

ORIGINAL ARTICLE

Does Women Empowerment Predict Contraceptive Use? A Study in a Rural Area of Hooghly District, West Bengal

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Abstract

Background: India launched the world's first national family planning programme in 1952. Unfortunately, considerable numbers of eligible couples in India are still not using any method of contraception in spite of the fact that knowledge related to contraceptives are not lacking. Studies reported that the status of the women in the family and largely in the community, represented by a measure 'women empowerment' plays a role in determining contraceptive use. However, there is dearth of literature in this regards especially among women of reproductive age of West Bengal. **Aims & Objectives:** To find out the current contraceptive use and its relationship, if any with women empowerment among adult married women of reproductive age group in a rural area of West Bengal. **Material & Methods:** Community based cross-sectional study was conducted among 151 WRA using interviewer-administered questionnaire. Current use of contraceptive was the outcome variable. The main explanatory variable was 'empowerment score'-a summed measure of four domains: 'financial autonomy', 'freedom of movement', 'involvement in household level decision making' and 'woman's power in sexual and reproductive decision making'. **Results:** 63.6% study participants were using any method of contraception at the time of study. Women empowerment [AOR (CI): 1.11 (1.02-1.22)] and education of women [AOR (CI): 2.56 (1.13-5.85)] were significantly associated with contraceptive use, even after adjustment with other independent variables. **Conclusion:** Educating women and empowering them will improve the family planning practices. This will, in long run play a pivotal role in improving family and community health.

Keywords

Contraceptive use, Women empowerment, WRA, Married, Family Planning

Introduction

Family planning is one of the universally accepted strategies to promote, protect and restore women health, especially in the developing countries (1) which is central to health and well-being of the community (2). India launched its national family

planning programme as early as in the year 1952, first of its kind in the world which went through several phases of reform to achieve the country's population goals and to improve reproductive health (3). Cafeteria choice of contraceptives is being offered to the beneficiaries in order to facilitate

acceptance. However considerable numbers of eligible couples are still not using any method of contraception. According to DLHS-4, 27.6% of the eligible couples in rural areas of West Bengal, India never used any method of family planning in their lifetime, if the modern methods are considered this figure rises to 38.6% (4).

Several factors that may have some associations with contraceptive practice were studied; for example age of the woman (5,6), age at marriage (7,8), literacy status or education of the women, socio-economic status (6–8), educational status of the husband (6,9), religion (5,7,10), occupation (8), number of living children (6) etc. Knowledge of the woman regarding contraceptive methods has been given stress in some studies (7,9) although it has been seen that high level of contraceptive awareness is not being reflected in the actual practice (6,10,11). This gap provides with the insight that ability to adopt and maintain family planning measures does not merely depend upon the knowledge but also the status of the women in the family and largely in the community. This status is reflected through some characteristics, collectively expressed by the measure 'women empowerment'. Empowerment has been defined as "The expansion in people's ability to make strategic life choices in a context where this ability was previously denied to them" (12). It is a multidimensional concept encompassing several dimensions and studies reported some or others of these (13). Participation of the woman in household decision making, mobility or freedom of movement, financial autonomy, decision making related to reproduction and fertility issues, inter-spousal communication, gender beliefs/attitudes, access to media etc. are some of the widely-used domains or dimensions to reflect empowerment. Studies from different parts of the world have shown that there is relationship between women empowerment and contraceptive use (9,14). NFHS-3 of India reported low level of contraceptive use (44%) among less empowered women (15). However, little is known whether this relationship exists even in presence of other important contextual factors especially among rural women of West Bengal

Aims & Objectives

1. To find out the proportion of current usage of contraception among adult married women of

reproductive age group in a rural area of Hooghly district, West Bengal.

2. To determine the relationship between women empowerment and contraceptive use among the study population, if any

Material & Methods

Study design and settings: This cross-sectional epidemiological study was conducted between December, 2015 to March, 2016 in rural communities of Singur block, Hooghly district of West Bengal which is the rural field practice area of All India Institute of Hygiene and Public Health (AIIPH&PH), Kolkata. This catchment area is served by 12 health units of RHUTC.

