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Involvement of Women in Household level Decisions in the Perinatal Period: Findings from a Rural Community in Sri Lanka

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Abstract

Safe motherhood initiative advocates on "Equity for women" as its foundation strategy. Household level decision-making is an indicator of household level equity. The perinatal period is considered as a crucial stage for the pregnant woman and her newborn and decisions made in this period can determine the well-being of the woman and newborn. The aim of the study was to describe the involvement of women in household level decision-making in the perinatal period in a rural community in Sri Lanka. A cross-sectional study design was used among 403 women recruited by a multistage sampling method from field antenatal clinic services in Polonnaruwa District. Data were collected by a household survey, using a pre-tested interviewer administered questionnaire. Percentages and 95% confidence intervals were used to present the findings. More than 80% of women were involved in making the selected decisions related to pregnancy. However, involvement in making other household level decisions was comparatively lower. In pregnancy-related decisions, all three decisions that determine the health-seeking behavior were taken by the woman and the partner collectively in the majority of households (when to seek medical care: *n* = 152, 49.4%; where to seek medical care: *n* = 190, 61.7%; and place to deliver: *n* = 130, 42.2%). In other household level decisions, the most common scenario was to take the decision collectively with the partner, except for spending on food. It was commonly decided by the partner alone (42.2%, *n* = 130). The women's involvement in making household decisions in the perinatal period was high. Sri Lankan rural communities probably display a higher level of gender equity in taking decisions in the perinatal period compared to its neighbor countries.

Keywords: Gender equity, Household, Perinatal period, Rural, Sri Lanka

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Introduction

Safe motherhood initiative, the strategic framework recommended to ensure the well-being of the mother and the newborn during pregnancy, advocates on "Equity for women as its foundation strategy."[1] Achieving "gender equity" is a major component of the process of empowering women and a determinant of their health and well-being.[2-4] Acknowledging the importance of these concepts in global development, "achieving gender equality and empowerment of all girls" is identified as a sustainable development goal.[4] Involvement in making decisions is a major indicator of gender equality in a relationship or in a household.[3-5] It also enhances the perceived sense of control, an attribute of psychological empowerment.[6] Existing global evidence suggests that lower middle-income countries have a lower level of equity in "reproductive, maternal, newborn, and child health" and economic status, education, sex, and place of residence are the dimensions of the observed equity breach.[7]

Sri Lanka, a lower middle-income country in the Region of Southeast Asia, shows good performance on indicators in maternal and child mortality compared to its neighbors.[8] The perinatal period defined as the period between 22 completed weeks (154 days) of gestation and ends 7 completed days after birth[9] is considered as a crucial stage for the pregnant woman and her newborn. The decisions made in this period, including the ones made at the household, can determine the outcome of the pregnancy, as well as the morbidity and mortality of the woman. The household level equity and differences in decision-making may have contributed to this difference. An extensive literature search failed to reveal documented findings on how the household level decisions are made in this important period and involvement of women in making them in Sri Lanka. Thus, this study aimed to describe the involvement of women in household level decision-making in the perinatal period in a rural community in Sri Lanka.

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Methods

Study Setting

This paper was based on a cross-sectional study which is a component of a PhD thesis that aimed to improve birth weight

in a community situated in the North Central Province and is identified as a predominantly rural and an agricultural setting[10] in Sri Lanka. The participants of the intervention group (conducted in Anuradhapura district) were subjected to a health promotion intervention that addressed determinants of care received by the pregnant woman and the new born at the household, which included household level equity and decision-making in pregnancy and the postpartum period. The data used in this publication were based on the survey conducted among the participants recruited as the comparison group of the main study (conducted in Polonnaruwa district).

Sampling

The sample size was calculated for the intervention component, using a standard formula based on the expected post-intervention low birth weight prevalence rates in intervention and comparison areas.[11] However, sampling adequacy for the present component was determined based on standard formulae for cross-sectional studies and ensured as satisfactory.[12] A multistage sampling method employing both simple random and systematic methods was used to recruit the sample ($n = 403$) from the pregnant women registered for field antenatal services, in the 3rd and 4th quarters of 2012. The primary sampling unit was the Medical Officer of Health (MOH) area ($n = 3$) and the secondary sampling unit was the antenatal clinic (ANC) ($n = 26$). The women, considered as the comparison group, received the standard normal care delivered freely from the government primary health-care system and were followed up until 4 weeks postpartum.

