International Journal of Community Medicine and Public Health
Garg S et al. Int J Community Med Public Health. 2022 Dec;9(12):4472-4477
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20223201

Original Research Article

Role of women in reproductive decision making and inter-personal communication regarding reproductive health

Shipra Garg[1]*, Dinesh Kumar[2], Savita Prashar[1]

[1]Centre of Public Health, Panjab University, Chandigarh, India
[2]Department of Community Medicine, Government Medical College and Hospital, Chandigarh, India

Received: 15 March 2021
Revised: 03 November 2022
Accepted: 04 November 2022

***Correspondence:**
Dr. Shipra Garg,
E-mail: shpgarg2@gmail.com

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

Background: Reproductive health of women plays a key role in overall development of a country. Lack of decision-making by women in reproductive health matters may lead to an unplanned pregnancy, unsafe abortion and other adverse reproductive health outcomes.
Methods: A cross-sectional study conducted among married women with at least one child aged 18-49 years in Punjab, India. Study variables included socio-demographic characteristics, reproductive health characteristics, contraceptive choices, interpersonal communication and interpersonal relationship with spouses.
Results: Among all surveyed married women, only 51 (58.6%) women reported to be physically and mentally ready for their marriage. 50 (57.5%) of women reported using condoms, while about one-third of the women were not using any kind of contraceptive method. 62 (75.5%) women reported decisions to be taken jointly for child health care. Place of delivery was reportedly discussed 78 (88.6%) by women with their spouses. Interpersonal communications were rated as either very good or good by 72 (81.8%) women. Also, women who were more educated than their spouses were less likely to be satisfied with inter-spousal communication. No significant association was observed between higher education of women than their spouses and active role in taking various decisions by women.
Conclusions: Women should be encouraged to take her own reproductive and health related decisions and other family members should support her. Efforts to increase awareness for sexual and reproductive issues should be initiated from adolescence phase.

Keywords: Fertility behaviour, Inter-personal relationship, Reproductive health, Spousal communication

INTRODUCTION

Reproductive health of women plays a key role in overall development of a country and it largely depends on status of women in the society. Women suffer a number of reproductive health issues and their access to healthcare varies significantly across countries and even within countries.[1] World Health Organization (WHO) defines reproductive health as a 'state of complete physical, mental and social wellbeing in all matters relating to reproductive system, its function and progress'.[2] Women's ability to make choices on their own about their sexual and reproductive health and rights is a key factor affecting their sexual and reproductive health outcomes. Reproductive health of women depends on role of women in decision making, their educational status, their participation in social, political and economic activities and several dimensions related to women's ability to make choices about their sexual and reproductive health.

Extent of participation of women in the key areas of reproductive and child health and agreement between husbands and wives on the unmet need for family planning is very crucial for reproductive and sexual health of women. Decision making by women for their reproductive health is related with their autonomy in the

society. Women's autonomy is widely referred to in many studies, especially about reproductive issues, there is no single widely accepted definition that represents the multiple dimensions of autonomy.[3] Women's autonomy is also defined as the capacity and freedom to act independently such as the ability to go places, health facilities or the market, or to make decisions regarding contraceptive use or household purchases alone and without asking anyone's permission.[4] It has also been defined as women's ability to make and execute independent decisions pertaining to personal matters of importance to their lives and their families.[5] Women's autonomy is also defined as the capacity and freedom to act independently.[6] Some studies show that women with greater autonomy are more likely to seek health care for themselves and use different forms of health care services available to them.[7] A qualitative study by in the Indian context, uses six indicators (education, educational freedom, economic contribution, economic freedom, household management and decision making, perceived status within the household and health) that directly influence the status of women empowerment. Education of women, is one of important factors that directly affect the level of participation of women in all the decision-making power in reproductive health matters.[8]

A study conducted in Delhi reported that women had very less discussion regarding their reproductive and sexual health and a verbal communication of family planning method with their partner which leads to unexpected pregnancies and also put adverse effect on women's health mainly in the later years of her life.[9] Women are often unable to make decision on their own regarding reproductive choices and also to access sexual and reproductive health services due to harmful and discriminatory social norms and practices and limited financial resources.