Study subjects: Adult married women of reproductive age (WRA) were included in the study, upper age limit was decided as 49years. Unwilling WRA, WRA found not using contraceptives because they want pregnancy during the study period were excluded from the study.

Sample size and sampling technique: Considering the proportion of current use of family planning (any method) as 74.9% in of rural Hooghly (Hugli) (16); using 5% alpha error, absolute precision 10% and design effect 2, the sample size obtained was 151. Multistage sampling was used. 2 health units were selected randomly and from each of them 2 villages were selected. Line listing of all the households was done and the sample households were selected randomly from 4 villages using Probability Proportionate to Size technique. As women living in the same household are not independent (17), one woman was selected from each household.

Study tool and technique: After obtaining approval from institutional ethics committee, house to house visits were made and interview using pre-designed pre-tested schedule was done. If any house found locked WRA of next household was approached. Explaining the academic nature of the study and ensuring anonymity and confidentiality informed consent was obtained. Each willing WRA was asked to choose a suitable place of her residence where she can feel comfortable to answer the questions. It was ensured that no other family member who might influence her responses remained present during interview. After completing the interview, participants who were not using any family planning methods were counseled and informed of its possible dangers.

Study variables: Outcome variable of our study was 'current use of contraceptive'. The WRA were divided into 3 categories: 'current users' (using any method during data collection of the study- this included acceptors of permanent method and traditional spacing methods), ever users (used any time in lifetime but not the 'current users') and 'never users'. Predominant reason for non-usage was also recorded.

The principle explanatory variable is 'woman empowerment'- a composite scale made up of four domains: 'financial autonomy' (4 items with yes/no response: employed for cash, having money in hand, ability to use it as per her wish, having a functional savings bank account), 'freedom of movement' (4 items with yes/no response: whether allowed to go alone to homes of friends and relatives, shopping, festivals or places of worship, places of official works), 'involvement in household level decision making' (6 items with alone/ with husband or someone else/never involved responses: own health, child's health, other decisions e.g. any ceremony in the family or change of job etc, major purchases in household such as land, furniture, vehicle etc.; minor or daily purchases in household and distribution of family budget) and 'woman's power in sexual and reproductive decision making' (4 items: preference for male child and ability to refuse husband if not willing for sex-both with yes/no responses; decision when to have child and decision related to family planning- both with alone/ with husband or someone else/never involved responses). Each of the favourable and unfavourable responses were given score one [1] and zero [0] respectively. Thus an 'empowerment score' was made with attainable score ranging from 0 to 18, and an increasing score representing increasing level of empowerment.

The background or contextual explanatory variables were age of the participant, religion, type of family (nuclear/ joint), number of family members, level of education- self and husband, occupation- self and husband and socio-economic status (Per-capita income was recorded and categorized as per modified B.G. Prasad's class (18)).

The variables were selected after extensive literature review and finalized after consultation with experts. Pilot testing with the prepared questionnaire translated in the local language i.e. Bengali was done among similar women of a neighbouring village that was not selected for the study. Reliability analysis of

the 4 domains of empowerment as well as all the 18 items of the empowerment scale was done. The Cronbach's alpha value ranged from 0.69 to 0.91.

Statistical analysis: Descriptive and inferential statistics were done using Microsoft Excel 2007 and IBM SPSS ver.16. Univariate and multivariable logistic regression analyses were performed to determine whether women empowerment explained the contraceptive use-alone and also after adjustment with relevant contextual independent variables. The decision to select the independent variables for inclusion in the final logistic regression model was based on its significant association with the outcome variable in univariate regression. Initially the 4 empowerment domains were individually tested for association with contraceptive use, however as those were significantly correlated, the final analysis was done based on score obtained by summing all of them. This sum score is one of the measures of multidimensionality (13).

Results

[Table 1](#) shows the background characteristics of the study participants. Majority of them were Hindus (61.6%), 12 (7.9%) of the women were illiterate while 32 (21.2%) had studied up to Higher secondary or more. About 13% of the husbands were illiterate. 114 (75.5%) participants were not employed for cash in this study and majority of those who were employed were bidi (hand-made cigarette) rollers, who work from their own residences. Considerable variations were there in husband's occupation where majority were farmers (46.4%). 63.6% belonged to joint families and almost half of the participants belonged to socio-economic class III. Age of the participants (in years), number of family members and duration of marriage (in years) was expressed in mean, standard deviation and range. The median values of these were 34, 5 and 14 respectively.