Designing Data Collection Instruments

When developing the questionnaire, the important decisions during the perinatal period were identified by review of literature and national guidelines,[5-12] key informant interviews with content experts and field level service providers, and focus group discussions with pregnant women and their partners. When identifying decisions, special attention was paid to select ones that reflect the power status of the woman in the household, which is an indicator of how considerate and respectful are the other household members toward the woman. The decisions identified were of two main categories; decisions related to the pregnancy (when to seek medical care, where to seek medical care, where to go for the delivery, which items to buy for the delivery, and which items to buy for the newborn) and household level decisions on spending monetary resources (spending on food, spending on newborn, spending on social activities, and long-term investments). The questions were developed in Sinhala language and reviewed by an expert panel (One Consultant Community Physician, one MOH, one Public Health Midwife, and the participant from the community-based organization) to ensure face, content, and consensual validity. The questionnaire was pre-tested in an adjacent district (Matale) to avoid contamination of the prospective study areas.

Data Collection

The data were collected at or around 28 days in the postpartum period by trained research assistants who visited the households in prior arranged dates.

Data Analysis

Percentages of women involved in making the selected decisions were calculated with the respective 95% confidence intervals. The person/persons in the household that made the ultimate decision were also described using percentages. Data were entered into Microsoft Excel and SPSS version 20 was used to analyze data.

Ethics Approval and Consent to Participate

Administrative clearance was obtained from the health administers at provincial and the regional levels and the respective MOH before conducting the study. Ethical clearance was obtained from the Ethics Review Committee of Faculty of Medicine, University of Colombo.

Results

The response rates and inclusion for analysis are presented in the Figure 1. Excluding the non-respondents ($n = 16$) and lost to follow-up participants ($n = 95$), 308 (76.4%) were included in the final analysis.

Description of Study Participants

The sociodemographic characteristics of the study participants and their partners are presented in Table 1.

Mean ages of women and their partners were 27.4 (SD = 5.4) and 31.3 (SD = 5.0) years, respectively. Majority of men (86.1%, $n = 265$) and women (91.3%, $n = 281$) both had completed secondary education (passed GCE O/L examination or above). The majority of women were housewives (72.7%, $n = 224$) and, of the employed ($n = 84$), 50% ($n = 42$) were employed in the government sector. None of women were in armed forces, unlike their partners, for which it was the second most common($n = 84$, 26.6%) employment category. Majority of partners were farmers, self-employed, or laborers (57.1%, $n = 176$).

Of the women, 40.9%, ($n = 126$) were primi mothers. About 37% ($n = 114$) stated that the pregnancy was not planned. About 40% ($n = 124$) lived in extended families, most commonly accompanied by the mother-in-law (59.7%, $n = 74$). The partner was not coming home daily in around one-third of the households (30.2% + 0.3%; $n = 93 + 1$).

