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Research Article

Assessment of women's autonomy at household level and utilization of antenatal services in married women of reproductive age group

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ABSTRACT

Objective: To assess the women's autonomy at household level and utilization of antenatal services in married women of reproductive age group.

Material and methods: This cross sectional study was conducted at Department of Community Medicine, Multan Medical & Dental College Multan from January 2017 to June 2017. Total 289 women were selected for this study.

Results: Overall autonomy found was 33.2% high, 37.8% medium and 29% low. Autonomy was more in young women as 40% high autonomy was found in 20-24 years age group followed by 30-35 years who had 36.7%high autonomy. Most of the uneducated women had 42.3%had low autonomy whereas 61.2%high autonomy was found in women who went to college. Regarding utilization of antenatal services it was found that 47.1%poor, 22.8%fair and 30.1%good utilization was observed.

Conclusion: One third of the women had high autonomy. Autonomy increased with maternal education, husband's education, employment, number of living sons, income and nuclear family type. About half of the women had poor use. The utilization of antenatal services was directly associated with maternal age, education, husband's literacy, employment, number of living children, number of living sons, income, nuclear family type and women autonomy.

Keywords: Women Autonomy, Antenatal Services, Antenatal care.

INTRODUCTION

The concept of women autonomy is very important in sociology & social studies for more than two decades. Autonomy is defined as "the degree of access to & control over material and social resources within the family, in the community and in the society at large". Autonomy has been broadened to include, "the ability to obtain information and make decisions about one's private concerns and those one intimates". Among women attaining such control is viewed as a key to improve their living conditions.[1]

There is no single definition of autonomy which represents its multiple dimensions. This involves the capacity and freedom of a women to act independently on her own and on the authority of others such as the ability to mover alone making decision regarding health care and household purchases. Recent studies show that status of women is an important determinant of maternal health.[2,3]Women autonomy and its relation to reproductive behavior is a major area of concern as it is an important determinant of maternal mortality and morbidity. Women autonomy is

quite interchangeably with women empowerment and women's status. Autonomy can be expressed through various channels like in term of right to health care, employment ,education and decision making power. [3]Women are about half of the world's population and other half directly or indirectly depends upon them.[4] In developing world women empowerment is considered a multidimensional concept and is determined by socioeconomic factors and cultural norms. The concept of women empowerment was introduced at the International Women Conference at Nairobi in 1985.During the last two decades women empowerment has become a popular issue.[5]

More than half billion of women in this world are Muslims; most of the Islamic countries have lower level of women status or empowerment and high level of gender gap.[6]For any county, participation of women in development process is of most necessity as they comprise of a half of the population percentage. Women are capable and have great potential but still the objective to empower women has not achieved. Therefore, development of the nation in true sense cannot be achieved without empowerment of women population.[7]

Several studies showed women's autonomy effects on reproductive behavior. In these studies women's education & employment were used as proxy measures of women's autonomy.[8] Education plays an important role to create awareness among women for their health matters and right to take decisions about themselves and children's education, health and household matters.[9] Evidence from other studies showed that women age and family structure are the strongest determinants of women authority in decision making. Older women and women of nuclear households are more likely to participate in family decisions.[10]

Autonomy and primary maternal health care utilization is much interrelated. Prominently in Asian studies, work on various dimensions of women's autonomy & maternal health care seeking has gained new height.[11] In Pakistan there is a greater disparity between men and women in the field of education, employment, political participation, decision making, controlling the resources and job opportunities.[12]

Keeping in view the situation this study is designed to evaluate the effect of women autonomy onuse of antenatal services so that policies and programs should be developed to improve the utilization of antenatal health services and ultimately reduction of maternal mortality in Multan City.

OPERATIONALIZATION

Women autonomy was assessed by asking questions on five aspects

1. Freedom to spend money was judged by asking questions regarding
   a). Purchase of household things
   b). Purchase of clothing of children
   c) Spend money on herself
2. Decision about family size was judged by asking questions regarding
   a). Use of contraception
   b). Decision about number of children
   c). Gap between children
3. Freedom regarding relatives and friends was judged by asking questions regarding
   a). Visit them by asking/informing husband
   b). Gifting them
   c). their visit or stay in home
4. Consultation for schooling of children was judged by asking questions regarding
   a). Selection of school
   b). Age of admission
   c). Participation in parents teacher meeting
5. Freedom of expressing views was judged by asking questions regarding
   a). Decisions in domestic affairs
   b). To vote
   c). Discussion about relatives

Response of each question was divided into two categories and each category was scored as Yes = 2 and No = 1. The composite score of each respondent was in between 15-30. Score 15 will be labeled as no autonomy. The women's autonomy on the basis of composite score was divided into three categories, the score in between 15-20 = low, 21-25 medium and ≥26 was taken as high.

