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Research Article

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WOMEN AUTONOMY IN HEALTH AND FAMILY PLANNING MATTERS: A CROSS-SECTIONAL STUDY OF URBAN JABALPUR, MADHYA PRADESH

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Abstract

Objectives: The process of empowerment gives people the ability to take command, develop self-assurance, increase awareness, increase mobility, and make decisions. Getting women's voices heard when making decisions that affect them, their families, and the community is essential to improving women's quality of life. According to an Indian study, women in both age groups have higher levels of education, are more progressive in their viewpoints, and have more influence over decisions made in the home.

Materials and Methods: For the study, 200 Indian women in Jabalpur, Madhya Pradesh, were surveyed to find out if they were involved in healthcare decisions. The multistage random sampling technique was used. To provide information, the family's female head filled out a semi-structured questionnaire. The study was conducted in accordance with the protocol approved by the Institutional Ethics Committee.

Results: A study in Jabalpur, MP, found that 42.5% of families make decisions on contraception, with women making more independent decisions about health care, shopping, and purchasing clothing and jewellery. Women's involvement in social and private affairs was low, with only 32.7% actively participating in health care decisions.

Conclusion: The study reveals that 85% of women have reduced autonomy in healthcare decision-making, despite having the right to participate. The findings suggest that educated partners and small families could improve women's decision-making autonomy in maternal health service use and family planning.

Keywords: Women, healthcare, contraception, autonomy.

Introduction

Empowerment is a process and outcome that empowers individuals to take charge, grow self-assured, raise awareness, improve mobility and choice, strengthen control over resources, and make decisions.[1] Decision-making is a vital part of women's empowerment, and India is one of the world's least gender-equal countries. The Global Gender Gap report placed India 127th out of 146 countries in the world, with lower rankings in health and survival, political empowerment, educational attainment, and economic participation and opportunity.[2]

Involving women in decision-making processes helps societies undergo positive transformations through changes in institutions, laws, policies, services, and social norms. To improve the quality of life for women at all societal levels, it is crucial to ensure their opinions are heard when making decisions that impact their own, families', and the community. Women must participate in decision-making in all spheres and have equal authority and representation to men. Society must guarantee equal access to all levels of decision-making and institutions that represent a diverse range of individuals and communities.[3]

According to a study done in India, women's place in the home has a moderate overall decision-making index score (75%). The findings show that women in both the younger and older age groups have more progressive views, have more say in decisions made in the home, and have significantly higher levels of education, all of which raise the empowerment indices of women.[4]This study will facilitate a more thorough examination of the barriers that prevent women from exercising their fundamental right to make decisions about their health and household affairs. The goal of the study is to determine how much women participate in social issues and healthcare decision-making, look into the factors that influence this involvement, and provide a foundation for future research.

Materials and Methods

The study was conducted in Urban Jabalpur, Madhya Pradesh, using a cross-sectional design. The sample size was calculated using the formula $n = z^2 \frac{pq}{l^2}$

