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## The roles of intra-household gendered dominance in unmet need for family planning across Myanmar

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## The roles of intra-household gendered dominance in unmet need for family planning across Myanmar

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### Abstract

**Background:** Unmet need for family planning in Myanmar (estimated 15.8% by the UN in 2017) is relatively high compared to other South East Asia countries. Moreover, Social Institutions and Gender Index in Myanmar is very high and cultural norms promote childbearing. Thus, this paper was conducted to examine role of intra-household gendered dominance (IHGD) in unmet need for family planning across Myanmar to set more effective intervention for family planning. **Methods:** The study utilized secondary data from 2015–2016 MDHS. Total 7,652 married women in reproductive age (MWRA) were included and 16% of them had unmet need for family planning. Binary Logistic Regression Analysis was conducted to examine the association of each explanatory variables with outcomes variables. **Results:** IHGD factors which are decision on women's health and women's attitude towards wife beating are significantly associated with unmet need. Moreover, socio-economic factors which are place of residence and women's education level have significant impact on unmet need as well. **Conclusion:** Based on the findings of this study, the government of Myanmar should address dominance of social and cultural gender norms by conducting gender equality awareness campaign and family planning program should target to reach rural and uneducated women.

*Keywords:* family planning, gender, Myanmar, unmet need

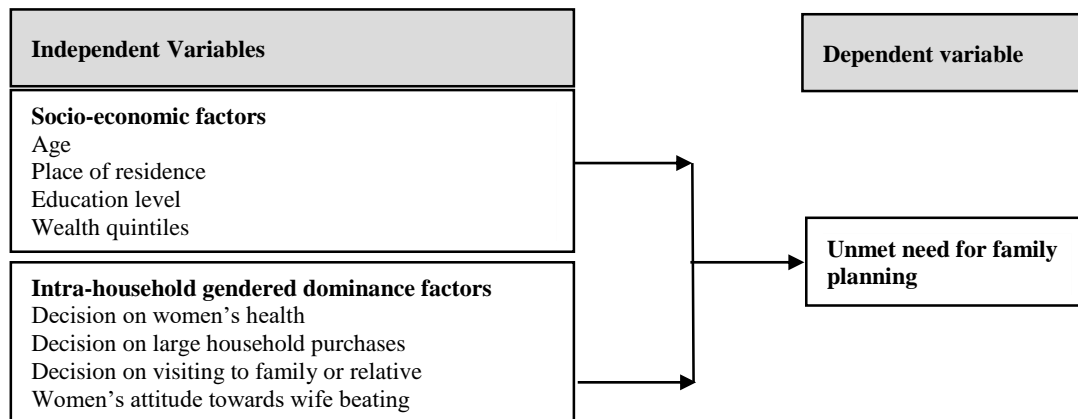
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### Introduction

Worldwide, almost 222 million women did not meet their needs for family planning in 2012 and among of them, 79% of women face unwanted pregnancy with the reason of unmet need for family planning.<sup>1</sup> Unmet need for family planning leads to unintended pregnancy and it generally ends with unsafe abortion and around 20 million unsafe abortion takes place annually and complications from unsafe abortion make 13% of maternal death in developing countries in 2008.<sup>2</sup>

According to the latest Myanmar Demographic and Health Survey (MDHS) in 2015–2016, 16% of currently married women in reproductive age (MWRA) did not meet their needs for family planning. This result indicates that Myanmar did not reach the target “to reduce unmet need for family planning to less than 10% in 2015” that has committed in Family Planning 2020.<sup>3</sup> Moreover, unmet need for family planning in Myanmar estimated to be 15.8% by the UN in 2017 is relatively high compared to other South East Asia countries, which are 5.7% in Thailand, 6.4% in Vietnam, 12.1% in Indonesia, and 12.5% in Cambodia. According to the 2004–2005 Nationwide Cause Specific Maternal Mortality Survey that was cited in National Health Plan (2011–2016), around 10% of maternal death caused by induced abortion and that was the third leading cause of maternal death in Myanmar.

Myanmar has signed the Convention to Eliminate all forms of Discrimination Against Women in 1997 and with adoption to this, the government has approved national strategic plan to improve gender equality in the areas of poverty reduction, education, health care, decision making and promotion of the welfare. Even though, Social Institutions and Gender Index (SIGI) score is high with 42% which include a composite score of a country's position across four sub-indices: Discrimination in the family, Restricted physical integrity, Restricted access to productive and financial resources and Restricted civil liberties.<sup>4</sup> In addition, traditional patriarchal values are enforcing gender stereotypes that contribute to the gender inequality in labor market and restraining women's participation in decision making in every level starting from household level to society at-large. These social and cultural norms promote childbearing, discourage family planning and defined women's role as reproductive role and subordinate, while men are the principal decision maker and head of household. The social and cultural norms prohibit women's opportunities for a healthy life and women are unable to decide for themselves concerning their own bodies which is a threat to maternal and child health.<sup>5</sup> Likewise, these norms limit women's access to sexual and reproductive health services.



