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Effect of Women autonomy on Child Care among Muslim: a cross countries comparative study in India, Bangladesh and Indonesia

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Introduction:

Autonomy is ideally define as self-sufficient or capability of a women in decision making. The dimensions of women's autonomy in terms of outside mobility, access to economic resources and involvement in household decisions has association with maternal and child health. Women's "status" refers to both the respect accorded to individuals and the personal power available to them. While women value prestige, it is the level of personal autonomy that appears to influence demographic behavior and resulting outcomes. Autonomy has been defined 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 (Basu 1992; Dyson and Moore 1983; Miles-Done and Bisharat 1990). Women's autonomy thus can be conceptualized as their ability to determine events in their lives, even though men and other women may be opposed to their wishes.

Social and economic status of women uses to judge the status of a country in terms of development. Women autonomy is a composition of decision making of women within and outside the family, mobility, freedom from threatening relations with husband, and access to and control over economic resources. India is second Populated country in the world with 1.27 billion population and containing approximately 17.5% of the world's population. Some of the well known reasons for India's rapidly growing population are poverty, illiteracy, high fertility rate, rapid decline in death rates or mortality rates and immigration. Currently, there are about 51 births in India in a minute, if current trend of population growth continue, it is projected to be the world's most populous country by 2025. India has more than 50% of its population below the age of 25 and more than 65% below the age of 35. It is expected that, in 2020, the average age of an Indian will be 29 years.

People live in India belongs to different regions speak different languages and they have different culture but fallow mainly four religions Hindu, Muslim, Sikh, Christian and a small proportion also share by Buddhist. Muslim is a second majority in India. Women's belong to Muslim religion consider as more vulnerable In India. Female autonomy has widely been acknowledged as a major factor that contributes to better demographic outcomes. Female autonomy is a multi-dimensional entity, which

refers to different aspects of women's life. We cannot imagine the better future without contribute of female. The Current sex ratio of India is 940 females for every 1000 males**.** It continuously decreases from birth to ages. This indicates towards gender disparity which is exists not only in India, Indonesia and Bangladesh but all over the world and especially in Asian. Muslim women are poor in autonomy and social capital; many national and international study and research address the poor autonomy and social capital which is directly linked with poor health and demographic outcome of women among Muslim, such as Caldwell state that Islam restricts women's activities in ways that other religions do not (Caldwell 1986). Many argue that Muslim societies are predisposed to high fertility, unmet need for contraception, pron-atalism, and infant and child mortality (e.g. Caldwell 1986; Faour 1989; Kirk 1968; Nagi1984;Youssef 1978). One hypothesis that has been offered to explain this poor demographic performance is that Islam promotes restrictions on women's power and autonomy in way that compromise women's ability to limit fertility or secure good health for themselves and their children.
In India and Bangladesh the status of women has been subject to many great changes over the past few millennia. From equal status with men in ancient times through the low points of the medieval period, to the promotion of equal rights by many reformers, the history of women in India has been eventful. Still the status of women is not equal men.

The Meaning of Women's Autonomy:

Autonomy defines as the capacity for a woman to achieve well being and a role in decision-making. Female autonomy has widely been acknowledged as a major factor that contributes to better health, demographic and social outcomes and health of children as well. Female autonomy is a multi-dimensional entity, which refers to different aspects of women's life.
Autonomy as 'the capacity to manipulate one's personal environment and the ability – technical, social and psychological to obtain information and to use it as the basis for making decisions about one's private concerns and those of one's intimates'.

Need of the study:

Some of the well known reasons for India's rapidly growing population are poverty, illiteracy, high fertility rate, rapid decline in death rates or mortality rates and immigration from Bangladesh and Nepal. Development having slower growth rate and our resources are not capable to cope up with rapid growing population, rapid growing population is a result of decline in mortality and high fertility rate which was high in older time and also high at this time. Low level of literacy is due to lower level of education among female, male get the preference at all resources as well as in education also. Female education and work participation are being considered as the two major proxy variables of women's autonomy. Studies conducted in the context of developing countries have documented the relative significance of these two factors particularly that of female education, in determining better demographic outcomes such as low fertility, child mortality and better health status etc.

The female disadvantage in less-developed countries like India and Bangladesh and in India also with regard to health and well-being has been documented abundantly (Santow 1995). The health status of both women and children, particularly female children, suffers in relation to that of males in areas where patriarchal kinship and economic systems limit women's autonomy (Caldwell 1986). Gender is a salient source of social stratification across many societies and the study of the autonomy and power of women relative to men reveals important insights about women's wellbeing (Presser 1997). Constraints on women's autonomy are also thought to relate to a variety of Demographic and health outcomes.

Women with closer ties to natal kin are more likely to have greater autonomy in each of these three areas. Women with greater freedom of movement, excess to economic resources and decision making in large and small household matters obtained higher levels of antenatal care and are more likely to use safe delivery care and personal and child health care. The influence of women's autonomy on the use of health care appears to be as important as other known determinants such as education. Female education, work participation and excess of economic resources and more importantly decision making power are being considered as the major proxy variables of women's autonomy. Particularly female education and excess to resources are use in determining better demographic outcomes such as low fertility, child mortality and better health status etc.

Muslim is the second majority in India and spared all over the India. Indonesia and Bangladesh are they countries where Muslim are in Majority. In India Muslim are most vulnerable people they are at the lower level in terms of education, social and economically according to **Sachar Committee report,** so we can understand the condition of Muslim and imagine the status of women among Muslim. The

report is first of its kind revealing the backwardness of Indian Muslims, according to Sachar Committee report some of the major concerns are:

- The status of Indian Muslims is below the conditions of Scheduled Castes and Scheduled Tribes.
- The overall percentage of Muslims in bureaucracy in India is just 2.5% whereas Muslims constitute above 14% of Indian population.

When compared to the Scheduled Castes and Scheduled Tribes the growth in literacy for Muslims was lower than for the former. The female urban enrolment in literacy ratio for the SCs/STs In Hindu was 40 percent in 1965 that rose to 83 per cent in 2001. The equivalent rate for Muslims—that was considerably higher in 1965 (52 per cent)—recorded a figure of 80 per cent, lower than the figure for the SCs / STs in Hindu.

So, we can understand the social, economic and educational condition of the Muslim community in India. Women's belong to Muslim religion consider as more vulnerable In India. Many study based on women autonomy and empowerment in Asia and India address that Islam is an obstacle in the development of women. The poor outcome of demography such as high fertility, poor health and nutritional condition of women and child among the people belong to the Muslim religion and low status and poor autonomy among Muslim women not only in India and Bangladesh but also in all over the Asia especially in South-east Asia. And these factors which mention above are strongly associated with maternal, infant and child health and subsequent maternal and child mortality, But the infant mortality (including parental and neonatal) are approximately equal to the people belong to Hindu religion.

Yet the relationship of these broad socio-demographic characteristics to actual behavior patterns and resulting health outcomes is not consistent across or within cultures. For example, greater selective discrimination against girls and higher birth order was observed among younger, more highly educated women in Punjab, India (Das Gupta 1987). Several studies in South Asia have observed variation in the effects 67% of these factors on direct measures of women's behavior and have concluded that socio-demographic variables are not reliable indicators of women's position. Rather, investigation~ of the impact of women's position on demographic and health outcomes should use direct measures reflecting women's degree of control and autonomy and in their lives. Evidence Show that Muslims in India are poor in terms of social and demographic indicators compare to the Bangladesh and Indonesia.

In this context this study, is an attempt make the understanding about the factors determining female autonomy among Muslim In India, Bangladesh and Indonesia and the relative significance of the some

proxy variables of Autonomy which affect the maternal and child health and their survival. Also, more important is to understand the indicators of the well being of women, which are often expected as the outcome of exercising their autonomy. Hence, the association between female autonomy and selected indicators of their well being such as health, Child care and survival, education in broad sense better demographic outcome, incidence of domestic violence and contraceptive acceptance also having need to analyzed.

Objective of the Study:

- To examine the state of women autonomy and its determinants among married Muslim women
- To examine the effect of women autonomy on child health care.

Data Source and Methodology:

Present Study uses the data from Demographic Health Survey (DHS) .DHS 2007 for Bangladesh and Indonesia and for India DHS 2006, which is global standard for systematically monitoring. DHS have large sample sizes (usually between 5,000 and 30,000 households) and typically are conducted about every 5 years, to allow comparisons over time. Demographic and Health Surveys (DHS) are nationally-representative household surveys that provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition etc. The 2007 Bangladesh Demographic and Health Surveys (DHS) is a nationally representative survey of 3,771 men age 15-54 from 10,400 households.

In Indonesia DHS is a nationally representative survey of 40,701 households, 32,895ecer married women age 15-49 and 8,758 currently married men age 15-54. In India DHs which is popularly known as National family Health Survey 2005-06 NFHS-3 collected information from a nationally representative sample of 109,041 households, 124,385 women age 15-49, and 74,369 men age 15-54. The NFHS-3 sample covers 99 percent of India’s population living in all 29 states. From among all the women and men interviewed nationwide, 102,946 were tested for HIV. This data provide the information such as religious and cultural contribution in empowerment and autonomy, health information and reported health problem., through which this cross-sectional study will provide a 'snap shot' of the autonomy of women, social capital, condition and use of health care services, provision of maternal services, and the level of child health care utilization.