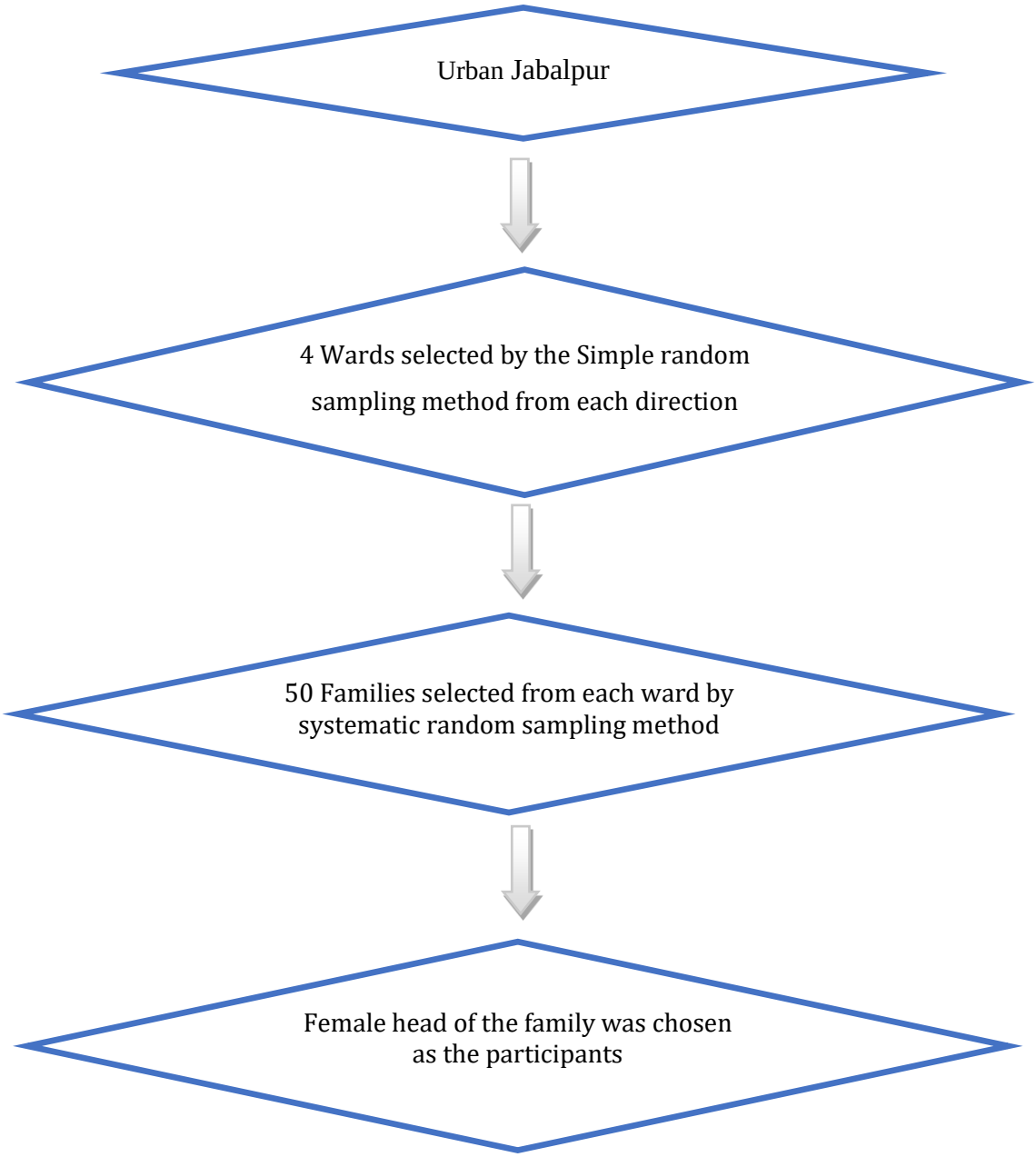
Where n is the desired sample,

p = Decision making index =0.75,

q = 1- p = 1-0.75 = 0.25,

l=10 % relative error = 0.075,

n = (4* 0.75 * (1-0.75)) / 0.0056=134. The minimum sample size was 148, and a sample of 200 was chosen. Multistage random sampling was used, with the selection of wards in the first stage and families from wards in the second stage.



Data included socio-demographic information, decision scores regarding four items: purchasing clothes and jewelry, going to markets, owning healthcare, and decision-making about contraceptives. We used a pretested interviewer-administered questionnaire to obtain the data from the female head of the family.

The decision-making index (DMI) was calculated by giving a score of 1 to matters where decisions were solely taken by women and 0 to those taken by others or in combination.

Calculation of the DMI score of individual respondents = Matters in which decision was taken by women/ total no of matters in which decisions were taken in percentage. The DMI score of individual respondents ranged from 0 to 100 and was grouped as low (0-40), medium (40-70), and high (70-100) based on the DMI score. The study followed the protocol approved by the Institutional Ethics Committee, obtained informed consent from participants, and informed them of the voluntary nature of their participation. Data analysis included descriptive statistics of the main variables and statistical analysis using SPSS version 23. Chi-square test was used to find the association.