[Table 2](#) shows the distribution of the participants according to the domains of women empowerment. Although only one-fourth of them were employed, 113 (74.8%) had access to money. It is a usual practice that the earning member (mostly husband, sometimes brother-in-law, father-in-law or son) sometimes keep a portion of his income with the woman. However, among them 35 (27%) were unable to expend it as per her wish. Regarding the mobility or freedom of movement it was found that for most of the women it was the usual practice to go to different places accompanied by husband or

someone else. Therefore, instead of reporting their practice our study inquired whether or not she was allowed to move alone to the places mentioned in the schedule. Less than one fifth of the WRA studied were allowed to go to the official places alone. Regarding the household level decision making, 'involved' category combined decision making either alone or jointly with husband or someone else. Only 26 (17.2%) could take decision regarding own health by themselves. This value for child health was 19 out of 147 WRA who had at least one child (13.8%) and for minor or regular purchases was 11 (7.3%). Only one respondent reported to take decision regarding family budget allocation herself. Power of reproductive and sexual decision making included one gender issue- preference of male child over female and it was reported by almost half of the participants. Only 41% of the study population was involved in decision making (either alone or with husband) related to contraception.

Out of 151 study participants, 96 (63.6%) were found to be the 'current users' of contraceptives. [Figure 1](#) shows the pattern of contraceptive measures adopted by them. Notably 15% of the study participants and 11 (24%) of the current users adopted traditional methods (Withdrawal, LAM, Calendar method etc.). All those who adopted permanent methods, have undergone tubectomy i.e. female sterilization.

[Table 3](#) shows the factors associated with use of contraceptive. The main explanatory variable 'empowerment score' was deduced in such a way that as the score increases, the empowerment level increases. A unit increase in the score significantly increases the odds of contraceptive use 1.16 times with 95% confidence interval of 1.08 to 1.26 times (univariate analysis), and when adjusted with significant contextual variables (Religion, education-self, number of family members and duration of marriage) it remained statistically significant [Adjusted odds ratio 1.11 (95% CI: 1.02-1.22)]. The goodness of fit of the model was assessed by non-significant Hosmer and Lemeshow test.

The predominant reasons as felt by the respondent for not using any family planning method currently were obtained. Out of 55 non-users 24 (43%) reported that husband did not want so and for another 20% of non-users it was the mother-in-law. This finding is corroborative with the involvement in decision making regarding FP as depicted by table 2. Fear of complications was the reason for 13 (24%) of

them. Lack of knowledge played a role only for 7 (13%) non-users and all of them were 'never users'.

Discussion

In the present study, 36.4% of the participants are not using any contraceptive method currently, this value is higher than the report in DLHS-4 for Hooghly (Hugli)(16). Out of total 151 participants, there were only 7 (4.6%) women who were not aware of any method of family planning. This finding is similar to study by Laxmi MM *et al* (10) where 95.2% were aware of at least one method of family planning although 29.8% were non-users. Prateek S *et al* (7) and Murakar SK *et al* (8) mentioned about fear of side effects or complications as reason of non-acceptance of family planning for 21.3% and 16.3% of the participants respectively, which for our study played a role in case of 24% of non-users. Some studies (7,10) reported want for more child as one of the major reasons, but this finding has not been reflected in our study as such women were excluded as per the set criteria. Husband and family opposition were mentioned as important reasons for this gap (8,19). In our study, too, these were the important barriers for contraceptive use felt by respondent.

In addition to these self-reported barriers of family planning, our study attempted to examine the aspects of women empowerment which were pertinent to the study population. This has the implication that overall improvement of their empowerment status is needed to improve their FP practice, since the former would overcome all the obstacles for contraceptive use. If we consider our national data, NFHS-3 (20) has given detailed account of several aspects of women empowerment. Employment among currently married women ranges from 31% to 50%. In our study this was only 24.5%. It might be due to the fact that this study did not encompass urban areas where more women are likely to be employed. However, only 8.5% women had a bank or savings account that they themselves use, this figure being pretty high (23.6%) in our study. According to NFHS-3, there was no decision which a majority of currently married could take alone. Women are least likely to make decisions mainly by themselves about major household purchases. Overall, only about half of all women are allowed to go to the market *alone*. These findings are very similar to what we found in this study.

