Sexual and reproductive decision-making among married and cohabiting women in Mahikeng.

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ABSTRACT

Background: Sexual and reproductive decision-making has emerged as an important health indicator as husbands dominate in family reproductive issues. While there is evidence of male dominance in sexual and reproductive decision, the role of socio-demographic factors on women's decision-making on sex and family size are not well understood. In the study, the theory of gender and power was used to characterise Socio-cultural and socio-economic factors influence women's decision-making on sex and family size.
Objectives: To examine the extent to which women in marital and cohabiting unions make decisions on sex and family size.
Method: Sexual and reproductive health decision-making survey of 568 respondents was conducted among married and cohabiting women in Mahikeng, South Africa in 2012. Data were collected on respondents' socio-demographic characteristics and their relationship reproductive health matters. Data were analyzed using descriptive and binary logistic analyses.
Result: The data revealed that 61% and 70% participate in decisions on when to have sex and family size. The background variables that play out on the outcome variables indicated that the theory of gender and power was partially validated. Type of union, employment status, arranged marriage, experiences of forced sex and perceptions that husbands had right to sex were associated with decision-makings on when to have sex. Decision-making on family size was associated with age, place of residence, type of union, number of children, experiences of forced sex and perceptions that husbands had right to sex.
Conclusion: Sexual and reproductive decision-making in marital or cohabiting relationships cut across secular, cultural and religious domain. Limited participation on sexual and reproductive decision-making stemmed from poor economic status, cultural gender norm and patriarchal dominance. These may have negative implications on women's sexual and reproductive health.
Recommendation: The commitment of husbands, traditional and religious leaders' is salient to improve married women's sexual and reproductive decision-making. Strategy should focus on empowering women with income earning skills and advocate free choice of husbands/partners, sexual and reproductive rights.

Introduction

The International Conference on Population and Development (ICPD) (UNFPA, 1994), Millennium Development Goals (MDGs) (UNITED NATIONS, 2000) and the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) (UNITED NATIONS, 2003) raise issues on reproductive health decision-making and the reproductive rights of women. Autonomy of women in reproductive health decision-making is considered a realization of their reproductive rights, gender equity and women empowerment. Autonomy has been defined only operationally by scholars due to a lack of a definitive consensus on the concept. Jejeebhoy & Sathar, (2001) define autonomy as the "control women have over their own lives—the extent to which they have an equal voice with their husbands in matters affecting themselves and their families, control over material and other resources, access to knowledge and information, the authority to make independent decisions, freedom from constraints on physical mobility, and the ability to forge equitable power relationships within families" (page 688). Mumtaz & Salway, (2009), fervent critics of the autonomy paradigm questioned the undue emphasis on women autonomy because in families, husbands and wives are united in an emotional and structural bond. They argued that "gendered inequality in access to resources beyond the home simply depicts that the interests of women are strongly vested in their families". Based on their argument, women's autonomy on reproductive health issues may continue to dominate in the development and reproductive policy agenda.

Reproductive decision-making social context of women in South Africa

The South African patriarchal society combined with the apartheid legacy impacted on poor reproductive health decision-making power and on sexual violence against women (Hargreaves et al., 2009; Maharaj, 2001; O'Sullivan, Harrison, Morrell, Monroe-Wise, & Kubeka, 2006). Partners programme

promoting sexual and reproductive health in South Africa revealed that the suppression of black women benefited black men during the apartheid era (Peacock & Levack, 2004). Sexual violence and reproductive health abuses against women have been reported in Cape Town and rural Transkei (Buga, Amoko, & Ncayiyana, 1996; Dunkle et al., 2004; Jewkes & Abrahams, 2002) (Jewkes, Vundule, Maforah, & Jordaan, 2001). The traditional attitude to sexual relationships that perceives a woman as an object for sex and a baby-making machinery has not changed (Posel, Rudwick, & Casale, 2011; Preston-Whyte, Zondi, Mavundla, & Gumede, 1990). For instance, men encourage young women to become pregnant as evidence of love, womanhood, and fertility (Gage, 1998; Preston-Whyte et al., 1990; Katharine Wood & Jewkes, 1997).