Results

This research is based on a field study that involved 200 families in Jabalpur, MP. In the majority of families, or 42.5%, both the husband and the wife decide on contraception. A comparatively greater proportion of wives were discovered to be capable of making decisions about their own health care (40%), going to the market (42%), and buying clothing and jewellery (35.5%) (Table 1).

Table 1. Distribution of decision-making

Decision Making	Wife alone (%)	Husband alone (%)	Husband and wife (%)	Others (%)	N/A (%)
Go to a social function	42	10	43	5	0
Purchase of clothes and jewelleries	35.5	5	59.5	0	0
Go to market	42	1.5	56	0.5	0
Own health care	40	5	54	1	0
Use of contraception	3	1.5	42.5	0.5	52.5

The DECISION-MAKING INDEX (DMI) revealed that the majority of women, or 85% fell into the low category, 10.5% into the medium category, and 4.5% into the high category (Figure 1).

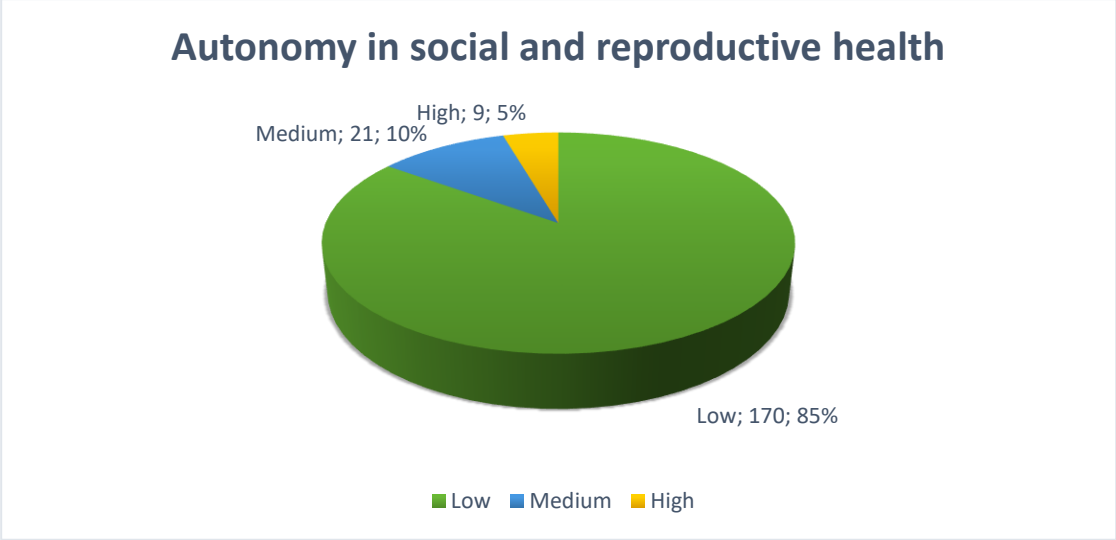


Figure 1. Decision-making index

We also inquired about the women's level of involvement in various social and private affairs (Table 2).

It was discovered that women generally accompanied their husbands to social events and the market. Most of the time, women made independent decisions about what jewellery and clothing to buy for themselves. However, it was discovered that certain groups of women did not fully enjoy independence, including women of joint families (27%), women of the scheduled caste/scheduled tribe category (6.1%), Hindus (33%), and non-working women (32.3%). According to our study, only 32.7% of women in the general category actively participated in choosing their own health care, and most of the time, the husband and wife made this decision together. A comparable situation was observed in families with Muslim members (20%), working women (31.7%), and joint families (27%). Second, family planning decisions were made jointly by the husband and wife, and it was discovered that the wife's contribution was extremely low—it never exceeded 15% overall, except for Christian women, who participated at a rate of 50%. Middle-aged women were found to be more decisive. Overall, women were more likely to purchase clothing, jewellery, go shopping, take care of their own health, and make fewer decisions when it comes to using contraception.