Bi- variate and logistic regression techniques have been used for analyzing the level and differentials of Autonomy of women and its impact on child care utilization across the selected countries. Where Bi-variate show the relationship between two variables (dependent and independent) and logistic regression use to observed the effect of independent variables on dependent variables since data is also providing information of family planning, maternal and child care use. Family planning, Maternal and child care have been considered as dependent variables.

The Level of women autonomy and its determinants among married Muslim women across the selected countries

Table 1 shows the level of autonomy, mean value gives the average value of women autonomy or decision making across the countries and within the different background categories, if women take decision alone. Women's in Indonesia are having higher value of autonomy in all background characteristics fallowed by India and Bangladesh. Table shows as age of women increasing autonomy of women also increasing till\age group 40-44 and then get decline with elder ages in Indonesia and Bangladesh but in case of India it get starts decline with 35-39 age group. The variation of autonomy or decision making power with age of women varies with faster rate in India and in Bangladesh which is not happening in Indonesia. In Indonesia it is fluctuating from younger to elder ages. By the place of residence it is always high in urban area in all selected countries, by the education of women it is high among educated women and low among uneducated women both In India and Bangladesh but in Indonesia the situation is inverse, it is high among uneducated although very less proportion of women in Indonesia belongs to non-educated category .Table shows that sex of head of household is very crucial in building women autonomy if the head of household is male there is low autonomy among women. If it is females, women are having great autonomy and it is seem more crucial factor in Bangladesh. Wealth of women is not showing any significant impact on women autonomy in all selected countries although is varies from poor to higher but with fluctuation and with very small difference. Occupations of women are showing as important factor for autonomy, women who are professional, services and skilled and unskilled manual they are rich in autonomy.

Figure 1.1 Mean score of women alone autonomy across the countries

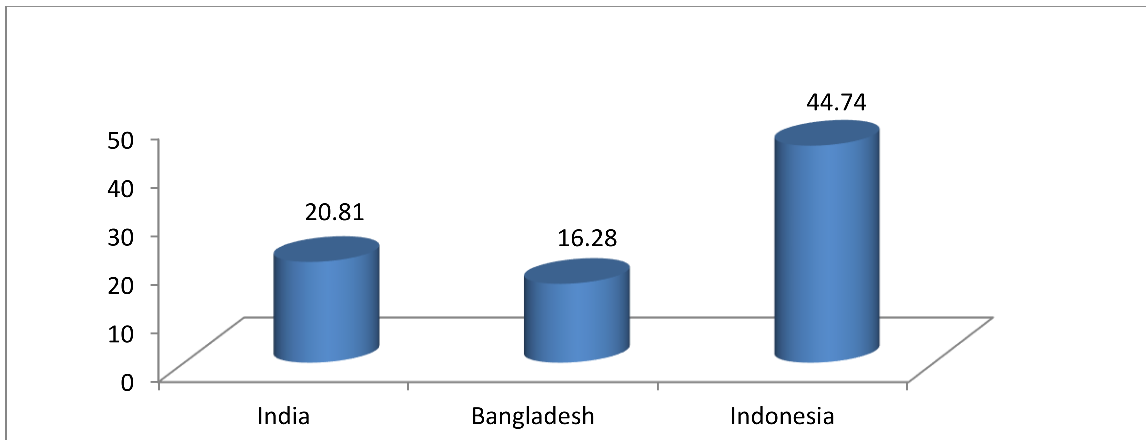


Figure shows the level of autonomy, mean value gives the average value of women autonomy or decision making across the countries, if women take decision alone. Figure shows that women's in Indonesia are having higher value of autonomy fallowed by India and Bangladesh.

Figure 1.2 Percentage distributions of women alone Autonomy across the selected countries:

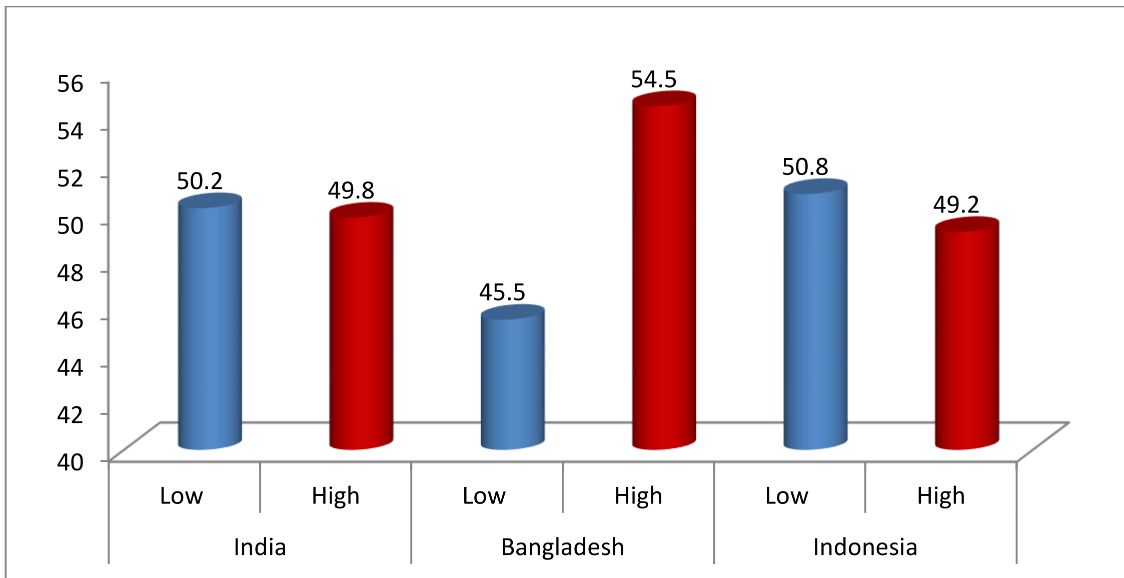


Figure shows women's in India and Indonesia are having approximately equal distribution of women alone autonomy but women in Bangladesh over all are having higher autonomy.

Figure 1.3 Mean score of women alone autonomy by age group of women in across selected countries

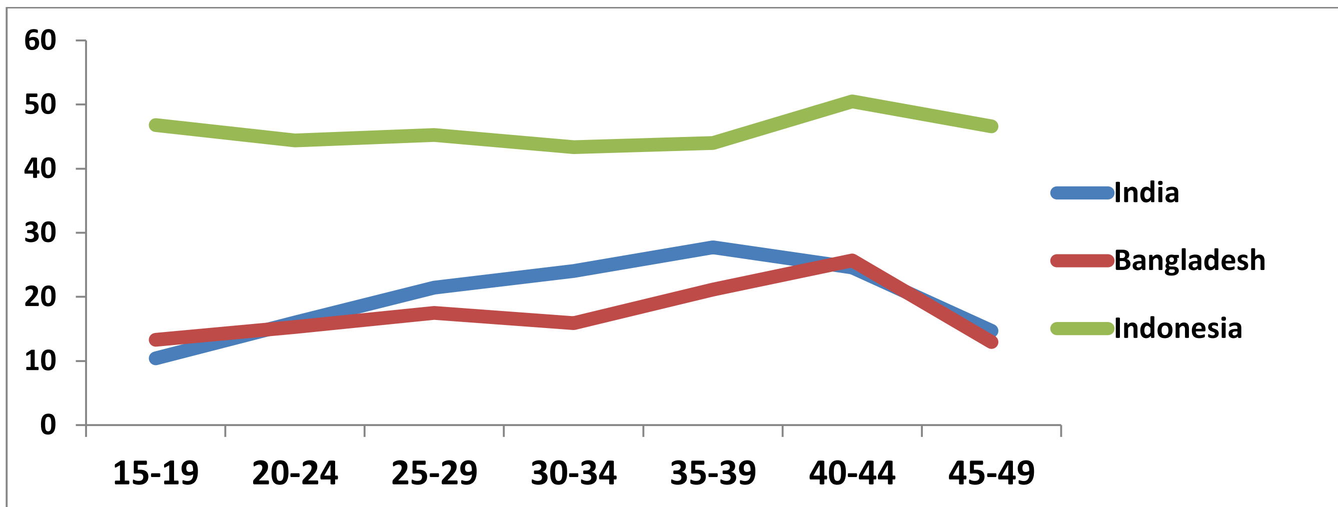


Figure shows as age of women increasing autonomy of women also increasing till\age group 40-44 and then get decline with elder ages in Indonesia and Bangladesh but in case of India it get starts decline with 35-39 age group. The variation of autonomy or decision making power with age of women varies with faster rate in India and in Bangladesh which is not happening in Indonesia. In Indonesia it is continue fluctuating from younger to elder ages.