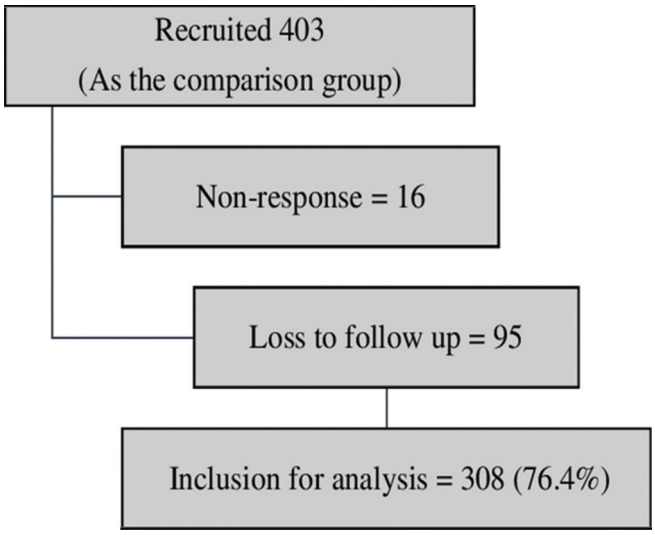

Figure 1: Study participants included for analysis

Table 1: Distribution of participants according to selected characteristics

Characteristic	*Women (n=308)*		*Partners (n=308)*	
	*n**	*%*	*n**	*%*
Age				
<20 years	32	10.4	3	1.0
21–35 years	242	78.6	240	77.9
More than 35 years	34	11.0	65	21.1
Educational level				
Primary education or no schooling	5	1.6	6	1.9
Secondary education	22	7.1	37	12.0
Passed GCE O/L	185	60.1	182	59.2
Passed GCE A/L or higher	96	31.2	83	26.9
Employment				
Housewife	224	72.7		
Employed in government sector	42	13.6	36	11.7
Employed in private sector	15	4.9	14	4.6
Farming/self-employed/laborer	27	8.8	176	57.1
Armed forces	0	0.0	82	26.6
Characteristics at couple level	*n (n=308)*		*%*	
Marital status				
Married	306		99.4	
Unmarried/never married	2		0.6	
Parity				
1st pregnancy (primi)	126		40.9	
2nd pregnancy	111		36.0	
3rd pregnancy	53		17.2	
4th or more	18		5.9	
	n (n=308)		*%*	
Pregnancy planned or not				
Yes	194		63.0	
No	114		37.0	
Family income per month (LKR)				
<15,000	77		25.0	
15,001–30,000	178		57.8	
30,001–45,000	34		11.0	
45,001–60,000	19		6.2	
Family type				
Nuclear family	184		59.7	
Extended family	124		40.3	
Husband's presence at home				
Lives at home	214		69.5	
Lives away from home (not abroad)	93		30.2	
Lives abroad	1		0.3	
Extended family members (in the pregnant woman's perspective)†; ‡				
Mother	37		29.8	
Father	20		16.1	
Mother-in-law	74		59.7	
Father-in-law	49		39.5	
Other	27		21.7	

*Excluding non-respondents; †categories not mutually exclusive; ‡only the participants with extended families

Table 2: Distribution of participants according to involvement in making decisions

Decision	*Number involved (%) n = 308*	*95% confidence interval*
Pregnancy related		
When to seek medical care	258 (83.8)	80.2–87.4
Where to seek medical care	260 (84.4)	80.9–87.9
Place to deliver	224 (72.7)	68.3–77.1
Items to buy for the delivery	286 (92.8)	90.3–95.3
Items to buy for the new born	266 (86.3)	82.9–89.6
Other household level decisions		
Spending on food	164 (53.2)	48.3–58.1
Spending on the new born	209 (67.8)	63.2–72.4
Spending on social/ recreational activities	194 (63.0)	58.3–67.7
Investments/savings	246 (79.8)	75.9–83.7

Women's Involvement in Decision-Making

Except for the "place of delivery" (*n* = 224, 72.7%), more than 80% of women were involved in making the selected decisions related to pregnancy. However, involvement in making other household level decisions was comparatively lower, except for decisions on investments or savings (*n* = 246, 79.8%) [Table 2].

Who Took the Decisions?

The person who took the decisions that determine was also explored into [Table 3]. In pregnancy-related decisions, all three decisions determine the health-seeking behavior during the perinatal period (when and where to seek medical care and place to deliver), woman and the partner collectively took the decision in the majority of households (when to seek medical care – *n* = 152. 49.4%; where to seek medical care – *n* = 190, 61.7%; and place to deliver – *n* = 130, 42.2%). The second most common scenario was the woman taking the decision alone (when to seek medical care – *n* = 104. 33.8%; where to seek medical care – *n* = 69, 22.4%; and place of delivery – *n* = 89, 28.9%). However, in all three decisions, the proportion of households in which the partner made the decision alone was more than 10%. Another noticeable fact was in the "place to deliver," for which, the decision was taken without the involvement of the woman or the partner in 52 (16.9%) households. In all the other decisions, the most common was for the woman to decide collectively with the partner, except on "things to buy for the delivery," for which the majority of women took the decision alone (*n* = 176, 57.1%).

In other household level decisions, the most common scenario was to take the decision collectively with the partner, except for spending on food. It was commonly decided by the partner alone (42.2%, *n* = 130). In three out of four households (74.7%, *n* = 230), decisions regarding long-term investments and savings were made collectively.

