WOMEN'S AUTONOMY AND UTILIZATION OF CONTRACEPTION IN URBAN POOR COMMUNITIES IN SUDAN

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Background: After the ICPD program of action (1994) as well as the MDGs (2000) highlighted the essential role of gender equity and women's empowerment as a substantial tool to achieve acceptable demographic changes in developing countries, literature concerning women's autonomy and its relation to fertility decline and utilization of family planning methods has become increasingly important and widespread. Several studies carried out in Asia provided evidence that women with high autonomy are more likely to use reproductive health care services as well as mother's empowerment may increase the likelihood of her child surviving due to the fact that autonomous mother is more likely to have the necessary negotiating power within her family, access and control over resources as well as ability in dealing effectively with health care institutions in order to protect her child. Yet, some studies fail to prove the strength of this relation especially when the other variables are adjusted for. The significance of this relationship is largely based on the type of the community under investigation, its family system, and to what extend culture, kinship, religion and traditions affected this community.

In Sudan, knowledge of family planning methods among ever married women is far from being universal. Astonishingly, knowledge of modern methods has not increase during the last decade. Quite recently, only two thirds of ever-married women reported knowing one or more family planning methods (FMOH et al., 2001). The poor knowledge of contraception has significant impact on women' utilization of family planning methods in particular modern family panning methods. The prevalence of family planning methods

in Sudan is 10% among married women of reproductive age, according to the estimates of the Population Reference of Bureau. Indeed, Sudanese women are lagging in the uptake of not only contraception but also reproductive health services more generally. The very high level of maternal mortality, maternal morbidity and prenatal and infant mortality are testament to this unfortunate lack of service use. Choosing Greater Khartoum gives a distinct opportunity to study a heterogeneous community in a sense that greater Khartoum includes deprived communities (i.e., Internally Displacement People's camps and 3rd class areas) as well as communities with a very high socio economic level. Further, the population of Greater Khartoum is about one-fourth of Sudan and therefore results from Greater Khartoum will inform us on the Sudanese situation as well as giving some insights on the situation in the Arab region more generally.

A number of terms have been used to indicate women's position in relation to men across different socio-cultures. The term women's status has been used in earlier studies to express gender disparities existing in a community with respect to development indicators wither on the micro or individual indicators or macro or structural indicators. However, it is used in other studies to refer to women vs. men positions across social, economic, and political hierarchies (Mason, 1987). Generally, the concept of women's status implies the women's position in the structure of a familial hierarchy (Mason, 1986; Larsen, 2003).

Other later studies have been used autonomy, empowerment, and gender stratification interchangeably in order to express the gender positioning in the communities without much conceptual precision (Morgan, 2002; Mason & Smith, 2000; Jejeebhoy, 2000) . However, women's autonomy is defined by United Nations as women's increased control over their own lives, bodies, and environment (United Nations, 1995). Moreover, Bloom et al. (2001: 68) defined it as “the capacity to manipulate one's personal environment through control over resources and information in order to make decisions about one's own concerns or about close family members”. It has also been defined as “the degree of women's access to (and control over) material resources (including food, income, land, and other forms of wealth) and to social resources (including knowledge, power, and prestige) within the family in the community, and in the society at large” (Mason, 1986: 286). In another study women's autonomy is defined as “the ability to obtain information and use it as the basis for making decisions about one's private concerns and those of one's intimates” (Dyson and Moore, 1983: 37). Indeed, autonomy is gaining power in order to achieving goals and overcome the rigid patriarchal system and gender based discrimination against women.

The linkage between women's autonomy and utilization of contraception is confronting lack of consensus on appropriate measurement across communities (Morgan, 1995). Some of this confusion may be attributed to the conceptualization of women's autonomy which has remained a challenge due to the cultural conditions, family system, and to what

extends kinship, religion and traditions affected community as well as its multi-dimensional nature in a sense that autonomy concept can be perceived form individual, household, or societal point of view. Thus, women's autonomy may affect women' fertility in different ways; that is, from the individual level, some wives prefer fewer children than husbands due to the fact that women disproportionately bear the cost of childbearing and childrearing therefore increasing women's power in negotiations and decision making inside household may help in achieving lower fertility levels. On the other hand, in strong patriarchal societies in which women consider children as a potential source of social security or wealth, empowering women should not be only within individual level but also societal level otherwise increasing in fertility will be the expected result from the empowerment process if it is focused only on women.

