free from torture and cruelty, inhumane or degrading treatment or punishment; and to be free from violence, abuse, exploitation and neglect [16]. However, women and girls across the world continue to be denied these rights. They remain vulnerable due to discrimination, coercion, sexual abuse, menstrual and sexual suppression, curtailment of parental rights, and other forms of torture or gender-based violence.

According to Sherfey (1966), the sex drive of the human female is innately stronger than that of the male. For a civilized society to develop, it is necessary, or at least helpful, for female sexuality to be stifled [18]. Social pressures such as those for parents and peer groups have contributed to women suppressing their own sexual desires by suppressing it. In India, the standards of sexual conduct are applied differently for men and women. A woman's situation is particularly difficult-she can neither express her desires freely nor refuse coitus as a consequence of which the sexual act, to the woman, is one of coercion.

Table 3 presents the interaction between women's empowerment and characteristics of reproductive health vulnerabilities in Bhubaneswar, Jaipur and Pune. Regarding lack of control over one's own sexuality, an indicator of reproductive health vulnerability, it was found that around 33 percent of women in Bhubaneswar had little or no control over own sexuality, followed by Pune (19%). The rich-poor gap was the widest in Bhubaneswar (8%), followed by Pune (5%) and Jaipur (2%). The results reveal the deprivation of urban poor women as not even one of the indicators of women's empowerment restrains the poor women from experiencing a lack of control over own sexuality except for the city of Jaipur.

Lack of control over own sexuality										
Women's Autonomy		**Bhubaneshwar**			**Jaipur**			**Pune**		
		Non poor	**Poor**	**Total**	**Non poor**	**Poor**	**Total**	**Non poor**	**Poor**	**Total**
Decision making power	Low	20.0	29.4	22.9	7.5	12.3	9.2	8.3	12.2	9.9
	Medium	33.2	37.2	34.6	4.4	6.5	5.3	16.7	22.9	19.2
	High	32.0	28.6	30.4	4.8	0	2.2	18.5	26.9	21.6
Freedom of Mobility	Low	10.3	25.3	17.8	2.7	1.0	1.9	10.3	18.5	14.8
	Medium	35.9	39.4	37.1	7.2	10.4	8.6	20.8	26.8	23.9
	High	25.2	32.5	26.9	2.5	3.9	3.0	15.8	21.4	17.7
Control over money use	Low	0.0	44.4	36.4	0.00%	6.7	4.2	11.1	8.3	9.5
	Medium	28.8	36.2	31.5	6.9	8.5	7.8	16.7	23.5	19.7
	High	35.0	42.9	38.2	2.5	5.3	4.1	7.7	13.5	10.4
Women's empowerment	Low	0.0	33.3	11.1	0.0	0.0	0.0	12.5	10.0	11.5
	Medium	34.9	37.0	35.6	6.6	8.6	7.4	18.9	26.4	22.8
	High	23.8	32.2	26.2	2.7	4.3	3.3	15.5	20.5	17.3
Total		32	36.2	33.4	4.8	6.9	5.7	16.2	22.5	18.8
Prevalence of STI										
Women's Autonomy		Bhubaneshwar			Jaipur			Pune		
		Non poor	poor	Total	non poor	poor	Total	non poor	poor	Total
Decision making power	Low	0.0	0.0	0.0	4.6	3.7	4.3	0.0	50.0	14.8

	Medium	1.6	3.3	2.3	7.4	9.8	8.3	1.9	7.7	3.8
	High	6.2	18.2	11.1	29.4	26.3	27.8	3.1	12.5	5.7
Freedom of Mobility	Low	0.0	0.0	0.0	6.3	4.5	5.4	12.5	0.0	6.2
	Medium	1.7	4.6	2.8	5.3	10.6	7.3	3.3	18.8	11.3
	High	5.0	20.0	8.0	10.1	11.5	10.6	1.5	10.0	3.6
Control over money use	Low	0.0	50.0	25.0	0.0	0.0	0.0	0	0.0	0.0
	Medium	0.0	0.0	0.0	9.5	10.0	9.8	4.3	14.3	6.7
	High	0.0	25.0	16.7	6.1	15.4	11.1	0	4.8	1.5
Women's empowerment	Low	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Medium	1.1	3.3	2.0	6.0	9.2	7.3	6.2	11.1	8.8
	High	5.7	15.4	8.3	9.7	11.0	10.2	1.4	12.2	4.2
Total		1.8	4.4	4.5	7.5	9.8	8.3	2.1	11.8	5.1