Preston-Whyte, (1988) observed that fertility is an integral part of the cultural construct of the female self among people regardless of age or marital status. The cultural importance of female fertility discouraged the motivation to negotiate contraceptive use among women in South Africa (Varga & Makubalo, 1996; Wood & Jewkes, 2006). The cultural milieu thus controls women's spheres of reproductive behaviour. Given that young women have been socialized to accept dependency raises the question as to whether women in marital and steady unions can participate in reproductive decision-making.

The post-apartheid era in South Africa did not witness only political emancipation but also a rapid socio-cultural transformation and changes in historical power differentials between men and women (Enslin, 2003; Posel, 2004). South African social and political climates offer equal opportunities to men and women. Women actively participate in the labour force: have access to education and access to family planning. The new dispensation has ushered in a flexible marriage system. Hence, women have a right to be in a marital relationship that is in community or out of community of property, a practice that seems peculiar to South Africa (Budlender, Chobokoane, & Simelane, 2004).

Marriage can give women access to control resources independent of husband/partners interference. These social transformations may alter the traditional sexual norms and values. This underscores the need for research into married and cohabiting women's participating in sexual and reproductive decision-making in the midst of socio-cultural dynamics.

Notwithstanding the modernization in South African society, reproductive decision-making involves a multifaceted interplay of individuals, family interactions and a range of socio-cultural factors. Studies in South Africa have shown that men dominate reproductive decision-making in marital or cohabiting relationships (Hargreaves et al., 2009; Mantell et al., 2009; Ragnarsson, Townsend, Thorson, Chopra, & Ekström, 2009). Women's aspirations to make sexual and reproductive health decisions independently spurred fierce criticism of rebellion against national, ethnic and religious identity (Klugman, 2000). Cultural, social and religious values on heterosexual marriage within South African take precedence over national law limiting women's sexual and reproductive decision-making (Boonzaier & de La Rey, 2003). Hence the call for research on sexual and reproductive decision-making remains a matter of concern which requires some sense of urgency.

Of a particular importance is the relative effect of socio-demographic variables on sexual and reproductive decision-making. Following the Cairo declaration in 1994, spectrum of studies on direct and proxy indicators of women's autonomy in reproductive health decision-making have emerged. The power imbalance that influences the sexual and reproductive decision-making capability of women operates through socio-cultural and structural factors such as economic dependency and feminization of poverty (Dunkle et al., 2004; Falola & Heaton, 2007; Wodi, 2005; Zulu, Dodoo, & Ezeh, 2003), religious beliefs (Falola & Heaton, 2007; Wyatt et al., 2000), and being in a consensual union (Grady, Klepinger, Billy, & Cubbins, 2010; Speizer, Whittle, & Carter, 2005). Others

studies found that constrained sexual and reproductive decision-making among women were associated with their limited formal educational opportunities (Mathews & Abrahams, 2001; Wodi, 2005), place of residence (Maharaj & Cleland, 2004; Wodi, 2005), age difference within a couple, duration of the union (Langen, 2007; Speizer et al., 2005; Wusu & Isiugo-Abanihe, 2010) and imposed marriages (Orisaremi & Alubo, 2012). Given the spectrum of factors that play out in women's reproductive decision-making, it was hypothesized that:

- Employed women are more likely to indicate that they participate in decision-making on when to have sex compared to unemployed counterparts.
- Women in an arranged union are less likely to indicate that they participate in decision-making on when to have sex compared to women who made the choice of their husbands/partners.
- Rural women are less likely to state that they participate in decision-making on family size compared to urban women.
- Women in traditional union are less likely to state that they participate in decision-making on family size compared to those in civil union.

Theory of Gender and Power

A theoretical framework such as gender and power is salient to understand sexual and reproductive decision-making. According to Connell, (1987), there are three distinct but overlapping structures of gendered relationship between men and women. These three structures are present at the societal and institutional levels and are sustained by social mechanisms. In the socio-cultural arena, there exist double standards which serve to intensify women's vulnerability in all spheres of life. The three structures are: Sexual division of labour – refers to economic inequity between men and women; Sexual division of power – refers to male dominance within relations; and the structure of the cathexis – refers to societal norms about gender roles.

