Understanding of Contraceptive Adoption in India:
Does Woman's Autonomy Matter?

Extended abstract:

Available evidence has established the fact that woman's autonomy is likely to have a significant impact on demographic and health seeking behavior of couples by altering women's relative control over fertility and contraceptive use. It has also been seen that educated women are more likely to have autonomy, which affect their fertility behavior (Gulati, 2002; Jeejebhoy, 1995; Dey and Ahavsar, 2002). Women's participation in decisions related to intra-household affairs was positively associated with contraceptive use. Sathar and Kazi (1997) concluded that women's autonomy had a strong role in explaining differentials in contraceptive use. Khan (1999) suggested that mobility is an important factor in assessing family planning services whereas some other studies shows that participation in household decisions was not be associated with adoption of contraceptives. Clearly the findings to date are mixed, and there is a need for further investigation.

In view of above discussion the broad objective of this paper is to examine the impact of woman's autonomy on use of contraceptive among currently married woman of India. The specific objective is to study the relative importance of physical, decision-making, and economic autonomy on the adoption of contraception.

The data for the present study has been utilized from National Family Health Survey-2 (1998-99). The ultimate sample size for this study is 90,303 ever-married women. Autonomy defines as the ability to act and make decisions without being-controlled by anyone else. To measure women's autonomy directly, NFHS-2 asked about women's participation in household decision-making, their freedom of movement, and access to money that they could spend as they wish. For the present study, woman's autonomy is divided into three parts and it is defined as:

1. **Physical autonomy**: The index of woman's physical autonomy has constructed with the help of two questions, which have been asked in NFHS-2 survey.
    (i) Whether the woman needs permission to go to the market (0/1).
    (ii) Whether she needs permission to visit relatives or friends (0/1).

A simple index of physical autonomy has been computed by summing over the above-mentioned two 0/1 variables.

2. **Decision making autonomy:** An index of decision-making autonomy based on information about whether the woman takes decisions herself, or at least jointly with her husband or others, on the following
    (i) What to cook (0/1).
    (ii) Whether to obtain health care for herself (0/1)
    (iii) Whether to purchase jewellery or other major household items (0/1)
    (iv) Whether to stay with her parents or siblings (0/1)
3. **Economic autonomy:** Similarly index of economic autonomy has computed by summing two 0/1 variables
    (i) Whether the woman is allowed to have some money set aside that she can use as she wishes (0/1)
    (ii) Whether she earns cash and participates in decisions on how to use it (0/1)

We adopt a multilevel modeling framework to explain the variation in use of contraception for a large sample of women across India. We include variables that relate to the different theories of fertility decline and to some of the explanations of changing fertility behaviour among Indian women. We develop our model at three levels: individual (level 1), household (level 2), and community (level 3). The individual level variables other than woman's autonomy included in the analysis are woman's present age (15-19/20-34/35-49); woman's educational status (illiterate/literate but less than middle school complete/high school complete and above); partner's educational status (illiterate/literate but less than middle school complete/high school complete and above); number of living sons (0-2/>2), whether woman has experienced child loss (none/1+), exposed to mass media (no/yes); religion (hindu/muslim/others); caste (scheduled caste (SC) and scheduled tribe (ST)/other than SC and ST). Household level variables are educational status of the household other than respondents (households with at least one member literate up to primary level, households with at least one member literate

higher than primary level but up to secondary level and households with at least one member literate beyond secondary level); user of contraceptive other than respondent (no other contraceptive user/1+ other contraceptive user); type of house (Kachha, semi-pucca and pucca). The community level variables are female/male child mortality rate ratio (low/medium/high); labour force participation rate (low/medium/high); muslim population (low/medium/high); percent ever-married women using any method (low/medium/high); percent eligible women visit extension worker (low/medium/high); community autonomy (decision making autonomy/physical autonomy/ economic autonomy).

The negative impact of son preference on contraceptive use is clearly visible in the analysis. The presence of one or more sons has the largest effect of all the variables. The result supports the hypothesis that women are much more likely adopt contraception once they are satisfied that their future is secure. The average physical autonomy in the community is positively related to use of contraceptives. At the individual level, such an effect is seen for decision-making autonomy. There is also an indication that the woman's own physical autonomy has a strong impact on adoption of use of contraceptive. Economic autonomy is not positively related to adoption of contraceptive use at community level.