Figure 1.4 Mean score of women alone autonomy by place of residence in across selected countries

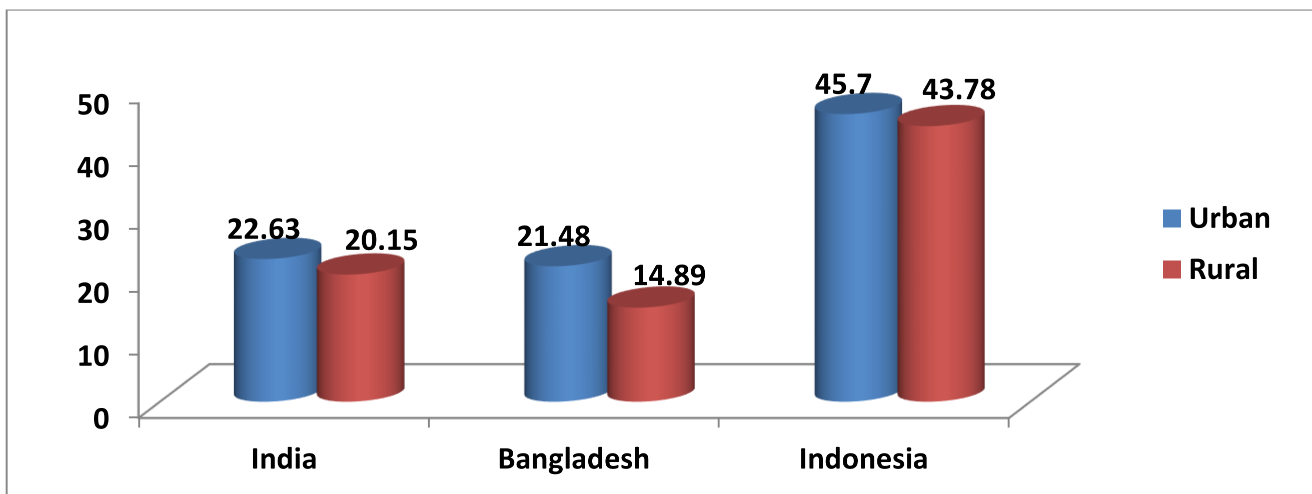


Figure Shows that the level of autonomy of women alone by the place of residence it is always high in urban area in all selected countries compare to the rural areas but higher differences observe in Bangladesh fallowed by India and Indonesia.

Figure 1.5: Mean score of women alone autonomy by the education of women across the selected countries

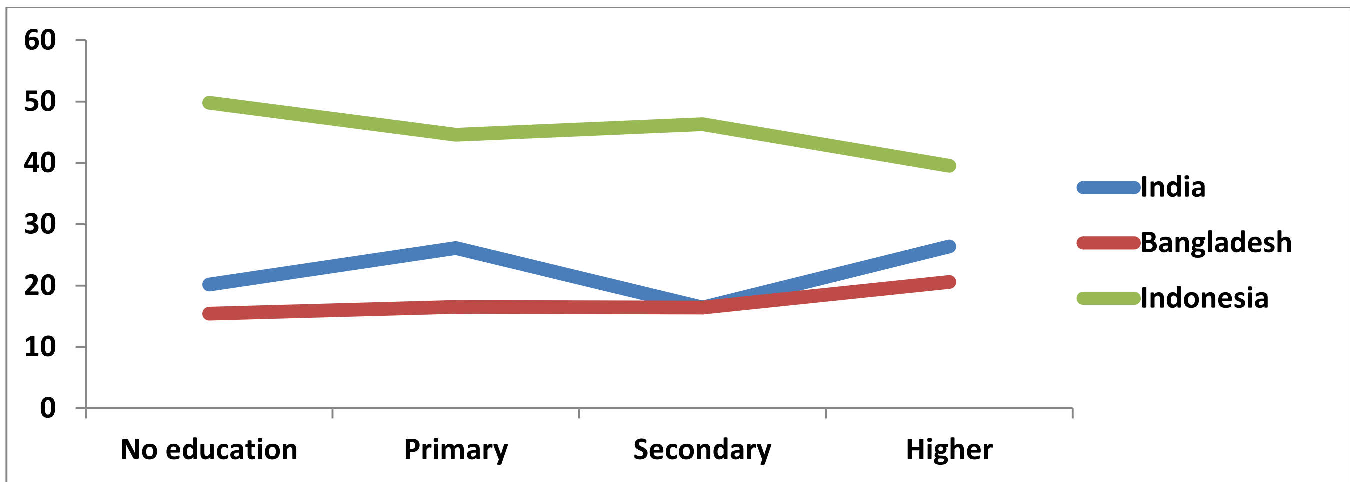


Figure shows the autonomy of women alone by the education of women is high among educated women and low among uneducated women both In India and Bangladesh but in Indonesia the situation is inverse, it is high among uneducated, although very less proportion of women in Indonesia belongs to non-educated category. In India it is high among primary educated women and approximately equally high among higher educated women and low among secondary educated women.

Figure 1.6: Mean score of women alone autonomy by sex of household head across the selected countries

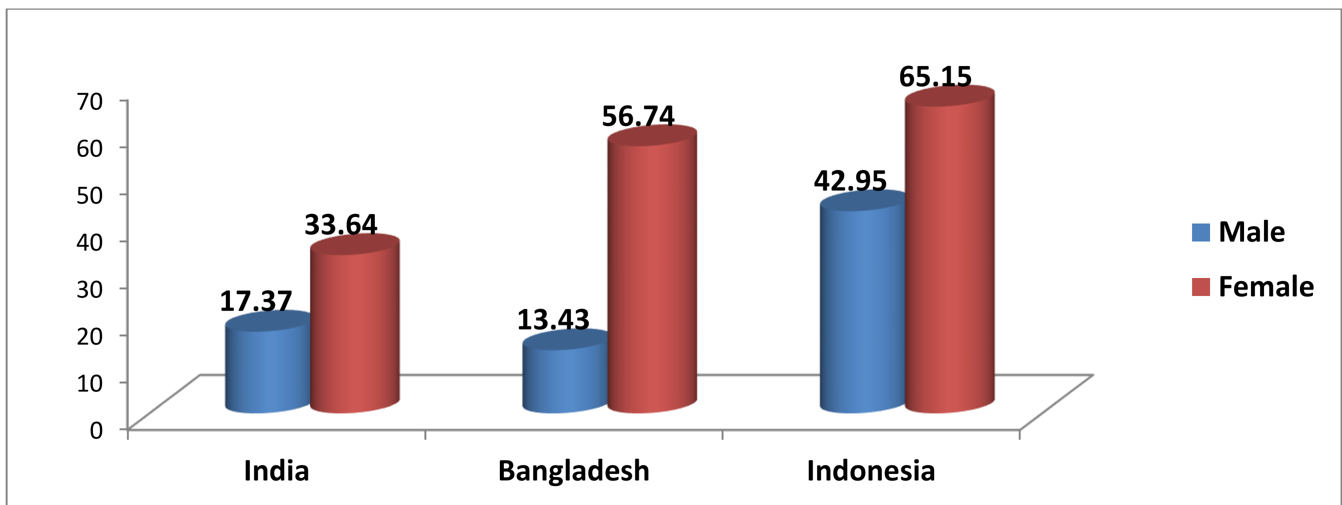


Figure shows the sex of household head of is very crucial in building women autonomy if the head of household is male there is low autonomy among women across the all selected countries. If it is females, women are having great autonomy and it is seem more crucial factor in Bangladesh fallowed by India and Indonesia.

Figure 1.7: Mean score of women alone autonomy by wealth of women across the selected countries

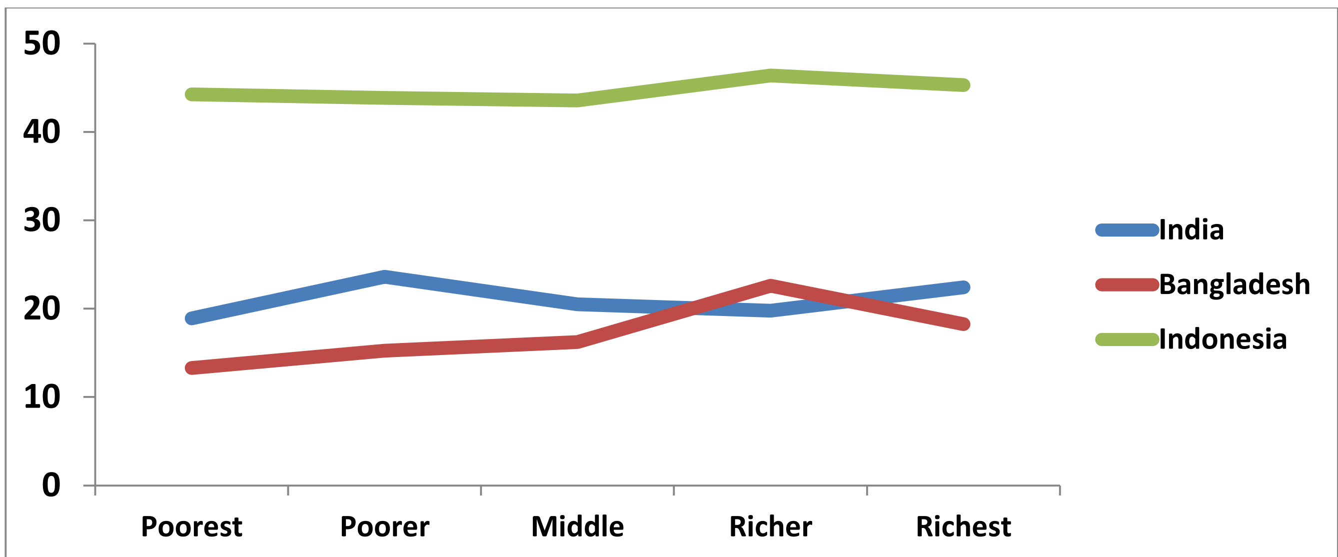


Figure show the autonomy score of women with wealth quintile of women. Figure shows as the level of wealth of women increase autonomy of women also increase. In Indonesia and Bangladesh autonomy of women is high among rich and richest women but in India it is high among poorer women than among the women belong to richest wealth quintiles.