The theory of gender and power is ideal for analysing intersecting identities such as culture, gender and sexuality. The three structures of gender and power theory put married/cohabiting women at the centre of the subject being investigated through the socio-cultural perspective for understanding the life experiences of these women. It offers a wide-ranging analysis of sexual dynamics promotes women empowerment and integrates male perspective into its definition. Studies have used this theory to account for sexual risk outcomes (Blanc, 2001; Pulerwitz, Gortmaker, & DeJong, 2000; Wingood & DiClemente, 2000) but limited in determining if the women's sexual decision-making power were compromised (Amaro, 1995; Upadhyay, Dworkin, Weitz, & Foster, 2014). Some researchers notably, Wingood and DiClemente (2000) extended the theory of gender and power to exposure, risk factors and biological features that influence women's susceptibility to HIV in public health models. This theory can also be extended to understand sexual and reproductive decision-making among women. The present study therefore applied the theory of gender and power on sexual and reproductive decision-making life experiences stemming from married/cohabiting women.

Methodology

The present study was an integral part of Mahikeng Sexual and Reproductive Health Survey that target heterosexual married women within the reproductive age range (18-49) in Mahikeng Local Municipality in 2012. Study details and findings have been published elsewhere (Osuafor & Mturi, 2014). The thrust of the current study was on the data collected on decision-makings on when to have sex and family size.

Measures

In this study autonomy is defined as the degree of women's participation in decision-making on when to have sex and on family size. Participation in reproductive decision-making was measured on two dependent variables which

are “when to have sex” and family size. Questions pertaining to the decisions on “when to have sex” has three actors: (1) husband; (2) wife; (3) both. Responses (2) is full autonomy; (3) is partial autonomy; whereas responses (1) indicated no autonomy because the woman is not the decision maker and was assigned the values 0.

Full autonomy and partial autonomy were combined in the case of “when to have sex” at bivariate and multivariate levels because the proportion of women reporting full autonomy was too small to stand alone in the analysis. Women were further asked “Can a woman decide on the number of children to have”? Question on number of children to have was measured as “Yes” coded as 1 and “No” coded as 0.

Data analysis

Statistical Package for Service Solutions (SPSS) version 22 was used for data processing. At the univariate level, frequency and percentages were used to describe demographic characteristics. Tests of association between decisions on sex, family size and demographic characteristics were conducted with chi-squares. Binary logistic models were used to examine the effect of the socio-demographic characteristics associated with women’s decisions makings on “when to have sex” and on family size.

RESULTS

Demographic characteristics presented in table 1 below shows an inverted u-shaped. Majority were residing in the rural area. Over one – third were in civil union while two-third reported Setswana as their home language. Slightly over half had primary or no formal education. Majority reported that they were employed. About one-third reported Pentecostal as their religious denomination. Slightly over half had one to two living children. Majority indicated that they chose their husband. Three-quarters stated that husbands had no right to sex while slightly over half had experiences of forced sex.

Table 1: Demographic characteristics of the respondent

Characteristics	N = (568)	Percent
Age group		
< 25	64	11.3
25-29	107	18.8
30-34	114	20.1
35-39	119	21.0
40-44	90	15.8
45-49	74	13.0
Residence		
Rural	445	78.3
Urban	123	21.7
Type of union		
Civil	212	37.3
Religious	112	19.7
Traditional	149	26.2
Cohabiting	95	16.7
Home language		
Setwana	376	66.2
Afrikaans	21	3.7
IsiXhosa	50	8.8
Sesotho	74	13.0
Zulu	47	8.3
Education level		
< Primary	291	51.2
Secondary+	277	48.8
Employment status		
Unemployed	169	29.8
Employed	399	70.2

Religion denomination		
Roman Catholic Church (RCM)	72	12.7
Methodist	146	25.7
Seventh Day Adventist (SDA)	95	16.7
Pentecostal	213	37.5
Other religion	42	7.4
Number of living children		
None	77	13.6
1-2	290	51.1
3-4	168	29.6
5+	33	5.8
I chose my partner		
No	40	7.0
Yes	528	93.0
Experience of forced sex		
No	291	51.2
Yes	277	48.8
Partner has right to sex		
No	435	76.6
Yes	133	23.4

Source: Mahikeng Sexual and Reproductive Health Survey, 2012. *Other religions include traditionalist and other religious affiliations whose samples was too small to stand alone in the analysis

Reproductive decision-making: Univariate Analysis

Table 2 shows that about 60% of the women reported that the decision on when to have sex was jointly made by the husband and wife. Over two-thirds reported that they have autonomy in decision on the number of children to have.