Table 3: *Interaction of women's empowerment and the characteristics of reproductive health vulnerabilities among urban poor and non-poor women.*

Non-poor women are relatively better placed in all the three cities than the poor. Lack of control over sexuality means women cannot take decision on their bodily rights, which can result in coercive, unwanted and unsafe sex. This puts women at higher risk of diseases affecting their reproductive health. The results are reversed when the STI trends are analyzed. The prevalence of STIs was the highest among women in Jaipur (8.3%), and followed by Pune (5%) and Bhubaneswar (4.5%). The rich-poor gap was 10% in Bhubaneswar and Pune, and only 2% for Jaipur. This is an indication that the poor women in Bhubaneswar and Pune are in a considerably more disadvantaged situation as compared to the non-poor women of the two cities.

Table 4 shows women's lack of control over their sexuality according to some background characteristics. The proportion of women having lack of control over own sexuality was the highest in Bhubaneswar (33%), followed by Pune (19%) and Jaipur (5.7%). Lack of control over own sexuality was found to be more prominent among the poor than the non- poor in all the three cities. This shows that urban poor women are at greater risk in the context of their reproductive health. Among the various background characteristics included in the analysis, women's educational attainment was found to be the most important predictor for making a positive contribution to their control over their own sexuality in all three cities.

Background Characteristics		**Bhubaneswar**		**Jaipur**		**Pune**	
		Lack control over own sexuality	**STI**	**Lack control over own sexuality**	**STI**	**Lack control over own sexuality**	**STI**
Women age in 10 years age group	15 to 24 years	34.9	0.0	5.5	8.0	22.9	13.3
	25 to 34 years	34.5	4.1	5.9	8.3	16.3	5.8
	35 + years	32.3	2.1	5.6	8.4	19.9	3.0
Years Of Education Completed	Less Than 5 Year	41.2	5.1	5.0	13.2	27.7	6.1
	5-9 Years	37.5	4.7	6.8	8.2	24.5	6.8
	10 & Above	30.6	1.7	5.4	4.9	14.7	4.7
Husband Education	Less than 5 years	40.6	8.3	10.0	6.5	31.8	0.0
	5 to 9 years	39.5	3.8	5.3	11.1	21.8	2.6
	10 Years and Above	31.1	2.0	5.8	7.8	17.4	5.6

Husbands alcohol behaviour	No	33.1	2.8	5.6	7.8	19.0	4.0
	yes	34.9	2.6	6.2	12.2	17.4	11.5
Exposure of Media	No Exposure	49.1	5.9	12.0	0.0	36.8	25.0
	Partial Exposure	32.9	2.8	5.7	7.8	18.5	5.2
	Full Exposure	19.0	0.0	4.8	13.7	16.9	0.0
Economic status	non poor	31.9	1.8	4.8	7.3	16.2	2.4
	poor	36.2	4.3	6.9	9.8	22.5	10.8
Total		33.3	2.8	5.7	8.3	18.8	5.1

Table 4: *Percentage of women reporting health vulnerabilities according to some selected background characteristics.*

Logistic regression odds ratios providing adjusted effects of different predictors on the variable under study (Table 5), i.e., lack of control over own sexuality, portray that urban poor women, who have 10 or more years of education, are 0.28 ($p < 0.01$) times less likely to report lack of control over own sexuality. This means that higher educational attainment of women motivates them to exercising their sexual rights. Exposure to mass media is found to play a positive role in asserting control over their sexuality. Women who have had partial exposure to mass media are 0.32 ($p < 0.05$) times less likely to have a lack of control over own sexuality. Interestingly, non-poor women, whose husbands are alcoholics, are 2.3 ($p <. 05$) times more likely to lack control over their sexuality. The situation is adverse for the non-poor women also.

