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HOUSEHOLD DECISION-MAKING AND USE OF CONTRACEPTIVES AMONG PAKHTUN WOMEN

Muhammad Nisar*[1], Nadia Farooq[2], Muhammad Adil[3], Aneesa Ibrar[4], Hina Iqbal[5]

[1]Assistant Professor, Department of Sociology & Political Science, Bacha Khan University, Charsadda, Pakistan

[2]Lecturer in Sociology, IBMS, The University of Agriculture Peshawar, Pakistan.

[3]Assistant Professor, Department of Management Sciences & Commerce, Bacha Khan University Charsadda.

[4]Lecturer, Department of Education, Bacha Khan University, Charsadda, Pakistan.

[5]Mphil scholar, Department of Sociology & Political Science, Bacha Khan University, Charsadda

Corresponding author: muhdnisar@bkuc.edu.pk

Abstract
The present study was cross-sectional in nature, aiming to discover the women's role in household decision-making and its effects on the adoption of family planning methods. Through multi-stage random sampling technique, a sample of 413 married women was selected from three tehsils of District Mardan. The data were collected through interview schedule from these respondents. Findings of the study show that a highly significant (0.000) and positive association (T^c= 0.322) was found between women decision about children education and use of contraceptives, choosing the healthcare in care of women illness and use of contraceptives (0.000, T^c= 0.314), a highly significant (0.000) and positive (T^c= 0.292) association was found between the use of contraceptives and women decision regarding the treatment of ill child, and highly significant (0.000) and positive (T^c= 0.162) association was found between women decision regarding their children's marriages and use of contraceptives. It seems that those women used contraceptives easily who were involve in major household decision-making as compared to their counterparts. The study recommended that through education, and formulation & implementation of laws, women may be aware of their rights and can be empowered due to which they can exercise their power in major daily routine like household and family planning matters.
Key words: Women, Household, Decision-making, Contraceptives, Pakhtun Society.

Introduction

Family planning is a crucial for ensuring population balance. It is regarded a significant development goal for many developing nations, including Pakistan, due to its substantial socioeconomic, environmental, and human rights ramifications. Family planning helps to achieve the Sustainable Development Goals (SDGs) by allowing for healthy birth spacing and lowering pregnancy-related mortality and morbidity." Contraception is an important part of family planning. Using a variety of contraceptive techniques is an important strategy for avoiding complex and undesired births. Contraception usage to prevent undesired pregnancies is one of the most cost-effective approaches to reduce maternal fatalities among various treatments (Bongaarts and Sinding 2009).

According to the Population Reference Bureau's (PRB) 2019 Family Planning Datasheet, 62 percent of women aged 15–49 use contraception for family planning, with 56 percent utilising modern contraceptives. Due to access, demand, and availability of family planning services, these rates are higher in developed countries (67 percent and 60 percent, respectively) than in poor countries (34 percent and 29 percent, respectively). Limiting family size in less developed nations is an important need of the timer, since Least Developed Countries (LDCs) have been expanding at a rate of 2.3 percent yearly since 2015, according to UN predictions of world population prospects 2019. This rate of growth is 2.5 times quicker than the global average of 1.08 percent.

The right to select one's own reproduction is a recognised human right. This human right to freely and responsibly choose the number, spacing, and timing of their children, as well as the information, education, and resources to do so, was recognised at the 1994 International Conference on Population and Development (ICPD PoA) (Bogale et al., 2011), and was reaffirmed at the Fourth World Conference on Women in Beijing (Edmeades et al., 2018). It is vital that this right to unlimited access to contraception be realised (Edmeades et al., 2012).

