What is Associated with Married Women's Contraceptive Behavior in Ghana?

by

Loretta Bass
University of Oklahoma
Email: Lbass@ou.edu

and

Morgan A. Richards
University of Oklahoma
Email: mrichards721@yahoo.com

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Abstract

Using the 2008 Ghana DHS data, this research models what is associated with married women's contraceptive behaviors and uses logistic regressions to examine whether a woman reports: 1) ever using contraception and 2) ever using a condom. Using social dominance theory's four bases of gendered power, authors find partial support to the hypothesis that a woman's increased power vis-à-vis her husband translates into higher likelihoods of contraceptive use. Both greater male household and sexual decision-making power and greater women's resource control are associated with lower odds of contraceptive use, while having more children is associated with higher odds, net of other effects. Condom use operates differently than the broader contraceptive use category; greater male sexual decision-making power is associated with a lower likelihood of ever using a condom, while having more children is associated with a lower probability of ever using a condom.

Introduction

Contraception use is important in the African context on the one hand as stemming population growth, and on the other, certain forms of contraception such as the condom are important in the prevention of sexually transmitted diseases. Taking the case of Ghana, the prevalence of contraception use is low, where less than 20% of women ages 15-49 report current use of any form of contraception, and less than 50% of their male counterparts report ever using a modern form of contraception (Ghana Statistical Service 2009). At the same time, fertility is higher than the replacement rate, 2.1 children per woman, as the average Ghanaian woman will have four children in her lifetime (Central Intelligence Agency 2011; World Economic Forum 2010). Research shows that high levels of fertility generally retard national economic growth (Barro 1991; Galor and Weil 1996; Martin, Doppelhofer and Miller 2004; Durlauf, Kourtellos and Tan 2008), as high fertility creates economic strain for at the household and the national levels. In terms of disease prevention, understanding what predicts condom use is also salient. The HIV/AIDS infection rate in Ghana is about 1.8% among adults, and the country ranks 23rd globally in the number of people living with HIV/AIDS and 17th in the number of deaths (Central Intelligence Agency 2010). Research shows that families and national economic growth are negatively affected by HIV/AIDS infection (Boutayeb 2009; Masanjala 2007), as sick people are not as productive and care of the sick is costly for society as a whole.

This research seeks to understand what explains married women's contraceptive-use behavior, and uses Social Dominance Theory's (STD) (Rosenthal and Levy 2010) four bases of gendered power and the most recent data available, the 2008 wave of the Ghana Demographics and Health Survey (DHS). To our knowledge, this is the first time that this theory and these recently released data have been used for this purpose. Logistic regressions explore whether the four bases of gendered power (i.e., consensual ideologies, social obligations, force and resource

control) help us understand (women's status within a relationship and) what is associated with two types of contraceptive use: 1) whether a woman reports she has ever used contraception, and 2) whether a woman reports she has ever used a condom. The next section explores SDT as it may be useful for this study, and then operationalizes its components using the Ghana DHS data. The interpretation of the logistic regressions will enable the understanding of women's contraceptive behavior as well as serve as an evaluation of this theory for this type of research question.

Social Dominance Theory

In a recent article on HIV infection and gendered power, Rosenthal and Levy (2010) applied Social Dominance Theory (SDT) to the position of women in decisions regarding the use of condoms. SDT holds that society is characterized by hierarchies based on social categories, including gender, and holders of disadvantaged statuses lack equivalent levels of power because of their group membership. Within the SDT school of thought, Pratto and Walker (2004) introduced the four bases of gendered power that provide those who hold more advantaged statuses better access to power. These include: consensual ideologies, social obligations, resource control, and force.

The first base of power is *consensual ideologies*, which include "gender roles, norms stereotypes, and any other beliefs or expectations about men and women that are generally agreed upon in a society or culture, putting women in weaker positions in comparison to men" (Rosenthal and Levy 2010: 26). These consensual ideologies that put women in a weaker position compared to men may result in a diminished ability on women's part to negotiate the use of contraception and condoms.

Empirical evidence does support this association. For example, women in one study described certain gendered norms, including the requirement that married women bear many children, as reasons why their husbands did not want them to use contraception (Nalwadda et al. 2010). Another study comparing the influence of male dominance on fertility in rural versus urban areas found that in rural areas, where traditional ideologies remain and provide men with greater power, their fertility desires shaped outcomes more than the desires of their wives, in contrast to urban areas where traditional ideologies were less pervasive and women's desires held more sway (Dodoo and Tempenis 2002). Similarly, couples in which the husband was more egalitarian, in which his ideology did not put women in as weak a position, were more likely to use condoms, further suggesting the importance of ideology.