Table 2: Percentage distribution of women's participation in sexual reproductive decision-making

Decision on:	**N**	**Husband/partner**	**Women**	**Jointly**
When to have sex	568	39.1	1.2	59.5
		NO	**YES**	
Family size	568	29.9	70.1	

Source: Same as Table 1

Patterns in decision-making on when to have sex and family size by socio-demographic characteristics of respondents: Bivariate analysis

Chi-squared analyses indicated significant association between all socio-demographic variables examined and decision-making on when to have sex. Table 3 below shows that the domination of the husband in decision-making on when to have sex increased consistently from 34% for women aged 30-34 to 64% for those aged 45-49. Husband's dominance was also common among rural dwellers, those in traditional union, IsiZulu speaking, primary or no formal education, unemployed women, professing traditional religion and among women with 5 or more living children The influence of the husband in decision-making on when to have sex was more dominant among women in arranged marriages, reporting that a husband has a right to sex and experiences of forced sex.

Women below 25 years old reported higher percentage for joint decision-making on when to have sex compared to 45-49 age group. Reporting joint decision-making on when to have sex was high among urban women. Women in civil unions showed the highest percentage (65%) reporting a joint decision-making on when to have sex. The proportion reporting joint decision-making on when to have sex was higher among Afrikaans speaking compared to IsiZulu speaking women. Women with secondary education or more and employed women showed highest percentages in reporting joint decision-making on when to have sex. Methodist women compared to those who professed traditional religion had higher percentage in joint decision-making on when to have sex. Women with five or more children had lowest percentage in stating that they both make decision on when to have sex. Joint decision-making on when to have sex was common among those who chose their husband. Furthermore, joint decision-making was higher among women who stated that husbands have no right to sex compared to those who reported that husbands have right to sex. Women without

experiences of forced sex showed a higher percentage in joint decision-making compared to those whose husband uses force to have sex.

Decision-making on family size showed significant association with the demographic characteristics with the exception of employment status. Decision-making on family size decreases consistently with increasing age. The highest percentage in reporting sole decision-making on family size was observed among those living in urban areas, in civil unions and those who speak Afrikaans. Reporting sole decision-making on family size was widespread among women with secondary education or more, and Seventh Day Adventists. Sole decision-making on family size decreases consistently with the increasing number of living children. Reporting sole decision-making on family size was 72% among women who chose their husbands/ partners, higher than those in arranged marriages. The highest percentages in reporting sole decision-making on family size were observed among women who reported 'no' to a husband's right to sex and those with no experiences on forced sex.

Table 3: Percentage distribution of respondents by pattern of decision-making on when to have sex and demographic characteristics

		Decision on Sex			Decision on	
Characteristics	**N = (568)**	**Husband**	**Joint**	**p value**	**Family size**	**p value**
Age group				0.000		0.000
< 25	64	25.0	75.0		93.8	
25-29	107	36.4	63.6		80.4	
30-34	114	34.2	65.8		67.5	
35-39	119	38.7	61.3		64.7	
40-44	90	40.0	60.0		63.3	
45-49	74	63.5	36.5		55.4	
Residence				0.001		0.000
Rural	445	42.9	57.1		64.3	
Urban	123	26.0	74.0		91.1	
Type of union				0.000		0.000
Civil	212	27.4	72.6		78.8	
Religious	112	38.4	61.6		68.8	
Traditional	149	55.0	45.0		57.7	
Cohabiting	95	42.1	57.9		71.6	

Home language				0.001		0.002
Setwana	376	35.4	64.6		73.7	
Afrikaans	21	14.3	85.7		85.7	
Isixhosa	50	48.0	52.0		64.0	
Sesotho	74	47.3	52.7		64.9	
IsiZulu	47	59.6	40.4		48.9	
Education level				0.000		0.000
< Primary	291	49.1	50.9		61.2	
Secondary+	277	28.9	71.1		79.4	
Employment status				0.000		0.059
Unemployed	169	59.2	40.8		64.5	
Employed	399	30.8	69.2		72.4	
Religion				0.022		0.034
Roman Catholic church	72	41.7	58.3		63.9	
Methodist	146	33.6	66.4		73.3	
SDA	95	36.8	63.2		76.8	
Pentecostal	213	39.0	61.0		70.4	
Other religion	42	61.9	38.1		52.4	
Number of living children				0.000		0.000
None	77	33.8	66.2		88.3	
1-2		30.7	69.3		74.5	
3-4	168	47.6	52.4		61.3	
5+	33	84.8	15.2		33.3	
I chose my partner				0.000		0.000
No	40	77.5	22.5		45.0	
Yes	528	36.4	63.6		72.0	
Partner uses force for sex sometimes				0.000		0.000
No	291	29.6	70.4		80.4	
Yes	277	49.5	50.5		59.2	
Partner has right to sex				0.000		0.000
No	435	31.0	69.0		75.4	
Yes	133	66.2	33.8		52.6	

