Gender Power Relations in Reproductive Decision-Making: The Case of Migrant Weavers of Addis Ababa, Ethiopia

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Abstract

In many developing countries most of reproductive decisions are made by men although it is, as well, the concern of women. Hence, this study was undertaken with the objective of assessing reproductive decision-making among migrant weavers in Addis Ababa. Three hundred seventeen married couples were randomly selected and data collected from them through structured questionnaire. Descriptive statistics and multinomial logistic regression was used to analyze the data.

Accordingly, about 45% and 35% of women respondents reported that their husbands dominate the contraceptive use and maternal health service utilization decision-making, respectively. On the other hand, about 33% and 36% of women respondents made the contraceptive use and maternal health service utilization decisions jointly with their husbands, respectively. Women who are older, literates, have fewer children and media access made the contraceptive use decisions by their own or jointly with their husbands. Literates and working women made the maternal health service utilization decisions by their own or jointly. Women who are not victim of physical harassment or verbal abuse made the maternal health service utilization decisions jointly. Besides, working women and those having media access made the contraceptive use and maternal health service utilization decisions by their own, respectively. Empowering women is recommended to bring about egalitarian or women-centered reproductive decision-making pattern.

Keywords: Contraceptives use; maternal health service utilization; gender; power relations; decision-making.

1. Introduction

In most societies, women usually have less power than men in all spheres of life (Eguavoen, Odiagbe and Obetoh 2007). The patriarchal, hierarchical and polygynous organization of many African households, the young age at marriage for women, patrilocal residence after marriage, the large age difference between spouses, the unequal work burden between the sexes, the high bride price, and the low educational level of women tends to perpetuate the low status of women and make them voiceless and powerless in all spheres of life including sexuality and reproduction (Makinwa-Adebusoye 2001; Boserup 1985). Consequently, women's needs and preferences are neglected, and their knowledge and experience are not used to help guide decisions in their family as well as in their community (Kuponiyi and Alade 2007; Arkutu 1995). Accordingly, in many developing countries, most of decisions regarding sexual activity, fertility, and contraceptive use are made by men (Oladeji 2008).

The situation is similar in Ethiopia, where women generally do not have equal right with their husbands to have access for resources, to make decisions regarding their desire number of children, to use contraception and even to space or stop childbearing (Olokodana and Yeshi 1998). Consequently, women's decision-making abilities remain constrained and subjugated to the political, socio-economic and cultural dominance of men (WHO 1999). The consequent gender based power inequalities hinder communication between partners about reproductive health decisions, constrains their access to reproductive health services, prevent them from attaining the highest level of sexual health and pleasure and this, in turn, contributes a lot to poor health outcomes (Blanc 2001; Speizer, Whittle and Carter 2005).

Understanding women's reproductive needs and identifying the key factors which influence reproductive negotiation process between husband and wife are necessary to formulate policies aimed at creating conducive environment to improve women's reproductive health, general well-being and their decision-making power (Xu 1999). Furthermore, understanding the linkage between gender power relations and reproductive decision-making is among the key factors which can help to assess the extent of gender inequality. Thus, this study aimed to fill the knowledge gap by using data collected from weavers in Addis Ababa who are from Gamo Gofa zone of Southern, Nations, Nationality and People's Region (SNNPR).

Women of the weaver's community are highly responsible for both productive and reproductive activities. With these backgrounds the research tried to answer whether women in the study population enjoy similar power and rights in making reproductive decisions as they take the lion share of

production as well as reproduction activities in their households? In addition, majority of weavers are migrants from Gamo Gofa zone of SNNPR. As most part of Ethiopia, there is gender disparity in Gamo Gofa zone. Hence, the research tried to answer whether gender disparity in their zone is reflected in Addis Ababa or not. The main research questions are: Who is responsible for reproductive decision-making in the household? What are the determinants of reproductive decision-making?