One form of consensual ideology that can place women at a disadvantage involves gender roles that provide men with more decision-making power. Thus, in one study in Zimbabwe, women's lack of decision-making power, which stemmed from gender roles regarding the household division of labor, decreased the odds of intending to use contraception or ever using contraception (Hindin 2000). And, a similar relationship exists between women's gender-role based power and the use of condoms. In one Ugandan study, women's household decision-making power significantly increased couples' odds of ever using a condom (Bland and Wolff 2001). Women in a focus group study confirmed this association, explaining they did not use condoms because they lacked the required decision-making power to do so within the relationship (Hebling and Guimarães 2005). Similarly, a study using an experimental gel for HIV/AIDS prevention in sub-Saharan Africa described how the product, designed to be female-controlled, became subject to the will of male partners of female participants because of the higher status of men as the decision-making authority in those relationships (Montgomery et al. 2008).

Thus, consensual ideologies – gender roles, norms, or expectations that limit the decision-making power of women within the home and regarding sexual encounters with their partners – diminish women's ability to negotiate the use of contraception and condoms. Therefore, we hypothesize with hypothesis 1 that both female household decision-making power and sexual decision-making power will be associated with higher odds of a woman reporting both ever using contraception and ever using a condom.

The second base of power is *social obligations*, or the responsibilities that individuals have toward others (Rosenthal and Levy 2010). These obligations may place women in a weaker position regarding their contraception use desires. Thus, one marital obligation involves childbirth and childcare; women in sub-Saharan Africa are expected to begin giving birth shortly after marriage to fulfill their roles as wives *and* mothers (Hindin and Fatusi 2009). Thus, married women may be less able to negotiate the use of contraception because they feel obligated to bear children as part of their marital responsibilities. With this, the higher the number of living children a women has the more likely the couple should be to use contraception because women with more children feel they have fulfilled their social obligation as wives and are subsequently able to use contraception as they desire.

This obligation regarding childbearing may be especially true for wives in polygynous relationships. Such wives tend to be less likely to use contraception, perhaps because wives in such relationships feel more obligated to bear children in order to abide by the pronatalist desires of their families and communities. However, childbearing may also involve dual social obligations as "reproductive output to a large extent guides subsequent male investment [in the wife]," suggesting that polygynous wives may bear children also to access resources their husbands feel obligated to supply when they are provided with offspring (Bove and Valeggia 2009: 24). In addition, in polygynous marriages, couples, and especially husbands, tend to feel

less committed. Husbands are more likely to have affairs and couples communicate less and have looser emotional ties (Bove and Valeggia 2009). If, as this suggests, polygynous husbands are less committed and less communicative with their wives, they may be less likely to listen to her desires regarding contraception use. Thus, polygynous wives are expected to be less likely to use contraception compared to non-polygynous wives.

Another such obligation is faithfulness. Woman report that requesting the use of condoms can lead their partners to believe they have been unfaithful (Hebling and Guimarães 2005; McPhail et al. 2009), suggesting women may fear their partner will assume they have failed in their obligation concerning fidelity if they try to assert their desires regarding condom use. In addition, women are expected to show trust toward their partners. However, when they suggest the use of a condom, research indicates (Montgomery et al. 2008) that partners perceive this as an accusation of unfaithfulness, or an indication that a woman does not trust her partner. So, assuming feelings of obligation increase with the duration of a relationship, women in longer-term relationships may be less likely to suggest the use of condoms for fear that their partner might perceive such a request as an indication of unfaithfulness on the women's part or an accusation of unfaithfulness on the man's part, both of which violate key social obligations regarding faithfulness and trust. Indeed, studies from a variety of contexts have suggested that women in long-term committed relationships (Amaro and Raj 2000; Gomez and Marın 1996; Mays and Cochran 1988) or marital relationships (Maharaj and Cleland 2005) are less likely to use condoms to protect themselves. So, due to the social obligations outlined above, the length of marital relationships is likely to be negatively associated with the use of condoms.

