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Spousal Participation in the Familial Decision Making: A Gender Sensitive Study in North East India

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Abstract:

In this paper the gender disparity in familial decision making between husbands and wives has been analyzed across the eight north eastern states in India. The study primarily focused on the construction of rural-urban gender inequality ratio and investigating the extent and variation in the familial decision-making participation as per the employment status of women. The analytical methodology of the study is basically descriptive in nature comprising t:Test and ANOVA. Based on the National Family Health Survey (NFHS)- 5 data, it has been found that, women residing in both rural and urban area are most neglected and remain non participant in the familial decision making at per with men in the states of Assam, Manipur, Meghalaya, Tripura, Arunachal Pradesh and Sikkim. However, women possess the familial decision making autonomy in the states of Mizoram and Nagaland. Further, it has been found that, familial decision making participation is more among employed women and less among unemployed women with statistically significant variation observed therein. Suggestions are forwarded on the basis of findings of the study.

Keywords: Familial Decision Making, Health Care, Outside Mobility, Employment Status

1. Introduction

Women are born with equal rights as men but people make this difference and discriminations on the ground of gender. God has not made anyone superior and inferior on basis of gender but females are always the second priority for every task in many less developed countries. From birth to death women face many discriminations and atrocities. Women do not have rights to decide their own educational field, career, life-partner etc. (Russell, 2017).One of the aspects of women empowerment is decision-making in family. Women participate in family decision economically, socially and culturally. The role of women has been changed over time due to egalitarian family structure though (Kiani, 2012).Women's autonomy refers to their ability and freedom to make decisions and act autonomously, including their ability to explain strategic choices, and access to and control over resources. It is the control women

have over their own lives and the extent to which a woman has an equal voice with her husband in all matters affecting themselves and their families, control over resources, access to information, authority to take independent decisions and freedom of mobility. (Osamor & Grady, 2016; Adhikari, 2016).Women plays an important role in household activities. It is often claimed that her contribution is undermined and that decision-making power is very limited (Saikia, 2021). But the majority of women have not yet given due importance to decision-making around agricultural and household activities (Baba et al. 2015). Most decisions are made by the male head of the family. Women do not enjoy high degree of autonomy in making decisions or giving suggestions in the family in spite of having significant contribution to economic activities (Balian, 2014). In patriarchal settings, men are the sole decision-makers and wives are considered subordinates, supporter of men's decision and at the extreme end women are considered as male properties (Dingeta et al., 2019). Women are found to involve less in decision-making where male members of family usually make decisions about family matters. Women are frequently ignored and not even discussed (Rashid & Islam, 2011). Women's autonomy to achieve their choices, which includes a larger preference for preserving their health, is linked to their decision-making autonomy and the use of maternal health services (Allendorf, 2016). They grow under the fear of society and family which abolish their confidence and keep them away from decision-making. Talking about personal empowerment, many times women do not have rights to decide what to wear, where to go, where to study, where to work (Davis LM et al. 2014). Inclusion of wives and husbands in decision-making may have better reproductive health outcomes than men who make decisions alone, which could be owing to the fact that joint decision-making allows the husband and wife to share responsibility for the decision. In Bangladesh, it is very crucial to understand the decision-making process as a negotiation between husbandsand wives. When it comes to his wife's healthcare, the husband is frequently involved especially when it requires her to leave the house. This is ostensibly owing to Bangladeshi women's limited mobility as well as educational and economic prospects (Story & Burgard, 2012). Various studies have shown that women's flexibility in decision making in healthcare is crucial to better outcomes in maternal and child health (Adhikari, 2016, Seidu et al., 2021 & Mistry et al. 2009). Married women's contribution to their healthcare, movement in terms of visits to family and friends, and capability of negotiating with their partners for safer sex or otherwise are key determinants of their autonomy (Ung et al., 2014).Researchers have demonstrated that women's decision-making related to their own healthcare strengthens their healthcare-seeking behaviour, which implies that women's decision-makingand healthcare-seeking behavior

