

Women's Autonomy in Decision Making in Rural Village in Assiut Governorate

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Abstract: Background Women's autonomy in decision making is the ability to obtain information and make decisions about one's own concerns. This study aims to study the extent of women's autonomy in decision making and how sociodemographic background influences it. **Methods** This cross sectional community based survey was carried out in BakourVillage, Aboteeg district, Assiut Governorate using systemic random sample to select 273 women taking every 5th house. **Results** In terms of household decision making autonomy, 76.3% and 82.4% of the women respectively were involved in decision making about daily purchases and child health care and 38.4% of the women make decisions about visits to family or relatives jointly with their husbands. Whereas, decisions about female circumcision and antenatal care use were present among 56% and 51% of the women respectively. Regarding family planning use, most decisions were taken by women jointly with husbands (52.4%). Women's increased education was significantly associated with autonomy in making some decisions such as family planning use and visits to family of relatives. Women working for cash were more likely to participate in the decision about making large purchases. Husband's occupation showed significant association with women's participation in some decisions such as visits to family or relatives, family planning use and having another child. **Conclusions** Women from rural areas need specific empowerment programme to enable them to be more autonomous in the decision making. Women's autonomy by education, employment needs a further social science investigation to observe the variations within each stratum. A more comprehensive strategy can enable women to access community resources, to challenge traditional norms and to access economic resources. This will lead the women to be more autonomous in decision making in the due course.

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Key words: Women's autonomy- Decision making- Sociodemographic variables.

1. Introduction

Autonomy is defined as the technical, social and psychological ability to obtain information and to use it as the basis for making decisions about one's private concerns and close relations [1]. The concept of women's autonomy, although related to women's status, is more closely associated with women's power and agency. An autonomous woman has the power to act for the benefit of her health and the health of loved ones [2]. Women's autonomy does not imply prestige or position within a social context. It is not necessarily accorded to women as women's status generally is, but reflects personal capacities. Measures of women's autonomy have included decision making autonomy, permission to go out and financial autonomy [3, 4]. Autonomy facilitates access to material resources such as food, land, income and other forms of wealth, and social resources such as knowledge, power, prestige within the family and community [5]. Women's autonomy in health-care decision-making is extremely important for better maternal and child health outcomes, and as an indicator of women's empowerment [6]. Gender-based power inequalities can restrict open communication between partners about reproductive health decisions as well as women's access to reproductive health services. This in turn can contribute to poor health outcomes [7]. Evidence from

other developing countries show that women's age and family structure are the strongest determinants of women's authority in decision making [8]. Older women and women in nuclear households are more likely than other women to participate in family decisions [9]. There is also a common assumption that education leads to autonomy as it helps women to stand up to their husbands and provides them a forum to learn about fertility control and make effective use of the health care system [10]. Egyptian DHS, 2008 inquires about women's participation in decision making regarding own health care, large household purchases, daily household purchases and visits to family or relatives. It showed that, with respect to all four types of decisions, the majority of currently married women reported that the decisions were either made jointly or by husband or someone else. Women were most likely to say they alone made decisions in the area of daily household purchases and 6% of women said they had no involvement in making any of the four types of decisions. Also, this survey revealed that the likelihood of a women being involved in household decision making generally increased with age of the women and with parity up to four children. Rural women, especially those living in Upper Egypt, and women from the frontier Governorates were generally less likely than other women to report that

they make decisions alone or jointly. Education and wealth were directly related to involvement in making the various household decisions. Women working for cash were also more likely than other women to report having a say in the various decisions [11].

Aim Of the Study

The present study aims at studying the extent of women's autonomy in decision making and the impact of socio-demographic background of women and their autonomy.

2. Subjects and Methods

Study area The field work was carried out in Bakour Village, Aboteeg District, Assiut Governorate. It lies 24 kilometers South to Assiut city. The total population according to the census 2006 was approximately 26226 individuals. The village consists of a mother village and two satellites. However, the field work was carried out in the main village. It is entirely a rural population for whom the main occupation was farming. The Bakour village was chosen because of its accessibility.

Study design Cross sectional community based survey.

Sample size Systemic random sample was done to select 273 women in the reproductive age (15-49 years) taking every 5th house.

