Educational outcomes in health and fertility: a study of education and poverty in Ghana, India, Kenya and Pakistan.

Terms of Reference

1. Research Objectives:

The proposed objectives of the research are to discover:

- Whether the orthodoxy on the strong positive relationships between a woman's schooling and her decision-making power is robust, and if so, what are the pathways or mechanisms through which schooling has this effect;
- Whether schooling 'works' (if it does) mostly through community or individual influences;
- Whether there are thresholds to the schooling effects on men and women, and if so, whether they are stable or changing;
- Whether schooling for poor men and poor women is different in its effects on health and fertility from that for the less-poor;
- Whether the relationships between education and health/fertility are changing, and if so, why;
- How teachers, government officials, NGOs and other educational stakeholders might develop better strategies to enhance pro-poor policies in local communities.

Data to provide the basis for answering these questions could come from both the household survey and special studies using various qualitative research methods. This note deals only with proposed research contributions that could be made by qualitative studies.

2. Research Focus

The focus of this study is on two types of social and human development outcomes:

(a) *Health- and Fertility-Related Behaviour* in relation to:

Reproductive health and other 'gendered' health outcomes

Child health

Contraception

Use of health facilities

Gender bias with respect to sons and daughters

(b) *Women's Agency and Empowerment* in relation to:

Confidence

Decision Making

Domestic violence

3. Conceptual Framework and Literature Review

We suggest that a primary theoretical orientation would be that people are not entirely defined and confined by social categories (such as 'educated', 'low caste' or 'poor') but that there are cultural resources through which individuals and social groups negotiate their ways through the different arenas in which their lives are played out. This is a very general orientation amongst qualitative social scientists, but one might go further through the use of Bourdieu's approach to the roles

played by schooling in highly inegalitarian societies, and his understanding of the contributions of schooling to the development of social and cultural capital (Bourdieu 1977; Bourdieu 1984; Bourdieu 1986). We could, therefore, consider the extent to which schooling provides poor people with a particular 'habitus' (the totality of learned habits, bodily skills, styles, tastes, and other non-discursive knowledges that might be said to "go without saying" for a specific group) that gives them more self-confidence and the ability to negotiate different outcomes for themselves within the household, or more generally in interactions with government as well as private providers of health or other services. Such resources may allow young adults (either as individuals or as couples) to take more independent decisions, or to access a wider range of external resources than their equivalents with less schooling. But schooling can also influence the internal dynamics of couple relationships: most authors suggest that these changes are all positive, but some evidence suggests that we may need to be cautious about accepting this claim too readily.

We suggest that it will not be possible to consider the full range of ways in which schooling might have an influence on health and fertility outcomes for poor households. For most young women in South Asia, Ghana and Kenya the domestic arena is likely to be the most crucial, and women's reproductive and community organisation roles (Moser 1993) are the ones that we will be focusing on. Nonetheless we need to be clear about how poor women's work roles impact on their health and health behaviour. We might also be able to make a contribution not provided in much of the literature by looking at the ways in which young men with more or less schooling relate to their partners in ways that affect the health outcomes for their children, and fertility levels (and patterns, such as sex preferences). The main research questions we suggest as follows:

a: Does schooling lead to 'autonomy' for women in the spheres of health and fertility?

It is generally assumed (rather than argued on the basis of valid and reliable data) that schooling leads to increased autonomy for women when they enter marriages or stable unions. But when direct evidence is collected (e.g. on whether women can shop on their own) the results are not always consistent. Critics also argue that these simple questions capture neither the reality of women's values (do they *want* to shop on their own?) nor the complexity of decision-making in real-life situations. If women who have spent longer in school are better able to negotiate to meet their own goals, is it the schooling that makes the difference? Is it, for example, the *content* of the schooling, the experience of *going to school* and being away from the home, the *cognitive skills* provided by the schooling or the *kinds of homes* from which educated girls come or into which educated girls are married?

Is there something special about an educated man who marries an educated woman: merely by marrying an educated woman, is this man saying something about himself or his household of origin? Is he not just a random educated man who then has his attitudes and preferences moulded by his educated spouse, but possibly a man who is already disposed to seeking a more companionate marriage (Basu 2002)?

b: Community vs. Individual influences

A woman's education may not influence her contraceptive use through a strengthening of her individual bargaining power and skills in relation to that of others in her household on its own; some scholars find that a woman's general knowledge seems to reduce education effects appreciably. Alternatively, higher levels of schooling may change general levels of expectation within a 'community' (which of course needs to be carefully defined and not assumed to exist on the basis of propinquity or common class or status) about things like whether and when to get children immunised, to take children for treatment, or to begin to use modern contraception. In support of the significance of the latter process, studies have suggested that the average educational level of other women in the census-enumeration area is strongly correlated with a woman's contraceptive use above and beyond that of her own education, in both Sub-Saharan Africa and in South Asia (Kravdal 2000; Moursund & Kravdal 2003).

c: Are Threshold Effects Changing?

