Economic Theories of Household Bargaining

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Maternal and child health is severely impacted by adverse birth outcomes leading to a public health concern. A whole host of socioeconomic factors are instrumental in determining birth outcomes. Importantly, there is an intricate relationship between women's autonomy, the perpetration of intimate partner violence in households, women's paid work status and their consequent impact on birth outcomes.

adverse birth outcomes women's autonomy intimate partner violence

1. Introduction

Women's autonomy, as defined in academic literature, is derived from measures such as decision-making capacity in the household, freedom of mobility and financial stability. Such autonomy is thought to contribute towards a woman's enhanced status in the household, and such women are more likely to be aware of and responsible for their reproductive healthcare needs (Bloom et al. 2001; Fikree and Pasha 2004). Thus, it is not surprising that the utilisation of maternal healthcare services and pregnancy care is found to be contingent upon the extent of autonomy that women enjoy (Ghosh and Ghosh 2020; Rizkianti et al. 2020). The potential importance of women's autonomy in influencing their healthcare-seeking behaviour, particularly reproductive health, which can lead to adverse birth outcomes, is important from both an economic and developmental perspective. The prevalent gendered social and health disparities typically work across multiple socioeconomic levels; however, the constraints imposed by the partner are particularly critical for women's reproductive autonomy and hence birth outcomes. While supportive partners tend to augment women's health and well-being, non-supportive, controlling, or violent partners can impede it. When it comes to partner-related constraints on women's reproductive autonomy, the focus of studies has largely been on the most severe limitations and outcomes, such as intimate partner violence (IPV), where worldwide, one in three women is known to experience IPV during their lives (WHO 2018). However, women's autonomy–both economic as well as partner-related, are by and large studied in separate contextual frames, with little attention being given to analysing the interactive effect of partner-related constraints on women's reproductive health and birth outcomes.

Adverse birth outcomes such as spontaneous abortion (generally referred to as a miscarriage), induced abortion, stillbirth, low birth weight (henceforth, LBW) and preterm birth (henceforth, PTB) are major threats to both maternal and child health. Apart from being a major cause of long-term morbidity and mortality for women (Yokoe et al. 2019), these have consequences for long-term growth, health, and developmental outcomes of the children too (Bailey 2010; Rao et al. 2016). Globally, a higher burden of adverse birth outcomes is borne by developing countries on account of their insufficient healthcare systems, flailing infrastructure and sociocultural norms (WHO

2018). Moreover, these pregnancy outcomes eventually snowball into public health problems which entail high healthcare costs for the household. In fact, LBW and PTB together contribute to being the leading causes of neonatal deaths in under-five mortality (Campbell et al. 1999; Beck et al. 2010; Sigalla et al. 2017) and characterise over 60% of births that take place in the middle and low- income countries (Frey and Klebanoff 2016; Dadi et al. 2020).

Adverse birth outcomes are contingent on a wide spectrum of alterable and non-alterable exposures. Sociodemographic factors such as maternal age, maternal nutrition, area of residence, educational status, experiences of health, abusive behaviours, and utilisation of maternal healthcare services play an instrumental role in determining the reproductive health of a woman, thereby leading to disparities in pregnancy outcomes. Some of the above sets of factors have been extensively dealt with in the literature (see Babu and Kar 2009; Dalal and Lindqvist 2012; Dhar et al. 2018; Silverman et al. 2019; Avanigadda and Kulasekaran 2021 for more on the impact of these factors). However, partner-related constraints such as perpetration of violence, reproductive coercion etc., that are likely to impact women's health and birth outcomes have not been extensively dealt with, especially for countries like India where one in every three women is subjected to IPV (Krishnamoorthy et al. 2020). As a matter of fact, evidence from the National Family Health Survey-5 suggests that 32% of ever-married women aged between 18–49 years have lifetime experiences of IPV in India. Physical violence has the highest prevalence (28%), followed by emotional violence (14%) and sexual violence (6%). Women with lifetime experiences of IPV invariably report poor health outcomes, and cross-country analyses confirm that the prevalence of IPV and its strong impact on poor reproductive outcomes are observed across both high-income (Zorrilla et al. 2010; Costa et al. 2016) as well as low-income countries (Garcia-Moreno et al. 2005; Sarkar 2008; Pallitto et al. 2013) with disproportionately more adverse outcomes among the South Asian countries5.