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Table 2. Decision regarding social and healthcare

Variables		Go to a social function	Purchase of clothes and jewelleries	Go to market	Own health care	Use of contraception
Religion	Hindu	22(11.83)	63(33.87)	82(44.09)	76(40.86)	5(2.639)
	Muslim	0(0)	7(70)	0(0)	2(20)	0(0)
	Christian	2(100)	2(100)	1(50)	1(50)	1(50)
	Others	0(0)	0(0)	0(0)	0(0)	0(0)
	P value	*0.050*	0.108	0.359	0.910	0.126
Educational status of husband	Illiterate	1(14.2)	0(0)	3(42.86)	5(71.43)	0(0)
	Primary	5(20)	1(4)	16(64)	18(72)	2(8)
	Secondary	2(6.06)	8(24.24)	13(39.39)	13(39.39)	2(6.06)
	Higher secondary	5(15.63)	15(46.88)	9(28.13)	12(37.5)	1(3.13)
	Graduation	6(10.71)	24(42.86)	23(41.07)	20(35.71)	1(1.79)
	Post graduation	4(11.11)	19(52.78)	15(41.67)	10(27.78)	0(0)
	Professional	1(9.09)	5(45.45)	4(36.36)	1(9.09)	0(0)
	P value	0.572	*0.002*	*0.003*	*0.001*	0.282
Educational status of wife	Illiterate	5(22.73)	1(4.55)	10(45.45)	13(59.09)	0(0)
	Primary	1(3.57)	3(10.71)	14(50)	17(60.71)	2(7.14)
	Secondary	3(10)	13(43.33)	12(40)	9(30)	1(3.33)
	Higher secondary	5(16.13)	12(38.71)	11(35.48)	16(51.61)	2(6.45)
	Graduation	6(9.84)	27(44.26)	25(40.98)	17(27.87)	0(0)
	Post graduation	4(16.67)	14(58.33)	9(37.5)	7(29.17)	1(4.17)
	Professional	0(0)	2(50)	2(50)	0(0)	0(0)
	P value	0.654	*0.001*	0.753	*0.014*	0.115
Income status per capita	>=5113	24(13.19)	72(39.56)	82(45.05)	72(39.56)	5(2.75)
	1257-5112	0(0)	0(0)	1(8.33)	5(41.67)	1(8.33)
	1553-2556	0(0)	0(0)	0(0)	2(50)	0(0)
	3767-1532	0(0)	0(0)	0(0)	0(0)	0(0)
	<767	0(0)	0(0)	0(0)	0(0)	0(0)
	P value	0.114	0.181	0.435	0.209	0.678
Type of family	Nuclear	18(12.24)	52(35.37)	61(41.5)	62(42.18)	3(2.04)
	Joint	2(5.41)	10(27.03)	11(29.73)	10(27.03)	2(5.41)
	Three Generation	4(25)	10(62.5)	11(68.75)	7(43.75)	1(6.25)
	P value	0.055	0.124	0.077	*0.004*	*0.032*
Working status	Employed	7(11.67)	26(43.33)	23(38.33)	19(31.67)	2(3.33)
	Non employed	17(12.14)	46(32.86)	60(42.86)	60(42.86)	4(2.86)
	P value	0.177	0.331	0.456	0.063	0.699
Age of marriage	10-19 years	13(16.88)	13(16.88)	40(51.95)	45(58.44)	6(7.79)
	20-29 years	10(9.01)	53(47.75)	39(35.14)	31(27.93)	0(0)
	30 and above	1(10)	5(50)	3(30)	3(30)	0(0)
	P value	0.759	*0.002*	0.517	*0.010*	0.355
Age of the woman	10-19	0(0)	0(0)	0(0)	0(0)	0(0)
	20-29	1(2.94)	4(11.76)	14(41.18)	16(47.06)	1(2.94)
	30-39	5(7.25)	26(37.68)	23(33.33)	26(37.68)	0(0)
	40-49	12(17.65)	25(36.76)	33(48.53)	29(42.65)	3(4.41)
	50-59	6(26.09)	12(52.17)	11(47.83)	7(30.43)	2(8.7)
	60=+	0(0)	5(83.33)	2(33.33)	1(16.67)	0(0)
	P value	0.204	*0.003*	0.640	0.682	0.541
Age of first conception	NA	0(0)	3(60)	4(80)	2(40)	0(0)
	10-19	8(25)	5(15.63)	20(62.5)	22(68.75)	5(15.63)
	20-29	14(9.33)	59(39.33)	55(36.67)	51(34)	1(0.67)
	30-39	2(16.67)	4(33.33)	3(25)	4(33.33)	0(0)
	40-49	0(0)	1(100)	1(100)	0(0)	0(0)
	50+	0(0)	0(0)	0(0)	0(0)	0(0)
	P value	0.559	0.220	0.258	0.158	*0.003*