Higher rates of contraction of sexually transmitted diseases among polygynous couples (Bove and Valeggia 2009) suggest women in polygynous relationships may be less likely to use condoms, a tendency which may result from the different social obligations inherent in this type

of relationship. As stated, polygynous marriages tend to be characterized by less commitment and looser emotional ties (Bove and Valeggia 2009), suggesting husbands might feel less socially obligated to their wives and thus, less compelled to listen to her desires regarding condom use. And, because women in such marriage arrangements are obligated, perhaps even more than in monogamous relationships, to remain faithful, any request on their part for the use of condoms may be perceived as a violation of this obligation and denied. This suggests condom use should be less likely among polygynous couples. From this, we therefore expect with hypothesis 2 that the number of living children born by the respondent should be associated with higher rates of ever using contraception and ever using a condom, while marital duration and polygynous marriage should be associated with a lower propensity for a woman to report ever using contraception and ever using a condom.

Force, the third base of power, involves any act or threat of violence that undermines women's power (Rosenthal and Levy 2010). Evidence suggests that violence or the threat of violence is associated with lower use of contraception and a lowered ability on the part of women to negotiate protection against disease. Regarding contraception, one study (Bawah et al. 1999) performed using focus groups in Ghana found that women cited violence as a form of retaliation for using or even attempting to discuss the use of contraception. Another study using clients from a nongovernmental organization (i.e., NGO) in Zimbabwe found low contraception use for women who feared violence in response to discussing contraception with their partners or in hiding their pills or other contraceptive methods if their efforts would be discovered (Njovana and Watts 1996). Further, childhood abuse, sexual assault, and intimate partner violence are all associated with greater risk for contracting HIV/AIDS (Rosenthal and Levy 2010), suggesting that the act or threat of violence (i.e., experiencing force as a power differential) discourages the use of protective measures like condoms. Thus, the use or threat of force may diminish women's

ability to advocate for the use of contraception and condoms to prevent disease. With this, we expect with hypothesis three when women who report a high degree of support for the right of men to use force against women will be less likely to report ever using contraception and condoms, separately.

Finally, *resource control* is defined here as access to employment. Unequal access to employment can leave women economically vulnerable and dependent upon their partners (Rosenthal and Levy 2010). On a macro scale, employment (Schultz 1990; Galor and Weil 1996; Lagerlof 2003; Soares and Falcao 2008; Klassen and Lamanna 2009) tends to be associated with reductions in national fertility rate, presumably through increasing women's status within the home and their ability to advocate for their own fertility desires through the use of contraception. Several studies on an individual or household-level support this assumption as women's employment tends to increase the likelihood of contraception use (Hindin 2000; Beekle and McCabe 2006; Bently and Kavanagh 2008). A similar relationship exists regarding the use of disease prevention measures, with more economically vulnerable women at higher risk for engaging in unprotected sex (Salem and Bobak 2005; Rosenthal and Levy 2010). Thus, women's ability to access resources through employment also improves their status relative to their partners' and their ability to negotiate the use of contraception and condoms. Hence, we expect with hypothesis four that women's employment should be positively related to whether a woman reports ever using contraception and condoms.

Methods

This research uses a sample of married women (i.e., 2,853 to examine contraception and 2,603 to examine condom use) from the most recent wave of the Ghana Demographics and Health Survey (DHS 2008). To our knowledge, these data have not been applied to this task

elsewhere. Logistic regressions are appropriate to estimate the relationship with a dichotomous dependent variable, in this case whether an event will happen or not. The dependent variables are dichotomous measures of whether or not the respondents reported ever using contraception (including traditional or folkloric methods), and whether or not respondents reported ever using a condom. This study first estimates the log odds or propensity (i.e., expressed as odds ratios) that a woman will report ever using contraception in Table 2, and that she ever used a condom in Table 3.

Two scales are used to evaluate the effect of *consensual ideology* on the use of contraception or condoms. Both scales relate to decision-making power, following the assumption that such power is reflective of couples' ideologies regarding gender roles and norms. The first scale evaluates household decision-making power and is the sum of scores on a series of questions regarding who makes household decisions. These questions are: 1) "Who usually makes decisions about health care for yourself?"; 2) "Who usually makes decisions about making major household purchases?"; 3) "Who usually makes decisions about making purchases for daily household needs?"; 4) "Who usually makes decisions about visits to your family or relatives." Answers to these questions were averaged to create an overall score of household decision-making power, with higher values indicating more male decision-making power. The Cronbach's alpha for this factor is .66, which is considered very good to excellent (Tabachnick and Fidell 2001).