Figure 1.8: Mean score of women alone autonomy by profession of women across the selected countries

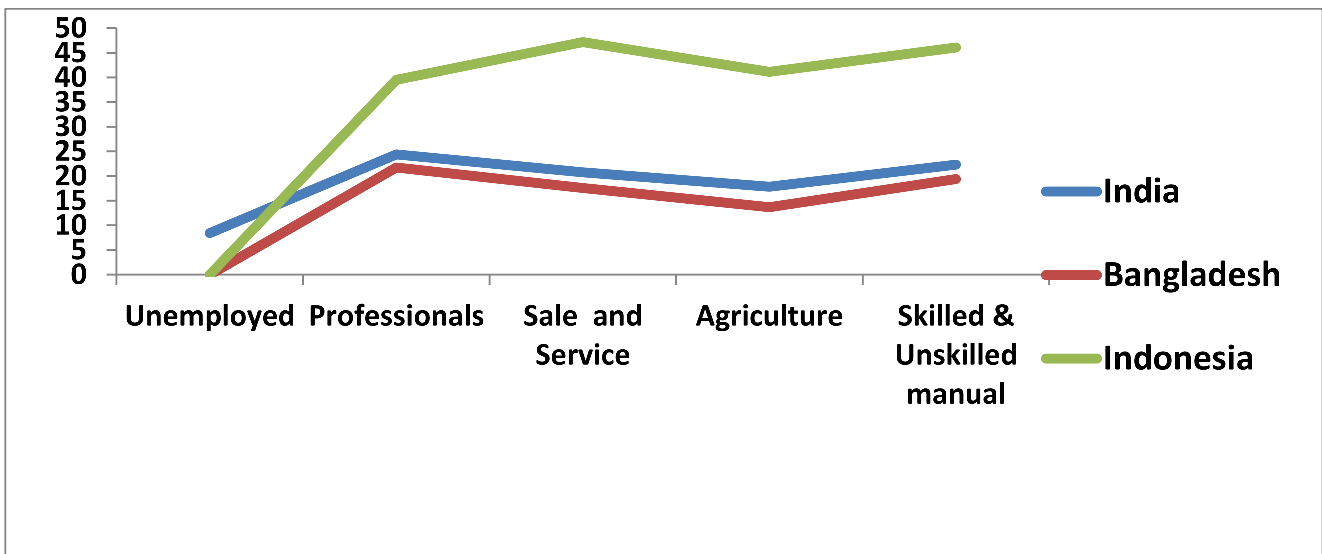


Figure shows that women who are professional (including teacher, professor, bankers, clerks etc.) are having higher autonomy in India and in Bangladesh but in Indonesia higher autonomy associated with sales and services than skilled and unskilled manual.

Table 2 shows that women with joint autonomy are having higher value in all background categories as compare to women with alone autonomy. Women with joint autonomy (Including women, husband and

other family member's decision combine) get 3-4 fold up in autonomy, in Bangladesh it is more than 4 time high joint autonomy compare to women alone autonomy fallowed by India and in Indonesia. And the variation of autonomy within the different background categories is very less, if we compare to women alone autonomy.

Figure 2.1 mean autonomy score of women joint autonomy across the countries

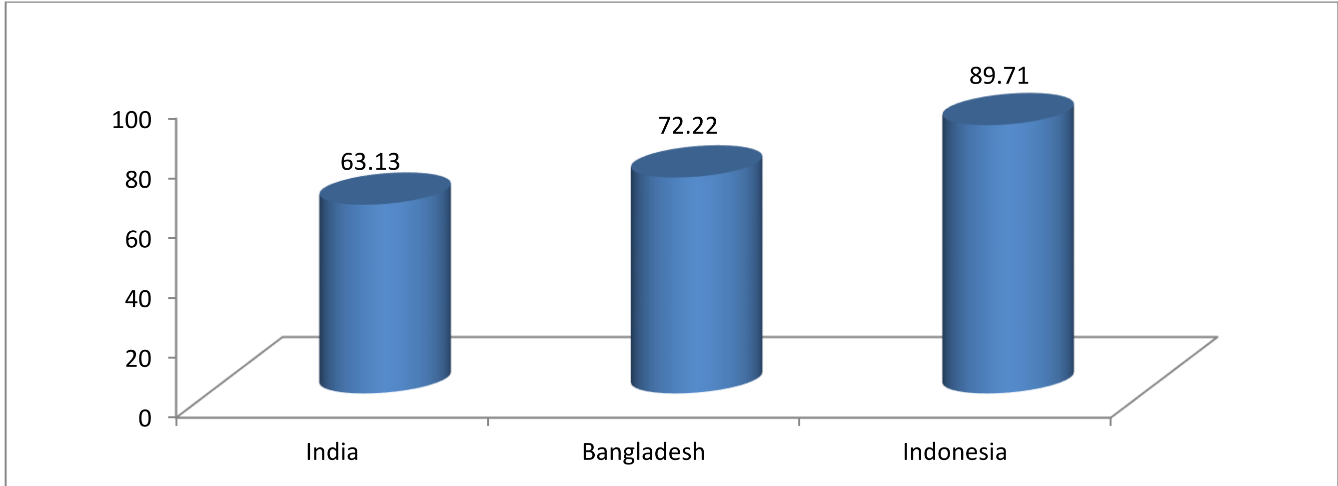


Figure shows that women with joint autonomy (Including women, husband and other family member's decision combine) get 3-4 fold up in autonomy, in Bangladesh it is more than 4 time high joint autonomy compare to women alone autonomy fallowed by India and in Indonesia.

Figure 2.2 Percentage distributions of women joint Autonomy across the selected countries:

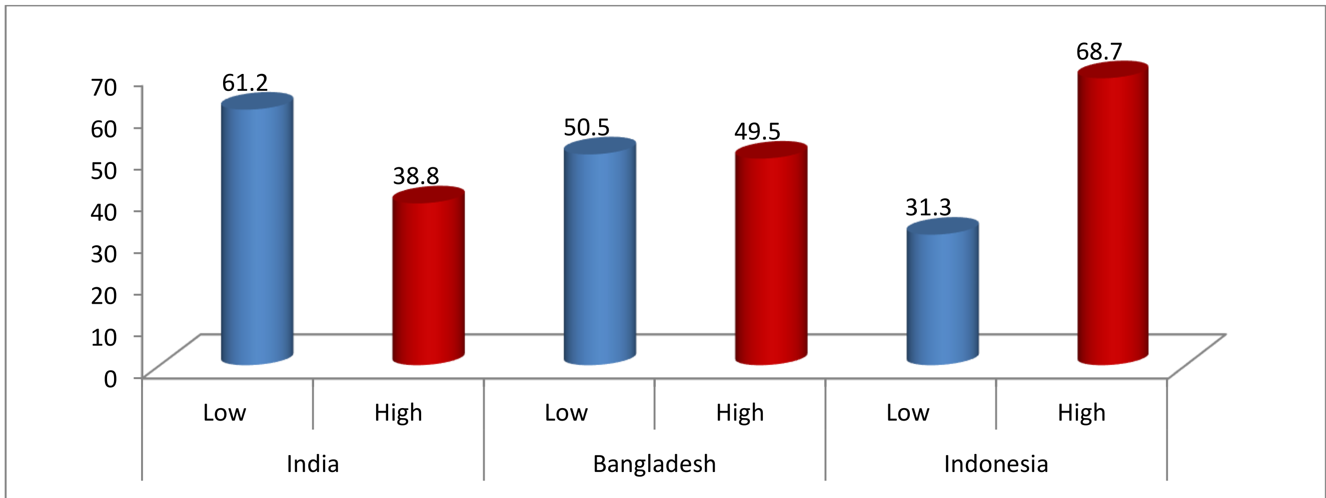


Figure shows that if women take joint decision with husband and other family members. The percentage distribution of low women joint autonomy gets higher in India and in Bangladesh. In India this difference gets higher percentage if we compare to women alone autonomy and in Bangladesh also but

in Indonesia percentage of women with higher joint autonomy increase when women take joint decision. This was approximately equal if woman take alone decision.