2. Methodology

2.1 Sampling and Data Collection Method

Among ten sub-cities of Addis Ababa, the study site, Gulele sub-city, was purposely selected for the reason that majority of weavers are living. A multistage sampling procedure was employed to select the study respondents. Of ten kebeles[1] in Gulele sub-city, large concentration of weavers resides in two of the kebeles; namely kebele 18 and 19. In the first stage, two clusters were formed using the two kebeles. Using simple random sampling one of the cluster, kebele 18, was chosen. In the second stage every tenth household from the selected kebele were chosen. Then from each household both wife and husband, who satisfied the inclusion criteria, were interviewed. The inclusion criteria for the study respondents were: the couples should be living together in Addis Ababa during the time of the survey; the couples should be migrants from Gamo Gofa zone of SNNPR; women should be in the reproductive age category (15-49 years) and men should be in (15-69 years) age category.

The sample size was determined using the formula

$$n = Deff\left(\frac{z_{\alpha/2}}{e}\right)^2 pq$$

where $Deff$ is the design effect = 1.5; α is level of significance = 5%; e is level of precision = 5%; p is estimated proportion of joint reproductive decision-making and estimated to be 0.5. Substituting the values in the above formula and by adding 10% of the sample size to compensate for non response, 317 couples, i.e., 634 individuals fulfilling the inclusion criteria were selected for the study. Then the data was collected by using well designed structure questionnaire. Two independent questionnaires were prepared for husband and wife. The husband's questionnaire contains the demographic, socioeconomic and cultural variables only whereas the wife's questionnaire contains reproductive issues and patterns

[1] Smallest administrative unit in Ethiopia

of reproductive decision-making in addition to variables included in the husband's questionnaire. The data collection was undertaken from February 09, 2009 to February 16, 2009. The response rate of the questionnaire was 100%.

2.2 Variables in the Study

The response variable of the study is the pattern of reproductive decision-making (decisions regarding contraceptive use and maternal health service utilization). It is categorized in to three: men-centered/husband-dominated, women-centered/wife-dominated and joint decision-making.

The explanatory variables included in the study are: age, religion, Educational level, work status, number of children, exposure to media, physical harassment or verbal abuse and years lived in Addis Ababa.

2.3 Data Analysis Methods

Frequency distribution and charts are employed to get the sample characteristics and multinomial logistic regression is used to identify the determinant factors of reproductive decision-making.

Let Yi be a random variable representing decision-making pattern of an individual. We assume that each respondent can have discrete, mutually exclusive choice of decision-making. The decision-making patterns (Yi) are functions of demographic, socioeconomic and cultural variables (X). The multinomial logistic regression model for decision-making specifies the following relationships between the probability of choosing option Yi and the set of explanatory variables xi

$$P(Y_i = j) = \frac{e^{\beta_j x_i}}{\sum_{k=0}^{j} e^{\beta_k x_i}}, \qquad j = 0, 1, \ldots J$$

where β_j is a vector of coefficients for category j and xi is the vector of explanatory variables for observation i. Moreover, model assumptions including multicollinearity, independence of irrelevant observations, outliers and influential values were checked and addressed accordingly.

3. Results and Discussion

3.1 Sample Characteristics

The mean and median ages of the wives were 27.3 and 26 respectively with standard deviation of 5.9 years and that of husbands were 33.5 and 30 with standard deviation of 10.1 years. On the average husbands were six years older than their wives. About 12% of the couples do not have children while 46% have one or two children and the remaining 42% have three or more children. On average a couple had 2.88 children. About 49%, 30% and 21% of women have been living in Addis Ababa for less than 11 years, 11-20 years and 20 plus years, respectively. Among the men respondents, about 18%, 42% and 40% have been living in Addis Ababa for less than 11 years, 11-20 years and above 20 years, respectively. Regarding educational level, 66% of women were illiterate, 28.7% primary and 5.3% are secondary and above; this figures were 30%, 57.4% and 12.6% for men respondents, respectively. There is discrepancy in the educational attainment between couples. Women are underestimated than men in the sample. Concerning religious affiliation, about 68% and 74% of women and men, respectively, were Orthodox Christians and 32% and 26% of women and men, respectively, were Protestants. About 57% of women were engaged in income generating activities and the remaining 43% were not. All men respondents were primarily engaged in weaving activity and generate their own income. The media exposure indicated that 57.4%, 22.4%, 20.2% of women had no access, occasional, and regular access to media, respectively, while 4.7%, 67.2% and 28.1% were the respective figures for men respondents. Women are more disadvantaged than men in media consumption. Majority of surveyed women (69%) claimed that their husbands committed physical harassment or verbal abuse while the remaining 31% reported that they have never been harassed or abused. (see Table 1 below).