Study population The target population was married women in the reproductive age who are inhabitants of Bakour village.

Instrument A semi-structured questionnaire was constructed for direct interviews.

The questionnaire asked about women's autonomy in decision making either household decision making or reproductive decision making. The household decision making include asking about daily purchases, large purchases, child health care and visits to family or friends while, reproductive decision making include asking about family planning use, whether to have more children or not, female circumcision and antenatal care use.

To assess women's autonomy in decision making, women were asked questions about who in the household had the final say in making these decisions: 1-women 2- women jointly with husband 3- husband 4- someone else. We grouped the first two responses (in which she has some power) and responses 3, 4 (in which she has no say in the decision). Socio-demographic data of the women was inquired about. The Socio-demographic data include women's age, women's education, women's occupation, husband's education and, husband's occupation.

Ethical considerations

Formal administrative approvals were taken before the start of the study. These approvals included those obtained from the Ethical and Technical Review

Committee of the study proposal and the Directorate of Health.

Informed consent was taken from the study participants and privacy and confidentiality of data were assured.

The women were assured that their responses would be confidential and voluntary. They were informed that they are free to decline from participation in the study at any time.

Data collection

Before starting final data collection, a pilot study was carried out on a sample of 20 participants (not included in the study) and the necessary modification in the questionnaire was done.

Fieldwork took place in July 2012.

Data collection was done by data collector under supervision of the researchers.

The questionnaire was completed by direct interview with women anonymously. The questionnaire filling took 10- 15 minutes on average. The researchers assured that the women had a comprehensive understanding of the questionnaire with full explanation of misunderstood questions.

Statistical analysis

Data analysis was performed using SPSS version 16. Descriptive statistics were calculated. Then cross tabulations were performed between women's autonomy in decision making and socio-demographic data. The 0.05 level was chosen as the level of significance and 95% confidence interval.

3. Results

Table (1) started with the description of the women socio-demographic data such as women's age, women's education, women's occupation, husband's education and husband's occupation. The age of women participated in this study ranged between 16 and 49 years old with a mean age 30.82 and a standard deviation 8.08. The data revealed that most of the respondents (65.8%) were less than thirty five years old. In terms of women's educational attainment, the findings indicated that most of the women were illiterate (74.7%). Some women (17.5%) had secondary education followed by basic education (4.8%) and university education (3%). As depicted in Table (1), the majority of the women (94.6%) were house wives or not working for cash and about 5.4% were working for cash. In terms of husband's education, the majority of the husbands (56.2%) were illiterate. Secondary education occurred among 29% of husbands followed by basic education (8.1%) and lastly university education (6.7%). Regarding husband's occupation, most of husbands (35.8%) were unskilled workers followed by farmers (20.7%), skilled workers (20.2%) and employees (16.4%). Whereas, 7% of the husbands were professionals.

Table (1): Socio-demographic data of the respondents

	No. (n= 372)	%
Women's age:		
< 25 years	87	23.4
25 - < 30 years	82	22.0
30 - < 35 years	76	20.4
35 - < 40 years	62	16.7
≥ 40 years	65	17.5
Mean ± SD (Range)	30.82 ± 8.08 (16 – 62)	
Women's education:		
Illiterate	278	74.7
Basic education	18	4.8
Secondary education	65	17.5
University education	11	3.0
Women's occupation:		
Working for cash	20	5.4
Not working for cash	352	94.6
Husband's education:		
Illiterate	209	56.2
Basic education	30	8.1
Secondary education	108	29.0
University education	25	6.7
Husband's occupation:		
Employee*	61	16.4
Unskilled worker	133	35.8
Skilled worker	75	20.2
Professional**	26	7.0
Farmer	77	20.7

* Employee: Those have secondary education and sectary.

** Professionals: Include doctors, chemists, engineering, grand sellers, and university graduate.

Table (2) showed the percentage of women who report that the household decisions were made by herself, husband, jointly with husband or by someone else. Women were most likely to say they alone made decisions in the areas of daily purchases and child health care (76.3% and 82.4% respectively). However,

most husbands made decisions alone in the area of large purchases (74.5%). Regarding visits to family or relatives, most decisions were taken by husband alone (42.7%) and about 38.4% were taken by women jointly with husband.