Most of the existing literature around couple communication in India as well as in other developing countries has focused on components of reproductive health, mostly contraceptive behaviour, sexuality or high-risk sexual behaviour. However, there is hardly any literature focusing on couple communication in rural married couples, with a comprehensive understanding of the details of the process of communication. Educational status of women may have direct or indirect influence on fertility, since education affects the attitudinal and behavioral patterns in the individuals. Men are usually dominant decision-makers in most reproductive health issues. Due to lack of women's reproductive decision-making on the use of family planning, poor maternal and child health outcomes are obtained. Women are often asked not to share any problem regarding their reproductive health especially with the males. Due to this tendency, they feel hesitant and uncomfortable to discuss about their sexual health and family planning method even with their husband as she feels her partner may not accept this. Lack of decision-making by women in reproductive health matters may lead to an unplanned pregnancy, unsafe abortion and other adverse reproductive health outcomes that affect maternal health and their children health negatively. This study presents findings from a cross-sectional study exploring women's experiences of reproductive health related decision-making. Communication between any relation specially between spouse/partners are important for a healthy life. Also, there is not much study carried out in the rural areas especially of Punjab.

This study attempts to investigate fertility behavior of women and their role in decision making of reproductive health issues. Spousal communications concerning reproductive health issues between wives and husbands and their interpersonal relationships have also been explored. This study may be helpful in suggesting some measures for encouraging inter-spousal communication by identifying the existing gaps.

METHODS

Present cross-sectional study was conducted among married women aged 18-49 years with at least one child giving consent during March 2021 to July 2021.

Unmarried women, who were not in a condition to answer the questions/not giving consent and women not having child were excluded.

Non-probability sampling method/ convenience sampling was used and survey was conducted using Google forms due to COVID-19 situation. Assuming 31% women taking reproductive decisions as anticipated proportion, 95% confidence coefficient and 10% permissible error sample size came out to be 87.

A self-designed semi closed questionnaire both closed ended and open ended was made in the Google form. The questionnaire was sent to the targeted population through online mode as due to COVID-19 situation. Study variables will socio-demographic characteristics like educational status, occupation, income, age, religious status, number of children, reproductive behavior in terms of past/future fertility desires, fertility preferences, contraceptive choices, gender preference, contraceptive choices, interpersonal communications interpersonal relationships with spouses etc.

Data were described by using proportions/percentages for qualitative data and means±SD and medians for quantitative data. Normal test of proportions were used for testing the significance of differences in proportions in two different sub groups. Chi square (χ^2) test was used for testing the significance of associations. Binary logistic regression analysis was done to investigate of predictors factors associated with male participation in reproductive matters. Odds ratios along with 95% confidence interval were calculated for potential risk factors. Latest version of SPSS software was used for data analysis.

Ethical issues

ICMR ethical guidelines for biomedical research on human participants, 2017 were followed.[10] Informed consent was taken and confidentiality of responses was ensured maintaining privacy of respondents.

RESULTS

Among all surveyed women, 40 (46.0%) were belonging to age group of 34-42 years. There were 59 (67.8%) women who were post graduates and about 55% of women were home makers. Only 21 (24.1%) of their spouses were post graduates. Majority of women were Hindus and about 68% of women were from joint families. Socio-demographic characteristics of women are presented in Table 1.

Table 1: Distribution of women by socio-demographic characteristics.

Socio-demographic characteristic	Number	%
Age in years		
18-25	4	4.6
26- 33	37	42.5
34-42	40	46.00
43-49	6	6.9
Education level		
Matriculate (10th)	1	1.1
Secondary (10+2)	6	6.9
Graduate	21	24.1
Post graduate	59	67.8
Education level of husband		
Matriculate (10th)	8	9.2
Secondary (10+2)	15	17.2
Graduate	43	49.4
Post graduate	21	24.1
Occupation of women		
Businesswomen	4	4.6
Housewife	48	55.2
Student	1	1.1
private employee	21	24.1
government employee	8	9.2
Others	5	5.7
Occupation of spouse		
Businessman	72	82.8
private employee	8	9.2
government employee	5	5.7
Other	2	2.3
Religion		
Hindu	80	92.0
Sikhism	7	8.0
Overall	-	-

About 78% women were of the opinion that girls should be married in the age group of 23-26 years while about 75% were married in this age group. Only 51 (58.6%) women reported to be physically and mentally ready for the marriage at the time of marriage.