Due to a shortage of mother and child health care facilities, family planning (FP) is a critical issue in many developing countries (Yigzaw et al., 2015). According to studies, contraception saves 272,040 lives each year by lowering the risk of pregnancy and associated complications (exposure reduction), lowering the risk of having an unsafe abortion (vulnerability reduction), delaying first pregnancy in young women who may have

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premature pelvic development, and reducing frailty risks from high parity and closely spaced pregnancies (Ahmed et al., 2012). Increasing contraceptive use by 15 to 17 percent, according to studies, reduces population increase by one birth per woman (Cleland et al., 2012).

Pakistan is the world's fifth most populous country, with 207 million people, and its population is growing at a rate of 2.4 percent each year (World Development Indicators, 2018). Pakistan confronts significant challenges in almost every development metric, particularly maternal and child health. Failure to manage the reproduction rate and rapid population growth has severe repercussions for development indicators such as education, poverty, and life expectancy, particularly for the health of mothers and children. In the Pakistan Demographic and Health Survey (PDHS) 2017–18, the fertility rate per woman was 31% higher than the goal rate. A woman has an average of 3.6 children in her lifetime, according to the poll, and the fertility rate in rural regions is greater (3.9) than in urban ones (2.9). Furthermore, just 34% of Pakistani women used contraception (urban = 43 percent, rural = 29 percent). Contraceptive use has been steady over the previous five years (35 percent in 2012–13 and 34 percent in 2017–18), according to the PDHS. To keep the population under control, contraceptive use must be expanded.

Since the 1950s, Pakistan has maintained an active family planning programme. Recent investment shows a shift away from the population growth concerns that motivated the project in the first place, and toward public health delivery systems that prioritise responsiveness to women's reproductive health needs, rights, and informed choice. Pakistan pledged to enhance contraceptive prevalence and minimise unmet need among reproductive-age women at the London Summit on Family Planning in 2012, and prepared Coasted Implementation Plans to achieve so (Ewerling et al., 2017; Family Planning of Pakistan, 2020; Balochistan Govt, 2018; GoKPK, 2018; Govt of Punjab, 2018).

Literature review

Studies show that lack of women’s authority unable them to make decisions regarding FP practise (Blanc, 2001). Despite the fact that women's empowerment is critical to utilising contraceptives (Do & Kurimoto, 2012), most spouses in underdeveloped countries consider women as second-class citizens in all aspects of decision-making (Bourey et al., 2012). Furthermore, little is known regarding the relationship between household decision-making and the use of modern contraceptives (MC) among young women in Pakistan, particularly in Pakhtun society.

Despite the fact that each generation gets more tolerant comparatively the one before, males still make the majority of decisions in many societies and mostly the women are forced to obey these decisions, including family planning (Chandra-Mouli et al., 2014). When Family Planning programmes compare couples' use of various contraceptive methods, severe gender inequalities may be noted, as can the fact that the majority of users are females. Because most sexual and reproductive health (SRH) decisions are made via males, gender disparities benefit them. Women are the primary clients of the FP programme. There is typically a paucity of knowledge on men's viewpoints while establishing programmes since they are seen as irresponsible or unsuitable clients at reproductive health facilities (World Health Organization, 2014a, 2014b).

The relative powerlessness of women may be one reason restricting the usage of modern contraception. Pakistan, like its South Asian neighbours, is characterised by patriarchal gender norms (Khan et al., 2015). This includes patrilineal marriage lines and a focus on fertility as a source of women's status; purdah; clearly gendered spheres, with men active in economic and political spheres and women active in domestic and reproductive spheres; and restrictions on women's ability to make independent decisions (MacQuarrie & Aziz., 2022).

In a research conducted in Pakistan, MacQuarrie & Aziz (2022) discovered that contraceptive decision-making is more relevant to women's contemporary contraceptive usage than household decision-making, and that contraceptive decision-making is impeded when spouses are the key decision-makers. Joint decision-making, on the other hand, makes it easier to utilise contemporary contraception in general, and condoms in particular. When a choice is made by someone other than the wife or her spouse, the usage of contraception is lowered.