Source: Same as Table 1

Multivariate analysis of the factors related to women's autonomy in decision-making on when to have sex and family size.

Sixty-one percent of the women exhibited partial autonomy in decision-making on when to have sex. In the model of women's autonomy in decision-making on when to have sex shown in table 4 below, the hypothesis that employed women were more likely to participate in decision-making on when to have sex

compared to unemployed counterparts was confirmed. In addition, women in arranged marriages were less likely to participate in decision-making on when to have sex compared to those who chose their husbands/partners was confirmed. Furthermore, type of union, number of living children, experienced forced sex and perception that husbands have the right to sex were significant predictors of decision-making on timing of sex. Women in religious and traditional unions were less likely to participate jointly in decisions about when to have sex compared to those in civil marriages. Lower likelihood in joint decision-making about sex was observed among women with 5 or more living children. Women who were experiencing forced sex had 33% reduced odd of participating in joint decision-making on when to have sex. Women who stated 'Yes' to husband's right to sex showed 62% reduced odds of participating in joint decision-making on when to have sex. However, there was no significant association between decision on when to have sex and education, place of residence, home language, and religion.

Over two-thirds reported full autonomy in decision-making on family size. Table 4 indicates that the hypothesis that rural women were less likely to exercise autonomy in decision-making on family size compared to their urban counterparts was endorsed. Likewise, women traditional union were less likely to state participation in decision-making on family size was confirmed. Furthermore, age, forced to have sex, number of living children and partner has right to sex were significant predictors of women's autonomy in decision-making on family size.

A low likelihood to decide on family size was observed among women of age 30 and above. The urban women were 4 times more likely to decide on family size compared to their rural counterparts. Women in traditional union showed 48% reduced odds in family size decision-making autonomy. Reduced odd in family size decision-making was observed among women who had 5 living children or

more. Women who were experiencing of forced sex had 54% reduced odds. Women who reported 'Yes' to a partner had a right to use force for sex showed 40% reduced odds in family size decision-making autonomy. However, education, occupation, religion and choosing a husband/partner were found to be non-significant predictors of decision-making on family size.

Table 4: Parsimonious logistic regression showing the factors related to decision-making on when to have sex and family size

	When to have sex		**Family size**	
Characteristics	**ORs**	**95% CI**	**ORs**	**95% CI**
Type of union				
Civil (Ref)	1.000		1.000	
Religious	**0.558***	0.329 - 0.949	0.640	0.363 - 1.128
Traditional	**0.518***	0.313 - 0.857	**0.519***	0.303 - 0.889
Cohabiting	0.563	0.315 - 1.007	0.515	0.264 - 1.004
Employment status				
Unemployed (Ref)	1.000		-	-
Employed	**2.066****	1.353 - 3.155	-	-
Number of living children				
None (Ref)	1.000		1.000	
1-2	0.980	0.541 - 1.775	0.621	0.255 - 1.512
3-4	0.565	0.297 - 1.078	0.510	0.197 - 1.324
5+	**0.155****	0.048 - 0.509	**0.285***	0.081 - 1000
I chose my partner				
No (Ref)	1.000		-	-
Yes	**3.499****	1.474 - 8.303	-	-
Partner uses force for sex sometimes				
No (Ref)	1.000		1.000	
Yes	**0.674***	0.456 - 0.994	**0.459****	0.301 - 0.700
Partner has right to sex				
No (Ref)	1.000		1.000	
Yes	**0.380****	0.238 - 0.605	**0.598***	0.369 - 0.970
Age group				
< 25	-	-	2.923	0.882 - 9.685
25-29 (Ref)	-	-	1.000	
30-34	-	-	**0.392****	0.200 - 0.771
35-39	-	-	**0.388****	0.195 - 0.774
40-44	-	-	**0.345****	0.158 - 0.753
45-49	-	-	**0.376***	0.165 - 0.858
Residence				
Rural (Ref)	-	-	1.000	