Table 2: Distribution of women by reproductive behavior (n=88).

	N	%
Were they physically and mentally ready at the time you got married?		
Yes	51	58.6
No	8	9.2
Does not think about it	28	32.2
Contraceptive practice		
Condom	50	57.5
Withdrawal method	29	33.3
Copper-T	3	3.4
Male sterilization	1	1.1
Female sterilization	2	2.3
Others	2	2.3
Decisions regarding use of contraception		
Self	5	5.7
Spouse	9	10.3
Mutually	72	82.8
Family members	1	1.1
Knowledge about sexual and reproductive health		
Friends	38	43.7
Family	20	23.0
Gynecologist	6	6.9
Internet	10	11.5
Spouse	13	14.9
Decisions regarding child care		
Self	8	9.1
Jointly	62	70.5
With family members	18	20.4
Support from family in RCH decisions		
Always	76	86.4
Sometimes	9	10.3
Never	3	3.4
Decisions concerning reproductive health		
Jointly with spouse	63	71.6
With family members	8	9.1
Self	7	7.9

Among all surveyed women 50 (57.5%) of women reported using condoms, while about one-third of the women were not using any kind of contraceptive method. Only 5 (5.7%) of women had decided using contraceptive method at their own and 72 (82.8%) women said that they mutually decide with their partner about the method and use of contraception. When they were asked about their source of awareness about sexual and reproductive health matter 38 (43.7%) reported that their source of awareness was friends, 13 (14.9%) women reported they got reproductive health awareness after marriage from their husbands only 6 (6.9%) reported to be aware from gynecologists. Around 85% of women answered that

they accompanied for regular check-ups for ANC by their family members mainly spouses. When asked about decisions related with child care, 62 (75.5%) women reported decisions to be taken jointly while only 8 (9.1%) reported that they were took decisions themselves. Majority, 76 (86.4%) women reported that they always got family support in taking reproductive and child health related decisions. While only 3 (3.4%) of women reported that they were not supported by the family to take decision concerning RCH matters and decisions were either taken by her husband or other family members.

Table 3 presents inter-personal communication among women. It was found out that only 55 (62.5%) of women reported discussions concerning timings to have their first child with their partners on regular basis. Only 61 (69.3%) of women or their spouses always discussed about child care. Also 72 (81.8%) of women reported spousal communication about her RCH problems and in majority of cases spouses initiated discussions. Place of delivery was reportedly discussed 78 (88.6%) of women with their spouses. With overall discussions with any of RCH related matters, only 61 (69.3%) women reported that they were highly satisfied. Whereas, 10 (11.4%) reported not satisfied at all. Interpersonal communications were rated as either very good or good by 72 (81.8%) women while remaining 16 (18.2%) women were not certain on rating of their inter-personal relationships.

Table 3: Distribution of women by inter-personal communication.

Inter-spousal communication	N	%
Discussion when to have a child		
Always	55	62.5
Never	24	27.3
Sometimes	9	10.2
Discussion about place of delivery of previous baby		
Yes	78	88.6
No	10	11.4
Discussion about care of child		
Always	61	69.3
Never	10	11.4
Sometimes	29	19.3
Discussion about RCH problems		
Always	72	81.8
Never	4	4.2
Sometimes	11	12.8
Satisfaction with inter personal communication		
Highly satisfied	61	69.3
Little satisfied	17	19.3
Not satisfied	10	11.4
Rating of overall Inter-personal relationships		
Very good	55	62.5
Good	17	19.3
Can't say	16	18.2

Table 4 presents role of education in taking active role in decision taking by women. Among women who were more qualified than their spouses, 42 (73.6%) of 57 women were playing active role in decisions concerning child health care as compared to 28 (98.3%) of 31 women who were not more qualified than their spouses. Percentage of more qualified women satisfied with inter-spousal communication was also found less as compared to those satisfied among women who were not more qualified than their spouses (76.8% versus 77.8%). However, these percentages were not statistically significant. Among women who were more qualified than their spouses, 52 (91.2%) of 57 women were playing active role in decisions concerning fertility and contraceptive as compared to 25 (80.6%) of 31 women who were not more qualified than their spouses. Similarly, among women who were more qualified than their spouses, 46 (80.7%) of 57 women were playing active role in decisions concerning fertility and contraceptive as compared to 24 (77.4%) of 31 women who were not more qualified than their spouses. No significant association between higher education of women than their spouses and active role in taking various decisions by women at different levels of significance as presented in the table.