Several studies have identified a threshold, but we don't really understand why the height of the threshold (the number of years of schooling needed before a statistically robust correlation with fertility or health behaviour outcomes can be identified) differs from place to place (and possibly for different ethnic groups, fractions of the poor, or in urban areas). Some recent work suggests that even very small amounts of schooling can have an effect (Basu & Stephenson 2005). We need to try to find out whether thresholds are a result of school characteristics, or a result of the differing contexts within which the schooling takes place.

d: Schooling for the poor

Very few studies seem to have focussed on the effects of schooling among poor people, either as a means of moving out of poverty (and therefore possibly reducing the costs of health care, for example) or as a change in the degree of social exclusion they face. But some studies of households falling into and climbing out of poverty suggest that schooling is seen neither as a protection against falling into poverty nor always as a way of climbing out of poverty (Krishna 2006; Krishna et al. 2004). Despite these negative findings, does schooling still have an effect on health and fertility practices, and if so, why?

The roles of poor people's changing aspirations, and the effects of different forms of mass media, are aspects that have not been fully understood (Basu 2002; Bhat 2002). Does schooling change people's aspirations directly, through increasing their consumption of mass media, or through wider exposure to the outside world?

e: The Effects of Social Change

Are the findings from earlier studies still valid? Or do the correlations between numbers of years of schooling and health or fertility outcomes change when schooling is widespread, or later in educational/demographic transitions?

What happens as demographic transitions progress (Bongaarts 2003; Cleland 2003)? Much of the recent reduction in fertility and the rise in contraceptive levels in India, for example, has come, from changes in the reproductive behaviour of illiterate women themselves rather than because more women are becoming literate (Bhat 2002b). Is this also true for health-related behaviour, or for women in other parts of the world?

4. Research Design

Some of the material needed to answer the research questions might come from interviews and discussions with key respondents in the course of the long-term engagement with the communities before the specific period of data collection for this sub-project. Others might emerge from the household survey, and the preliminary results of that should guide the final details of the design of the qualitative research. We suggest that this project would be best carried out after at least 6-9 months of research within the villages/slums, and the provisional analysis of household censuses, the household survey and other scoping exercises.

a. Sample selection:

In order to avoid problems of recall and of asking couples about hypothetical situations ('How many children would you like?') and in order to limit variability on the basis of age and so on, we suggest that this part of the research be conducted with women aged 25-34 and their husbands and parents-in-law. This is an appropriate age group for considering health and fertility issues because (i) younger women are likely to see questions on fertility planning as very hypothetical, whereas women aged 25-34 may be actively considering (and possibly acting on) family limitation; (ii) they will have young children and relatively fresh memories of child-birth, so questioning about reproductive and child health decision-making will be meaningful; and (iii) they are more likely to have had varied educational experiences than older married women. There are, however, local decisions that would have to be made about how to operationalise this sample selection, since in Ghana and Kenya it may be that many poor women in this age group are not in stable unions, and

so do not have a husband or 'parents-in-law'; and some might be in polygynous unions, in which elder wives might be more important influences on their health and fertility decision-making. We suggest that selecting women who meet the main criteria (poor, in the right age-group, reproductively active, and fitting into one of the relevant educational categories) could be the starting point. The next step would be to identify the most important other contributors to her ecision-making, and to ensure that they are included in interviews and discussions.

We suggest the selection of about 20 households in rural settings and 20 in an urban setting, in each of the selected districts in each South Asian country. This would generate a total sample of about 80 households in each country. For Kenya and Ghana, if one urban and one rural field-site is selected, the sample might comprise 20 households in each field-site, or a total of 40 households. In selecting the field-site care should be taken to ensure that a range of ethnic backgrounds is represented. The samples could be selected to produce matched pairs of 'more' and 'less' educated women, or there could be three groups of couples, some with little or no schooling, some with average schooling, and some with the most schooling to be found amongst the poor in that particular setting. The detailed criteria should obviously emerge from the separate sites. In some cases, for example, the samples might need to include different kinds of schooling (*madrasah*, vocational, informal schooling).

b. Methods that could be used:

(i) semi-structured interviews with each spouse separately, alone, if possible. (We would want to include husbands who are out-migrant: attempts might be made to talk to them if they are back on short trips or can be traced.)

(ii) semi-structured interviews with the husband's parents, separately and alone, if possible, for women who are currently married

(iii) focus group discussions (whether arising by chance or specifically organised) with other members of the household who might be available.