Most studies, according to Allendorf (2007), give support for one convincing proposition: women who have significant home autonomy have higher ability to regulate their bodies and attain desired fertility. Spousal relationships often have a major influence on decisions on family planning, such as utilising contraceptives for spacing or liming births.

Women who lived in female-headed families were more likely to feel powerful than those who lived in male-headed households in rural Nigerian (Ayevbuomwan et al., 2016). Similarly, a research based on data from the Pakistan Integrated Family Survey found that women in female-headed families were more empowered than those in male-headed households, owing to their increased involvement in household decision-making (Naqvi et al., 2002). A woman-headed home does not rule out the presence of males or their assistance. According to the literature, both men and women participating in home decision-making contribute to increased household and societal well-being (Yogendrarajah, 2013).

Women's enhanced household decision-making was connected with decreased fertility and having discussed optimum family size with their partners, according to a research based on the 1994 Zimbabwe DHS. It was shown that adding decision-making variables to standard measures of women's status, such as educational attainment and labour force participation, gave independent explanatory power beyond that of traditional measures of women's status (Hindin, 2000).

In Egypt, Kishor (1988) discovered three different autonomy indices: customary (making decisions related to procreation and child bearing), non-customary (making decisions outside these areas), and realised (freedom of movement), and she discovered that the non-customary index was the strongest predictor of contraceptive use among the three indices. Non-customary autonomy included women's decisions in areas dominated by men in Egypt, such as making daily or large household purchases and visiting family or friends, in contrast to customary autonomy, in which women are expected to be free to make decisions about their children's health care and what to cook for their families.

Research methodology

Research design and universe of the study

The study was conducted following cross-sectional design (Babie, 1989) in three tehsils (Mardan, Katlang & Takht Bhai) of district Mardan of Khyber Pakhtunkhwa.

Sample size and sampling procedure

Multi-stage random sampling procedure was adopted for the selection of respondents consisting the following steps. At first stage district Mardan was selected as universe of the study. At stage second, three tehsils were selected. At third stage, 179458 households were selected from three tehsils (according to Census report, 2017), from which the required sample was calculated as 413. At stage four, through proportional allocation method proposed by (Pandey & Ram VERMA, 2008), the number of respondents were taken from each Tehsil. Only those women were selected in the study who were married and using contraceptives.

Conceptual framework of the study

A conceptual framework composed of one independent variable (women's autonomy in household decision-making) & one dependent variable (use of contraceptives) was adopted for the study given in table 1.

Table 1. Conceptual framework

Independent variable	Dependent variable
Household decision-making	Use of contraceptives

Tools of data collection

Data were collected through interview schedule, which was designed in the light of conceptual framework of the study given in table.1. The tool was pre-tested with 25 before the final data collection to alter all ambiguities. A team of female researchers was trained as well for the collection of data.

Ethical considerations

As the data was of sensitive nature, informed consent from women was sought before data collection. Further, as the data were collected only from women, only female investigators were used for this purpose to avoid any inconvenience. Anonymity of the respondents was assured to them.

Data Analysis

The association between dependent and independent variables were measure through Chi-square test as suggested by Tai (1978).

$$\chi^2 = \sum_{i=1}^{r} \sum_{j=1}^{c} \frac{(Oij - eij)^2}{eij}$$

Results

Demographic profile of the respondents

Results in table 2 shows that 51% of the respondents were between the age group of 30-44 years. Most of the respondents (78%) were literate. Most of the respondents (36.3%) started contraceptives use after 5 children, for which majority of them (48.4%) used government hospitals. Similarly, majority of them (42.8%) used injections and pills as contraceptives to control their fertility.