Background Characteristics		Non-Poor		Poor	
		Sig.	Exp(B)	Sig.	Exp(B)
Age of women	15 to 24 years®				
	25 to 34 years	0.521	2.003	0.477	1.794
	35 + years	0.663	1.606	0.440	1.899
Women's education (years)	Less than 5 years®				
	5 to 9 years	0.261	2.341	0.771	0.899
	10 Years and Above	0.626	1.484	0.011	0.276***
Husband's education (years)	Less than 5 years®				
	5 to 9 years	0.867	0.842	0.701	0.839
	10 Years and Above	0.295	0.334	0.844	1.105
Husband's alcohol behaviour	No®				
	Yes	0.029	2.348**	0.998	1.001
Exposure to mass media	No Exposure®				
	Partial Exposure			0.037	0.318**
	Full Exposure	0.474	0.570	0.732	1.672
Decision making	Low®				
	Medium	0.801	1.165	0.398	0.597
	High	0.233	2.379	0.571	0.657
Freedom of mobility	Low®				
	Medium	0.370	2.082	0.157	3.153
	High	0.962	1.040	0.054	4.809**

Control over money use	Low®				
	Medium	0.204	4.012	0.832	1.142
	High	0.608	1.769	0.478	0.616
City	Bhubaneshwar®				
	Jaipur	0.000	0.104***	0.000	0.173***
	Pune	0.036	0.446**	0.037	0.415**
	Constant	0.185	0.062	0.783	0.670

(*= p<0.10; **=p<0.05; ***=p<0.01)

Table 5: *Determinants of Lack of Control Over Own Sexuality across three cities of India.*

Analysis also revealed that poor women, who enjoyed the freedom of mobility, are vulnerable. They are 4.8 ($p < 0.05$) times more likely to have lack control over their sexuality. It also came as a surprise to find that women in Jaipur and Pune, irrespective of their poverty status, are significantly more likely than women in Bhubaneswar to have control over their sexuality and hence, are less vulnerable to reproductive health issues.

Autonomy, or the lack of it, has impact on sexual behavior. Absence of autonomy leads to forced sexual behavior (or activity). Coercion or force is against the sexual and reproductive rights of women, but its extent is found to increase with alcohol use, exposure to mass media and sexual stimuli, and with leisure time activity [20]. Coercive sex, especially unprotected intercourse, significantly increases the risk of Sexually Transmitted Infections (STIs).

It can be seen in Table 4 that prevalence of a STI is the highest among women in Jaipur (8.3%) followed by Pune (5%) and Bhubaneswar (3%). Poor women from urban areas are more likely to suffer from any STI than their non-poor counterparts in each of the three cities.

In Bhubaneswar, the prevalence of STIs among the urban poor is the highest among women in the age group of 25 to 34 years (4.1%), while in Pune, younger women (15-24 years) are more than four times more likely to suffer from STIs than those aged 35 years and above. The educational attainment of women is inversely related to the prevalence of STIs in each of the three cities except for women in Pune who had 5-9 years of schooling.

Alcohol-influenced behavior of husbands has emerged as a strong predictor of prevalence of STIs among women in Jaipur as well as Pune, where the relatively larger proportion of the women report as exercising their sexual rights. This may be primarily due to lack of safe sexual practices because of which the women are at higher risk of infection by their husbands' sexual practices. Therefore, alcoholism in married males should be given importance in any effort to ensure women's reproductive and sexual rights in the context of reducing their reproductive health vulnerabilities.

Discussion

A major factor of concern emerging from this study is that empowerment does not have a role to play in the factors influencing reproductive health vulnerabilities. Firstly, empowerment of women is found to be low in Bhubaneswar despite increasing urbanization and modernization. This can be attributed to the fact that society in Bhubaneswar remains largely traditional and conservative. A study by Hans and Patel (2012) shows that age at marriage in urban areas of Odisha is lower than that of rural areas [21] and that poor urban women are more prone to domination by their husbands and in-laws.

Empowerment among poor urban women was found to be high in Pune. A possible explanation is that Pune, which is regarded as Maharashtra's cultural hub, is also acknowledged as the place where several reform movements started. Jaipur, on the other hand,

showed mediocre level of women's empowerment which may be because it is slowly coming in proximity to capital Delhi and continuously eliminating the existing milieu of feudal society. The finding that women with alcoholic husbands are more empowered may be explained by the fact that these men are mostly migrants with low paid or irregular jobs, or even unemployed. Alcoholism is seen as the outlet for frustration [22]. The women have no other option than to find whatever work they can to meet their living expenses. This appears to have an empowering effect on them.

