WOMEN AUTONOMY AND CONTRACEPTIVE USE BEHAVIOUR: A CROSS-SECTIONAL ANALYSIS OF PAKHTUN SOCIETY

Hina Iqbal[1], Muhammad Nisar[2], Imtiaz Ali[3], Asad Zia[4]

[1,2,3]Department of Sociology & Political Science, Bacha Khan University Charsadda

[4]Mphil Scholar, Department of Sociology, International Islamic University Islamabad

Corresponding Author Email: [2]muhdnisar@bkuc.edu.pk

ABSTRACT

The present study was framed under a quantitative research design, aimed at investigating the role of women's autonomy in the adoption of contraceptive use behavior in district Mardan. Through multistage random sampling technique, a sample of 413 married women was selected from the study area based on Sekaran's (2003) method of sample size. An interview schedule was used as a tool for data collection. The collected data were analyzed through SPSS in the shape of descriptive statistics and multiple logistic regression analysis. Findings show that household decision-making significantly affected contraceptive use behavior by women autonomy (P=0.000). However, the other variables (financial decision making (0.127), and physical mobility (0.120) were non-significant predictors. The exponential-B value helped interpret the model as; by improving women household decision making, their use of contraceptives could be improved (EαP B = 3.118). The model further explained that the freedom in financial decision-making of women rise could enhance the likelihood of their use of contraceptives by 1.4 times (EαP B = 1.4). The model further showed that freedom in physical mobility of women could increase the likelihood of use of contraceptives by (EαP B = 0.708). The study recommended that women could use contraceptives more easily if they have given their due status in the family, the women in-laws stay away from the family matters of husband and wife, and proper education and employment opportunities are given to the women folk which stable their economic as well as household decision-making opportunities in their families.

INTRODUCTION

Individuals and couples can attain their desired number of children as well as timing and spacing between births through family planning. It can be achieved by using contraceptives. Family planning implies that husband wife discusses when and how many offspring they can have so they can give the highest care to their child, psychologically, financially and socially (WHO, 2009).

Across the world, majority of the women are using contraceptives for controlling their fertility. In 2017, worldwide 63 percent of the married or in-union women were using some form of contraceptives. Moreover, more than one in ten sexually active women are living with an unmet need for family planning. These females want to avoid or delay pregnancies but do not use any contraceptives. The unmet need for family planning is projected to remain above 10 percent globally between 2017 and 2030 despite the reduction anticipated in some regions (United Nations, 2017). Contraceptive use has its impact on population growth, fertility and economic development as well as in protecting women health and rights. (Darroch et al., 2008).

It is the fundamental right of women to decide the number of births and timing. Controlling fertility is an important strategy for women to improve their reproductive rights and to decrease their unmet need for family planning. Fertility involves both biological factors as well as personal decisions of individual, which are further affected by culture and socioeconomic conditions. Decisions regarding reproduction are influenced by a complex set of norms and values which can further influence the behaviour at individual, family and community level (Withers, 2009).

Fertility has been reduced due to the introduction of modern contraceptives in 1960s (Glasier et al., 2006). However, there are a lot of problems in the adoption of contraceptives. The problems lie either in the cultural barriers to contraceptive use, religious legacies hindering its adoption to the women or economic reason for non-adoption (Smith, 2012).

Pregnancy and childbirth related complications are common in developing countries. Family planning can protect women's health by avoiding dangerous abortions, unintended pregnancies, preventing late or early pregnancy and by allowing adequate spacing between births. However, inaccessibility and rejection of contraception always restricted health related wellbeing in women (Best, 1998).

LITERATURE REVIEW

One of the indictors through which women's autonomy is affected in a marital relationship is spousal communication of contraception (Blanc, 2001). According to Gage (1995), spousal communication about family planning is also a sign of women's autonomy. Communication with the partner has also been linked with contraception in women because many of the minority of females referred their husbands for not using contraceptives, even though they never told them about family planning. That's why, the researchers concluded that most of the women wrongly perceive the attitudes of their partners towards contraceptives (Bongaarts and Bruce, 1995). Studies from across sub-Saharan

Africa revealed that the contraception prevalence is higher among those women who discussed contraceptives with a partner (Sharan & Valente, 2002).

Usually, women marry in late teen or early twenty and start giving birth to children. In late 20s these couples attain their desired family size and then want to limit birth contraceptives. The use of contraption increases for the age group of 30-39 and decrease for 40-49 because of their perimenopausal and menopause. Elfstrom and Stephenson (2012) said that women of ages 20 to 34 likely to use contraceptives more than other age groups. Education help to increase the knowledge and cognitive skills of the people which can further increase their autonomy in accessing health services (Solar & Irwin, 2010).