Urban	-	-	4.430**	2.239 - 8.765

Source: same as table 1. *significant at $p < 0.05$; **significant at $p < 0.001$, 1.000– Reference category, ORs- Odd Ratios

DISCUSSION

The extent to which women have equal voice on sex and family reproductive decision-making is a critical issue in reproductive health which appeals for theoretical validation. In the study, the theory of gender and power was partly validated in characterising socio-cultural factors that influence women's decision making on sex and family size. The findings of the study were discussed under the specific headings of the outcome variables.

Women's decision-making autonomy on when to have sex

It is expected that within the construct of cathexis women in religious and traditional marriages would participate less in decisions on when to have sex. South Africa is a secular society with a gender equality agenda that favours women in civil marriages. However, Religious and traditional marriages have their own sets of rules which are often in conflict with secular laws of marriages. Religious marriages use the Scriptures as the yardstick with regards to the conduct of men and women in marital affairs. Women are always advised not to deny their husband sex within marriage. In traditional marriages, women are admonished to be available to their husband for sex to avert marital conflicts. These finding are in consonance with previous studies that culture (Isiugo-Abanihe, 1994; Osuafor & Mturi, 2014) and religion (Osuafor & Mturi, 2014; Srikanthan & Reid, 2008) have shaped sexual decision-making ability of married women.

The study revealed a significant association between employed women and participation in decision-making on when to have sex. Support for this finding is found within the sexual division of labour that lack of economic privilege

impedes women's sexual decision ability. Employment of women in any job with remuneration bestows on them economic independence which enhances their decision-making power. This finding corroborates studies in Nepal (Acharya, Bell, Simkhada, van Teijlingen, & Regmi, 2010), Gautemala (Becker, Fonseca-Becker, & Schenck-Yglesias, 2006) and Nigeria (Iyayi, Igbinomwanhia, Bardi, & Iyayi, 2011; Ogunjuyigbe & Adeyemi, 2005) where women's economic dependence on their husbands impaired control over sexual decisions. On the other hand, the result contradicts other studies where economic advantage did not lead to women's participation in reproductive decision-making (Omeje, Oshi, & Oshi, 2011). The economic opportunities in South Africa are highly liberal. Women can enter into any occupation without restrictions, possess assets and productive resources. Hence they may have no difficulty in differentiating free engagement in sex from sex driven by economic pressure.

In the sexual division of power construct, women with five or more children tended to participate less in decision-making on when to have sex compared to those with no children. The lack of decision-making power among women with at least 5 living children on decision-making when to have sex may be linked to adherence to the cultural socialization of subservience to husbands inculcated in women from childhood about sex in marital relationships (Gage, 1998; Preston-Whyte, 1988). Large number of living children is generally associated with older woman, but behavioural factors such as absence of fertility regulation, poor communication and low self-efficacy may further account for their limited participation in sexual decision-making. This finding is in sharp contrast with studies in Lagos (Ogunjuyigbe & Adeyemi, 2005) and Southern Asia (Senarath & Gunawardena, 2009). An increase in the number of children ought to give women some sort of autonomy in reproductive decision-making. However, this was not the case in the study.

The findings that women in arranged marriages lacked ability to participate in decision on sex had a support in the structure of the cathexis of societal norm. An arranged marriage is a sexual slavery where a woman depicts a sex object to the husband. Thus, a woman is striped off her self-esteem. This finding concurs with other studies that documented lack of autonomy in decision-making about sex when marriage was imposed on a woman (Orisaremi & Alubo, 2012). There is a need to discourage arranged or imposed marriages on women and encourage a free spousal choice making as a strategy to establish relationships where egalitarian decision-making prevails on issues of common concern.

Within the construct of sexual division power the perception that husbands have a right to sex, even with force was validated. This finding is similar to other studies (DeKeseredy, Rogness, & Schwartz, 2004; Pornari, Dixon, & Humphreys, 2013; Ryan et al., 2009) which reported that societal patriarchy confers on men a right to sex in marital relationship. Similarly, findings that women who experienced forced sex had no say on when to have sex is not unexpected. Sexual abuse is an aspect of inequality that dehumanises women. These women failing to make a wilful decision about when, where and how sexual act can occur suggest that realization of their reproductive rights and equal voice with their husbands on sexual issues is unattainable.