Table 4: Distribution of women by inter-personal communication.

Educational qualification of women as compared to educational level of spouses	Active role in child health care decision making				Overall	Chi square (p value)
	Yes		No			
	N	%	N	%		
Decisions concerning child health care						
Equally or less qualified	28	98.3	3	9.7	31	2.94 (p=0.07)
More qualified	42	73.6	15	17.0	57	
Total	70	80.5	18	20.5	88	
Decisions concerning fertility and contraceptive use						
Equally or less qualified	25	80.6	6	19.4	31	0.89 (p=0.89)
More qualified	52	91.2	5	8.8	57	
Total	77	87.5	11	12.5	88	
Decisions concerning reproductive health						
Equally or less qualified	24	77.4	7	22.6	31	0.283 (p=0.58)
More qualified	46	80.7	11	19.2	57	
Total	70	80.5	18	20.4	88	
Satisfactory inter-spousal communication						
Equally or less qualified	24	77.4	7	22.6	31	0.005 (p=0.90)
More qualified	43	75.4	13	22.8	57	
Total	67	76.1	20	22.7	88	

DISCUSSION

In the present study, most of the women were in the age group of 34-42 years and all women were more qualified than their spouses. Only 58% women were mentally prepared to get married and 22% women were not sure to be ready at the time of marriage, may be lacking in reproductive awareness also. Several studies regarding role of women in RCH decision making in different parts of India showed inconsistency in results. The most popular contraceptive methods in use in the present study were condoms followed by withdrawal method reported by 57.5% and 33.3% women. Permanent methods were not so popular in use. Study also reported lack of active role of women in decision making choices in reproductive health matters and in spite of this fact more than 80% women were having satisfactory inter-spousal communication. About 72% of studied women were taking join decisions in reproductive health matters and only about 8% women were taking such decisions at their own. A study using nationally representative household surveys found that 13.4% of ever-married women in the reproductive age group in Nepal, 17.6% in Bangladesh, and 28.1% in India made decisions alone regarding care for their own health, including 11.5% of current users of contraceptives who reported that they alone made decisions to use contraception.[11]

In the present study, about 72% of studied women were taking join decisions in reproductive health matters and only about 8% women were taking such decisions at their own. Several studies have noted the regional variations reproductive decision making of women in India. Whereas, health care decisions were made without women's participation in the majority of Nepalese households (72.7%) and approximately half of Bangladesh (54.3%) and Indian (48.5%) households.[11] Findings of the present study are not consistent with the study findings among Bangladeshi women that more than one-third (37.3%) were not involved in decision-making about their own health care and among women in rural India, more than half (55.6%) were not involved in decision-making about their own health care.[12]

Education of women is considered to be is the prime and important factor found in women's autonomy power in a previous study.[13] However, education played a non-significant role in decision making power in the present study. This implies that women can't be empowered merely by raising their educational levels. There are some added factors not considered in the present study responsible to enable them and empowering them for decision making. Female autonomy has been widely acknowledged as a multi-dimensional entity that refers to different aspects of women's lives. Education and employment status of women plays a major role in decision making power. Low percentage of working women in spite of higher educational levels of women may also be a factor responsible for lack of active role in decision making by women at their own as they were dependant on their spouses/family members for financial matters. Increased age, paid employment, more education, and having a greater number of living children were all positively associated with women's autonomy in decision-making in an earlier study.[14]

Present study also reported lack of inter-spousal communication. In the present study there was lack of spousal communication regarding family planning and about 11% women were not satisfied with spousal communication and about 18% women were uncertain of goodness of their inter-personal relationships. In a study

conducted in Delhi, more than half of the women reported that they have not discussed about family planning methods with their husbands reflecting lack of spousal communication regarding family planning.[15] Education of women couldn't play any significant role in active decision-making role of women in reproductive health matters. A study conducted in Delhi reported 98.2% involvement of male partners in ANC of women. Lack of spousal communication in the present study may be attributed to lack of employment of women and also lack of their preparedness at marriage and lack of reproductive health awareness.[9] Therefore, this eventually leads to poor inter-spousal communication affecting their role in RCH decision making power. This finding shows that it is important to have good communication and understanding even before marriage which can lead to their active role in decision making after marriage. A study conducted in an urban slum of Delhi indicated only 56% of male participation in reproductive care and factors influencing good interpersonal relation.[9]