Stephenson et al., (2007) stated that if a female is able to decide to delay childbearing, plan for family, have access to paid employment, which may increase her overall financial position, and which also give more power and autonomy to women. The relationship between education, low fertility and higher use of contraception could be explained by higher economic development in community, or increase in women autonomy.

Hameed et al., (2014) revealed that in Pakistan those women get high decision-making power that belong to household with higher socio-economic status, higher number of children, education, and increased age. In another study Hameed et al. (2014) found that those women have the ability to make decisions in their husbands' home who were involved in decision making process in their parental homes.

If a woman can plan for her future family and delay having children, she will be able to find job, improving her entire financial situation and giving her more power (autonomy). As a result, the lady is able to finish her education, and the cycle begins all over again. According to a study based on 26 Demographic and Health Surveys (DHS) from across the world, the use of modern contraception increases significantly as education increases (Martin, 1995a).

RESEARCH METHODOLOGY

Study Design

The present study used a cross-sectional (Babie, 1989), as it is an appropriate design to study a problem or phenomenon by taking a cross-section of the whole population.

Study Universe and Sampling Method

The universe of the study was District Mardan of Khyber Pakhtunkhwa. A multistage random sampling procedure was adopted for the selection of the respondents as the researcher couldn't collect the data from all the married women in district Mardan. At first stage district Mardan was selected purposively as universe of the study. At second stage three out of five tehsils were selected as study areas purposively. The population in each tehsil was

taken from Pakistan Bureau of Statistics (2017). At stage three the required sample size was proportionally allocated to each stratum.

Sample Size

This research was interested in a number of aspects in a conceptual framework. With all of these factors in mind, the challenge remained how to decide on a sample size. According to both Sekaran's (2003) simplified technique and Cooper and Emory's (2000) calculation, a sample size of 384 was sufficient for a population of 311,868 houses (provided below).

$n = pq/\sigma p$
Where 'n' denotes the sample size.
pq = sample dispersion measurement (used as an estimate of population dispersion)
$\sigma p = 0.025$ = proportional standard error (0.05/1.96)
±0.05 = Desired Interval range for population percentage (Subjective decision)
For determining the interval within which to estimate population proportions,
1.96 σp = 95 percent confidence level (Subjective decision)
$n = 0.5 \times 0.5 = (0.025)^2$
$n = 384$

However, for a bigger population, such as the one in this research, Sekaran (2003) advised a sample size of more than 384 respondents. To be on the safe side, a sample size of 413 respondents was chosen at random from three tehsils as shown in Table 1. Using the suggested formula ni=n.Ni/N, the desired sample size is proportionately given to each Tehsil (Pandey & VERMA, 2008).

while 'ni'= Proportional sample size assigned to each UC
n= Number of people in the population
The total number of households in each UC is denoted by Ni.
N stands for the total number of households.
Table 1 shows the proportional allocation sample size for each Union Council (UC).

Table 1. Total household & sample size distribution in selected Tehsils of District Mardan

Name of District	Tehsils	Number of Household in each Tehsil	Sample Size
Mardan	Mardan	46024	106
	Takht Bhai	91,504	211
	Katlang	41930	97
Total	03	179458	413

Source: Pakistan Bureau of Statistics (2017)

Nature Of Respondents:

Respondents of the following characteristics were included in the study.

a.   Married women
b.   Belong to District Mardan
c.   Mentally sound to respond to questions

DATA COLLECTION

Data was collected using the interview schedule as a tool of data collection. Table 2 shows the conceptual framework for collecting primary data for the project. A brief description of the study's rationale was presented to the respondents in order to obtain the correct information. The interview schedule was pre-tested before heading to the field, with additions and deletions made as needed.

Table 2. Conceptual framework of the study

Independent Variables	Dependent Variable
Household decision making	Contraceptive use behavior
Economic decision making	
Physical mobility	

DATA ANALYSIS

The data was coded and put into SPSS software for processing, and it was examined using univariate and bivariate data analysis approaches, as described below.