Figure 2.3: Mean autonomy score of women joint autonomy by age group of women across the selected countries.

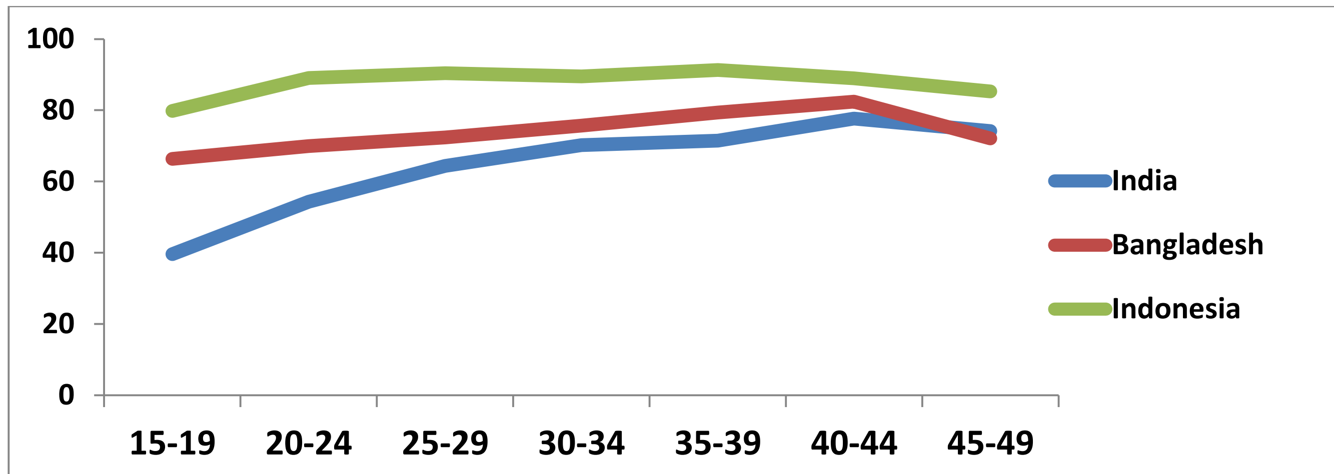


Figure shows that women joint autonomy increasing with increasing age but a certain point come from where autonomy goes down in all selected countries same as women alone autonomy in India and in Bangladesh it starts down with 40-44 age groups where in Indonesia it starts decline with 35-39 age group and in Indonesia it is also more fluctuation in autonomy with age.

Figure 2.4: Mean score of women joint autonomy by place of residence across the selected countries

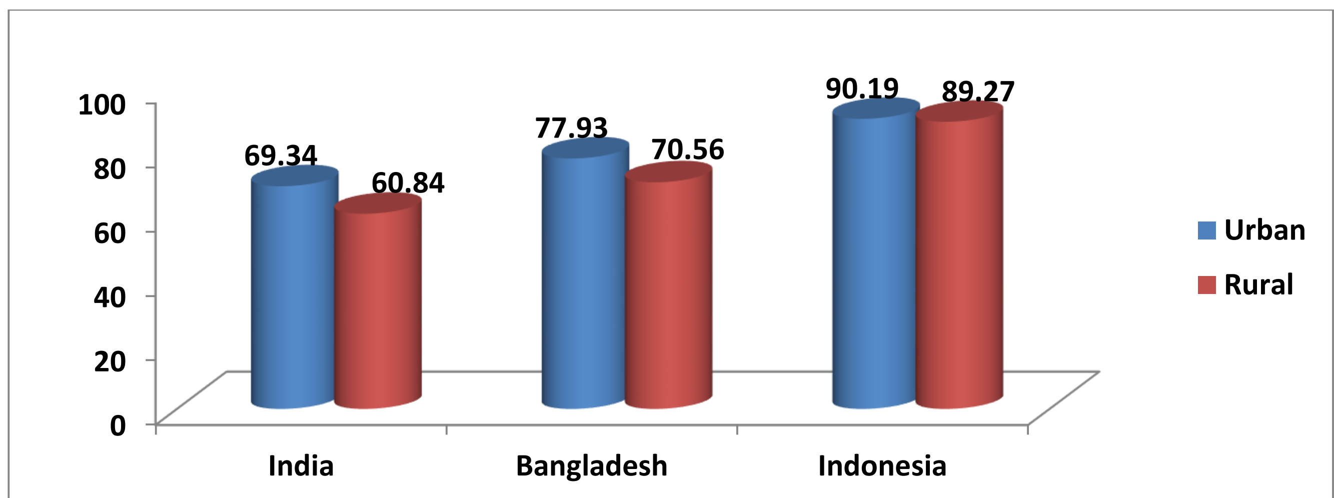


Figure shows that the women who belong to the urban areas having higher joint autonomy compare to the rural areas in all selected countries, more variation observed in India fallowed by Bangladesh and less in Indonesia.

Figure 2.5: Mean score of women joint autonomy by the education of women across the selected countries

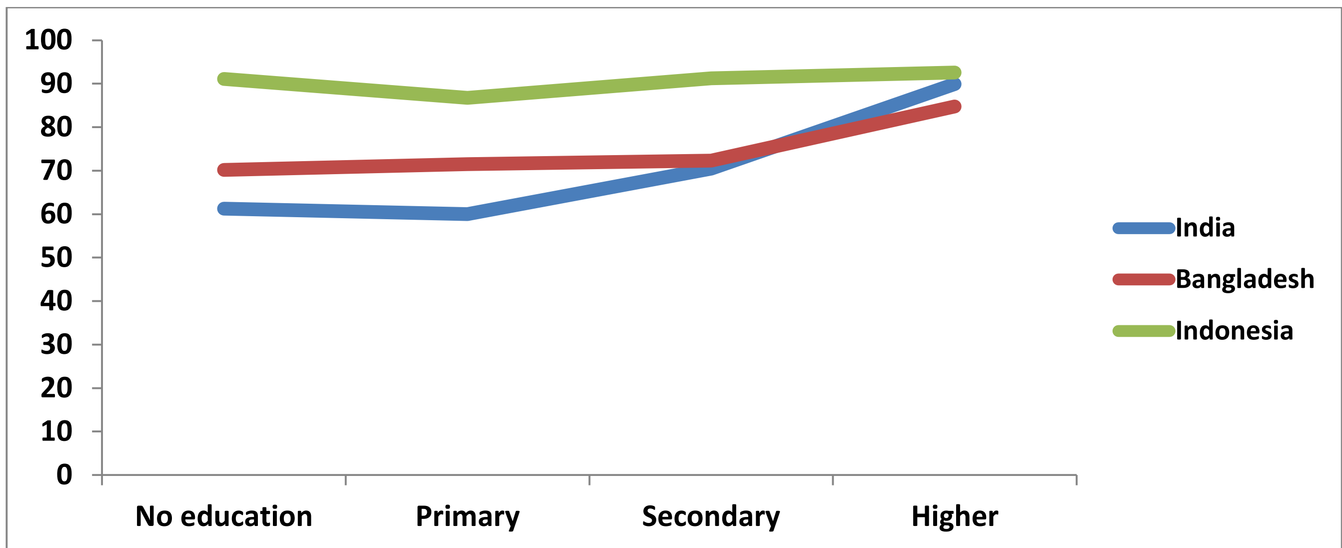
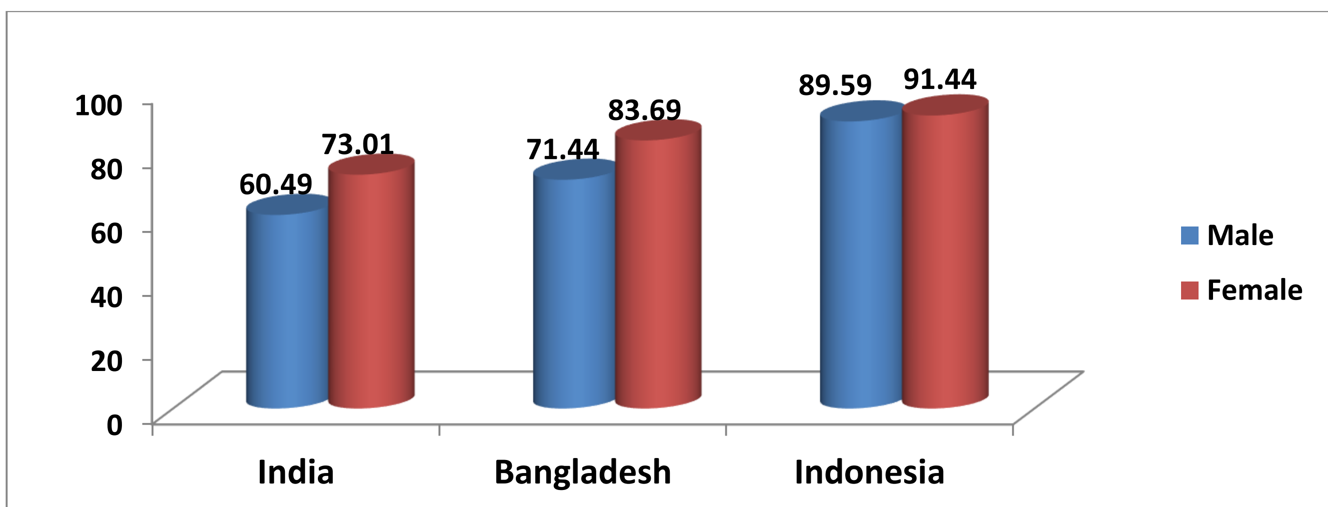