should be recognized as a cultural norm and prioritized as a component of the health system's design (Mainuddin et al., 2015). The ability of a woman to make decisions that influence her own personal circumstances is an important facet of empowerment and an important contributing element to her general well-being it has been found that, women participated in several types of household decisions—including the use of the woman's and spouse's incomes, major household purchases, food purchases, food preparation, their own healthcare, children's healthcare and visiting their family or relatives (Jennings et al. 2014).Women's participation in economic and non-economic decisions at the family level is a critical issue that holds great importance in both high-income and low-income and middle-income countries. However, even at the household level, women's non-participation or inability to make decisions is a public health and social concern (Roy et al. 2017).In rural China indicate that wives have a lower status compared with husbands in terms of household decision making (Hare, 1999; Y. Li, 2000; Mac Phail & Dong, 2007).Joint decision making on major family affairs is becoming increasingly common among married couples(Carlsson et al., 2012).Bargaining theory allows differentials between spouses to affect household decision making and claims that the allocation of household resources depends on the relative bargaining power of each household member (Flinn et al., 2018). The literature suggests that many factors which affect a woman's ability to make their own decisions, including better socioeconomic status, higher education level, older aged women, female household head, degree of household food security status and not experiencingdomestic violence (Acharya et al. 2010, Senarath et al. 2009, Hou & Ma, 2013 & Galie A et al. 2019).Women's autonomy is important in their own right and is crucially linked to women's health and health-related Issue (Green et al., 2019).Evidence suggests that increasing the access of economic resources alone is insufficient but requires increased women's decision-making and control of household resources is also highly required. In order to practice good health-seeking behaviors, women's ability to participate in decision-making over certain important matters such as major household purchases or personalhealth care is essential (Peterman et al., 2021; Seymour & Peterma, 2018).Policymakers and researchers have called for an emphasis on improving women's decision-making power to improve women's health and health seeking behaviors in developing countries (Dancer & Rammohan, 2009).Studies in South Asia and sub-Saharan African countries indicated that women's decision-making autonomy has been linked to many positive outcomes such as reductions in infant mortality, better child and women nutritional outcomes, and increased use of health care services (Woldemicael & Tenkorang, 2010; Singh et al., 2013).Some studies indicated that the decision-making capabilities of women in a

society might have also an effect on their health and health-related behavior, more than the effect of individual women's autonomy for two major reasons. The first reason is that the presence of high numbers of a greater proportion of empowered women in a community could contribute to the information distribution related to better health outcomes to those with lower autonomous levels through formal and informal social networks. The other reason is that communities with a higher proportion of autonomous women might be economically advantaged because more women are employed (working outside of the home). This will empower them to make better investments in the health sector creating an opportunity for less autonomous women more access to health information and services for themselves and their families (Ebot, 2014; Tiruneh et al. 2017; Kravdal, 2004).

Several studies attempted to analyse and investigate the women's status and position in connection with the household decision making ability but few studies directly focused on the issue from the gender disparity perspective in the context of north eastern region of India. To primarily address this research gap, the present study has been undertaken in the context of north eastern states of India to analyze the disparity in familial decision making participation between husbands and wives.

1.1 Objectives of the Study

1. To understand the recent status of spousal participation in familial decision making across the rural and urban residence in north eastern states in India.
2. To construct the Gender Inequality Ratio (GIR) of spousal participation in selected familial decision making area across the rural and urban residences of north eastern states.
3. To investigate the extent and variation in women's participation in familial decision making in terms of their employment status across north eastern states.

2. Sources of Data and Methodology

2.1 Data sources:

The present study is purely based on the secondary sources of data derived from the National family Health Survey (NFHS)-5 reports of 2019-21 published by the International Institute for Population Sciences, Govandi Station Road, Deonar, Mumbai-400088 under the Ministry of Health and Family Welfare (MoHFW), Government of India.

2.1.1 Target Group:

The target group in the present study comprises of currently married men and women in the age group of 15 to 49 years of age who have participated alone or jointly with their spousein

the familial decision making across three important area- decision about own health care, major household purchase and outside mobility of women.