**Figure 1.** Conceptual framework

Regarding to theoretical framework, this study applied Social Dominance Theory (SDT) to explain IHGD that might affect unmet need for family planning. SDT mainly emphasizes power within hierarchical societies that are based on social categories (e.g. race, religion, gendered, class, sexuality). SDT explains the importance of institutional inequality and individual discrimination to understand group-based gendered power and its consequences. This theory has been used in many different populations. For example, SDT was applied to understand women’s risk for HIV infection in 2010.<sup>6</sup>

In 2012, Bradley et al revised the definition of unmet need for family planning using data provided by the series of Demographic Health Surveys that had been conducted since 1990.<sup>7</sup> In terms of concept of unmet need for family planning, unmet need for family planning means that MWRA who are fecund and want to postpone childbirth by at least a couple of years or want no more children do not use contraceptive methods, including both modern and traditional methods. Unmet need for family planning can be categorized into two groups which are unmet need for limiting and unmet need for spacing. If a woman did not desire the current pregnancy or an amenorrheic woman did not desire the last child, or if a non-pregnant/non-amenorrheic woman wants no more children, and these women are not using contraception, they are considered as having unmet need for limiting. If a woman says her current pregnancy was mistimed, or an amenorrheic woman said her last child was mistimed, or if a non-pregnant/nonamenorrheic woman wants to space her next birth, and these women are not using contraception, they are considered as having unmet need for spacing.

Based on theory and concept, review of previous studies in Myanmar and other countries, decision making on women’s health, decision making on large household purchases, decision making on visiting to family or relative and women’s attitude towards wife beating were

defined as IHGD factors<sup>8–14</sup> and socio-economic factors which are age of women, place of residence, education level and wealth quintiles are used as explanatory variables which might effect on unmet need for family planning<sup>15–31</sup> (Figure 1). Based on the contexts of Myanmar which is high unmet need for family planning, high SIGI score and review of previous studied, this study was conducted to examine the roles of IHGD in unmet need for family planning across Myanmar. In addition, there were no previous findings from previous this studies that can be utilized by policy makers to consider new policies and strategies for the family planning program to meet the needs of women for family planning in Myanmar.

## Methods

This study used 2015–2016 MDHS which already permitted by Demographic and Health Survey. The 2015–2016 MDHS is the nationwide survey and the sample in this survey represents the characteristics of general population of the entire country. The study was carried out in accordance with the ethical standards of the Helsinki Declaration. The sample size of this study is 7652 since this study emphasizes MWRA in Myanmar. In this study, Binary logistic regression analysis with Enter Statistical Method, Odds Ratios (OR) and 95% confident interval (CI) was applied to examine the roles of IHGD in unmet need for family planning after controlling the effect of socio-economic factors in unmet need for family planning. Data analysis was done by SPSS 22. The dependent variable was simply operationalized as “no unmet need” and “unmet need” for family planning among MWRA in Myanmar and it was operationalized into two groups as 0 = No, 1= Yes. The term unmet need for family planning refers to married women in reproductive age who are fecund and those women who want to postpone childbirth at least couple years or want no more children without using any contraceptive method.<sup>15</sup> The unmet need for family

planning of this study was already calculated in DHS data set based on revised definition of unmet need for family planning in currently married women.

Gender dominance in decision on women's health, large household purchase, visiting to family or relative by using question "Who usually makes decisions about health care for yourself? Who usually makes decisions about large household purchases? Who usually makes decisions about visits to your family or relatives?". The responses were recoded as 0 = no dominance (making joint decisions by wife and husband), 1 = dominance (making decisions by the wife or husband alone or by someone else).

Women's attitude towards wife beating was measured by asking the following standard five scenario questionnaires of women: "In your opinion, is a husband justified in hitting or beating his wife in the following situation: (1) if she goes out without telling him; (2) if she neglects the children; (3) if she argues with him; (4) if she refuses to have sex with him; (5) if she burns the food".

The responses were 0 = No; 1 = Yes, for each situation. In this study, the respondent's answers were summed to create an index and total score ranging is from 0 to 5 and operationalized in two groups which is score 1 to 5 as 1 which means agree on at least one situation in giving situation and score 0 is disagree on wife beating on any of given situation.