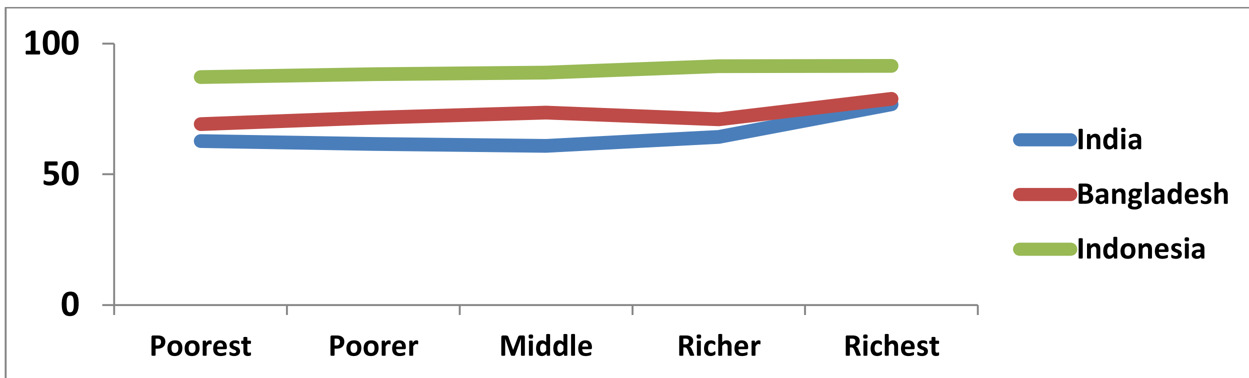
Figure shows that education playing very crucial role for building the autonomy. It is lower among no educated and primary educated women and high among secondary and higher educated women. Women who are higher educated having higher autonomy in all the selected countries. Less variation in autonomy of women with education level shows in Indonesia.

Figure 2.6: Mean score of women joint autonomy by sex of household head across the selected countries



This figure shoes the state of joint autonomy by the sex off household head. Figure shows that if females are household head, women autonomy is always high in all the selected countries. In India and Bangladesh there is more variation between male and female as household head but in Bangladesh it is not much difference compare to India and Bangladesh.

Figure 2.7: Mean score of women joint autonomy by wealth of women across the selected countries



Economic status of person which is consider as very crucial in decision making. This figure shows the women who belong to the richer and richest wealth quintile having higher autonomy but variation is very less among all quintiles and fluctuating. In India from poorest to middle it goes down than goes up till richest. In Bangladesh it goes up from poorest to middle among richer it goes down and again goes up among richest. In Indonesia it continues to increase with wealth of women from poorest to richest.

Figure 2.8: Mean score of women joint autonomy by profession of women across the selected countries

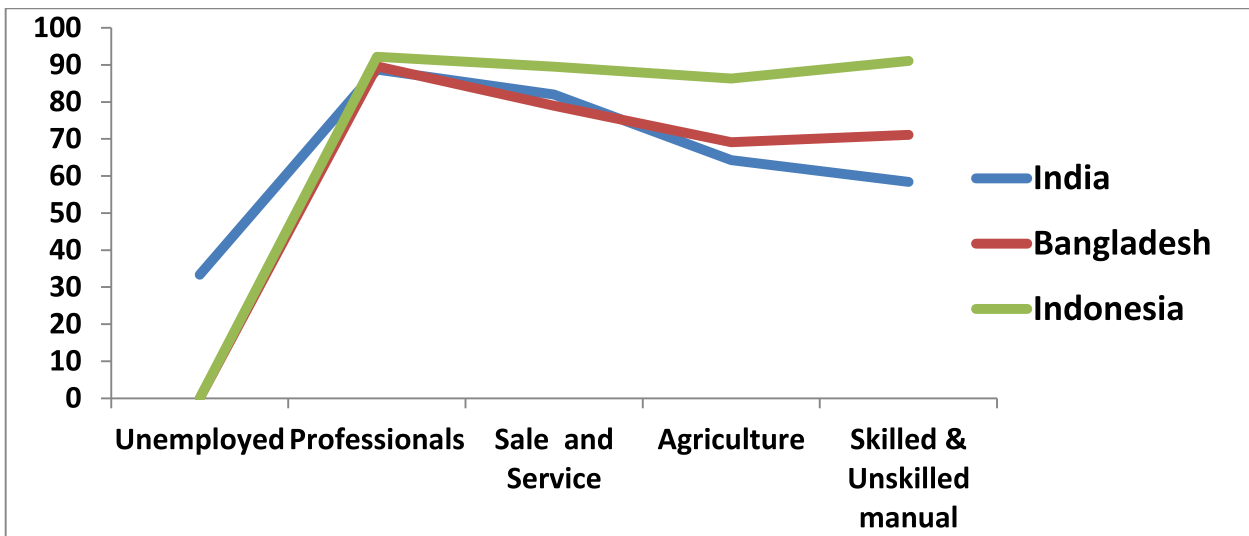


Figure shows that the women joint autonomy in higher among the women who are professional in all the selected countries.

Differentials in Child Care by Autonomy of women across the selected Countries

Table 3 shows that the distribution of Children of Muslim women among no, partly and full immunization of children across the selected countries by background characteristics. Over all among immunized children the percentage of full immunized is high in Bangladesh fallowed by Indonesia and India. By the Age of women full immunization of children in India increase with age group till 25-29 than get starts decline with elder ages and this also happening in Indonesia, in Bangladesh it is continue to increase with elder ages. Education of women is also playing a important role in immunization of children, women with higher education are with more fully immunized children and non educated with higher percentage of partly immunized children. Place of residence is very crucial in immunization of children, in urban setting there is higher percentage of full immunized children in all countries. By the sex of household head in India there is no much impact on immunization of children but in Bangladesh and Indonesia if household head is male, percentage of full immunization is high. Economic status of women are also shoeing very important , women with rich and richest wealth quintiles are having higher percentage of full immunized children in all selected countries as the wealth of women increasing the percentage of partly immunized decreasing and full immunized increasing. By the occupation of women, who are professional (including: teacher, professor, manager, clerks etc) are having higher percentage of full immunized children.

Figure 3.1 Percentage distribution of Immunization of child across the selected countries.

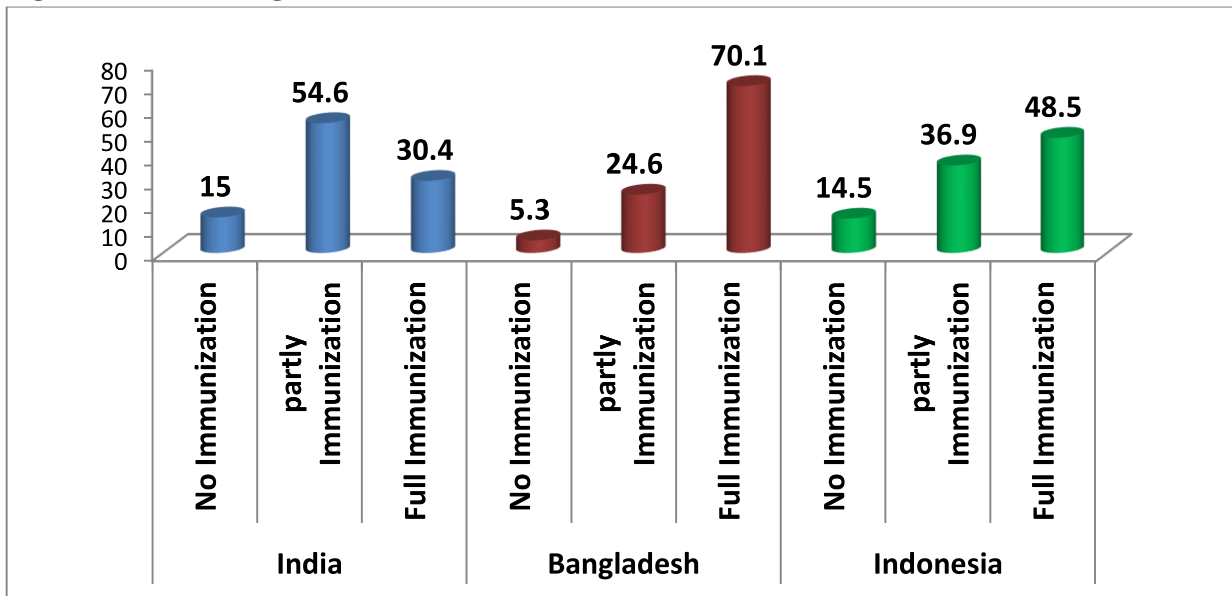


Figure shows the percentage distribution of child immunization among No, partly and full immunization. Figure shows in India higher percentage of partly immunization child than full immunization, but in Bangladesh and Indonesia there is higher percentage of full immunization of child

fallowed by partly and no immunization, if we compare the percentage of full immunization of children, Bangladesh at the first position than Indonesia and India at third position.