Women empowerment was found to be significant predictor of contraceptive use which is supported by the fact that as empowerment level increases, the odds of using contraceptives currently increases significantly. Do and Kurimoto (21) showed positive associations between the overall empowerment score and family planning method use in all the African countries (relative risk ratios, 1.1-1.3) included in their study. Kidayi *et al* (22) found women empowerment had an OR of 1.3 (95% CI: 1.16 - 1.56) on modern contraceptive use. Crissman *et al* (23) established that increasing levels of sexual empowerment are found to be associated with use of contraceptives, even after adjusting for demographic predictors of contraceptive use and this association is moderated by wealth. The autonomy of women was found to be a significant factor that influences contraceptive use in Asian population as shown by Najafi Sarjabad *et al* (24). Woldemicael G (25) found that women who reported their husbands had all the decision-making power regarding small or large household purchases were more likely to desire large families (five or more children) compared to women who had at least some say in household decisions (OR 1.39, $p < .05$). Our study findings are in congruence with all these studies.

Women's educational status has been reported either as one of the socio-demographic controls in multivariable analysis or itself as a proxy measure of empowerment across studies (13). Our study used it in the former way where it remains significant even after adjustment. Those who attained education of secondary school level or more had 2.56 times higher odds of using any FP methods than those who had below secondary level of education. Here lies the importance of female education which has immense role in regulating family planning practice and ultimately betterment of family health.

Future study with larger sample size including the male counterparts would be required to address these issues.

Conclusion

Contraceptive use among rural married WRA studied here is still not satisfactory. Educating women and empowering them will improve the family planning practices. This will in long run play a pivotal role to improve reproductive, maternal and child health of the community.

Recommendation

All the IEC activities need to emphasize more on gender role. Women should be aware of the existing income generation schemes. All women of reproductive age and their family members should be sensitized for the benefits of contraception. The eligible couples should be made aware of the high failure rate of the traditional methods. All round efforts should be made to alleviate fear and misconceptions.

Limitation of the study

Inclusion of other important aspects pertaining to or affecting women empowerment, for example, intimate partner violence and male participation in reproductive and sexual decision making would have brought out clearer picture

Relevance of the study

The combined role of freedom of movement of a woman, her ability to make household-level decisions as well as reproduction related decisions and access to financial resources on contraception was not studied much. Here, these domains were put together as 'women empowerment' that was found to be significantly associated with contraceptive use, even after adjusting with other contextual factors. Therefore, any effort directed to improve or sustain family welfare need to address women empowerment.

Authors Contribution

All the authors have made valuable and substantial contribution to the study process and to the drafting of the article.

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Tables

TABLE 1 BACKGROUND CHARACTERISTICS OF STUDY PARTICIPANTS [N=151]

Variables	mean (SD), range	Frequency (%)
Age (in completed years)	33.2 (8.9), 18-49	
Religion		
Hindu		93 (61.6)
Muslim		58 (38.4)
Education-self		
Illiterate		12 (07.9)
Primary		69 (45.7)
Secondary		38 (25.2)

Higher Secondary and Above		32 (21.2)
Education-Husband		
Illiterate		19 (12.6)
Primary		67 (44.4)
Secondary		23 (15.2)
Higher Secondary and Above		42 (27.8)
Occupation- Self		
Homemaker		114 (75.5)
Bidi worker		28(18.5)
Other manual labourer		02 (01.3)
Shopkeeper		02(01.3)
Semi-skilled worker		04 (02.7)
Skilled/ Professional worker		01 (00.7)
Occupation- Husband		
Unemployed/At home		01 (00.7)
Farmer		70 (46.4)
Other manual labourer		12 (07.9)
Shopkeeper/ Small businessman		24 (15.9)
Jwellery worker		31 (20.5)
Semi-Professional/professional worker		13 (08.6)
Type of family		
Nuclear		55 (36.4)
Joint		96 (63.6)
Number of family member	5.23 (2.2), 2-13	
Duration of Marriage, in years	14.1 (9.2), 1-34	
Socio-economic Status (Modified Prasad’s Classification, May 2014)		
Class I		09 (05.4)
Class II		61 (37.0)
Class III		77 (46.7)
Class IV		15 (09.1)
Class V		03 (01.8)