2.1.2 Methodology:

The methodology of the study is basically descriptive in nature. Data has been analyzed with the help of tabular and diagrammatic presentation to meet the objectives of the study. Moreover, the variation in the women's participation in familial decision making has been examined with the help of t:Test. Following Sing, P.K (2013), the Gender Inequality Ratio (GIR) has been calculated as a ratio of husband's participation to wives participation in familial decision making as-

$$\text{GIR} = \frac{\text{Percentage of husbands partcipated in familial decsion making}}{\text{Percentage of wives partcipated in familial decsion making}} \text{ X } 100$$

GIR value of 100 in the above inequality ratio would imply that there was no gender differential in participation of husbands and wives in the familial decision making. However, a value above 100 would indicate gender disparity against wives and a value below 100 would indicate gender disparity against husbands in the said participation context.

3. Data Analysis and Discussion

Recent Status of Spousal Familial Decision Making acrossRural -UrbanResidences in North Eastern Region

The decision taken alone by husbands and wives in the two selected area of familial participation- own health care and major household purchase in the context of both rural and urban residences across the eight north eastern states are presented in the figures 1 and 2.

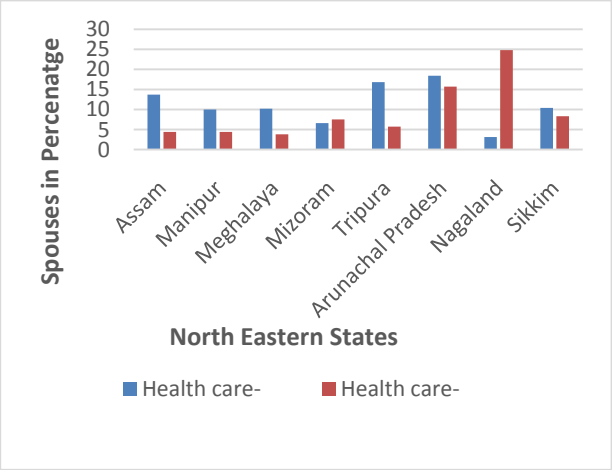

Figure 1(A): Spousal decision in own health care- Rural

Source: Compiled from NFHS-5 report

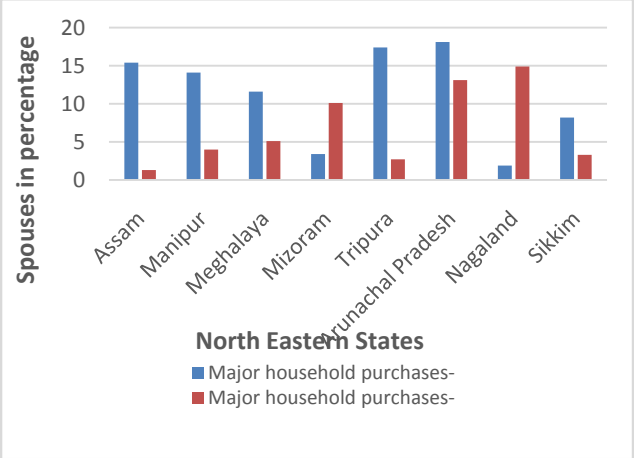

Figure 1(B): Spousal decision in major household purchase-Rural

Source: Compiled from NFHS-5 report

Figure 1 (A) and (B) clearly reflects the relative status of husbands and wives in deciding alone about their own health care and major household purchase across the north eastern states. It is seen that, in the rural area of Nagaland and Mizoram, wives are in the dominant position while deciding alone about their own health care and major household purchase compared to their husbands. In rest of the six states husbandsare dominant while deciding about their own health care. The high level of disparity in the spousal decision about own health care is found to be in the states of Tripura and Nagaland while the disparity in deciding alone about major household purchase is found to be high in the states of Assam, Manipur, Tripura and Nagaland. A close look at both the table reveals that, in the rural area of Nagaland and Mizoram the wives are in the prestigious position while deciding alone about the two area of familial decision.