Age of women refers to completed women's age and was calculated by using the question, "How old were you at your last birthday?" Age was recoded into four categories as 0 = < 25, 1 = 25–29, 2 = 30–34, and 3 = 35 years or over. Place of residence means urban or rural area where women currently live. It was coded as 0 = urban and 1 = rural. Women's education level means the highest level of education completed by women. Education level was categorized into three categories: no education, primary, and secondary or higher and coded as 0 = no education, 1 = primary, 2 = secondary or higher. Wealth quintiles are five sub-groups of the population ranging from one (poorest) to five (richest). In this study, quintile one and two is defined as poor and coded as 0 and quintile three is defined as middle and coded as 1 and quintile four and five is defined as rich and coded as 2.

This study used the 2015–2016 Myanmar Demographic and Health Survey Data which is already permitted by the Demographic and Health Survey website ([www.dhsprogram.com](http://www.dhsprogram.com)). The dataset can be accessed by registration and providing information on the study. Since, this study used secondary data, there was limitation on data analysis. There were no direct questions on ethnicity, religion, quality of family

planning services, detailed distance to a health facility, and cost of family planning services, spousal communication, and income level of women. The question on the decision to use family planning can be a measurement of gender dominance but was not included in this study because this question did not cover all study sample. Thus, the findings of this study only give a partial picture on related factors of unmet need for family planning. There may be many factors related to unmet need for family planning. However, for this study only some potential predictors are analyzed.

## Results

The total of 7652 MWRA included in this study. Among of them, 16% of MWRA had unmet need for family planning. In terms of gender dominance in household decision making and women's attitude on using physical force by husband, gender dominance in household decision making occurs in around half of MWRA and 43.7% of MWRA agree with using violence by husband, as shown in Table 1. In terms of socio-economic characteristics, the majority of MWRA stay in rural area (73.9%) and completed primary education (47%). One fifth of MWRA are from rich wealth quintiles.

Table 2 indicates the association between IHGD factors and unmet need for family planning after controlling socio-economic factors. Results of binary logistic regression analysis depict that women who reported that there is gender dominance in decision for women's health are 1.16 times more likely to have unmet need for family planning compared to their counterpart (CI=1.01–1.35,  $p < 0.05$ ). In addition, women who agree on wife beating are 1.16 times more likely have unmet need for family planning compared to women who disagree on wife beating in any of given situation (CI= 1.02–1.32,  $p < 0.05$ ). Further, rural women are 1.20 times more likely to have unmet need compared to urban women (CI=1.01–1.43,  $p < 0.05$ ). Moreover, women who completed primary, secondary, and higher education are 40–50% less likely to have unmet need compared to those who have no education level (CI=0.53–0.74,  $p < 0.05$ , CI=0.41–0.60,  $p < 0.05$ ).

## Discussion

This study reveals that IHGD factors which are decision on women's health and women's attitude towards wife beating are significantly associated with unmet need. Based on the key finding of this study, women who reported that there is gender dominance in decision for women's health and those who agree with husband's beating were more likely to have unmet need after controlling other variables which are socio-economic factors.

The finding of current study is consistent with previous studies.<sup>8-14</sup> Some researchers also revealed that contraceptive practicing was higher among women who reported that they can make decisions alone or can make a joint decision with their husband than women who did not participate in household decisions.<sup>8</sup> Other researchers also suggested that couples' joint decision making means no dominance in household and it decision making brings better reproductive health outcomes compared to men making decisions alone or women making decisions alone, i.e., gender dominance in the household.<sup>13</sup> Moreover, most of the studies found that women who had experienced intimate partner violence are less likely to use contraception and more likely to have unmet need compared to women who did not have experienced with intimate partner violence.<sup>12</sup> According to contexts of Myanmar, social and cultural norms look at the women's role is reproductive and encourage childbearing and prohibit contraceptive practicing. In Myanmar, husband is the principal decision maker, and women must conform and follow their husband's decision. In addition, society justifies men's violence to women who do not conform the cultural and social norms and society also marginalize and discriminate women who failure to conform to gender norms. Furthermore, social and cultural norms prohibit women's opportunities for a healthy life and women are unable to decide concerning their own bodies and that creates the reduction of maternal and child health concern including family planning.<sup>5</sup>

**Table 1.** Percentage distribution of background characteristics among MWRA in Myanmar, 2015–2016 (N = 7,652)

Variables	N (%)
Dependent variable	
Unmet need for family planning	1,231 (16.0)
No unmet need for family planning	6,421 (84.0)
Independent variable	
Place of residence	
Urban	2,000 (26.1)
Rural	5,652 (73.9)
Women's education level	
No education	1,168 (15.3)
Primary	3,600 (47.0)
Secondary and higher	2,884 (37.7)
Wealth quintiles	
Poor	3,061 (40.0)
Middle	1,530 (20.0)
Rich	3,061 (40.0)
Decision on women own health	
No dominance	3,314 (43.3)
Dominance	4,338 (56.7)
Decision of large household purchases	
No dominance	4,275 (55.9)
Dominance	3,377 (44.1)
Decision on visiting to family or relative	
No dominance	3,903 (51.0)
Dominance	3,749 (49.0)
Women's attitude towards wife beating	
Disagree	4,305 (56.3)
Agree	3,348 (43.7)