Table (2): Women's participation in household decision making

	Woman		Husband		Jointly with husband		Someone else	
	No.	%	No.	%	No.	%	No.	%
Daily household purchases*	284	76.3	17	4.6	60	16.1	11	3.0
Large household purchases**	28	7.5	277	74.5	46	12.4	21	5.6
Child health care***	294	82.4	20	5.6	39	10.9	4	1.1
Visits to family or relatives	55	14.8	159	42.7	143	38.4	15	4.0

* Daily household purchases are decided by the type of food cooked in most days of the week.

** Large household purchases are decided by rent, electricity and water expenses as well as the cost of clothes.

*** Child health care is determined by giving medicine to children in their sickness.

- 15 women had no children

Table (3) showed that participation in decision making about visits to family or relatives increased by women's education ($p=0.002$), from 48.2% among illiterate women to 81.8% in women graduated from universities. Also, women working for cash were more likely than other women to participate in decisions about making large purchases (45% versus 18.5%) and the difference is statistically significant ($p=0.009$). women's participation in decision making about visits to family or relatives also had a strong significant association with husband's occupation ($p= 0.000$) where woman married from a farmer has a lowest participation in decision making about visits to family or relatives (28.6%). Women's age and husband's education showed no significant relationship with women's participation in household decision making. No significant differences were found between women's participation in decisions about making daily purchases and large purchases or child health care and

women's education. Also, no significant differences were found between women's occupation and participation in decisions about making daily purchases, child health care and visits to family or relatives. Women's participation in decisions about making daily purchases and large purchases or child health care showed no significant relationship with husband's occupation.

Table (4) showed the percentage of women who report that the reproductive decisions were made by herself, husband, jointly with husband or by someone else. Women were most likely to say they alone made decisions about female circumcision and antenatal care use (56% and 51% respectively). However, most husbands made decisions alone about whether to have more children or not (37.8%). Regarding family planning use, most decisions were taken by women jointly with husbands (52.4%).

Table (3): Women's participation in household decision making according to Socio-demographic data

	Making daily purchases		Making large purchases		Child health care		Visits to family or relatives	
	Participate*	Don't participate**	Participate	Don't participate	Participate	Don't participate	Participate	Don't participate
Women's age:								
< 25 years	77 (88.5%)	10 (11.5%)	12 (13.8%)	75 (86.2%)	71 (93.4%)	5 (6.6%)	47 (54.0%)	40 (46.0%)
25 - < 30 years	76 (92.7%)	6 (7.3%)	23 (28.0%)	59 (72.0%)	78 (97.5%)	2 (2.5%)	48 (58.5%)	34 (41.5%)
30 - < 35 years	71 (93.4%)	5 (6.6%)	11 (14.5%)	65 (85.5%)	70 (92.1%)	6 (7.9%)	37 (48.7%)	39 (51.3%)
35 - < 40 years	60 (96.8%)	2 (3.2%)	16 (25.8%)	46 (74.2%)	55 (90.2%)	6 (9.8%)	35 (56.5%)	27 (43.5%)
≥ 40 years	60 (92.3%)	5 (7.7%)	12 (18.5%)	53 (81.5%)	59 (92.2%)	5 (7.8%)	31 (47.7%)	34 (52.3%)
<i>P-value</i>	0.445		0.081		0.477		0.620	
Women's education:								
Illiterate	260 (93.5%)	18 (6.5%)	54 (19.4%)	224 (80.6%)	252 (92.6%)	20 (7.4%)	134 (48.2%)	144 (51.8%)
Basic education	16 (88.9%)	2 (11.1%)	2 (11.1%)	16 (88.9%)	13 (86.7%)	2 (13.3%)	9 (50.0%)	9 (50.0%)
Secondary education	57 (87.7%)	8 (12.3%)	14 (21.5%)	51 (78.5%)	57 (96.6%)	2 (3.4%)	46 (70.8%)	19 (29.2%)
University education	11 (100.0%)	0 (0.0%)	4 (36.4%)	7 (63.6%)	11 (100.0%)	0 (0.0%)	9 (81.8%)	2 (18.2%)
<i>P-value</i>	0.283		0.408		0.383		0.002*	
Women's occupation:								
Working for cash	20 (100.0%)	0 (0.0%)	9 (45.0%)	11 (55.0%)	19 (100.0%)	0 (0.0%)	13 (65.0%)	7 (35.0%)
Not working for cash	324 (92.0%)	28 (8.0%)	65 (18.5%)	287 (81.5%)	314 (92.9%)	24 (7.1%)	185 (52.6%)	167 (47.4%)
<i>P-value</i>	0.381		0.009*		0.464		0.278	
Husband's education:								
Illiterate	197 (94.3%)	12 (5.7%)	41 (19.6%)	168 (80.4%)	191 (93.6%)	13 (6.4%)	103 (49.3%)	106 (50.7%)
Basic education	26 (86.7%)	4 (13.3%)	10 (33.3%)	20 (66.7%)	26 (92.9%)	2 (7.1%)	17 (56.7%)	13 (43.3%)
Secondary education	97 (89.8%)	11 (10.2%)	17 (15.7%)	91 (84.3%)	93 (92.1%)	8 (7.9%)	63 (58.3%)	45 (41.7%)