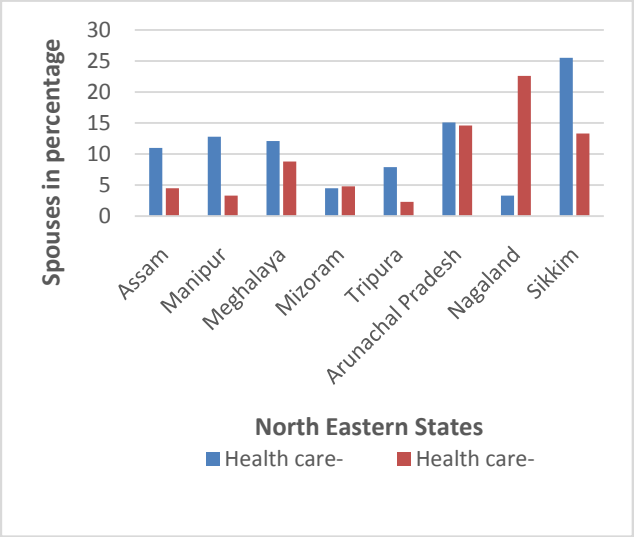

Figure 2(A): Spousal decision in own health care- Urban

Source: Compiled from NFHS-5 report

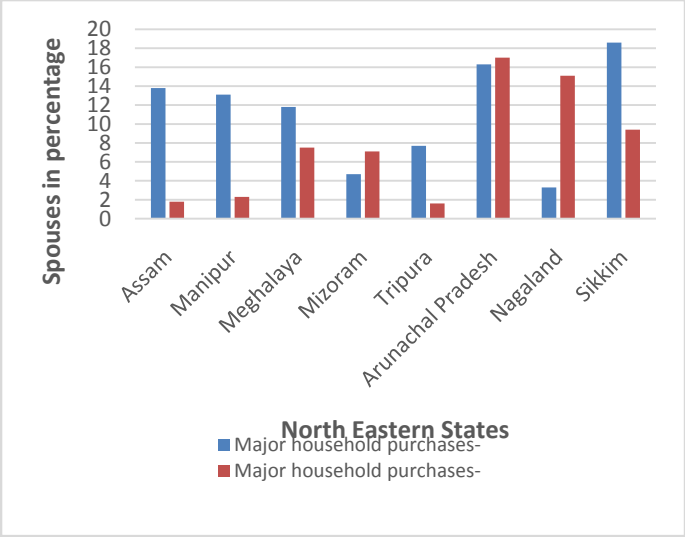

Figure 2(B): Spousal decision in major household purchase-Urban

Source: Compiled from NFHS-5 report

Figure 2 (A) and (B) reveals that, in the urban context among the north eastern states, wives are in the advantageous position while deciding alone about their own health care and major household purchase in the states of Mizoram, Nagaland and Arunachal Pradesh. In rest of the states, husbands occupies the dominant position in deciding about the said issues suppressing their wives. It is further evident from the figures that, the states like Nagaland, Sikkim, Assam, Manipur, Nagaland and Sikkim are reflecting high level of gender disparity in the spousal familial decision.

3.1 Gender Inequality of Spousal Participation in Familial Decision Making across the Rural and Urban Residences of North Eastern States.

Table 1:Gender Inequality Ratio (GIR) of Spousal Participation in Familial Decision Making-Rural

States	Health Care			Major Household Purchases		
	Husband's decide alone	Wives decide alone	GIR	Husband's decide alone	Wives decide alone	GIR
Assam	13.7	4.4	311.36	15.4	1.3	1184.62
Manipur	10	4.4	227.27	14.1	4	352.5
Meghalaya	10.2	3.8	268.42	11.6	5.1	227.45
Mizoram	6.6	7.5	88	3.4	10.1	33.66
Tripura	16.8	5.7	294.74	17.4	2.7	644.44
Arunachal Pradesh	18.4	15.7	117.2	18.1	13.1	138.17
Nagaland	3.1	24.8	12.5	1.9	14.9	12.75
Sikkim	10.4	8.3	125.3	8.2	3.3	248.48

Source: Author's calculation based on NFHS-5 report

GIR: Gender Inequality Ratio

Table 1 depicts the Gender Inequality Ratio to understand the extent of the gender disparity in spousal familial decision across the rural residences of north eastern states in India. It is seen that, the GIR is above 100 in all the states except Mizoram and Nagaland. This implies the gender disparity against wives exist in these six states while the said disparity is in favour of wives has been found in the states of Mizoram and Nagaland. GIR above 100 indicates that decision making ability of husbands are more compared to their husbands while GIR below 100 indicate the vice versa.The highest degree of gender disparity in own health care and major household purchasing decision has been found in Assam which implies the worst position of wives in decision about the area mentioned. It is quite interesting to note that, the GIR ratio is below 100 in the rural area of the states of Mizoram and Nagaland signifying the

fact that, wives dominate their husbands in deciding alone about their own health care and major household purchase.