Logistic Regression Analysis

The validity of the link between the various factors was further tested using the logistic regression test. Multiple Logistic Regression Model, also known as Binary Response Model, was used to conduct the study.This was interpreted as:

$Y = \alpha + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + e_i$ (Gujrati, 1995)
While Y= use of contraceptives among women
 α is Co-efficient constant
X1= Household decision making
X2 = Economic decision making
X3 = Physical mobility
$\beta_i's$ are the slops of the independent variables
e   is the Error

RESULTS AND DISCUSSIONS

Multiple Logistic Regression Model, also known as Binary Response Model, was used to conduct the study.

Logistic Regression Analysis

Using household decision making, financial decision making, and physical

mobility as predictor factors, a logistic regression analysis was undertaken to estimate the impact of women autonomy on contraceptive usage.

The test of the entire model versus the constant alone model was statistically significant, according to the Omnibus test of model coefficient. As a result, the set of predictor factors was able to better discriminate between women's contraceptive usage (Chi-square = 35.553, P= 0.000). The groping variables and prediction variable exhibited a weak connection (Nagelkerke's R Square = 0.114), and grouping variables explained 8% to 11.4 percent of variance in contraceptive usage behaviour. The Wald test confirmed that only household decision-making had a substantial impact on women's contraceptive usage behaviour (P=0.000). The other characteristics, however, were not significant predictors (financial decision making (0.127) and physical mobility (0.120).

The exponential-B value was used to interpret the model, which said that enhancing women's household decision-making might enhance their contraceptive usage (EP B = 3.118).

The model went on to say that increasing women's financial decision-making flexibility may increase their chance of using contraceptives by 1.4 times (EP B = 1.4).

The model also revealed that women's physical mobility might improve their chance of using contraceptives (EP B = 0.708).

Women's autonomy is measured using at least four distinct methodologies in the literature. One of them is household decision-making autonomy, which is the first and has been the subject of several researches on autonomy (Dyson and Moore, 1983). However, the issue with studies is that they often combine different types of choices, such as selecting what to cook, with decisions concerning children's education, health, or marriage. When many sorts of choices are combined, however, they may give important information on household decision-making processes (Malhotra, 2002). The role of women in household decision-making is important in the sense that it decides their place in the house and the extent of their inclusion in the important matters of the home as member of the family. Age limitations, marital status, and cultural restrictions are their basic considerations for their participation. Women are not the biological beings made up for the procreation and upbringing of children but also have social values regarding the decision of the important matters in the family side by side their spouses. Household decision-making indicated the power sharing between wife and husband in conjugal relationship. Those women who participate freely in decisions of household matters are considered to have more egalitarian relationship with husbands (Hindin & Adair, 2002).
The regression equation based on its calculated coefficients for the model is as:
$Y = a + b_1X_1 + b_2X_2 + b_3X_3$

Contraceptive use among women= .016 + 1.137 (Household decision making) + 0.337 (Financial decision making) + -.345 (Physical mobility)

Table 3. The influence of women's autonomy on contraceptive adoption

Independent variables	Unstanderdized coefficient		Exp(B)	Wald test value	Sig	Omnibus test of model coeffecients		Model summary	
	B	Std error							
						Chi-Square	Sig	Cox & Snell R Square	Nagelkerke R Square
Household decision making	1.137	.225	3.118	25.553	.000	35.857	.000	.083	.114
Financial decision making	.337	.221	1.401	2.330	.127				
Physical mobility	-.345	.222	.708	2.414	.120				
Constant	.016	.203	1.016	.006	.938				

CONCLUSIONS

The present study was limited to District Mardan and was focused on the role of autonomy in the use of contraceptives among women. As resources of earth are limited due to population explosion, these precious resources are exploited. To save the resources for future generations, population must be controlled. Population can be controlled through late marriages and with the use of family planning methods. If women use contraceptives, the chances of population growth will be lower as women are the prime members of society who give birth to children. That's why their decision to adopt contraceptives brings changes in population growth. However, the culture of the area is patriarchal where males are dominant in decision making process. Mostly men are considered as head of the households who decides all important matters of their families including the number of children and adoption of contraceptives by their wives. The most prime reason for such dominancy is because of economic determinism as men are the bread earner, so women depend on their husbands for livelihood due to which they have to make decision according to their wishes. It was found in the study that those women who considered as the co-partners in the family, and had a significant role in the family, where women had

an important role in decision making process of important family matters, had a vital role in the adoption of contraceptives and limiting the number of their children than their counterparts.

RECOMMENDATIONS

Following are some of the recommendations made on the basis of study findings. These recommendations will provide a pathway to improve women autonomy as well as contraceptive use behavior among them.