**Table 2.** Binary logistic regression of IHGD factors, socio-economic factors and unmet need for family planning among MWRA in Myanmar

Variables	OR	95% CI (Lower-Upper)	p
IHGD factors			
Decision on women own health			
No dominance	Reference	1.01–1.35	<0.05
Dominance	1.16		
Decision of large household purchases			
No dominance	Reference	0.94–1.28	>0.05
Dominance	1.10		
Decision on visiting to family or relative			
No dominance	Reference	0.98–1.33	>0.05
Dominance	1.14		
Women's attitude towards wife beating			
Disagree	Reference	1.02–1.32	>0.05
Agree	1.16		
Place of residence			
Urban	Reference	1.01–1.43	<0.05
Rural	1.20		
Women's education level			
No education	Reference		
Primary	0.63	0.53–0.74	<0.05
Secondary and higher	0.49	0.41–0.60	<0.05
Wealth quintiles			
Poor	Reference		
Middle	0.98	0.83–1.16	>0.05
Rich	0.93	0.79–1.09	>0.05
Constant	0.21		

Abbreviations: IHGD = Intra-Household Gendered Dominance, OR = Odds Ratio, CI = Confident Interval.

**Table 3.** Percent distribution of socio-economic factors to IHGD factors

Socio-economic Factors	Decision on women own health (%)		Decision on large household purchase (%)		Decision on visiting to family or relative (%)		Women's attitude towards wife beating (%)	
	Dominance		Dominance		Dominance		Agree	
	Yes	No	Yes	No	Yes	No	Yes	No
Place of residence								
Urban	11.9	88.1	23.6	76.4	10.8	89.2	47.9	52.2
Rural	18.2	81.8	26.3	73.7	12.8	87.2	59.2	40.8
Women's education level								
No education	18.8	81.2	26.5	73.5	13.3	86.7	64.8	35.2
Primary education	17.4	82.6	25.2	74.8	12.2	87.8	58.2	41.8
Secondary and higher	14.6	85.4	25.7	74.3	12.0	88.0	50.4	49.6
Wealth quintiles								
Poor	20.0	80.0	25.6	74.4	14.6	85.4	58.4	41.6
Middle	15.8	84.2	27.0	73.0	11.8	88.2	60.3	39.7
Rich	13.5	86.5	24.9	75.1	10.2	89.8	52.0	48.0

This gender dominance in household setting reflects less autonomy of women which might effect on couple communication and decision making for contraceptive use as well. Thus, as the negative impact of social and cultural norms, IHGD factors are the associated factors of unmet need for family planning in Myanmar. This finding highlights that gender inequality has negative impact on sexual and reproductive health including contraceptive practicing and unmet need for family planning. Thus, addressing the gender inequality is very important to overcome unmet need for family planning which can lead to unintended pregnancy and unsafe abortion which threaten the life of women.

As another key findings, socio-economic factors which are place of residence and women's education level are significantly associated with unmet need for family planning as well. These findings are consistent with previous studies.<sup>14,21-24</sup> The possible explanation for these findings are that generally, literacy rate is different by urban and rural area. According to 2014 national census, literacy rate is higher in urban women compared to rural women. Thus, rural women have lower education level and lower knowledge about family planning than urban women. As consequences, unmet need is high rural women compared to urban women. Moreover, educated women have more power to access health facilities and information about modern contraceptive methods than uneducated women, and educated women more practice contraception while uneducated women want many children.

This study also found that high gender dominance in household decision making and women's greater agreement on using physical force by her husband occur in women with poor socio-economic status more than better-off women. According to this finding, socio-economic status might be the external factor that affects both unmet need for family planning and IHGD.

The educated women might overcome gender dominance in household setting which related with unmet need for family planning. This finding highlights that empowering in women's education is an important way to decrease unmet need for family planning. Moreover, empowering women's education contribute to improve socio-economic status and support to overcome gender dominance which influences on unmet need.

## Conclusion

To be concluded, IHGD which is decision on women's health and women's attitude on wife beating have significant impact on unmet need for family planning. Thus, the government of Myanmar should address dominance of social and cultural gender norms by providing gender equality awareness campaigns and should enhance women's right and sexual and reproductive health and right to society. In addition, family planning program should be implemented together with gender integration to overcome gender barriers. Moreover, place of residence and women's education determine unmet need for family planning as well. Thus, family planning program should target to rural and uneducated women and should empower women in education which has significant impact on unmet need for family planning by providing compulsory free education.

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