Antenatal Services Utilization:
Antenatal services utilization was categorized on the basis of antenatal visits if everything was normal during pregnancy.

Poor no antenatal visit or 1-3 antenatal visits
Fair 4 antenatal visits
Good ≥ 5 antenatal visits

MATERIAL AND METHODS

This cross sectional study was conducted at Department of Community Medicine, Multan Medical & Dental College Multan from January 2017 to June 2017. Total 289 women were selected for this study.

Inclusion Criteria:
All the women of reproductive age (15-49 years) having at least one alive child less than one year of age irrespective of current pregnancy.If women have more than one alive child then we asked about antenatal care regarding last pregnancy.

Exclusion Criteria:
Not willing to be included in the study.

DATA COLLECTION:

Data was collected through preformed pretested questionnaire that comprised of two parts. Part-I included demographic variables as age, education, family income, number of live children, type of family, working status and part-II consisted of study variables i.e. women autonomy and utilization of antenatal services.

DATA ANALYSIS:

Data was entered and analyzed by using statistical package for social sciences (SPSS) version 17.0. Mean and standard deviation was calculated for numerical data like age.Frequencies and percentages were calculated for qualitative variables i.e. women's autonomy(high, medium, low) and utilization of antenatal services (poor, fair, good).

Stratification wasdone according to age, women's education, Husband's education, occupation of women,monthly family income, type of family, number of living children and number of living sons. Chi square test was applied to see any statistical difference between groups if existed. P value≤ 0.05 was taken as significant.

RESULTS

In this study a sample of 289 reproductive age group women was taken with mean age 28.26 years and standard deviation was 6.038. Keeping in view the overall autonomy, medium autonomy was found the maximum i.e. 37.8% (n=109) followed by high 33.2% (n=96) and low 29% (n=84) (Fig 1).

Relating women autonomy and age distribution of respondents it was found that age group 20-24 years had maximum high autonomy 40% (n=22) followed by 30-34 years in which 36.7% (n=33) high autonomy was found. Among 15-19 year age group most of the respondents 48% had low autonomy followed by 36.4% (n=12) low autonomy in 35-49 years women (Table 1).

Most of the uneducated women 42.3% (n=49) had low autonomy whereas 61.2% high autonomy was found in college educated women. Upto secondary educated 27% had high autonomy and 24.1% high autonomy was found in primary educated women (Table 2).

More of the employed women had high 46.6% and medium 45.4% autonomy whereas non working women had 36.5% low autonomy (Table 3).

The utilization of antenatal services was found to be 47.1% (n=136) poor, 22.8% (n=66) fair and 30.1% (n=87) good (Fig 2).

In relation to women's autonomy the women having high autonomy had 53.1% good ANC use whereas women with medium autonomy had 22.9% good and low empowered women had 13.1% good utilization.

High empowered women had 21.9% poor ANC use, medium autonomous had 41.2% poor ANC use and low autonomous had 83.3% poor ANC use (Table 4).