Table 4 shows that the affect of women alone autonomy in India on child Immunization. In Model-1 of table, odds show the effect of autonomy on our response variable (Full immunization) without controlling the effect of background factor in India, odds shows the women with alone higher autonomy are statistically significant more likely to have full immunization of child. Model -2 shoes the effect of autonomy on our response variable with controlling the effect of background factors. Odds show that the women with higher autonomy are significantly more likely to have full immunization of child as compare to the reference category which is low autonomy.

Table 5 shows that the affect of women alone autonomy in Bangladesh on child Immunization. In Model-1 of table, odds show the effect of autonomy on our response variable (Full immunization) without controlling the effect of background factor in Bangladesh, odds shows the women with alone higher autonomy are statistically significant more likely to have full immunization of child. Model -2 shoes the effect of autonomy on our response variable with controlling the effect of background factors. Odds show that the women with higher autonomy are significantly more likely to have full immunization of child as compare to the reference category which is low autonomy.

Table 6 shows that the affect of women alone autonomy in Indonesia on child Immunization. In Model-1 of table, odds show the effect of autonomy on our response variable (Full immunization) without controlling the effect of background factor in Indonesia, odds shows the women with alone higher autonomy are statistically significant more likely to have full immunization of child. Model -2 shoes the effect of autonomy on our response variable with controlling the effect of background factors. Odds show that the women with higher autonomy are significantly more likely to have full immunization of child as compare to the reference category which is low autonomy.

Table 7 shows that the affect of women Joint autonomy on child Immunization in India In Model-1 of table, odds show the effect of autonomy on our response variable (Full immunization) without controlling the background, odds shows the women with alone higher autonomy are statistically significant less likely to have full immunization of child. Model -2 shoes the effect of autonomy on our response variable with controlling the effect of background factors. Odds show that the women with higher autonomy are significantly more likely to have full immunization of child as compare to the reference category which is low autonomy.

Table 8 shows that the affect of women Joint autonomy in Bangladesh on child Immunization. In Model-1 of table, odds show the effect of autonomy on our response variable without controlling the background factor, odds shows the women with alone higher autonomy are statistically significant more likely to have full immunization of child. Model -2 shows the effect of autonomy on our response variable with controlling the effect of background factors. Odds show that the women with higher autonomy are significantly more likely to have full immunization of child as compare to the reference category which is low autonomy.

Table 9 shows that the affect of women alone autonomy in Indonesia on child Immunization. In Model-1 of table, odds show the effect of autonomy on our response variable (Full immunization) without controlling the background factor, odds shows the women with alone higher autonomy are statistically significant more likely to have full immunization of child. Model -2 shoes the effect of autonomy on our response variable with controlling the effect of background factors. Odds show that the women with higher autonomy are significantly more likely to have full immunization of child as compare to the reference category which is low autonomy.

Results:

Study result shows that mean of women autonomy increase with increase the level of background characteristics such as age, education, place of residence as urban, wealth, gender of household head as female and occupation of women. And it ultimately increases if women jointly take decision. The findings of this study show that the social –economic demographic factor of women is not affecting their autonomy in similar way. From younger ages to elder ages women are getting autonomous and a certain point come when they starts losses the autonomy. Which is in Bangladesh and Indonesia come at 40-44 age groups but in India in come early at 35-39 age groups? Female joint autonomy although increase with increase the social-economic and demographic level but if we talk about women alone as autonomous. In India it is high among poorer women but in Bangladesh it high among richer and richest women. As the level of education of women increase mean of autonomy start increase in India and in Bangladesh autonomy of women is high among higher educated women but in Indonesia it is high among non educated women. The affect of household sex, if it female, female autonomy ultimately increase. Decision regarding to women health care are mostly taken by husband and others, in Bangladesh mostly taken by women and husband and other jointly but in Indonesia mostly taken by women. Not only women health. Decision of large household purchase, daily household purchase and

decision on visits to relative and friend also have taken in similar way as decision on women health. Decision on money spending, there is a shift observed towards women in India and Bangladesh but large percentage shared by husband and others in India but in Bangladesh it is remain same and in Indonesia it is again by women alone.

Background characteristic such as age, place of residence as urban, education, sex of household head as women (high autonomy), wealth index and professional women are having more autonomy. Study shows that percentage of partly immunization is high in India and in Indonesia but in Bangladesh percentage of full immunization is high. Study also shows that women with high autonomy having more child immunization in All India, Bangladesh and Indonesia. There is no effect of age in India but in Bangladesh and Indonesia, it increase with age. Level of education (secondary education) is positively associated with immunization of child in India, Indonesia and Bangladesh. Level of wealth of women is also significantly associated with immunization of child in all the selected countries. Child immunization has also found significantly associated with occupation of women in India, it is more than 3 time more likely among profession women as compare to unemployed but no effect In Bangladesh and Indonesia either women alone or joint autonomous.

Table 1 Mean Autonomy score of Women for alone autonomy By Background Characteristics:

	India		Bangladesh		Indonesia	
	Mean	Std. Deviation	Mean	Std. Deviation	Mean	Std. Deviation
Age groups						
15-19	10.4	16.24	13.32	19.54	46.82	23.83
20-24	16.01	19.92	15.31	23.79	44.41	25.34
25-29	21.45	25.05	17.47	24.88	45.27	25.03
30-34	24.01	25.15	15.91	23.13	43.34	24.61
35-39	27.75	24.27	21.12	29.82	44.03	27.3
40-44	24.57	31.86	25.66	31.88	50.48	28.92
45-49	14.69	25.66	12.95	17.1	46.62	28.08
Place of residence						
Urban	22.63	26.61	21.48	27.54	45.7	25.3
Rural	20.15	23.02	14.89	22.99	43.78	26.19
Highest educational level						
No education	20.2	23.69	15.41	25.21	49.82	28.35
Primary	26.15	23.87	16.5	24.93	44.57	26.07
Secondary	16.44	23.89	16.43	22.6	46.3	25.89
Higher	26.41	29.31	20.62	23.69	39.51	23.16
Sex of household head						
Male	17.37	22.47	13.43	20.14	42.95	24.47
Female	33.64	25.47	56.74	36.46	65.15	30.69
Wealth index						
Poorest	18.9	23.56	13.31	21.74	44.26	28.19
Poorer	23.63	25	15.25	24.78	43.87	26.94
Middle	20.5	22.61	16.23	25.99	43.55	24.00
Richer	19.79	24.13	22.61	27	46.38	26.13
Richest	22.42	26.46	18.26	22	45.29	24.33
Women occupation						
Unemployed	8.39	13.98	**NA**	**NA**	**NA**	**NA**
Professionals	24.38	30.68	21.75	23.54	39.5	22.62
Sale Service and Domestic	20.75	27.37	17.54	28.6	47.21	26.71
Agriculture	17.82	22.21	13.7	21.63	41.14	25.31
Skilled & Unskilled manual	22.31	23.9	19.4	24.17	46.07	25.36
Business man	NA	NA	18.49	29.19	Na	NA
Total	**20.81**	**24.08**	**16.28**	**24**	**44.74**	**25.77**

Table 2 Mean Autonomy score of Women for joint autonomy By Background Characteristics:

	India		Bangladesh		Indonesia	
Age groups	**Mean**	**Std. Deviation**	**Mean**	**Std. Deviation**	**Mean**	**Std. Deviation**
15-19	39.58	29.66	66.39	30.58	79.82	23.14
20-24	54.29	33.0	69.97	31.87	89.08	19.9
25-29	64.39	33.96	72.41	30.73	90.44	16.54
30-34	70.24	31.33	75.72	28.11	89.48	19.05
35-39	71.51	31.69	79.33	30.01	91.34	16.26
40-44	77.68	27.65	82.4	29.59	88.97	19.21
45-49	74.16	18.23	72.1	31.77	85.3	20.3
Place of residence						
Urban	69.34	33.63	77.93	26.8	90.19	18.22
Rural	60.84	33.19	70.56	31.65	89.27	18.22
Highest educational level						
No education	61.29	34.07	70.17	33.4	91.07	15.37
Primary	59.99	30.07	71.49	29.47	86.77	20.23
Secondary	70.49	33.14	72.34	30.16	91.21	16.88
Higher	89.88	23.49	84.76	22.95	92.54	16.2
Sex of household head						
Male	60.49	34.43	71.44	30.86	89.59	18.42
Female	73.01	27.77	83.69	26.59	91.44	15.69
Wealth index						
Poorest	62.73	33.15	69.22	31.57	87.22	21.21
Poorer	61.59	33.36	71.67	30.76	88.4	18.13
Middle	60.88	32.85	73.7	31.18	88.97	18.46
Richer	64.31	35.3	71.08	32.85	91.36	17.39
Richest	76.83	32.2	78.92	24.78	91.51	16.41
Women occupation						
Unemployed	33.31	24.54	NA	NA	NA	NA
Professionals	88.71	23.76	89.61	13.42	92.22	16.04
Sale Service and Domestic	82.01	26.79	79	27.85	89.49	18.43
Agriculture	64.25	33.41	69.08	31.48	86.31	20.65
Skilled & Unskilled manual	58.38	33.17	71.07	31.61	91.03	16.87
Business man	NA	NA	77.1	27.84	NA	NA
Total	**63.13**	**33.5**	**72.22**	**30.71**	**89.71**	**18.24**