Discussion

This study found that women's involvement in making household decisions in the perinatal period was high in the studied community. The most common scenario in making pregnancy-related or other decisions was the woman to make them collectively with the partner. Above findings indicate that Sri Lankan rural communities display a higher level of gender equity in taking decisions in the perinatal period. This may have contributed for lower maternal mortality and child mortality rates leading to higher life expectancy at birth for females, compared to its neighbor countries.[5-8]

The above conclusion may be supported by other evidence from the study group. For example, females, being as well educated as males, suggest equal opportunities for a girl child for education. However, there are certain other characteristics in sociodemographic data and in decision-making that suggest that the equity level is not as high as the high-income countries.[5] For example, majority of women are housewives and dependent on the male partner for their income. Even when employed, none were from the armed forces, another indicator of gender-oriented perceptions toward employment. Majority of females who were living in extended family was living with their in-laws,

Table 3: Person/s involved in making the selected pregnancy-related decisions

Decision	*No. (%); n=308*				
	Woman	*Partner*	*Another person alone*	*Woman and partner*	*Other*
Pregnancy related					
When to seek medical care	104 (33.8)	49 (15.9)	1 (0.3)	152 (49.4)	2 (0.6)
Where to seek medical care	69 (22.4)	48 (15.6)	0 (0.0)	190 (61.7)	1 (0.3)
Place to deliver	89 (28.9)	32 (10.4)	52 (16.9)	130 (42.2)	5 (1.6)
Items to buy for the delivery	176 (57.1)	16 (5.2)	6 (1.9)	100 (32.5)	10 (3.2)
Items to buy for the new born	119 (38.6)	42 (13.6)	0 (0.0)	140 (45.5)	7 (2.3)
Other household level decisions					
Spending on food	50 (16.2)	130 (42.2)	14 (4.5)	110 (35.7)	4 (1.3)
Spending on the new born	78 (25.3)	99 (32.1)	0 (0.0)	131 (42.5)	0 (0.0)
Spending on social/recreational activities	16 (5.2)	110 (35.7)	4 (1.3)	170 (55.2)	8 (2.6)
Investments/savings	12 (3.9)	62 (20.1)	0 (0.0)	230 (74.7)	4 (1.3)

demonstrating the traditional norm of female leaving her home to live with the husband. When considering reproductive aspects, more than one-third of pregnancies were reported to be unplanned. However, it may be brought on by suboptimal family planning services and low motivation toward family planning in the community as well.[13] In decision-making, in general household decisions, involvement of the woman was comparatively low, and, the most important decision when considering the nutrition of the family, the money spent on food, was taken by the husband alone in majority of households. This fact may suggest that maybe in some households, involvement of the woman in the pregnancy related decisions was brought on by the fact that her having the highest contact with the health care services, and having access to higher level of information related to the decision.

AQ3 Promoting health of the people is not just a responsibility of the health sector. It requires a coordinated action by governments, non-governmental organizations, health, social and economic sectors, industry, media, and people in all walks of life need to mediate as individuals, families, and communities.[1,2,13,14] As concrete community participation is essential for the effective implementation of health promotion interventions,[1] the community-led workshops are ideal to convey how to implement health promotion interventions.

These findings from Polonnaruwa, a district that represents many such districts, in which rural agricultural communities predominant, can be generalized to other similar districts in Sri Lanka.[15] However, caution should be taken to compare the sociodemographic context prior to doing so, as ethnic and cultural aspects are known to be determinants of household level equity measures.[2-5] In interpreting and generalizing findings of this study, two major limitations should be considered. First, the study participants were recruited from among the registrants for the field antenatal care services, which may have led to a selection bias. However, as universal field ANC services is delivered free of charge through the government owned primary health-care system in Sri Lanka, actively registering the participants, this error can be low. The registration rate for the services is 92.1% in the country and 90.9% in the Polonnaruwa district.[13] The participants who are not registered for the services may be of two different categories, mothers who are registered only in the private sector and mothers who are not registered to any ANC services at all. Thus, due to the above missed groups which belong to the two extremes of the society, the findings may be either under or overestimates as economic condition is a strong determinant of gender equity.[5] Another limitation of the study was the probability for information bias. The data were collected by interviewers using recall method. Thus, social-desirability bias and recall bias may have limited the validity of the findings. Data collectors were trained to minimize those by being objective and using the exact words mentioned in the questionnaire, which was developed using gender-sensitive, non-discriminative, and objective language.

Conclusions

The women's involvement in making household decisions in the perinatal period was high in the studied community. Sri Lankan rural communities probably display a higher level of gender equity in taking decisions in the perinatal period compared to its neighbor countries.

These findings can be generalized to other rural agricultural communities in Sri Lanka while taking cautions to compare cultural and ethnic aspects.

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