Fig.1 Levels of Autonomy of Respondents

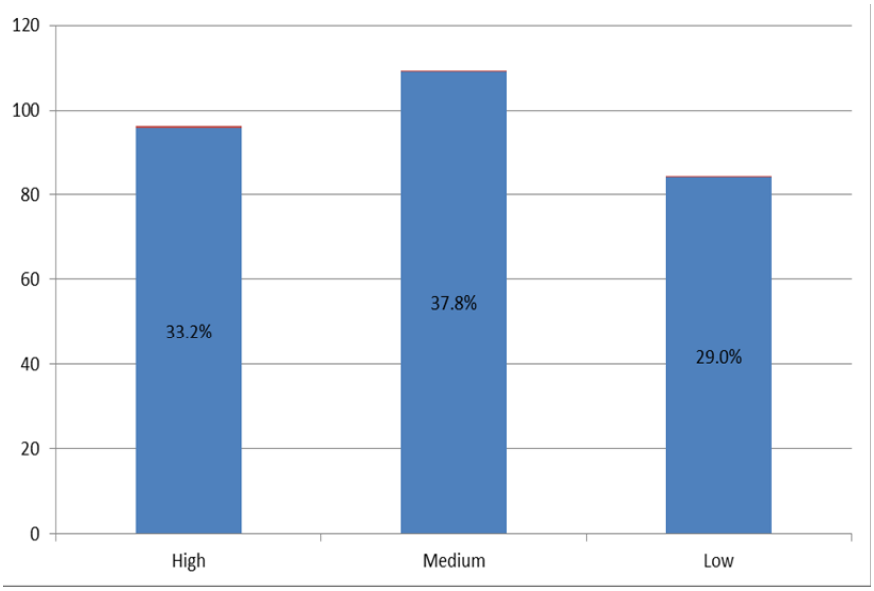

Table 1: Age of Respondents and Women's Autonomy (p = 0.316)

Age (years)	High	%	Medium	%	Low	%	Total
15-19	4	16%	9	36%	12	48%	25
20-24	22	40%	19	34.5%	14	25.5%	55
25-29	26	30.3%	37	43%	23	26.7%	86
30-34	33	36.7%	34	37.8%	23	25.5%	90
Above 34	11	33.3%	10	30.3%	12	36.4%	33

Table 2: Educational Level of Respondents and Women's Autonomy. (p = 0.0000)

Female Education	High	%	Medium	%	Low	%	Total
Uneducated	25	21.5%	50	43.1%	41	35.4%	116
Upto Primary	14	24.1%	27	46.6%	17	29.3%	58
Upto Secondary	28	42.4%	23	34.8%	15	22.8%	66
College	29	59.2%	09	18.4%	11	22.4%	49

Table 3: Working Status of Respondents and Women's Autonomy (p = 0.000127)

Female Employment	High	%	Medium	%	Low	%	Total
Unemployed	61	28.5%	75	35%	78	36.5%	214
Employed	35	46.6%	34	45.4%	6	8%	75

Fig. No: 2 Levels of Antenatal Services Utilization among Respondents

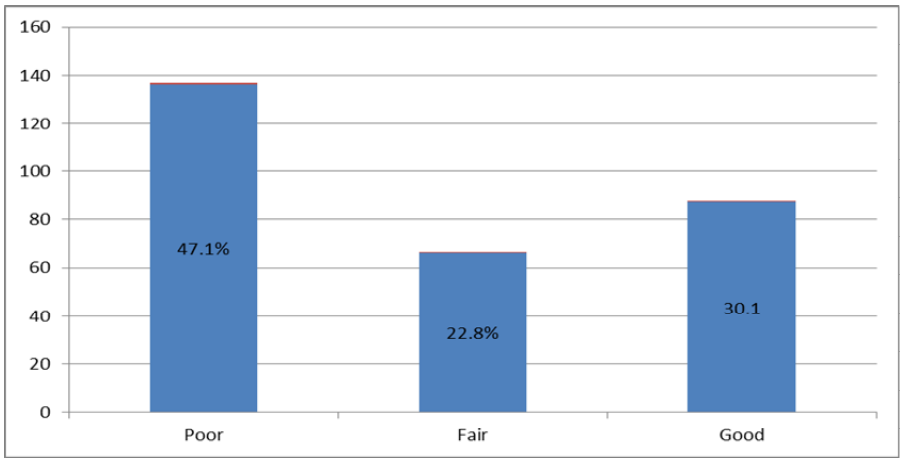

Table 4: Women's Autonomy and Use of Antenatal Services (p = 0.0000)

Women Autonomy	Good	%	Fair	%	Poor	%	Total
High	51	53.1%	24	25%	21	21.9%	96
Medium	25	22.9%	39	35.9%	45	41.2%	109
Low	11	13.1%	3	3.6%	70	83.3%	84