In contrast, the husband's dominance over the household level increases with education levels. In such households, women are less empowered. The finding shows that women's rights are not respected by their well-educated husbands. Though they have control over finances, decision-making powers, and freedom of mobility, a large proportion of the women, both poor and non-poor reported lacking control over their sexuality. This may be because women empowerment is not perpetuated to micro-level decision making, where coercion in sexual activity could be denied. Violence against women is not just domestic, but also often sexual, which is a serious crime and must be prevented.

The right over one's own sexuality and reproductive health is fundamental for all people [23]. But the fact is that sexual violence is not talked about openly, especially by the women, regardless of whether they are poor or non-poor. Sexual and reproductive health rights are key issues that affect the wellbeing of women, and must continue to remain the focus of health interventions for women.

Although reproductive health rights can be conferred by law, its observance is difficult because the sexual act is considered as private and hence, discussing it in public is considered as a taboo in a country like India. Therefore, there is an urgent need to educating people in sexual health rights, including raising awareness of bodily rights, and the right to have control over one's sexuality. This is lacking at present. This lack of awareness, combined with low level of women's empowerment from the health perspective, negatively affects the health of women. The consequence is unwanted or early pregnancies, or reproductive morbidity.

The past decade has seen growing concern with women's health in developing countries as evidenced by various safe motherhood initiatives [24]. This is mainly because of the vulnerabilities of women in respect of their reproductive health which can have serious repercussions for their overall wellbeing. These programmers reflect recognition of reproductive health vulnerabilities of women; however, their implementation has not yielded the outcomes they were expected to. Significant numbers of poor urban women remain unable to access these programmers for various reason. The socio-cultural barriers to respecting women's sexual and bodily rights continue to exist. Women continue to suffer, within and outside marriages. Coercive/forced sex greatly increase the risk of reproductive tract infections.

It is a matter of even graver concern that the risks of forced sex increases with consumption of alcohol, exposure to mass media and various sexual stimuli and with leisure time activity among urban poor [23]. According to the World Health Organization (2013), more than a million people acquire a sexually transmitted infection (STI) every day [24]. There is a direct link between intimate partner relationship and STI/HIV risk [23].Increased empowerment of women should reduce the risk and incidence of STIs, but the result shows that there is higher prevalence of STIs is among urban poor women who are highly empowerment. A possible explanation for this situation is that the women, who are otherwise empowered, are not sufficiently educated or aware of the causes, risks and consequences of STIs. Empowerment also does not necessarily signify control over own sexuality. Sexual harassment and abuse at both home and the workplace are common. The woman does not have a choice in the matter. Therefore, it can be said that empowerment of women does not result in respect for, or increased sexual rights for the women.

Conclusions

India's economic development has opened several opportunities for employment and entrepreneurship. Cities are driving the country's growth. In turn, they attract people from the countryside who are seeking a better quality of life. However, the recently created wealth has not been evenly distributed. Large segments of populations in cities remain poor and marginalized. There is a wide gap between demand and supply of healthcare services, leaving a sizable proportion of the people vulnerable to various illnesses.

This study of women's empowerment shows disadvantaged situation of poor urban women as compared to the non-poor. Lack of awareness at individual level about reproductive and sexual rights is affecting the physical and mental health of women. Women often justify the coercion that they are subjected to, which is a consequence of poor awareness of their rights. Empowerment has not resulted in overcoming cultural and traditional barriers. Women, by and large, accept themselves as the weaker section.

Empowerment has not resulted in a reduction in the prevalence of STIs. Therefore, healthcare planners and health educators must focus on changing traditional perceptions and drive women empowerment at macro as well as micro level so that decision-making is strengthened not only at household level, but also at individual level. It is only then the reproductive health vulnerabilities of these women can be minimized.

Innovative policies must be framed, and programmers designed, in such a manner that men are made active participants. They must be encouraged respect the rights of women and to share the responsibility for ensuring their reproductive health.

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