Table 2. Demographic profile of the women

Demographic profile		Frequency #	Proportion of the respondents %
Age of the respondents (in years)	15-29	133	32.2
	30-44	211	51
	45 & above	69	16.7
Level of education	Illiterate	91	22

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	Literate	322	78
Starting contraceptives	After 2 children	20	4.8
	After 3 children	113	27.3
	After 4 children	130	31.4
	After 5 children	150	36.3
	Govt. Hospitals	200	48.4
Facility used for contraceptives	Family planning clinic	104	25.1
	Private providers	109	26.3
Type of contraceptives using	Pills	177	42.8
	Injection	115	27.8
	Condom	82	19.9
	Spermicidal jelly	4	1
	Diaphragm	1	0.2
	IUD	6	1.5
	Douche	3	0.7
	Withdrawal	8	1.9
	Female sterilization	11	2.7
	Herbs/root drunk	1	0.2
	Safe days	4	1
	Abstinence	1	.2
	Total	**413**	**100**

Relationship between household decision-making and use of contraceptives among women

Table 3 show that 75.1% of the women whose decision are important regarding children education were preferred contraceptives as compared to 35.1% whose decision was not important. The association was found highly significant (0.000) and positive (T^c= 0.322) between women decision about children education and use of contraceptives. In addition, 71.1% of the women who preferred contraceptives were given importance in deciding the children marriages compare to 45.5% of the women who have importance in such decisions. The association was highly significant (0.000) and positive (T^c= 0.162) between women decision of children marriages and use of contraceptives. Furthermore, 75.5% of the women who preferred contraceptives have autonomy in deciding the source of healthcare in case of their illness, compare to 41% who don't have any autonomy in such decisions. The association between choosing the healthcare in care of women illness and use of contraceptives was found highly significant (0.000) and positive (T^c= 0.314). Moreover, the decision of almost 75% of the women who preferred contraceptives were given importance in case of treatment of ill child as compare to almost 40% whom decisions were not important in this regard. The results show that there was highly significant (0.000) and positive (T^c= 0.292) association was found between the use of contraceptives and women decision regarding the treatment of ill child.

Table 3. Association between household decision making and use of contraceptive among women

Do you think that	Attitude	Use of contraceptives			Statistics
		Not preferred	Preferred	Total	
your decision is important regarding education of children	Yes	72(24.9)	217(75.1)	289(100)	$\square^{2}$= 57.189 (0.000) T^c= 0.322
	No	74(64.9)	40(35.1)	114(100)	
	Don't Know	5(50)	5(50)	10(100)	
your decision is important in choosing source of healthcare in case of your illness	Yes	66(24.5)	203(75.5)	269(100)	$\square^{2}$= 48.114 (0.000) $\square^{\square}$= 0.314
	No	79(59)	55(41)	134(100)	
	Don't Know	6(60)	4(40)	10(100)	
your decision is important to seek treatment of ill child	Yes	68(25.1)	203(74.9)	271(100)	$\square^{2}$= 47.169 (0.000) $\square^{\square}$= 0.292
	No	78(60.5)	51(39.5)	129(100)	
	Don't Know	5(38.5)	8(61.5)	(100)	

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your decision is important regarding children marriages	Yes	73(28.9)	180(71.1)	253(100)	χ^2= 24.235 (0.000) [illegible]= 0.162
	No	67(54.5)	56(45.5)	123(100)	
	Don't Know	11(29.7)	26(70.3)	37(100)	

Percentages are given in parenthesis

Discussion

Household decision making is an important aspect of women autonomy. It shows the presence of a woman in the family as s social entity with a distinct place and identity. It shows the power of a woman in deciding the major household matters same as the man. In egalitarian societies, where men and women both have equal access to resources and have equal rights, the women have more autonomy in decision making process as compare to traditional patriarchal societies where men mostly decide the important matters of the family without the consent of the women. The idea of contraceptives use behaviour suggests that the women with more decision-making power in household will use more contraceptives as compare to their counterparts. The participants' demographic characteristics showed that majority of the women stated contraceptives after 5 children for which they were consulting government facilities. Similarly, most of them were using pills as contraceptives as it was found that pills were easily available and the women have had easily access to pills. These results show that majority of the women used contraceptives after completing thier desired family number (Letamo & Navaneetham, 2015; Austin, 2015).

