

The Role of Gender-Based Power Relations in Contraceptive Decision-Making for Indian Couples

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This paper uses data from the Survey of Women and Fertility (SWAF) to examine how the relative distribution of power within couples is affecting the method of contraception they choose to use. The data includes the Indian states of Tamil Nadu and Uttar Pradesh. India has been the focus of many family-planning initiatives due to the country's high population growth rate, and status as one of the most populous nations in the world. Population control in India is being achieved through increased contraceptive use, which at an individual level, is having an effect on the women whose childbearing patterns are altered. While more efficient modern methods of birth control have enabled many women to exert control over their bodies and limit childbearing, family planning can also oppress women where sterilization and other invasive methods are used coercively. This paper will examine how population and family planning policies have affected the lives of individual women through increased use of contraception, and what role their relationships with their partners have on the contraceptive method being used.

Background

According to the United States Census Bureau, India's current population is approximately 1,049,700,118 people, making it the second most populous nation in the world. It is poised to surpass China, and become the largest country in the world, with a rate of natural increase of 1.6%. As a result, India has adopted the United Nations Program of Action, which endorses family planning programs, the right of couples to freely choose a contraceptive method, provides couples with information to make informed choices, and makes available a vast array of methods (Zavier and Padumadas 2000). Zavier and Padumadas report that in developing nations, the contraceptive method most widely utilized is female sterilization (Zavier and Padumadas 2000). While this procedure is welcomed by some women as a permanent barrier to pregnancy, there are others who may be sterilized without the proper information about the procedure or complete understanding of the after effects.

India has a controversial history of sterilization. During the 1950s and 1960s, male sterilization was the main form of contraception being used. Between 1976 and 1977, the Emergency occurred in India, and men were offered compensation from the government in exchange for vasectomies, often without fully informing the men of the health risks and consequences. Since then, vasectomies are extremely rare, and in a survey done in Uttar Pradesh, it was found that married men believe that female sterilization is easier, less complicated, and has a shorter recovery time than vasectomy (Ringheim 1999).

The connection between women's status and power in relationships and the choices that men and women make about contraceptive use has been chronicled in a number of other studies. Ann Blanc writes, "The balance of power within sexual relationships is linked to sexual and reproductive health in three main ways: (1) directly,

(2) through its relationship with violence between partners; and (3) through its influence on the use of health services. Gender-based power relations can have a direct effect on the ability of partners to acquire information relevant to their reproductive health, on their ability to make decisions related to their health, and on their ability to take action to protect or improve their health or the health of those who depend upon them” (Blanc 2001). In a study done in South Asia by Karen Oppenheim Mason and Herbert L. Smith (2000), the findings indicate that gender stratification has a direct negative effect on determining whether contraception is used at all. If women have little autonomy and are unable to voice their opinions about issues within the home, their access to health services and information may be limited. The gender hierarchy that is present in some areas of India may leave women with little control over their fertility and contraceptive decisions.

However, Nancy Stark illustrates how women who face lower status within the household can use contraception to control their fertility preferences and circumvent family politics. Stark (2000) studied women in rural Bangladesh, and found that women secretly used contraception, with a high preference for Depo-Provera, which is given by injection every three months. The women stated that this was easy to conceal from their spouses, and allowed them to control their fertility in spite of their spouses’ desire for more children. Stark writes, “Attempts by the women in this study to control their fertility, and thus their social world, by using contraception is indicative of active, goal-oriented behavior in the face of many obstacles within society that restrict their personal autonomy.” Much like the women that Stark studied, Indian women can use sterilization to control their fertility and avoid pressure from their husbands and in-laws to have more children. After they have given birth to the desired number of children, these women can make autonomous decisions about contraception.