Table 1: Percentage distribution of sample of weaver by selected demographic, socioeconomic and cultural characteristics in Addis Ababa, 2009.

Characteristics	Women (n=317)		Men (n=317)		Total (n=634)	
	N	%	N	%	N	%
Age						
15-24	105	33.1	46	14.5	151	23.8
25-34	162	51.1	144	45.4	306	48.2
35+	50	15.8	127	40.1	177	28.0
Number of children						
0	38	12	35	11	73	11.5
1-2	150	47.3	142	44.8	292	46.1
3+	129	40.7	140	44.2	269	42.4
Educational level						
Illiterate	209	65.9	95	30	304	47.9
Primary	91	28.7	182	57.4	273	43.1
Secondary and above	17	5.4	40	12.6	57	9.0
Religion						
Orthodox	216	68.1	235	74.1	451	71.1
Protestant	101	31.9	82	25.9	183	28.9
Work status						
Working	181	57.1	317	100	498	78.5
Not working	136	42.9	0	0	136	21.5
Media exposure						
Regular	64	20.2	89	28.1	153	24.1
Occasional	71	22.4	213	67.2	284	44.8
Never	182	57.4	15	4.7	197	31.1
Physical harassment/verbal abuse						
Committed	219	69.1	75	23.7	294	46.4
Not committed	98	30.9	242	76.3	340	53.6
Years lived in Addis Ababa						
Below 11	156	49.2	59	18.6	215	33.9
11-20	96	30.3	132	41.6	228	36.0
Above 20	65	20.5	126	39.8	191	30.1

Note: age 35+ is (35-49) for women and (35-69) for men.

3.2 Reproductive Decision-Making of Women

All surveyed women have heard about at least one method of contraceptive. Injectables and pills were known by all of them whereas only 24.4% knows sterilization. About 60% of the women respondents have ever used contraceptive methods. Of 279 women who ever give birth, about 69% have obtained antenatal care from health centers and only 20% were assisted by health professionals for their last delivery.

Regarding decision-making, about 45, 33 and 22 percent of the women respondents reported that the contraceptive use decision was made by their husbands, jointly and by self, respectively, and this figure was 35, 36 and 29 percent, respectively, for maternal health service utilization (antenatal and delivery care) decision-making. (see Figure 1 below).