University education	24 (96.0%)	1 (4.0%)	6 (24.0%)	19 (76.0%)	23 (95.8%)	1 (4.2%)	15 (60.0%)	10 (40.0%)
<i>P-value</i>	0.267		0.184		0.912		0.385	
Husband's occupation:								
Employee	56 (91.8%)	5 (8.2%)	15 (24.6%)	46 (75.4%)	51 (86.4%)	8 (13.6%)	27 (44.3%)	34 (55.7%)
Unskilled worker	123 (92.5%)	10 (7.5%)	20 (15.0%)	113 (85.0%)	116 (92.8%)	9 (7.2%)	93 (69.9%)	40 (30.1%)
Skilled worker	68 (90.7%)	7 (9.3%)	17 (22.7%)	58 (77.3%)	66 (93.0%)	5 (7.0%)	38 (50.7%)	37 (49.3%)
Professional	25 (96.2%)	1 (3.8%)	8 (30.8%)	18 (69.2%)	25 (100.0%)	0 (.0%)	18 (69.2%)	8 (30.8%)
Farmer	72 (93.5%)	5 (6.5%)	14 (18.2%)	63 (81.8%)	75 (97.4%)	2 (2.6%)	22 (28.6%)	55 (71.4%)
<i>P-value</i>	0.907		0.263		0.080		0.000*	

* Participate: The decision was made by women alone or women jointly with their husbands.

**Don't participate: The decision was made by husband or someone else.

Table (4): Women's participation in reproductive decision making

	Woman		Husband		Jointly with husband		Someone else	
	No.	%	No.	%	No.	%	No.	%
Family planning use	75	21.0	93	26.1	187	52.4	2	0.6
Whether to have more children or not	89	24.9	135	37.8	122	34.2	11	3.1
Female circumcision	200	56.0	53	14.8	100	28.0	4	1.1
Antenatal care use	182	51.0	56	15.7	109	30.5	10	2.8

15 women had no children

Table (5) showed that participation in decision making about family planning use increased by women's education ($P=0.024$), from 69.5% among illiterate women to 81.8% in women graduated from universities. Women's participation in decision making about family planning use has a strong significant association with husband's occupation ($p=0.000$), where woman married from a farmer has a lowest participation in decision making about family planning use (57.1%) compared with 88% for woman married from a professional, 83.1% for woman married from a skilled worker, 80% for woman married from unskilled worker and 62.7% for woman married from employee. Also, women's participation in decision making about whether to have more children or not had a significant association with husband's occupation ($p=0.013$) where women married from a farmer has a participation in decision making by 49.4% compared to 76% to woman married from a professional. Women's age, women's occupation and husband's education showed no significant associations with women's participation in reproductive decision making. No significant differences were found between women's education and women's participation in decisions about whether to have more children or not, female circumcision and antenatal care use. Also, no significant differences were found between

husband's occupation and participation in decisions about female circumcision and antenatal care use.