DISCUSSION

Empowerment is an active, multi dimensional process which enables women to realize full identity and power in all spheres of life. The World Bank suggested that empowerment of women is the key agent of sustainable development. In most societies of Asia, women have a low social status and low level of autonomy.This study conducted in Multan City aimed at determining the frequency of women's autonomy at household level and utilization of antenatal services among married women of reproductive age group (15-49 years) in this city. Total 289 women were included in the study having mean age of 27.8 years. The study revealed that majority of the respondents had medium autonomy. Same results were found in a study conducted by Situ K.C in Nepal and in PauriGarwal Himalaya by Pushpa et al.[2,13] The results found are in contrast with studies conducted in Chiniot, Sailkot and Odisha where majority of the respondents had high autonomy.[1,7] The women's autonomy is a complex measure. There are many factors involved in measuring and affecting it. In our society social and cultural factors are much involved in determining women autonomy. They might be responsible for the results of this study. The study showed non-significant relationship of women autonomy and increase in age (p= 0.316). There is no effect of increase in women age in her empowerment. The highest autonomy was found in 20-34 years age group. Same results were found in a study conducted in Western Nepal by Bhandari TM et at where no significant relationship was found between women age and autonomy.[14] The findings concur with the results found in the study conducted in Odisha by Gargi Das, in Ethiopia by Wado YD et al and in Nepal by Acharya et al.[7,8,10] In these studies significant relationship of autonomy with increase in age was found. The reason might be in this study was that women of young age were more conscious, confident and took decisions regarding household issues. With increasing age they became careless and let their families to decide.

In the study the educational level increase showed significant relationship with autonomy (p=0.0000). In a study conducted in Bahawalpur by Badar S et al significant relationship of education and autonomy was found.[4] Similar findings were observed in the studies conducted Internationally in, Odisha, Nepal, Bal Zone, India and National study in Chiniot.[7,10,15-17] The autonomy in uneducated group in the study might be low because of the reason that they only accepted whatever their partners decided for them but on the other hand education gives a new orientation to women and liberates them. Education is very important for everyone it makes individuals able to decide and take actions. Education gives them a better opportunity to live in the society and improves their empowerment. In the study the literacy rate among respondents was found 60% which is better than literacy rate of women in Pakistan is 47% (Economic Health Survey 2014-15) might be because of good educational opportunities for women in the city.

Considering effect of employment on autonomy of the women the study showed that more than two third employed were autonomous showing significant result. In a study conducted by Wado YD et al in Ethopia employment had a positive significant result on autonomy.[8] Employment gives women confidence and recognition in the families. Economic self independence empowers the women to take own decisions. The results are comparable with other studies.[7]

Antenatal visits allow management of pregnancy, detection and treatment of complications and

promotion of better maternal and child health. Low up take of ANC is an important determinant of high maternal mortality rate in developing countries. It is one of the basic components of maternal care on which life of mother and babies depend.About half of the respondents in the study had poor ANC utilization attending no visits or at least three visits. The findings are comparable with studies done different countries where ANC use was found as Japan (64.3%), South West Ethiopia (42%), rural Bangladesh (55%), Punjab (55.9%), KPK (51%), Jhang (35%),Ghana(26%), Gilgit(26.6%)and Dhaka (36%).[11,18-24] The ANC use was found even worse in rural Baluchistan (85.6%) poor because of cultural barriers faced by tribal women.[25] These findings are opposite from the findings found in studies of Vietnam and Islamabad where (97.2%) and (84.4%) good utilization was found because of high literacy and more facilities provided to women.[26-27] Association of different factors like age, literacy, income, social and cultural norms and employment may vary the utilization of antenatal services in different countries.

Regarding relationship of women autonomy and use of antenatal services significant positive relationship was found. Women who were more empowered had more antenatal use whereas those with less autonomy. Similarly in a study done by Haque in Bangladesh he found significant relationship between women empowerment and ANC use.[28] The positive effect of women autonomy on antenatal utilization was also revealed by studies done in Jhang, Bangladesh and Ethiopia whereas it was found that more autonomous women attended more antenatal visits than less autonomous.[23,29,30]Women who had more decision making power had more chances of seeking health services. Low autonomy status of women associated with poor access to their basic needs .Women's personal autonomy contributes to create a conducive social environment in controlling financial and physical resources. Autonomy makes the women aware of their rights and enables them to take decisions regarding themselves, their children and families in the matters of health and education. So steps for the betterment of women in every aspect especially in terms of decision making should be encouraged.

CONCLUSION

This study concluded that women autonomy increased with increase in maternal education, husband literacy, working status, number of living sons, income and nuclear type of family. Regarding utilization of antenatal services it was concluded that ANC care was positively associated with increase in maternal age, maternal education, husband education, number of living children, number of living sons, income ,nuclear family type and women autonomy.

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