It is evident from the results that women's autonomy played a vital role in the decisions regarding their children like their education and marriages when they grown up. The traditional set up of the society mostly does not allow women to participate in such important and sensitive decisions. Men head of the household usually decide such decision without the consent of the women. The education of children, especially of female whether they will get schooling or is decided by their fathers rather than their mothers. Similarly, marriage is an important institution in every society. It is the base of the family institution. Marriage is an understanding of the two opposite human beings. In Pakhtun society in the past, women mostly not considered regarding the marriages of their children. The elder of the family (male) decided the marriages of their children and women would just be informed without any prior consent. Swara and child marriages were common practices among Pakhtun society. Similarly, they were not asked by husband regarding their children marriages. With the emergence of NGOs working for the rights of women, laws have been passed in favour of women autonomy, which give them freedom and their due status in society. As decision of their children's marriages and education is an important matter of the family, it shows the autonomy of women how they participate and influence such decisions. Similarly, women with the authority to influence such decisions may also have the power to utilise contraceptives (Osamor Grady, 2016). Household decision-making autonomy was ranked top among all female domains in the study, and it was found to be strongly linked to women's reproductive and sexual behaviour indices. These findings are similar to those reported in previous research by Binyam et al. (2011), Haque et al. (2012), Khan (1997), and Rahman et al. (2014).

Decision regarding women's own health and their children are a sign of autonomy. It shows that women have control over their bodies and have the power to influence their household decisions. Mostly in rural traditional societies, matters related to maternal and child healthcare decided by the male members, as women are considered as subordinate in their families. With the advent of modernism and education, the scenario has now been changing. Women are aware of their rights as well as men are believing in power sharing of their spouses, due to which women take part actively in household decision. Hence, those women who can choose source of treatment in case of their own illness and that of their children, they are more autonomous, and can also use contraceptives compared to their counterparts. However, these results are in contrast to with the earlier studies in various parts of the world which favours collective decision-making with their spouses rather than individually as found by Hameed et al., (2014) and Islam (2018), the chance of utilising MC is higher when husband and wife jointly make decisions regarding respondent's personal health care or child health care than when they make these decisions alone. It was also discovered that when decisions concerning women's health care or child health care were made only by the husband, the chance of using MC was higher than when women made these decisions alone. The involvement of male member in the decision process regarding household increases the chances of contraceptive use among women (Hakim et al., 2003). Likewise, participation of male members of the family in the decision regarding contraceptives is considered as an important tactic for increasing family planning methods (Manaf & Manaf, 2010).

Conclusions

Household decision-making have important implication in the life of people especially of women. Those women who can participate and manipulate important household decisions are considered autonomous. They considered as co-partners in important familial matters. They are aware of their rights and have control over their bodies. They come out of the strict clutches of patriarchal structure and able themselves to be treated equally like men. Those women, who took part in household activities, may visit healthcare units for their health, for the treatment

of their children, as well as for using contraceptives and deciding the number and spacing and number of their children. It seems that women autonomy in case of deciding household matter play a vital role in the adoption of contraceptives. Mostly in traditional and closed societies, where women are not given their due rights, free will, take away from familial matter and considered as second class citizens, they have no autonomy, no power and cannot take part in household decision-making, and hence, and cannot adopt family planning methods compared to their counterparts.

Recommendations

Following are some of the recommendation through which the women household decision-making power can be increase through which they can participate in important matters of the family and can use contraceptives.

1. Through the provision of education to the women, so they can be aware of their rights.
2. By making and implementing the women laws that can protect women from physical and sexual assault, so they can fight for their rights.
3. Through counselling it should be inculcated to the males that women are their partners not their competitors. They should be given their due status in the family as they are equal members of the family. With given their due status, men will not lose their status.

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