The second scale evaluates decision-making regarding sexual behaviors. This scale consists of the following questions: 1) "If a wife knows her husband has a disease that she can get during sexual intercourse, is she justified in refusing to have sex with him?"; 2) "Is a wife justified in refusing to have sex with her husband when she is tired or not in the mood?"; 3) "Is a wife justified in refusing to have sex with her husband when she knows her husband has sex with

other women?" These items were also averaged, with higher numbers indicating more male decision-making power. The Cronbach's alpha for this factor is .55, which is considered to be a good factor loading (Tabachnick and Fidell 2001).

Three independent variables will be used to evaluate the relationship between power differentials in *social obligations*: a count of the number of living children born to the respondent; marriage duration in years; and a dummy variable for whether or not the respondent is in a polygynous marriage.

Resource control is operationalized using a dummy variable which indicates whether or not the respondent currently works outside the home.

Finally, a scale reflecting respondents' attitudes toward the *use of force* in intimate relationships represents the effect of force on respondents' use of contraception and condoms. Scores on the scale reflect the respondents' answers to the following queries. "Sometimes a husband is annoyed or angered by things that his wife does. In your opinion, is a husband justified in hitting or beating his wife in the following situations: 1) If she goes out without telling him; 2) If she neglects the children; 3) If she argues with him; 4) If she refuses to have sex with him; 5) If she burns the food. Scores were averaged with higher values representing higher levels of belief in a husband's right to use force on his wife. The Cronbach's alpha for this factor is .82, which is considered to be an excellent loading (Tabachnick and Fidell 2001).

The regression models also control for other socio-economic and demographic factors that may influence decision-making power or condom and contraception use. We control for demographic characteristics with dummy variables including religion (i.e., Christian versus non-Christian) and place of residence (i.e., rural versus urban). Other control variables that may influence decision-making power include age, respondent's education, and partner's education, which are all measured in years and treated as continuous.

Other factors that may affect condom and contraception use include the desire for more children and interaction with family planning workers. The respondent's desire for more children is measured by a dummy variable indicating whether the respondent wants another child or not. In addition, the husband's fertility preference relative to that of his wife is included as a control using a dummy variable indicating whether or not his fertility preference differs from that of his wife or not. Interaction with family planning workers is operationalized using a dummy variable indicating whether or not the respondent was visited by a family planning worker in the last 12 months.

Results

Descriptive Results

Table 1 provides a profile of married Ghanaian women who report ever using contraception and then ever using a condom. Overall, 57.5 percent of women report ever using contraception and 19.2 percent of women report ever using a condom. In general, we see predictable patterns. To a certain age, 39 years, women are increasingly likely to have ever used contraception and condoms. Urban women, Christian women, and women with greater education and who husbands have greater education, are all more likely to report ever using contraception or condoms compared to their counterparts in the population.

Women who prefer no more children have a higher rate of ever using contraception (i.e., 8 percentage points higher) than those who may want more children, yet the relationship is reversed when considering ever using a condom. This suggests that perhaps women's fertility preference has no bearing on condom use, as this may seen more as a man's contraceptive choice. Women who have been visited by a family planning worker have higher rates of contraception and condom use.

In terms of the focal variables, the two measures falling under consensual ideologies indicate as men's power increases in both household and sexual decision-making realms, fewer women report ever using contraception. In terms of condom use, household decision-making does not seem to pattern ever using a condom, but higher men's sexual decision-making power does pattern a much lower ever used condom rate (12.7 percent at the higher male-power category compared with 20.3 percent at the lower category). Across the social obligations factors, polygynous marriage patterns a higher rate of ever using contraception but a lower rate of ever using a condom, which means that these two areas of contraception operate differently. With higher scores (or greater agreement) on men's power to use of force, women are less likely to have ever used contraception or condoms. Finally, the fourth base of power, resource control, indicates that women who are employed outside the home report a lower rate of ever using a condom than women not employed outside the home, and no discernable different is apparent between being employed and whether a woman has ever used a condom for contraception. Again, this suggests that perhaps this is a male decision, regardless of woman's relative position vis-à-vis her male partner.