1.   Women should be treated as co-partner in family rather than just as entity. It will give a sense of recognition and they will decide their important matters in their families like family planning.
2.   Husband should involve his wife in household decision matters and the in-laws should stay away from their matters including the decision regarding limiting the number of children.
3.   Women should be educated in order to be aware of their rights due to which they will know that the decision to use of family planning methods cannot only be enforced by their husbands rather it is their prime right as well.
4.   Women should get access to jobs and other economic opportunities in order to stable their position in their families which will help in household decision-making including the use of contraceptives.

REFERENCES

Babie, E. 1989. The Practice of Social Research, Belmont, California, Wades worth

     Publishing Company.

Best, K. (1998). Contraception influences quality of life. Network, 18(4), 6-9, 33.

Blanc, A.K. (2001). The effect of power in sexual relationships on sexual and reproductive health: An examination of the evidence. Studies in Family Planning, 32(3), 189–213.

Bongaarts, J., & Bruce, J. (1995). The causes of unmet need for contraception and the social content of services. Studies in Family Planning; 26, 57–75.

Cooper, R. D. and C. Willam Emory. 2000. Business Research Methods. (5th ed.), Islamabad. National Book Foundation.

Darroch, J.E., Singh, S., & Nadeau, J. (2008). Contraception: an investment in lives, health and development. In: In Brief (No.5). New York: Guttmacher Institute and UNFPA.

Elfstrom, K. M., & Stephenson, R. (2012). The role of place in shaping contraceptive use among women in Africa. PLOS One, 7(7), e40670.

Gage, A.J. (1995). Women's socioeconomic position and contraceptive behavior in Togo. Studies in Family Planning, 26(5), 264–277.

Glasier, A., Gülmezoglu, A. M., Schmid, G. P., Moreno, C. G., & Van Look, P. F. (2006). Sexual and reproductive health: a matter of life and death. The Lancet, 368(9547), 1595-1607.

Hameed, W., Azmat, S. K., Ali, M., Sheikh, M. I., Abbas, G., Temmerman, M., & Avan, B. I. (2014). Women's empowerment and contraceptive use: The role of independent versus couples' decision-making, from a lower

middle income country perspective. PLOS One, 9(8), e104633. doi: 10.1371/journal.pone.0104633

Hindin, M. J., & Adair, L. S. (2002). Who's at risk? Factors associated with intimate partner violence in the Philippines. Social Science & Medicine, 55(8), 1385-1399.

Malhotra, A., & Schuler, S. R. (2005). Women's empowerment as a variable in international development. Measuring Empowerment: Cross-disciplinary Perspectives, 1(1), 71-88

Martin, T. C. (1995a). Women's education and fertility: results from 26 Demographic and Health Surveys. Studies in Family Planning, 187-202.

Pakistan Bureau of Statistics. 2017.

Pandey, R., & Ram VERMA, M. (2008). Samples Allocation in Different Strata for Impact Evaluation of Developmental Programme, (4), 103–112. Retrieved from http://jaguar.fcav.unesp.br/RME/fasciculos/v26/v26_n4/A7_Artigo_Verma.pdf

Sekaran, U. 2003. Research methods for business: A skill building approach. John Wiley & Sons.

Sharan, M., & Valente, T.W. (2002). Spousal communication and family planning adoption: effects of a radio drama serial in Nepal. International Family Planning Perspectives, 28 (1), 1–17.

Smith, R. (2012). The faces of unmet need for family planning. Population Reference Bureau, from http://www.prb.org/Publications/Articles/2012/faces-unmet-need-familyplanning.aspx

Solar, O., & Irwin, A. (2010). A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice). Geneva: World Health Organization.

Stephenson, R., Baschieri, A., Clements, S., Hennink, M., &Madise, N. (2007). Contextual influences on modern contraceptive use in sub-Saharan Africa. American Journal of Public Health, 97(7), 1233.

United Nations, Department of Economic and Social Affairs, Population Division (2017). World Family Planning 2017-Highlights (ST/ESA/SER.A/414).

Withers, H. M. (2009). Fertility Preferences, Intentions and Outcomes: A mixed-methods study of fertility in a Balinese Village. University of California, Los Angeles, Ph.D Dissertation.

World Health Organization. (2009). Achieving Millennium Development Goal 5: Target 5A and 5B on reducing maternal mortality and achieving universal access to reproductive health Retrieved December 2, 2013, from http:// whqlibdoc. who.int/hq/2009/WHO_RHR_09.06_eng.pdf