DISCUSSION

This study demonstrates that women are most likely to feel autonomous in household decisions such as making daily purchases (76.3%), child health care (82.4%) and visits to family or relatives (alone represent 14.8% and jointly with husband represent 38.4%) (Table 2). Also, women are most likely to feel autonomous in reproductive decisions such as female circumcision (56%), antenatal care use (51%) and family planning use (alone represent 21% and jointly with husband represent 52.4%) (Table 4).

A study was conducted in rural India showed that women's autonomy was generally low. In terms of decision-making autonomy, more than half of the mothers were not involved in decision-making about their own health care (55.6%), buying major household items (55.4%), or going and staying with natal kin (59.6%). A large majority of women needed permission to go to the market (71.3%) or to visit relatives or friends (82.2%) [12]. A paper by Kishor *et al.*, 1999 using results from the women's empowerment module of the Egyptian DHS 1995 [13], an earlier paper using data from the Egyptian DHS 1989 and national surveys, [14], are among the few studies on this issue that are readily available from the

region. Kishor *et al.* found that mean decision-making of Egyptian women in 1995 on a seven-point scale was 4.7. They were asked “Who has the final say in your family on ...”: what foods to cook, the use of contraception, having another child, children’s medicine, children’s education, budget and visits to friends and family. Around 3% of Egyptian women were not responsible for any of these decisions but nearly 21% were involved in all seven.

Our study showed that there was no relationship between women’s participation in decision making and women’s age (Tables 3, 5). This is in line with Handy and Kassam, 2006 which noted there was no relationship between empowerment and age [15]. But National Health Survey, 2000 conducted in Sultanate of Oman showed that the higher the age group of the wife, the more likely she takes decision in food cooked, expenditures, having another baby [16]. The difference may be due to different place and the sample in the study conducted in Sultanate of Oman includes rural and urban women.

Women’s education considered as the key factor in women’s empowerment. Ackerly, 1995 and Kishor, 2000 argued that empowerment can be measured directly through education level and knowledge [17, 7]. Cochran, 1979 has noted emphasized on education as the key factor to increase women’s empowerment by increasing their self-confidence and understanding of how to operate in the world [18]. Further, Dighe, 1998 discussed that education has the strength to enable women to think critically and to question their disempowerment [19]. Therefore, education could provide opportunities for women to evaluate themselves, and gradually develop self-confidence and a positive self-image so that they begin to appreciate their own capacities and potentialities. Our study indicated that there was significance association between educational attainment and women’s participation in decisions about visits to family or relatives and family planning use (Tables 3, 5).

Table (5): Women's participation in reproductive decision making according to Socio-demographic data

	Family planning use		Whether to have more children or not		Female circumcision		Antenatal care use	
	Participate	Don't participate	Participate	Don't participate	Participate	Don't participate	Participate	Don't participate
Women's age:								
< 25 years	59 (77.6%)	17 (22.4%)	44 (57.9%)	32 (42.1%)	67 (88.2%)	9 (11.8%)	65 (85.5%)	11 (14.5%)
25 - < 30 years	62 (77.5%)	18 (22.5%)	56 (70.0%)	24 (30.0%)	68 (85.0%)	12 (15.0%)	71 (88.8%)	9 (11.2%)
30 - < 35 years	58 (76.3%)	18 (23.7%)	45 (59.2%)	31 (40.8%)	59 (77.6%)	17 (22.4%)	58 (76.3%)	18 (23.7%)
35 - < 40 years	44 (72.1%)	17 (27.9%)	36 (59.0%)	25 (41.0%)	53 (86.9%)	8 (13.1%)	46 (75.4%)	15 (24.6%)
≥ 40 years	39 (60.9%)	25 (39.1%)	30 (46.9%)	34 (53.1%)	53 (82.8%)	11 (17.2%)	51 (79.7%)	13 (20.3%)
<i>P-value</i>	0.144		0.094		0.436		0.158	
Women's education:								
Illiterate	189 (69.5%)	83 (30.5%)	152 (55.9%)	120 (44.1%)	228 (83.8%)	44 (16.2%)	219 (80.5%)	53 (19.5%)
Basic education	12 (80.0%)	3 (20.0%)	10 (66.7%)	5 (33.3%)	13 (86.7%)	2 (13.3%)	11 (73.3%)	4 (26.7%)
Secondary education	52 (88.1%)	7 (11.9%)	42 (71.2%)	17 (28.8%)	51 (86.4%)	8 (13.6%)	50 (84.7%)	9 (15.3%)
University education	9 (81.8%)	2 (18.2%)	7 (63.6%)	4 (36.4%)	8 (72.7%)	3 (27.3%)	11 (100.0%)	0 (0.0%)
<i>P-value</i>	0.024*		0.159		0.708		0.290	
Women's occupation:								
Working for cash	17 (89.5%)	2 (10.5%)	9 (47.4%)	10 (52.6%)	15 (78.9%)	4 (21.1%)	17 (89.5%)	2 (10.5%)
Not working for cash	245 (72.5%)	93 (27.5%)	202 (59.8%)	136 (40.2%)	285 (84.3%)	53 (15.7%)	274 (81.1%)	64 (18.9%)
<i>P-value</i>	0.103		0.285		0.534		0.358	
Husband's education:								
Illiterate	142 (69.6%)	62 (30.4%)	116 (56.9%)	88 (43.1%)	171 (83.8%)	33 (16.2%)	170 (83.3%)	34 (16.7%)