Further evidence that women’s autonomy has a direct effect on their access to diverse contraceptive methods was found in a study done by A. Dharmalingam and S. Philip Morgan (1996). To measure autonomy, the authors used a combination of women’s perceived economic independence, their freedom to move between villages and “spousal interaction”, which included discussions about finances and desired family size. Dharmalingam and Morgan found that women’s autonomy has a large impact on the likelihood of them using contraception, and that women with a high level of autonomy are twice as likely to use contraception than those with low levels of autonomy.

Data and Methods

This paper uses the Survey of Women and Fertility (SWAF), which was conducted by the University of Pennsylvania between 1993 and 1994. These data focus on five countries: India, Pakistan, Malaysia, Thailand, and the Philippines. Married women between the ages of 15-39 and their husbands were interviewed separately in face-to-face interviews. The survey questions were written with women’s issues in mind, and give historical and current information about fertility and contraceptive practices. I chose to focus solely on the Indian survey due to its high rate of natural increase and the attention its been given internationally for its population growth rate.

The SWAF completed surveys with 1,941 couples in Tamil Nadu and Uttar Pradesh. One of the most important advantages of this dataset is the use of couples to obtain information on various household issues, including contraceptive practices, division of household labor, economics, and decision-making. Both the eligible respondent (wife) and husband were asked a similar set of questions, allowing their responses to be matched after the data collection was finished. This adds an extra dimension to the data analysis: the ability to test if differences between wives' and husbands' answers indicate a power distribution that is not measured elsewhere in the data. I would expect those couples with higher disagreement in their answers to have less egalitarian gender role attitudes.

The dependent variable in this analysis is the method of contraception being used by the couple. The methods included are: female sterilization, male sterilization, the birth-control pill, IUD, diaphragms/foam/jelly, condoms, periodic abstinence, withdrawal, induced abortion, and any other methods. The independent variables will include years of formal schooling completed, age of respondent, if the couple desires anymore children, religious affiliation and caste (if applicable). To measure the economic status of the household and the wife's role in bringing in household income, I will use variables that measure whether or not the female works outside of the home, who has control of funds within the household, and whether or not women have a say in how funds are spent. To measure relative gender-based power within the household, I will create an index that measures how much freedom women have to move within and outside the household, as well as an index that measures attitudes about different gender roles, including who is responsible for household tasks and care of the children. In addition, there are variables available in the eligible respondent questionnaire that measure whether or not a wife is experiencing physical and/or mental abuse in the relationship.

To analyze the relationship between these independent variables and the method of contraception being used, I will run a multinomial logit regression. In order to analyze whether or not the couples' responses match, I will use the kappa statistic to measure similarity or dissimilarity between responses. If there is a high disagreement in responses, I will examine what makes these couples different from those that agree, and how it affects the methods of contraception being used.

Expected Findings

I expect to find that couples with more egalitarian gender attitudes and practices will be more likely to use reversible methods of contraception, and will make contraceptive decisions together. Of those couples who choose female sterilization as their first and only method of contraception, I believe they will be more likely to follow more traditional patriarchal gender role ideologies, including restriction of women's movement outside of the home, as well as male control over most household finances. In addition, I would expect these couples to make contraceptive decisions individually, with less communication about what method is being used. Finally, of those couples who

have disagreement in their responses to the survey questions I am analyzing, I would expect these couples to more closely resemble couples with a traditional household division of labor. I posit that there will be a discrepancy in survey responses due to lack of communication between members of the couple, which is more likely to occur when both members of the couple do not have equal power in decision-making.

In addition, I expect contraceptive decisions to be affected by differences in couples' education and class. I hypothesize that couples with higher levels of education will be more likely to use reversible methods before sterilization to control spacing and timing of births. Those couples with comparatively low levels of education will tend to use non-reversible methods of contraception as their first and only method. Finally, couples who come from the lower classes with limited economic means will be more inclined to use non-reversible methods due to the low one-time cost of sterilization. Because some methods can be costly in both visits to the physician and prescription costs, sterilization may be more attractive to those couples who do not want anymore children and cannot afford the continued costs of reversible methods.

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