Table 2:Gender Inequality Ratio (GIR) of Spousal Participation in Familial Decision Making- Urban

States	Health Care			Major Household Purchases		
	Husband's decide alone	Wives decide alone	GIR	Husband's decide alone	Wives decide alone	GIR
Assam	11	4.5	244.44	13.8	1.8	766.67
Manipur	12.8	3.3	387.88	13.1	2.3	569.57
Meghalaya	12.1	8.8	137.5	11.8	7.5	157.33
Mizoram	4.5	4.8	93.75	4.7	7.1	66.20
Tripura	7.9	2.3	343.48	7.7	1.6	481.25
Arunachal Pradesh	15.1	14.6	103.42	16.3	17	95.88
Nagaland	3.3	22.6	14.60	3.3	15.1	21.85
Sikkim	25.5	13.3	191.73	18.6	9.4	197.87

Source: Author's calculation based on NFHS-5 report

GIR: Gender Inequality Ratio

Table 2 reveals the extent of gender disparity in spousal decision in terms of GIR in urban residences across north eastern states in India. It is seen that, in the context of own health care decision and major household purchase, GIR is above 100 in all the states except Mizoram, Nagaland and Arunachal Pradesh. This implies the gender disparity against married women in deciding of their own health care prevails in the states of Assam, Manipur, Meghalaya, Tripura, Arunachal Pradesh and Sikkim and the said disparity prevails against married men in the states of Mizoram and Nagaland. In the same perspective of GIR, it is interesting note that gender disparity against married women while deciding of major household purchase is not observed in Arunachal Pradesh. Regarding the decision of household purchase, gender disparity still prevails against women in the 5 states and against men in 3 states. GIR is highest in Manipur and Assam while the spousal decision about own health care and major

household purchase respectively are considered. This further implies that, women are the worst sufferer in Manipur in taking decision alone about their health care and they are also the worst sufferer in Assam in taking decision alone about the major household purchase.

3.1.1 Extent and Variation in Familial Decision of Women as per Employment Status

Table 3: Extent and Variation in Women's employment status and Familial Decision Making in North East India

Participation area	Women's employment status	Mean	SD	t Value
Own Health Care	Employed for cash	90.68	3.97	2.20
	Unemployed	86.03	6.82	
Major Household Purchase	Employed for cash	91.16	4.90	2.16***
	Unemployed	85.24	6.94	
Outside Mobility	Employed for cash	92.46	3.32	2.23***
	Unemployed	87.49	6.41	

Source: Author's calculation based on NFHS-5 report

SD: Standard Deviation; *** Significant at 10% level (P<0.10)

Table 3 reveals the extent of employed and unemployed women's decision making ability alone or jointly with their husbands and the resultant variation across three specified participation area- own health care, major household purchase and their outside mobility. The term outside mobility can be defined as the ability of women to visit her family members and relatives without any objection from her husband. It is seen that, almost 91 to 92 percent married women who are employed and earn cash are found to take self-decision or jointly with husbands about their health care, household purchase and outside mobility. On the other hand, the participation of unemployed women in these area ranges from 85 to 87 percent. It is to be noted that, ability to take familial decision is more among employed women compared to the unemployed women across the north eastern states. Further, the decision making ability of women is not prevalent uniformly rather it varies as evident from the standard deviation value. Highest and lowest variation in women's decision making ability is observed in major household purchase in the category of unemployed women and outside mobility in the category of employed women. Statistically significant variation has been found in between employed and unemployed women while they take decision alone or jointly with husbands in the area of their own health and outside mobility. The mean value are the indicators of

average percentage of women's decision making ability while the degree of non-uniformity in the said decision is indicated by the standard deviation value.