Table 3 Percentage Distribution of Immunization of Children among women across the selected countries by background Characteristics:

	India			Bangladesh			Indonesia		
	No Immunization	partly Immunization	Full Immunization	No Immunization	partly Immunization	Full Immunization	No Immunization	partly Immunization	Full Immunization
Age group									
15-19	20.9	54.0	25.1	7.2	32.2	60.5	32.7	46.4	20.9
20-24	13.0	54.2	32.8	4.5	24.8	70.7	15.9	39.8	44.3
25-29	14.1	53.9	32.0	4.8	22.7	72.5	13.9	38.0	48.0
30-34	14.5	56.2	29.3	6.6	21.7	71.6	12	33.4	54.6
35-39	19.6	55.0	25.3	4.1	19.8	76.1	13.9	33.5	52.7
40-44	26.8	55.5	17.7	7.3	25.8	66.9	14.6	39.7	45.6
45-49	11.1	64.4	24.4	5.3	5.3	89.5	20.4	35.7	43.9
Place of residence									
Urban	9.0	50.6	40.4	4.8	23.4	71.8	10.3	35.2	54.5
Rural	17.9	56.6	25.5	5.5	25.0	69.6	17.8	38.2	44.0
Level of Education									
No education	18.7	62.3	19	8.2	27.3	64.6	34.6	43.4	22.0
Primary	14.7	47.9	37.4	5.4	24.5	70.1	20.0	39.2	40.8
Secondary	8.1	43.4	48.5	3.8	23.2	73.0	10.2	36.1	53.7
Higher	0.0	31.6	68.4	2.5	22.2	75.3	5.1	26.7	68.3
Sex of Household head									
Male	14.9	54.2	30.9	5.3	24	70.6	14.5	36.7	48.8
Female	15.2	56.9	27.9	5.3	30.4	64.3	15.2	39.5	45.3
Wealth Quintiles									
Poorest	22.7	57.4	19.8	5.7	25.6	68.7	27.1	37.4	35.4
Poorer	17.0	60.4	22.5	6.5	27	66.5	16.8	38.5	44.6
Middle	13.9	58.8	27.3	5.6	24.3	70.1	13.1	39.6	47.3
Richer	10.8	47.7	41.5	4.8	23	72.2	10.0	37.4	52.6
Richest	5.0	43.5	51.5	3.7	22.7	73.6	6.0	31.3	62.6
Occupation of women									
Unemployed	15.7	53.3	30.9	5.8	25.1	69.1	16.3	37.9	45.7
Professionals	4.9	52.5	42.6	4.3	17	78.7	6.8	28	65.3
Sale Service and Domestic	13.3	52.6	34.1	7.8	23.9	68.3	11.2	35.7	53.1
Agriculture	13.4	63.8	22.9	2.7	23.9	73.5	17.3	39.4	43.3
Skilled & Unskilled manual	11.4	55.6	33	4.4	22.2	73.4	9.9	34.1	56.0
Businessman	**NA**	**NA**	**NA**	7.5	26.9	65.7	**NA**	**NA**	**NA**
Total	**15**	**54.6**	**30.4**	**5.3**	**24.6**	**70.1**	**14.5**	**36.9**	**48.5**

Table 4 Women alone Autonomy in India:

Model-1	Model-2
Full Immunization	Full Immunization
Autonomy Of Women Alone	
Lower®	
Higher 1.40***	1.097**
Age	
15-19®	
20-24	1
25-29	0.69
30-34	1.05
35-39	0.86
40-44	1.21
45-49	1.57
Education	
No education®	
Primary	2.246***
Secondary	2.400***
Higher	2.325
Place of residence	
Urban®	
Rural	1.496*
Sex of Household head	
Male ®	
Female	0.691
Wealth Index	
Poorest®	
Poor	1.456
Middle	1.124
Richer	2.519***
Richest	2.569**
Occupation	
Unemployed®	
Professional	3.401**
Sale & service and domestic	3.233
Agriculture	1.395
Skilled & Unskilled manual	2.877
Business	NA
Constant	0.54**

Table 5 Women alone Autonomy in Bangladesh:

Model-1	Model-2
Full Immunization	Full Immunization
Autonomy Of Women Alone	
Lower®	
Higher 1.09**	1.05**
Age	
15-19®	
20-24	1.188
25-29	1.938**
30-34	2.143**
35-39	2.017**
40-44	1.237
45-49	1.21
Education	
No education®	
Primary	1.1373
Secondary	1.808**
Higher	0.583
Place of residence	
Urban®	
Rural	0.793
Sex of Household head	
Male ®	
Female	0.454***
Wealth Index	
Poorest®	
Poor	1.005
Middle	1.444
Richer	1.2
Richest	1.931**
Occupation	
Unemployed	NA
Professional®	
Sale & service and domestic	0.333**
Agriculture	0.532
Skilled & Unskilled manual	0.424*
Business	0.534
Constant	38.247

Table 6 Women Autonomy alone in Indonesia:

Model-1	Model-2
Full Immunization	Full Immunization
Autonomy Of Women Alone	
Lower®	
Higher 1.05**	1.019*
Age	
15-19®	
20-24	1.664
25-29	1.617
30-34	1.717*
35-39	1.907**
40-44	1.803*
45-49	2.487**
Education	
No education®	
Primary	1.645**
Secondary	2.011***
Higher	2.362***
Place of residence	
Urban®	
Rural	1.033
Sex of Household head	
Male ®	
Female	0.743**
Wealth Index	
Poorest®	
Poor	1.226
Middle	1.311**
Richer	1.448***
Richest	1.666***
Occupation	
Unemployed	NA
Professional®	
Sale & service and domestic	0.891
Agriculture	0.823
Skilled & Unskilled manual	1.076
Business	NA
Constant	1.07

Table 7 Women Joint Autonomy in India:

	Model-1	Model-2
	Full Immunization	Full Immunization
Autonomy Of Women joint		
Lower®		
Higher	0.965**	0.791**
Age		
15-19®		
20-24		1.031
25-29		0.735
30-34		1.118
35-39		0.938
40-44		1.281
45-49		1.763
Education		
No education®		
Primary		2.326***
Secondary		2.478***
Higher		2.386
Place of residence		
Urban®		
Rural		1.435*
Sex of Household head		
Male ®		
Female		0.714
Wealth Index		
Poorest®		
Poor		1.47
Middle		1.133
Richer		2.542***
Richest		2.55
Occupation		
Unemployed®		
Professional		3.8
Sale & service and domestic		3.57
Agriculture		1.519
Skilled & Unskilled manual		2.976
Business		NA
Constant		0.551*

Table 8 Women joint Autonomy in Bangladesh:

	Model-1	Model-2
	Full Immunization	Full Immunization
Autonomy Of Women joint		
Lower®		
Higher	1.08**	1.03*
Age		
15-19®		
20-24		1.179
25-29		1.928**
30-34		2.131**
35-39		1.993**
40-44		1.632
45-49		1.532*
Education		
No education®		
Primary		1.384
Secondary		1.808**
Higher		0.584
Place of residence		
Urban®		
Rural		0.787
Sex of Household head		
Male ®		
Female		0.461***
Wealth Index		
Poorest®		
Poor		1.002
Middle		1.44
Richer		1.213
Richest		1.925**
Occupation		
Unemployed		NA
Professional®		
Sale & service and domestic		0.333**
Agriculture		0.539
Skilled & Unskilled manual		0.431*
Business		0.54
Constant		38.715

Table 9 Women joint Autonomy in Indonesia:

	Model-1	Model-2
	Full Immunization	Full Immunization
Autonomy Of Women joint		
Lower®		
Higher	1.175**	1.126**
Age		
15-19®		
20-24		1.625
25-29		1.591
30-34		1.678
35-39		1.856**
40-44		1.759*
45-49		2.441**
Education		
No education®		
Primary		1.66**
Secondary		2.017***
Higher		2.36***
Place of residence		
Urban®		
Rural		1.032
Sex of Household head		
Male®		
Female		0.739**
Wealth Index		
Poorest®		
Poor		1.236*
Middle		1.324**
Richer		1.453***
Richest		1.677***
Occupation		
Unemployed		NA
Professional®		
Sale & service and domestic		0.897
Agriculture		0.831
Skilled & Unskilled manual		1.083
Business		NA
Constant		1.044

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