Women's decision-making autonomy on family size

The inability of women in traditional unions to exercise autonomy in family size is consistent with previous studies (Bledsoe, 1990; Isiugo-Abanihe, 1994; Osuafor & Mturi, 2014). This finding that women in traditional union lack participation on decision-making on family size validates the cathexis of the theory of gender and power. A traditional union suggests that the process of instituting the marriage adheres to the concept of ownership of the woman by the husband through the payment of *lobola*. By this the reproductive rights of the

women are transferred to the husband. This may suggest that men still hold decision-making power over the fertility of women.

Women with five or more children do not have the ability to exercise autonomy in family size decision-making. It seems that family size is determined by the patriarchal structure in which men derive joy from a large family size. This may suggest male-dominance in family size which is consistent with previous studies (Dyer, Abrahams, Mokoena, & Van der Spuy, 2004; Isiugo-Abanihe, 1994). In addition, cultural values on women's fertility confers more social status on women with children (Dyer, Abrahams, Hoffman, & van der Spuy, 2002; Isiugo-Abanihe, 1994). It appears that decision-making on family size is relinquished intentionally by women for the advantage on having a large family size.

The study revealed lack of participation in decision-making on family size among women who reported being forced to have sex found support within the sexual division of power construct. Over three-quarters of the women conceded that partners do not have the right to use force for sex. However, it was observed that a proportion (49%) of the women reported experiences of forced sex. Forced sex suggests devaluation of self-worth and may have serious implications on the sexual and reproductive health of women. In line with a previous study in South Africa, forced sex is associated with inability of women to exercise reproductive health autonomy (Pettifor et al., 2004).

Women who agreed that a partner has a right to use force for sex also revealed lack of autonomy in family size decision-making. This suggests a gap in the knowledge of the reproductive health rights of these women. This group of women may have difficulty in meeting their reproductive health goals. Sexual rights of women have been promoted to enhance women's ability to exercise autonomy over their sexual and reproductive health. It is not surprising that some women were not well informed on the reproductive rights of their partners given

that the geographical location of Mafikeng is a challenge to obtaining reproductive health information (Versteeg & Murray, 2008).

The findings that women aged 30-49 years old tended to have low decision-making power on family size may be due to socialization of such women. Previous studies have shown that at a young age, women were socialized to be wives, mothers and submissive to their husbands (Kambarami, 2006; Kulu, 1990). It would appear that inability to decide on family size among women aged 30 and over may be the influence of traditional socialization of women to be submissive to men on reproductive issues. This suggests that modernisation has not completely transformed the traditional patriarchal attitude on sexual and reproductive decision-making as reported in earlier studies in KwaZulu-Natal (Dyer et al., 2002; Varga, 2003).

As expected, urban women were more likely to participate in decision-making on family size than their counterparts in rural areas. The theory of gender and power was validated on account of non-participation of rural women in decisions on family size. Similar findings have been found in Nigeria (Ogunjuyigbe & Adeyemi, 2005) and South Asia (Acharya et al., 2010; Senarath & Gunawardena, 2009). Traditionally, it was the duty of the husband, as the sole decision maker, to provide for the family. In recent times the high cost of living and the living arrangements in urban areas have made the income of the husband inadequate to sustain his family. In addition, women are compelled to engage in jobs for pay and become co-providers which give them courage to participate in decisions on the family size. Furthermore, urban women are exposed to and have access to basic social, economic and health services which give rise to an egalitarian relationship which enhances their decision-making ability. The supremacy of traditional patriarchal society may overrule rural women's participation in reproductive decision-making on family size. Women in rural

areas may deem childbearing more important to them than the economic implications of having many children.

CONCLUSION

South Africa has undergone socio-cultural changes with the demise of apartheid in the level of women's participation in sexual and reproductive decision-making. However, socio-cultural inequalities between men and women on sex and reproductive decision-making have not been eroded. There is a need to empower women by giving them income yielding skills. Given that egalitarian decision-making is ideal in marital or cohabiting relationships, Community health programmes that promote free choice of husbands/partners, sexual and reproductive rights may avail women equal voices with their partners on sexual and reproductive issues.

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