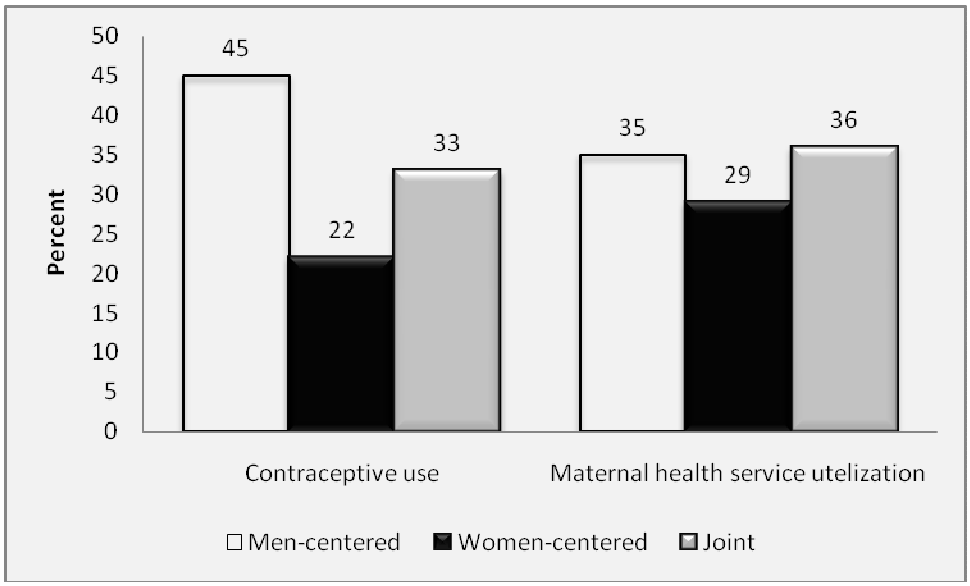

Figure 1: Reproductive decision-making among sample of women respondents, Addis Ababa, 2009.

3.3 Determinants of Reproductive Decision-Making of Women

The following results are based on the multinomial logistic regression analysis output (see Table 2 below).

Compared to older women (35-49 years of age), younger women (15-24 years of age) and middle aged women (25-34 years of age) are less likely to participate in the contraceptive use decision-making. This might be due to the lower bargaining power of younger women coupled with their low socioeconomic status and information exposure made them to live in the household where husband dominated the

contraceptive use decision-making. This result is in line with the study conducted by Lapeyrouse (2002) that younger women have low bargaining power regarding contraceptive use.

Literate women made the contraceptive use decision alone or together with their husbands. Additionally, the maternal health service utilization decision-making is their own business. The higher the level of education for women, the more knowledge she acquires for the use of family planning methods (CSA and ORC Macro 2006), increase the desire to limit or space births and increase the use of and the intention to use contraceptives (Hogan, Betemariam and Assefa 1999). Furthermore, women's education provides them with more opportunity to participate in the process of modernization and enable them to bring about changes in the economic and social situation. This, in turn, improves their knowledge and practice of reproductive health rights and improves their decision-making power in their household. Moreover, this finding is in agreement with different research findings which concluded that education for women positively affects conjugal communication and facilitates egalitarian decision-making (Chapagain 2006; Hossain 1998; Laban and Gwako 1997).

Having fewer children is attributed to have women-centered or joint contraceptive use decision-making. The possible explanation for this result is that women who delay or avoid births can bring about significant economic advantages over women with large number of children when terminating consensual union. Therefore, having fewer children can improve a woman's ability to end an unsatisfactory relationship (Dixon-Mueller 1993) and it enables them to exercise more freedom within marriage. Prasadja et.al (1997) concluded that women with two or fewer children have greater control of their reproductive lives than women with three or more children.

Compared to not-working women, working women (women generating their own income) are more likely to participate in contraceptive use decision-making. Also working women made the maternal health service utilization decision alone or jointly with their husbands. Having own income for women increases their economic independence and challenges the traditional belief of men dominance in decision-making and hence improves their bargaining power within the household. Cash work and control over earnings for women improves women's autonomy and stimulates spousal communication and hence creates decision-making power (Chapagain 2006; Hossain 1998; Laban and Gwako 1997; Gage 1995).

Women with regular/occasional access to media are more likely to make the contraceptive use decision by their own than those women with no media access. They also take the lion share of maternal health service utilization decision-making process in their household. Exposure to media, especially programs

related to family planning, widens the scope of understanding issues related to contraceptive use and helps in realizations of its importance in achieving desired family size (CSA and ORC Macro 2006). Thus, better media consumption will equip them with information about the reproductive health issues including reproductive health rights and it encourage them to make active participation in the reproductive decision-making process in their household.

Women who have not harassed or abused by their husbands are more likely to make joint maternal health service utilization decisions in their household than those who have harassed or abused. This finding corroborates the study result of Chapagain (2006) which concluded that women experienced violence from their husbands are less likely to participate in antenatal care decision-making.