4. Conclusion and Suggestions

Gender disparity in spousal decision making in the family is still wide spared across the north eastern states. In this study it has been found that, tribal married women enjoys more autonomy in familial decision making regarding their own heath care, household purchase and in case of their outside mobility. In the tribal states of Mizoram and Nagaland, gender disparity against married men is observed while they take familial decision in the said participation area. It has been found that, decision making ability of married women in the three area of participation is high among the employed women who earn cash while the decision making ability is low while they are unemployed. This implies that, employment status of married women is a boosting factor behind the ability to take familial decision. In the context of spousal familial decision, the scenario of rural and urban area across the north eastern states are almost similar except favouring women in urban segment of Arunachal Pradesh. The present study is a primary attempt to analyze the gender aspects of familial decision making in the context of rural and urban area in north east India and it is too early to suggest policies. However, based on the crucial findings it is suggested that, women must be given opportunity to take part in familial decision which not only make them empowered for themselves rather to boost up the economic conditions of the family as well. Government must take steps to provide employment opportunities in non-tribal states in north eastern region of India.

5. Limitation and Future Scope

The study is basically an analytical one exploring the basic issue of the extent of gender disparity and its variation in the major familial decision across the north eastern states. It has the limited coverage as only the north eastern states are considered. Future research in this area invites scholars to take up the issue of finding out the reason behind the backwardness in women's familial decision making ability both in the regional and national context.

References

1. Acharya DR., JS. Bell, P. Simkhada et al., 2010:"Women's autonomy in household decision-making: a demographic study in Nepal",Reproductive Health, 7, 15-27.
2. Adhikari R., 2016: "Effect of Women's autonomy on maternal health service utilization in Nepal : A cross sectional study", BMC Womens Health, 2, 1–7.

3. Allendorf K., 2016:"The quality of family relationships and maternal health care use in India", HHS Public access, 41, 263–276.
4. Baba IB, RMD. Zain, H.U, Idris, A.N. Sanni, 2015): "The role of women in household decision making and their contribution to agriculture and rural development in Nigeria" IOSR Journal of Humanities and Social Science, 5(1), 30-39.
5. Balian K., 2014: "Factors affecting participation of woman in household decision making: Implication for family welfare and agriculture development", Socio- economic Voices, 8, 220-228.
6. Carlsson, F., H. He, P. Martinsson, P. Qin & M. Sutter, 2012:"Household decision making in rural China: Using experiments to estimate the influences of spouses",Journal of Economic Behavior & Organization, 84(2), 525–536.
7. Dancer, D., A. Rammohan, 2009: "Maternal autonomy and child nutrition", Indian Growth Development Review, 2(1), 1753–8254.
8. Davis LM et al. , 2014: "Women's empowerment and its differential impact on health in low-income communities in Mumbai, India", Global Public Health, 9(5), 481–494.
9. Dingeta, T., L. Oljira, A. Worku & Y. Berhane, 2019: "Unmet Need for Contraception among YoungMarried Women in Eastern Ethiopia", Open Access Journal of Contraception, 10, 89–101.
10. Ebot JO., 2014: "Place matters community level effects of women's autonomy on Ethiopian children's immunization status" African Population Studies, 28(2), 1202-1215. https://doi.org/10.11564/28-0-568.
11. Flinn, C. J., P. E. Todd & W. Zhang, 2018:"Personality traits, intra-household allocation and the gender wage gap" EuropeanEconomic Review, 109, 191–220.
12. Galie, A., N. Teufel , AW. Girard et al., 2020:"Women's empowerment, food security and nutrition of pastoral communities in Tanzania"Global FoodSecurity, 23, 125–134.
13. Green, SH., C. Wang, SS, Ballakrishnen, H. Brueckner, P. Bearman, 2019:"Patterned remittances enhance women's health-related autonomy" SSM Population Health, 9, 1003-1012.https://doi.org/10.1016/j.ssmph.2019.100370
14. Hare, D., 1999: "Women's economic status in rural China: Household contributions to male–female disparities in the wage–labor market"World Development, 27(6), 1011–1029.
15. Hou, X., N. Ma, 2013:"The effect of women's decision-making power on maternal health services uptake: evidence from Pakistan"HealthPolicy Plan, 28, 176–184.