*p value < 0.05- significant, Chi-square test was employed to find the association

Table 3. DMI of individual variables

	Go to a social function	Purchase of clothes and jewelleries	Go to market	Own healt care	Use of contraception
Mean DMI	12.77	37.07	39.70	36.78	4.27
SD	14.86	23.67	18.60	17.14	8.12

Discussion

The emphasis on freedom of movement as a human right is found in Article 13 of the Universal Declaration of Human Rights. However, unsafe environments and cultural practices limit women's freedom. Due to the limitations on their educational and career options, they follow tradition by getting married, becoming stay-at-home mothers, and accepting domestic roles. This has a significant impact on women's empowerment, and finding a solution requires more thoughtful discussion. [4] Compared to the extreme age groups, women in the mid-age range think more progressive ideas and participate in decision-making.[4] There are studies where older women often have greater autonomy in healthcare decision-making due to their life experiences and past decisions [5–7]. However, it might be due to the newlywed women's status in the household. Because they have less decision-making authority as a newlywed daughter-in-law, they defer to the main decision-makers. In addition, younger women face more stringent gender norms than older women, including pressure to have children. As a result, as they age, they gain authority with more and bigger responsibilities and the ability to make their own decisions.[6]

According to this study, there is no correlation between a husband's educational background and women's empowerment. It is a well-known fact that education gives women the ability to rise from positions of weakness and exert control over various aspects of life, including the reduction of gender inequality. [8,9]

In our study, over 83% of respondents are Hindu, making it unfair to compare women's autonomy with faith. Further exploration of determinants of women's autonomy among Muslim, Christian, and other religious women is recommended. We found that the Indian culture's ingrained preference for sons may be the reason for women's low regard for their freedom to choose how many children to have; in India, the husband and his family typically make this decision [4] Decision-making authority was frequently subordinated to the influence of customs and culture. Moreover, women had to make decisions during childbirth, but their husbands and families also had an impact. [10] This was also the scenario of Nigeria as we went through the literature.[11] Low

levels of autonomy can result in low uptake of delivery care services even for women who have sufficient financial resources, education, or both.[12,13] Since achieving women's economic empowerment is essential to achieving gender equality and women's rights, women may use health services more frequently as their economic status rises and they gain more financial autonomy. Research carried out in developing nations has revealed that women's economic status has an impact on their independence in making decisions and using their power for their own advantage.[6] We observed in our study that DMI was not improved with levels of education or employment.

According to a study by Yogendra Rajah (2013), getting health care had a positive moderate relationship with empowerment (<0.50).[14] Research has indicated that there may be a strong conceptual overlap between mental health and empowerment, and that there may be mutually reinforcing pathways in the realisation of these concepts. As a result, community-building development initiatives may also advance mental health and well-being. [15]

According to a summary of the findings, women most frequently chose not to participate in interventions aimed at improving their health because they felt unsupported by their husbands and families.[7] Support networks have been associated with better physical and mental health outcomes and are an essential part of social cohesion, the biggest social determinant of health.

Even though every woman has the right to participate in her healthcare decision making, 85% women have diminished autonomy in decision making regarding their health service use and social participation. This study concludes that well-educated partners and small family size could lead to women’s decision-making autonomy on maternal health service use and family planning. The discussion calls for comprehensive strategies that go beyond simplistic solutions, fostering inclusive dialogue and addressing the root causes of inequality to move towards a more equitable future.

Ethical Considerations: The study was approved by the Ethics Committee at the Netalji Subhash Chandra Bose Medical College, Jabalpur (Date: 17.12.2019; No: IEC/2019/10108)

Conflict of Interest: The authors declare no conflict of interest.

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