Logistic Regressions: Predictors of Ever Contraception Use

Model 1 through Model 4 of Table 2 show the bivariate relationships of each of the gendered power focal variables on ever using contraception among married women, and Model 5 presents the estimates of the gendered power variables simultaneously. For contraception use, all of the focal variables are significant and are in the anticipated directions except marital duration and employed away from home. With greater male power in decision-making in both the household and sexual matters, there is a lower likelihood that a woman has ever used contraception. Similarly with social obligations, with greater obligations and responsibilities in

the marital relationship, we would expect a higher likelihood of ever using contraception. We do find that polygnyny is associated with a lower likelihood of ever using contraception as men are less obligated to each wife, and that with more ties together in the form of more children we can expect a greater likelihood of ever using contraception, as a result of agreement on fertility preferences. A longer marriage predicts a lower likelihood of ever using contraception. Rather than speaking to the second basis of power, social obligations, this seems to suggest a cohort effect wherein women who have been married longer are older women who were not socialized to use contraception. Last, for women with higher attitudes that men may use force in intimate relations and higher resource control (i.e., being employed outside the home), lower likelihoods of ever using contraception prevail. This makes sense given the SDT, but being employed outside the home runs in the opposite direction as one would expect.

The full model presented in Model 6 indicate that the negative relationships between increased men's household and sexual decision-making power being associated with lower contraception use prevail. Additionally, the relationship with a greater number of children (e.g., more social obligation) predicting greater contraception use holds, while the marital duration and polygynous marriage effects are no longer hold. Attitudes about male use of force is no longer significant, while being employed away from home remains a significant predicator of having a lower rate of ever using contraception. This could be due to a cohort effect, so further analysis of the data is needed to disentangle these interrelationships. Last, among the control and other variables of interest, older age and rural residence are associated with a lower propensity of ever using contraception, whereas being Christian (as compared to non-Christian), respondent's greater education, respondent's husband's greater education, being visited by a family planning worker and having different fertility preferences than a husband all are associated with increased reporting of ever having used contraception.

Logistic Regressions: Predictors of Condom Use

Similar to the modeling for contraception use, Models 1-5 in Table 3 show the effects of the gendered power variables on the propensity to have ever used a condom. Once the controls are included in Model 6, most of the relationships fall away. The final story is that greater male sexual decision-making power and a greater number of children are both independently associated with a lower propensity to have ever used a condom, net of other effects. Considering the relationships across the control and other variables of interest, respondent's increased age and rural residence are associated with a lower propensity of having ever used a condom. Also, Christian religion, respondent's and husband's greater educational levels, being visited by a family planning worker, having a fertility preference of no more children and the couple having different fertility preferences all are associated with a higher propensity of having ever used a condom.

Discussion and Conclusions

This study contributes to the field by using the most recent DHS data from Ghana for the to examine women's contraceptive behavior, and the first study to use the gendered power typology of Social Dominance Theory (SDT) put forward by Rosenthal and Levy (2010) to examine the position of women in the decision-making regarding these contraceptive behaviors. Overall, we find some support for the first base of power, consensual ideologies, and more limited support for the second base of power, social obligations, in shaping whether women have ever used contraception. However, we find no relationships in the full models across the final two bases of power, force and resource control, as shaping contraception behavior. Further, Social Dominance Theory is less useful in explain ever using a condom among married

Ghanaian women. There is limited support for the first base of power, consensual ideologies, as men's greater sexual power is associated with a lower propensity of ever using a condom. There is a relationship with having more children, within the second base of power, but it is in the opposite direction as hypothesized by this research. Having more children is associated with a lower propensity of ever using a condom. In addition, there are differences across these two areas of contraceptive behavior, and the results presented in this study across these two areas can serve as a baseline for future research.

Although not all elements of the gendered power typology bore out in these analyses, there is evidence in support of power differentials at play in predicting these contraceptive behaviors. In addition, it could be that education is a counter to the bases of power. There is a positive association between education and ever using contraception, and this same association holds in the analysis of condom use. It could be that it is education that shapes both the development of consensual ideologies and attitudes toward the use of force. Supplemental regression analyses showed that women with more education were more likely to claim greater household and sexual decision-making power and more likely to express negative attitudes toward the use of force in marital relationships. In this way, education shapes the way women view certain social obligations, like bearing large numbers of children, as there is also a negative association between education and the number of children a woman bears.[3] Furthermore, education shapes women's ability to earn money and gain resource control. In this way, this analysis reveals the potential of education to attenuate the strength of the four bases of power.