2. Women's Autonomy Linked to Their Power

Existing literature provides evidence that women's autonomy is intricately linked to their power and agency and plays an instrumental role in their reproductive health decisions (Bloom et al. 2001; Ram et al. 2022). This implies that there are increased chances for them to avert an adverse birth outcome. For women lacking reproductive autonomy, the risk of unsafe and self-managed pregnancies increases (Goemans et al. 2021). Whereas women exercising reproductive autonomy are able to access safe abortion services for mistimed or unwanted pregnancies (Pallitto et al. 2013). The lack of reproductive autonomy also has implications for sex-based coercive miscarriages. The chances of LBW and PTB are significantly reduced with access to maternal healthcare utilisation (Shome et al. 2018).

The documented evidence on the association between IPV and poor reproductive outcomes such as miscarriage and abortion at a global scale is robust (Garcia-Moreno et al. 2005; Sarkar 2008; Devries et al. 2014). Studies by Lee-Rife (2010) and Stephenson et al. (2016) on married Indian women concluded strong associations between IPV and abortion, whereas the study by Dhar et al. (2018) in Bihar, India, showed no significant association between IPV and abortion.

Bramhankar and Reshmi (2021) found that women exposed to physical violence by their spouses had greater chances of miscarriage on account of physical assault. Perinatal stress causes deregulations in the neuroendocrine, neural and immune systems, thereby disrupting biological mechanisms. The exposure to perinatal stress is heightened with incidences of intimate partner violence in an abusive environment. This in turn increases the chances of adverse birth outcomes, notably LBW and PTB. IPV induces restrictive foetal growth (Alemu et al. 2019; Rahman et al. 2021). Sigalla et al. (2017) found that women with previous adverse pregnancy outcomes such as miscarriages or abortions and with current experience of IPV have increased chances of LBW and PTB. This brief discussion of previous studies concludes that IPV invariably causes adverse birth outcomes.

The economic theories of household bargaining (Agarwal 1997) state that a woman's autonomy in the household increases her bargaining power which has implications for intra-household dynamics. Being engaged in paid employment is one channel through which women exercise an increase in bargaining power within the household (Aizer 2010; Majlesi 2016). The extensive literature on the perpetration of IPV propounds that women who lack paid employment opportunities are at higher risk of domestic violence. (Occean et al. 2021; Rayhan and Akter 2021). Alternatively, paid employment should invariably reduce the chances of perpetration of IPV (Eswaran and Malhotra 2011). Studies in cross-country contexts have examined the association between IPV and women's autonomy and have highlighted that engagement in paid work outside the household might be regarded as a violation of traditional gender roles and thus induce partner violence (Gracia et al. 2018; Sanawar et al. 2018; Islam et al. 2021; Dhanaraj and Mahambare 2021). This is indicative of the fact that increased economic opportunities for women outside the household might not necessarily prevent them from IPV. In certain instances, women themselves defend the IPV inflicted on them (Islam et al. 2021; Dhanaraj and Mahambare 2021). The impact of women's involvement in paid work on birth outcomes has also been previously studied. Studies have concluded that financial autonomy, which is brought about by a paid work status, increases access to safe abortion services, while certain kinds of occupational exposures might lead to an increase in the chances of a miscarriage (Kant et al. 2015; Dhar et al. 2018; Kumar et al. 2019).

Based on a brief discussion of the extensive literature that traces the socioeconomic determinants of adverse birth outcomes, this research tries to culminate the possible causes that contribute towards adverse birth outcomes that, in turn, are gradually magnifying as a public health problem. Since none of the factors can be singularly traced for their impact on maternal and child health, it necessitates the need to account for multiple factors and their interactive effects in determining health outcomes. This research takes into account women's perception towards IPV as a measure of autonomy to further interrogate its impact on birth outcomes. The effect that a woman's paid work status in interaction with the perpetration of IPV has on birth outcomes will also be studied.

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