16. Jennings, L., M. Na, M. Cherewick et al., 2014:"Women's empowerment and male involvement in antenatal care: analyses of demographic and health surveys (DHS) in selected African countries"BMC PregnancyChild birth, 14, 297-315.
17. Kiani, M., 2012: "How Much Are Women Involved in Decision Making in Family in Iran" Sociology Study, 2(6), 417-427.
18. Kravdal, O., 2004: "Child mortality in India: the community-level effect of education" Population Studies, 58(2), 177–92. https://doi.org/10.1080/0032472042000213721
19. Li, Y., 2000:"Women's movement and change of women's status in China"Journal of International Women's Studies, 1(1), 30–40.
20. Mainuddin, A., Ara Begum H, LB, Rawal et al., 2015:"Women empowerment and its relation with health seeking behavior in Bangladesh"Journal of FamilyReproduction Health, 9, 65-75.
21. Mistry, R., O, M. L. Galal, 2009: "Women's autonomy and pregnancy care in rural India: a contextual analysis" Social Science Medicine, 69, 926–933.
22. Mac Phail, F., & X. Y. Dong, 2007, "Women's market work and household status in rural China: Evidence from Jiangsu and Shandong in the late 1990s"Feminist Economics, 13(3–4), 93–124.
23. Osamor, PE., C. Grady, 2016:"Women's autonomy in health care decision-making in developing countries: a synthesis of the literature"International Journal of Womens Health, 8, 191-200.
24. Peterman, A., B. Schwab, S. Roy, M. Hidrobo, DO, Gilligan, 2021: "Measuring Women's Decision making: indicator choice and survey design experiments from cash and food transfer evaluations in Ecuador, Uganda, and Yemen" World Development, 141, 105-115. https://doi.org/10.1016/j.worlddev.2020.105387
25. Rashid, MU, MM, Islam, 2011: "Women's participation in family decision making in Dumki Upazila of Patuakhali district" Agriculturists, 9, 137-142.
26. Roy PK, S. Haque, A. Jannat et al., 2017: "Contribution of women to household income and decision making in some selected areas of Mymensingh in Bangladesh"Progressive Agriculture, 28, 120-.129.
27. Russell, Kabir et al., 2017: "Exploring the decision making power of Bangladeshi women of reproductive age: results from a national survey" South East Asia Journal of Medical Sciences, 5(6), 287-300.

28. Saikia P., 2021: "Decision making pattern of farm women in different farm and non-farm activities" Asian Journal of Agricultural Extension, Economics and Sociology, 39(12), 13-18.
29. Seidu A-A, RG. Aboagye , J. Okyere et al., 2021: "Women's autonomy in household decision-makingand safer sex negotiation in sub-Saharan Africa: An analysis of data from 27 Demographic and Health Surveys"SSM - Population Health, 14, 100-117.
30. Senarath U., NS. Gunawardena, 2009: "Women's autonomy in decision making for health care in South Asia"Asia Pacific Journal of Public Health, 21, 137–143.
31. Seymour, G., A. Peterman, 2018: "Context and measurement: an analysis of the relationship between intrahousehold decision making and autonomy" World Development, 111, 97–112. https://doi.org/10.1016/j.worlddev.2018.06.027
32. Singh, K., E. Haney, C. Olorunsaiye, 2013: "Maternal autonomy and attitudes towards gender norms: associations with childhood immunization in Nigeria" Maternal Child Health Journal, 17(5), 837–41. https://doi.org/10.1007/s10995-012-1060-5
33. Singh, P.K., 2013: "Trends in Child Immunization across Geographical Regions in India: Focus on Urban-Rural and Gender Differentials" PLoS ONE 8(9), 86-95. doi:10.1371/journal.pone.0073102
34. Story WT., SA. Burgard , 2012: "Couples' reports of household decision-making and the utilization of maternal health services in Bangladesh"Social Science Medicine, 75, 2403–2411.
35. Tiruneh, FN., K-Y, Chuang, Y-C. Chuang, 2017: "Women's autonomy and maternal healthcare service utilization in Ethiopia"BMC Health Services Res, 17(1), 718-728. https://doi.org/10.1186/s12913-017-2670-9
36. Ung, M., G.O. Boateng, F. A. Armah, J.A. Amoyaw, I. Luginaah & V. Kuuire , 2014: "Negotiation for safer sex among married women in Cambodia: The role of women's autonomy"Journal of Biosocial Science, 46(1), 90–106.
37. Woldemicael. G, EY, Tenkorang , 2010: "Women's autonomy and maternal health seeking behavior in Ethiopia" Maternal Child Health Journal, 14(6), 988–98. https://doi.org/10.1007/s10995-009-0535-5

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