This research fills a gap in the literature by employing a large, representative dataset which, to our knowledge, has not been applied to the analysis of contraception and condom use, and furthermore, has not been applied to the African context. This research also attempts to measure the effect of a typology of gendered power which is relatively new (Pratto and Walker

2004), and again, to our knowledge, has not yet been quantitatively applied to predicting the use of contraception and condoms. Finally, this research has important implications for family planning and disease prevention efforts, in terms of how to target women to encourage contraceptive behavior.

Notes

[1] Condom use was regressed on all variables used in Model 6 along with a new variable for husbands fertility preference with three categories, “"No Disagreement,” "Husband Wants More," "Husband Wants Fewer" “No Disagreement” served as the omitted category. There was a significant association for “Husband Wants Fewer” as compared to the omitted category, while there was no such association between the omitted category and “Husband Wants More.”

[2] A regression of force on respondent’s education, husband’s education, place of residence, and religion reveals that attitudes toward the use of force in intimate relationships are significantly predicted by each of these variables.

[3] Four separate regressions examined the dependent variables of male household decision-making power, male sexual decision-making power, attitudes toward the use of force, and number of living children as dependent variables. In addition to education, these regressions included partner’s education, age, marital type and duration, employment status, place of residence, religion, and contact with family planning workers.

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Table 1: Ever Contraception and Condom Use among Married Women in Ghana

	Contraception Use			Condom Use		
		Ever Used			Ever Used	
	Total	Percent		Total	Percent	
Total, Married Women	2,855	57.5	%	2,605	19.2	%
Control & Other Factors of Interest						
Age in years						
15-19	96	47.9	%	84	27.4	%
20-24	435	57.0		385	27.5	
25-29	615	60.3		573	25.1	
30-34	525	61.0		483	17.4	
35-39	527	60.1		492	15.0	
40-44	367	54.8		331	12.4	
45-49	290	47.6		257	11.3	
Place of Residence						
Urban	1,489	65.7		1,426	25.5	
Rural	1,366	48.5		1,179	11.7	
Religion						
Christian	1,992	64.9		1,884	23.0	
Non-Christian	860	40.4		719	9.3	
Educational Attainment						
No Education	1,071	37.1		826	6.8	
Primary	630	64.3		597	17.1	
Secondary	1,098	69.9		1,073	27.5	
Tertiary	101	47.0		101	44.6	
Husband's Educational Attainment						
No Education	769	33.0		612	4.3	
Primary	236	57.2		216	10.7	
Secondary	1,404	67.2		1,348	25.0	
Tertiary	292	75.7		289	32.5	
Fertility Preference						
Maybe Another Child	1,845	54.6		1,669	20.1	
No More Children	1,004	63.0		930	17.6	
Husband's Fertility Preference						
Same as Wife	2,138	55.8		1,935	18.5	
Different from Wife	707	63.2		660	21.8	
Visit from Family Planning Worker						
No	2,452	56.9		2,228	18.8	
Yes	401	61.1		375	21.9	
Focal variables						
Consensual Ideologies						
Household Decision-Making Power						

1	177	61.0 %	164	18.9 %	
2	1,742	59.3	1,600	19.0	
3	876	51.1	785	19.0	
Sexual Decision-Making Power					
1	2,445	59.7	2,259	20.3	
2	393	44.3	332	12.7	
Social Obligations					
Marital Duration					
0-4 Years	558	56.8	509	32.8	
5-9 Years	615	62.9	572	22.2	
10-14 Years	516	56.8	463	16.4	
15-19 Years	460	59.8	424	15.8	
20-24 Years	372	56.7	334	11.7	
25-29 Years	245	46.9	220	8.2	
30+ Years	89	48.3	83	8.4	
Marriage Type					
Polygynous	2,245	60.4	513	11.9	
Non-Polygynous	585	47.0	2,071	21.1	
Number of Living Children					
0	154	52.6	143	39.9	
1	487	54.2	452	27.9	
2	595	60.7	552	20.1	
3	516	61.8	473	19.0	
4	418	60.1	380	16.1	
5	295	56.6	267	13.1	
6+	390	50.8	338	6.2	
Attitudes about Male Use of Force					
1	2,293	59.8	2,116	20.8	
2	560	48.0	487	12.3	
Resource Control					
Not Employed Outside Home	875	59.4	792	19.3	
Employed Away from Home	1,973	56.6	1,806	19.2	

Note: The measures for consensual ideologies and attitudes about male use of force have been reorganized into categories to show relative bivariate relationships.
A higher score can be interpreted as more male power for each measure.