TABLE 2 STUDY PARTICIPANTS ACCORDING TO DOMAINS OF EMPOWERMENT [N=151]

Domains	Items	Frequency (%)
Financial autonomy	Employed for cash	37 (24.5)
	Has money in hand	113 (74.8)
	Able to expend it as per her wish (n=113)	82 (72.6)
	Has own functioning savings bank account	35 (23.2)
Freedom of movement	Allowed to go alone to friends’ or relatives’ home	93 (61.6)
	Allowed to go alone to market/for shopping	64 (42.4)
	Allowed to go alone to attend festival/places of worship	89 (58.9)
	Allowed to go alone to attend official works (bank, post office etc.)	28 (18.5)
Household level decision making	Involved in decisions related to own health	118 (78.1)
	Involved in decisions related to child’s health (n=147)	119 (81.0)
	Involved in other major decision (job, any ceremony in the family etc.)	68 (58.9)
	Involved in decisions related to major purchases	58 (38.4)
	Involved in decisions related to minor/regular purchases	111 (73.4)
	Involved in decisions related to distribution of family budget	67 (44.4)
Woman’s power in sexual and reproductive decision making	No preference for male child	76 (50.3)
	Presence of ability to refuse husband if not willing for sex	90 (59.6)
	Involved in decisions related to when to have child	84 (55.6)
	Involved in decisions related to family planning	63 (41.7)

TABLE 3 UNIVARIATE AND MULTIVARIABLE LOGISTIC REGRESSION FOR FACTORS ASSOCIATED WITH CURRENT USE OF CONTRACEPTIVES [N=151]

Explanatory variables	Frequency n=151 [No. (%)]	Current users n= 96 [No. (%)]	OR (95% CI)	AOR (95% CI)
Empowerment Score^a	-----		1.16 (1.08-1.26)*	1.11 (1.02-1.22)*
Age of the participant (in yrs)	-----		0.97 (0.94 – 1.01)	-----
Religion				
Hindu	93 (61.6)	66 (71.0)	2.28 (1.15-4.51)*	1.87 (0.84-4.15)
Muslim	58 (38.4)	30 (51.7)	1	1
Education (Self)				
Secondary and above	68 (45.0)	51 (75.0)	2.53 (1.26-5.09)*	2.56 (1.13-5.85)*
Below Secondary	83 (55.0)	45 (54.2)	1	1
Education (Husband)				
Secondary and above	65 (43.0)	44 (67.7)	1.37 (0.68-2.69)	-----
Below Secondary	86 (57.0)	52 (60.5)	1	
Occupation of Husband				
Professional, semi-professional	13 (08.6)	09 (69.2)	1.56 (0.44-5.48)	
Shopkeeper, Jewelry workers	55 (36.4)	38 (69.1)	1.55 (0.75-3.19)	
Farmer, labourer, at home	83 (55.0)	49 (59.0)	1	-----
Type of Family				
Nuclear	55 (36.4)	38 (69.1)	1.46 (0.72-2.96)	-----
Joint	96 (63.6)	58 (60.4)	1	
Number of Family members	-----		0.73 (0.62-0.86)*	0.85 (0.70-1.03)
Duration of Marriage (in yrs)	-----		0.96 (0.93-0.99)*	0.98 (0.95-1.02)
Socio-economic Status				
Class II and above	63 (41.7)	44 (69.8)	1.6 (0.81-3.18)	-----
Class III and below	88 (58.3)	52 (59.1)	1	

*a Higher score represents higher level of empowerment; *Significant at p<0.05 level*

Figures

FIGURE 1 PATTERN OF CONTRACEPTIVE MEASURES ADOPTED BY PARTICIPANTS [N=151]