CONCLUSION

In the present study, women got knowledge about sexual and reproductive health from different sources but least from health staff/doctors. There are chances to get substandard knowledge. Efforts to increase awareness for sexual and reproductive issues should be initiated from adolescence phase for healthy reproductive life of women and planned parenthood. Women should be encouraged to take reproductive health related decisions and other family members should support them in decision making. Efforts should be made to strengthen spousal communications and inter-personal relationships to empower women in decision making of reproductive health issues. Pre-marital counselling may be a good idea to increase reproductive health awareness of women and to strengthen their inter-personal relationships. Inter-spousal communication may strengthen decision making power of women in reproductive health related matters.

ACKNOWLEDGEMENTS

Authors acknowledge assistance provided by centre of public health (CPH), Panjab University, Chandigarh and to all staff at CPH for providing necessary inputs and support for conducting present research. We are also thankful to all participant women for their contribution.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES

1. Research on factors that determine women's ability to make decisions about sexual and reproductive health and rights. Global Goals Indicator 5.6.1 Volume I. INFPA; 2019.
2. Khanna J, Van Look PFA, Griffin PD. Challenges in reproductive health research. Biennial Report 1992-93. Geneva: World Health Organization; 1994.
3. Park K. Park's Textbook of Preventive and Social Medicine. 26th edn. Banarsidas Bhanot Publishers; 2021.
4. Basu AM. Culture, the status of women, and demographic behaviour: illustrated with the case of India. Oxford, UK: Clarendon Press; 1992.
5. Mason K. Gender and Demographic Change: what do we Know. Vol. 3. Liege, Belgium: International Union for the Scientific Study of Population; 1995:31
6. Basu AM. Culture, the status of women, and demographic behaviour: illustrated with the case of India. Oxford, UK: Clarendon Press; 1992.
7. Bloom SS, Wypij D, Das Gupta M. Dimensions of women's autonomy and the influence on maternal health care utilization in a north Indian city. Demography. 2001;38(1):67-78.
8. Banerjee B, Pandey GK, Dutt D, Sengupta B, Mondal SD. Teenage pregnancy: a socially inflicted health hazard. Indian J Community Med. 2009;34(3):227-31.
9. Dutta M, Kapilashrami MC, Tiwari VK. Knowledge, awareness and extent of male participation in key areas of reproductive and child health in an urban slum of Delhi. Health Popul Perspect Issues. 2004;27(2)49-66.
10. ICMR Ethical Guidelines for Biomedical and Health Research involving Human Participants, 2017. Available from: https://aiimsbhubaneswar.nic.in/pdf/Brochure-1912018.pdf. Accessed on 5 July 2021.
11. Senarath U, Gunawardena NS. Women's autonomy in decision making for health care in South Asia. Asia Pac J Public Health. 2009;21(2):137-43.
12. Rahman MM, Mostofa MG, Hoque MA. Women's household decision-making autonomy and contraceptive behavior among Bangladeshi women. Sex Reprod Healthcare. 2014;5(1):9-15.
13. Walia M, Mittal A, Kumar D. Male participation in reproductive health care of women and factors associated with interpersonal relationship: a cross-sectional study in a rural community of Ambala District in Haryana. Indian J Public Health. 2021;65:178-84.
14. Acharya DR, Bell JS, Simkhada P, van Teijlingen ER, Regmi PR. Women's autonomy in household decision-making: a demographic study in Nepal. Reprod Health. 2010;7:15.
15. Dabral S, Malik SL. (2004) Demographic study of Gujjars of Delhi: IV. KAP of family planning. J Hum Ecol. 2004;16(4)231-7.

Cite this article as: Garg S, Kumar D, Prashar S. Role of women in reproductive decision making and inter-personal communication regarding reproductive health. Int J Community Med Public Health 2022;9:4472-7.