Table 2: Multinomial logistic regression analysis result of reproductive decision-making of women respondents, Addis Ababa, 2009.

Characteristics	Contraceptive use decision-making						Maternal health service utilization decision-making					
	Wife Vs Both		Husband Vs Both		Wife Vs Husband		Wife Vs Both		Husband Vs Both		Wife Vs Husband	
	Se(β)	RRR	Se(β)	RRR	Se(β)	RRR	Se(β)	RRR	Se(β)	RRR	Se(β)	RRR
Age												
15-24	0.74	0.18	0.82	14.4**	0.94	0.01**	0.74	1.21	0.96	1.56	0.49	0.77
25-34	0.6	0.3	0.62	1.3	0.71	0.22*	0.33	0.71	0.37	0.76	0.48	0.93
35-49 (ref)												
Literacy status												
Illiterate (ref)												
Literate	0.56	0.59	0.59	0.05**	0.66	11.00**	0.92	2.24*	0.13	.27**	0.95	8.14**
Religion												
Orthodox (Ref)												
Protestant	0.56	5.5	0.54	2.15	0.55	2.57	0.34	0.92	0.4	1.1	0.33	0.84
Number of children												
0	0.96	4.4	1	0.55	1	8*						
1 – 2	0.56	1.9	0.66	0.24*	0.74	7.9**	0.32	0.79	0.51	1.2	0.29	0.64
3+ (ref)												
Work status												
Working	0.55	1.4	0.47	0.51	0.6	2.7*	0.23	0.66	0.07	.22**	1.1	3**
Not working (ref)												

(Table 2, Continued)

Characteristics	Contraceptive use decision-making						Maternal health service utilization decision-making					
	Wife Vs Both		Husband Vs Both		Wife Vs Husband		Wife Vs Both		Husband Vs Both		Wife Vs Husband	
	Se(β)	RRR	Se(β)	RRR	Se(β)	RRR	Se(β)	RRR	Se(β)	RRR	Se(β)	RRR
Media exposure												
Regular/Occasional	0.57	2.9*	0.62	0.81	0.63	3.6*	0.71	1.76	0.28	0.66	1.1	2.7*
No access (ref)												
Physical harassment/ verbal abuse												
Committed (ref)												
Not committed	0.48	1	0.45	0.74	0.51	1.34	0.15	.41*	0.22	0.63	0.27	0.65
Years lived in Addis												
Below 11 (ref)												
11 – 20	0.6	1.5	0.51	1.85	0.64	0.84	0.22	0.56	0.19	0.49	0.51	1.15
Above 20	0.7	2.1	0.79	0.41	0.84	5.1	0.77	1.54	0.68	1.22	0.64	1.25
LR chi2(22)	***109.30***						***109.30***					
Prob > chi2	***0.000***						***0.000***					

**Significant at 1%; *Significant at 5%; ref- indicates reference category; unmarked- indicates insignificant variables; RRR- relative risk ratio; Se(β)-standard error of the coefficient; the significant LR statistics (Prob>chi2=0.000) shows that all the regressors have significant impact on decision-making pattern.

4. Conclusion and Recommendations

The study demonstrated the subordinate position of women in the weaver's community. Accordingly, wives are less educated, less likely to have their own income, have a lower exposure to media, are prone to physical harassment or verbal abuse and also younger in age compared to their husbands. Consequently, majority of them relays on their husbands for the reproductive decision making, especially for contraceptive use decision-making.

The result underscored women's empowerment through education and economic activities as one of the entry point for enabling them to make the reproductive decisions by their own or jointly with their husbands. Thus, policies which advocate women's empowerment (polices like National Policy of Ethiopian Women, National Population Policy, The Ethiopian Education and Training Policy and Health Policy) should be implemented in well organized and integrated way. Moreover, efforts should be made to foster the elimination of gender imbalance and promote gender equality in the study communities, especially among those categories who have reported men-centered reproductive decision-making (younger, illiterate, not working, no media access, having more than two children and who have victim of physical harassment or verbal abuse).

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