Several studies carried out in Asia have provided evidence that women with high autonomy are more likely to use reproductive health care services (Bloom et al., 2001) as well as mother's empowerment may increase the likelihood of her child surviving due to the fact that autonomous mothers are more likely to have the necessary negotiating power within her family, access and control over resources as well as ability in dealing effectively with health care institutions in order to protect her child (Caldwell,1986; Hobcraft, 1996). Yet, some studies fail to prove the strength of this relation especially when the other variables are adjusted for (Kishor, 1998). The significance of this relationship is largely based on the type of the community under investigation, its family

system, and to what extent culture, kinship, religion and traditions affected the community (Kishor, 2000; Jejeebhoy, 2000). Further, in Ibrahim's study (2004), it is quite difficult to apply or even compare the exact concept used in the west to non-western communities although many of these communities are passing through demographic transitions and they are trying to imitate the west in their behaviours. Therefore, we need to develop new indices particular to Arab context. On the other hand, measuring women's autonomy is a problematic issue. One obstacle is the way of treating this concept; it needs to be defined differently in each setting based on the nature of the society and its culture. That is, women's autonomy in the Arab context is very different from European and American settings. The Arab and Islamic settings are perhaps relatively conservative compared with women living in Europe, for instance. Moreover, because of the way of raising females in the Arab context and the rigid social rules, Arab women may be found less autonomous if one follows the western concept of autonomy. From the other side, the majority of these traditional communities oblige women to be economically dependent on a male kin. Consequently, women may have some access to the household's resources but lack control over them.

Generally, understanding women's behaviours in relation to fertility in the Sudanese culture is quite difficult because the kinship structure that affects women’s autonomy has its own attributes. Also, there is very little literature that addresses quantifying women’s autonomy in relation to reproductive health issues in Arab settings. The available

literature constructs women's autonomy indices following European and South East Asian contexts may not capture or reflect autonomy in Arab setting. By and large, the variables used in constructing women's autonomy indices are needed to re-conceptualize to reflect the actual autonomy precisely with respect to Sudanese context.

Objective: This study aims to achieve the following,

- Providing insights about women's autonomy in the Sudanese culture and which are the most appropriate approaches that can be adopted in order to improve women's status in Sudan within the Arabic, Muslim communities through implementing both qualitative and quantitative research techniques.
- Identifying barriers from the women's standpoint in using modern family planning contraception as a determinant that has crucial influence in reducing women's fertility.
- Studying the other possible determinants that may significantly affect women's fertility in Sudan.
- Identifying the key dimensions of women's autonomy in Sudan
- Making recommendations to policymakers and intervention organizations on how to improve reproductive health services in particular family planning services.

Data: Data used in the current study come from Urban Health and Poverty Survey that was carried out in 2006 in three impoverished communities in Greater Khartoum:

Omdurman, Khartoum North, and Khartoum. Two questionnaires are applied in this survey. The household questionnaire consists of two parts: a household schedule which gathers data related to basic demographic information from all individuals included in the household whereas the second part of the household questionnaire obtains information on characteristics of the physical and social environment of the household. Woman's questionnaire addressed twelve sections related to women and child health, contraception, social network and social services aspects. 2148 women aged 15 to 49 years, ever married are successively interviewed. Also, maternal health services mapping was conducted in Khartoum in order to control for availability of health services.

Methods: The analysis will employ descriptive statistics. Further, bivariate analysis will be applied to asses the effect of each explanatory variable on total fertility rate. Also, a number of logistic regression models will be run to assess the impact of women's autonomy on their fertility levels after adjusting for other independent variables.

Significance: This study fills a current gap in research on women's autonomy with respect to fertility issue in Sudan. It provide insights on main factors that determine women's autonomy in poor settlements and inform decision makers with some guidelines to intervene and reduce fertility in Sudan and increase the utilization of family planning contraception. Further, Some policy implications of the findings and measurement issues pertaining to women’s autonomy in poor communities will be discussed.