Table 2. Odds of Having Ever Used Contraception among Women in Ghana

	M 1		M 2		M 3		M 4		M 5		M 6	
	Odds Ratio	SE	Odds Ratio	SE	Odds Ratio	SE	Odds Ratio	SE	Odds Ratio	SE	Odds Ratio	SE
Focal variables												
Consensual Ideologies												
Male Household Decision-Making Power	0.79***	0.06							0.75***	0.06	0.81**	0.07
Male Sexual Decision-Making Power	0.59***	0.04							0.61***	0.04	0.74***	0.06
Social Obligations												
Marital Duration			0.92***	0.03					0.90***	0.03	0.97	0.05
Polgynous Marriage (R=Non-polygnous)			0.60***	0.06					0.66***	0.07	1.03	0.12
Number of Living Children			1.06*	0.03					1.09***	0.03	1.24***	0.05
Attitudes about Male Use of Force												
Use of Force					0.73***	0.05			0.79***	0.05	0.94	0.07
Resource Control (R=Not employed)												
Employed, Works Away from Home							0.89	0.07	0.85*	0.07	0.85*	0.08
Control & Other Factors of Interest												
Respondent's Age											0.85***	0.05
Rural Place of Residence (R=Urban)											0.77***	0.08
Christian Religion (R=non-Christian)											1.61***	0.17
Respondent's Education											1.46***	0.09
Husband's Education											1.40***	0.08
Visited by Family Planning Worker (R=Not visited)											1.28*	0.16
Fertility Pref No More Children (R=Maybe another)											1.17	0.14
Couple Has Different Fertility Pref (R=Same pref)											1.25**	0.13
_cons	2.66***	0.428	1.64***	0.07	1.55***	0.14	1.46***	0.10	4.19***	0.85	0.85	0.24
N	2,779		2,830		2,853		2,848		2,745		2,574	

* p<.10; ** p<.05; *** p<.01; SE = Standard Error; R = Omitted Category

Source: Demographic and Health Survey, Ghana 2008

Table 3. Odds of Having Ever Used Condoms among Married Women in Ghana

Variable	M 1 Odds Ratio	SE	M 2 Odds Ratio	SE	M 3 Odds Ratio	SE	M 4 Odds Ratio	SE	M 5 Odds Ratio	SE	M 6 Odds Ratio	SE
Focal variables												
Consensual Ideologies												
Male Household Decision-Making Power	1.03	0.11							0.97	0.11	1.09	0.13
Male Sexual Decision-Making Power	0.59***	0.07							0.62***	0.07	0.75**	0.09
Social Obligations												
Marital Duration			0.85***	0.04					0.84***	0.04	0.90	0.06
Polgynous Marriage (R=Non-polygnous)			0.64***	0.10					0.72**	0.11	1.16	0.20
Number of Living Children			0.84***	0.03					0.84***	0.04	0.85***	0.05
Attitudes about Male Use of Force												
Use of Force					0.63***	0.06			0.65***	0.07	0.86	0.10
Resource Control (R=Not employed)												
Employed, Works Away from Home							0.99	0.11	1.08	0.12	1.08	0.13
Control & Other Factors of Interest												
Respondent's Age											0.84**	0.06
Rural Place of Residence (R=Urban)											0.67***	0.09
Christian Religion (R=non-Christian)											1.57***	0.26
Respondent's Education											1.34***	0.11
Husband's Education											1.55***	0.14
Visited by Family Planning Worker (R=Not visited)											1.53***	0.24
Fertility Pref No More Children (R=Maybe another)											1.65***	0.26
Couple Has Different Fertility Pref (R=Same pref)											1.28*	0.16
_cons	0.28***	0.02	0.24***	0.02	0.67***	0.07	0.26***	0.05	0.92	0.25	0.16***	0.06
N	2,603		2,598		2,584		2,536		2,506		2,350	

* p<.1; **p<.05; *** p<.01; SE = Standard Error; R= Omitted Category

Source: Demographic and Health Survey, Ghana 2008