Basic education	18 (64.3%)	10 (35.7%)	17 (60.7%)	11 (39.3%)	23 (82.1%)	5 (17.9%)	20 (71.4%)	8 (28.6%)
Secondary education	83 (82.2%)	18 (17.8%)	65 (64.4%)	36 (35.6%)	86 (85.1%)	15 (14.9%)	81 (80.2%)	20 (19.8%)
University education	19 (79.2%)	5 (20.8%)	13 (54.2%)	11 (45.8%)	20 (83.3%)	4 (16.7%)	20 (83.3%)	4 (16.7%)
<i>P-value</i>	0.069		0.604		0.980		0.474	
Husband's occupation:								
Employee	37 (62.7%)	22 (37.3%)	29 (49.2%)	30 (50.8%)	48 (81.4%)	11 (18.6%)	43 (72.9%)	16 (27.1%)
Unskilled worker	100 (80.0%)	25 (20.0%)	85 (68.0%)	40 (32.0%)	105 (84.0%)	20 (16.0%)	102 (81.6%)	23 (18.4%)
Skilled worker	59 (83.1%)	12 (16.9%)	40 (56.3%)	31 (43.7%)	58 (81.7%)	13 (18.3%)	58 (81.7%)	13 (18.3%)
Professional	22 (88.0%)	3 (12.0%)	19 (76.0%)	6 (24.0%)	23 (92.0%)	2 (8.0%)	23 (92.0%)	2 (8.0%)
Farmer	44 (57.1%)	33 (42.9%)	38 (49.4%)	39 (50.6%)	66 (85.7%)	11 (14.3%)	65 (84.4%)	12 (15.6%)
<i>P-value</i>	0.000*		0.013*		0.745		0.270	

The influence of women's education on family planning use are likely to be the result of influences such as socioeconomic development and governmental policy of universal education and this confirm the previous findings [3, 20, 21]. The National Health Survey, 2000 conducted in Sultanate of Oman also showed that educational level seems to have an effect on wife's decision making [16].

Employment can improve women's empowerment for some reasons i.e., because it gives women access to their own earnings or contributions to family income that in turn increase the women's power at household and community level [22, 23]. Our study showed that women working for cash are more likely to participate in the decision about making large purchases only (Table 3). This may be due to the majority of women (94.6%) in our study were housewives or not working for cash. The National Health Survey, 2000 conducted in Sultanate of Oman revealed that working wives and those unrelated to their husbands are more likely to take decisions in most of the tasks [16]. The rural society is very gender stratified, which places limits on the decisions women can make [24 - 26]. This study showed that husband's occupation plays an important role in women's participation in some decisions. Professionals as a husband's occupation is associated with a high women's participation in the decisions especially the decisions about visits to family or relatives, family planning use and having another child (Tables3, 5).

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