(iv) focus group discussions (whether arising by chance or specifically organised) with other people from the target age groups

These four methods would be the core of the data collection for this sub-project. The analysis of qualitative material would also draw on field-notes and other interviews from the scoping exercise and the other work carried out in the field-centres during the research prior to (and possibly after) this part of the research. If time permits, and local staff feel they want to add some more aspects to the research, the following might be added:

(v) other data collection exercises, involving the same groups or as a means of starting discussions, depending on local conditions and the time available, might include, for example, giving disposable cameras to women to photograph people, places, situations that are important to them, and then discussing these photographs in small groups; or using vignettes of common situations and how they respond to them

(vi) interviews with the parents of the woman (which, in Pakistan and India at least, might often require travel beyond the village or slum).

c. Topics that could be covered in semi-structured interviews or in focus group discussions would include:

- what local terms there are for 'autonomy', 'self-confidence', 'agency' or 'empowerment'; whether these are gendered, what kinds of behaviour might count as examples, and how these are valued;
- the expectations held by parents/parents-in-law of the role of education in affecting their choices of a daughter-in-law and/or son-in law;
- the extent to which those expectations have been met in practice
- the schooling experiences of a woman's own siblings, and her husband's siblings

- perceptions of the costs and benefits of schooling of boys and girls, held by parents/parents-in-law as well as by the target couples (issues of knowledge, manners/behaviour, parents' contributions to their own children's schooling, possibilities of economic benefits): the extent to which schooling is seen as contributing to routes out of poverty, and whether and how poverty constrains access to schooling
- reflections by young men and young women on the extent to which they have consciously used their schooling status to affect how they have been treated by their parents/parents-in-law; and their perceptions of whether they are seen differently from, e.g., less or more educated siblings or co-daughters-in-law
- recall of decisions with respect to fertility, children's health and women's health over the previous year
- reflections on decisions with respect to children's/grandchildren's schooling (including views on the different kinds of education available to them and the significance of different thresholds and transitions, e.g. from primary to upper-primary, or from upper-primary to secondary and beyond)

c. Approximate time and personnel involved:

Based on experience with similar kinds of research in north India we would expect that carrying out interviews with 20 households will take at least 6 weeks. It may not be possible to arrange an interview on first visiting a household, and it may be particularly hard to find men in this age group during the day. At least two visits to each household should be assumed. Further shorter visits could be combined with other work. These visits would not need to be continuous but rather dependent on when the members of the household are free and willing to talk. Flexibility of timing will be essential: the poor are often pushed for time (even if unemployed). Some times of day may be suitable for meeting some members of the household and not for others, and some seasons (e.g. harvest followed by rapid replanting) may need to be avoided.

The semi-structured interviews would take between 45 minutes and an hour each; focus group discussions should last no longer than 45 minutes, but some might be shorter (or with changing personnel as people join and leave). If two research assistants work together and one conducts an interview while the other makes notes, and then these roles are reversed at the next household, two interviews could be conducted in one day. But the next day will be needed to write up the interviews. Consideration would need to be given to whether or not interviews should be tape-recorded (see the Discussion Paper on Translation Issues on this). If the same people are largely responsible for this data collection in each district, then, at least 3 months would need to be set aside for this project in each district, in addition to prior time spent in piloting and time afterwards to ensure that the data are cleaned, translated and ready for analysis.

d. Data analysis

We have proposed using Atlas-TI to help index and sort the material that is generated. Atlas-TI has a very user-friendly interface and allows the inclusion of material stored in a number of formats, including (if necessary) photographs or other non-textual material. Since the main focus of this sub-project is on the content of the interviews and discussions (rather than, say, the use of particular phrases or speech patterns) Atlas-TI can be used straightforwardly as an indexing programme on materials transcribed from tape recordings and from field-notes whether written in the original language and translated into English, or written originally in English. This will make comparisons easier than if the analysis is carried out on the original language, but for each country it may be worthwhile to consider analysing the untranslated materials for use in local-language publications.

The files of interviews should allow for identifiers to be used to provide background information on each interview. The indexing can take place through a mixture of theoretical concepts (e.g. 'social capital', 'empowerment') and ordinary language categories (e.g. 'friendship', 'relationship

with mother-in-law'). This will allow rapid recovery of all the materials that relate to particular themes.

It is also possible to use Atlas-TI to map relationships between topics, whether theoretical or everyday. This can be done graphically, as well as by analysing relationships between concepts (e.g. whether two concepts are often used together or separately, for example in whether 'conflicts within the household' overlap with 'attitudes towards mother-in-law' or 'relationship with husband').

As with all qualitative data analysis soft-ware packages, Atlas-TI has many other additional features, but there is a danger in attempting to use them all. The extra sophistication may be beyond what the data can bear, and many researchers have realised that they have wasted time learning features that add very little useful to the analysis. We will offer to carry out introductory training in Atlas-TI in each country at a convenient point before the data analysis gets under way.

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