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Decision Making in Family Planning: A Human Rights Issue

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***Abstract**:* A woman has the right to control over her own body and take decision regarding reproductive health free from any form of coercion, discrimination and violence. She further has the right to be informed and have access to safe, effective, affordable and acceptable methods of family planning. The present study was conducted on a group of married Muslim women of West Bengal with the objective to understand the role of these women in taking decision in adopting family planning practice and choosing contraceptive types. Data on socio-economic details, family planning practices and decision making ability were collected on 100 women, who were in wedlock and with at least one child. Results of the study reveal that 69 per cent of the study population was adopters of family planning, and in all the cases the husbands of these women took decision in choosing contraceptive types.
Key words: Family planning, Decision making, Human Rights, Muslim women

Introduction

Family planning reinforces people's rights to anticipate and attain their desired number of children and the spacing and timing of their births (Engender Health 2003). An estimated 222 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception. A woman's ability to choose when to become pregnant has a direct impact on her health and well-being. Family planning not only allows spacing of pregnancies, delay pregnancies in young women who are at increased risk of

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health problems but can prevent pregnancies among older women who also face increased risks. Family planning enables women who wish to limit the size of their families to do so.

In 1994, at the International Conference on Population and Development (ICPD), 179 countries came together and adopted a Programme of Action, in which they agreed that population policies must be aimed at empowering couples and individuals—especially women—to make decisions about the size of their families, providing them with the information and resources to make such decisions, and enabling them to exercise their reproductive rights. For the first time in an international consensus document, states agreed that reproductive rights are human rights that are already recognized in domestic and international law. The ICPD Programme of Action recognizes that realizing the right to reproductive health is a critical element of guaranteeing reproductive rights. The conference also noted that "improving the status of women also enhances their decision-making capacity at all levels in all spheres of life, especially in the area of sexuality and reproduction [United Nations (UN) 1994]. A woman's autonomy is generally defined as the ability to make and execute decisions regarding personal matters of importance on the basis of the woman's power over others, access to information, control over material resources, and freedom from violence by her husband or other men (Caldwell and Caldwell 1993, Dyson and Moore 1983, Jejeebhoy and Sathar 2001). Others have conceptualized autonomy as women's ability to determine events in their lives, even though men and other women may be opposed to their wishes (Mason 1984 and Bloom et al. 2001).

In the Cairo Programme of Action, many Latin American and Islamic states made formal reservations regarding its concept of reproductive rights and sexual freedom, to its treatment of abortion, and to its potential incompatibility with Islamic law (UN 1994). The rights of Muslim women to attain highest standard of sexual and reproductive health, and to make their own decisions regarding marriage, motherhood, contraception, abortion and sexuality free of coercion, discrimination and violence are articulated in the basic goals or principles of Shari'ah. There have been conferences which aimed at promoting responsible parenthood by enabling couples to space their children through mutual agreement by all legitimate and safe means within the framework of Islam (The Rabat, Banjur and Dakar Conference on Islam and Family Planning in 1971, 1979 and 1982 respectively). Serious discussions on these rights however are still lacking and rarely problems have been analyzed within the context of the local situation (Sisters in Islam 1998).

The objectives of the present study were to understand the role of women in taking decision in adopting family planning practice and choosing contraceptive types.

Materials and Methods

The present study was conducted in the areas under Budge Budge Municipality, South 24 Parganas, West Bengal. The study area has been selected on the basis of operational convenience.

Data were collected on 100 Muslim women (working 30 and non working 70), who were in wedlock and aged between 18 and 48 years, have at least one child, and have volunteered to participate. In the present study, women who were engaged in domestic works (homemakers) have been considered as 'non working group' and those who get wages for working are categorised under 'working' category.

A well-tested and structured schedule was canvassed in person to collect data on socio-economic condition which includes variables like, age, occupation, educational level, monthly household expenditure and so on. Data on reproductive history include the number of surviving and deceased children per couple, desire for more children, knowledge and practice of various family planning methods, reason for selecting a particular contraceptive type, and the role of women in taking decision in adopting family planning and its type(s). Information on reproductive decision making, desire number of children, contraception (method used for family planning) and abortion (fertility regulation) were collected to assess the reproductive autonomy of the participants. The categories made were (i) self involved, which means when decisions were taken by the participants and their husbands, (ii) self not involved when decisions were taken solely by their husband. Case studies were taken from some of the women to get an insight about their own reproductive life and ability to take decision in reproductive matters. The data were collected during the period December, 2008–April, 2009.

The nature of research was explained to all of the participants, and verbal consent was taken from each of them before the data collection. Statistical analysis of the data was done using the software SPSS V. 11.0.

Results

Table 1: Socioeconomic characteristic of the participants

	Frequency
Mean and Sd of the age of the participants (in years)	34.5±7.9
Completed years of education	
Non educated	68(68.0)
1-4	14(14.0)
5 and above	18(18.0)
Occupation	

Working	30(30.0)
Non working	70(70.0)
Occupational types	
Homemaker	70(70.0)
Small scale business	21(21.0)
Labor (unskilled)	9(9.0)
Monthly household expenditure (in Indian Rupees)	
≥4000	74(74.0)
<4000	26(26.0)
Family types	
Nuclear	80(80.0)
Joint or extended	20(20.0)

*Figures in the parenthesis indicates percentages

From table 1 it appears that the mean age of the participants was around thirty four years. Almost two third of the participants were non-educated. Only eighteen per cent of the participants have completed primary level of education. Majority of the women were homemaker compared to one third of the working group. The working women were engaged as embroidery workers and in domestic help. The options of employment were also limited to the women. The monthly expenditure of majority of the families was below Rs. 4,000. Majority of the women lived in a nuclear family set-up and has a household size of ≤4 persons. Around half of the women of the working category owned a house compared to those of the non-working group.

Table 2: Reproductive history of the participants

	Mean/Frequency
Mean (Sd) age at marriage (in years)	17.0±4.2
Mean (Sd) Number of children	3.2±1.7
Number of surviving children	
1	15(15.0)
2-4	59(59.0)
Above 4	26(26.0)
Number of deceased children	26(26.0)
Number of reproductive wastage	19(19.0)
Number of family planning method adopters	69(69.0)

Types of family planning method used	
Irreversible (female sterilization only)	26(35.8)
Reversible	43(64.2)
Different types of reversible methods practiced	69(69.0)
Oral Contraceptive Pill (OCP)	25(25.0)
Condom	1(1.0)
Intra Uterine Device (IUD)	1(10.)
Traditional method (includes withdrawal, periodic abstinence based on menstrual cycle)	17(17.0)
Number of Non adopters of any kind of family planning method	31(31.0)
Reasons for non adoption of family planning method	
Husband does not like	11(35.5)
Desire for male child	10(32.2)
Religious restriction towards use	5(16.1)
Self belief of not getting pregnant	5(16.1)

*Figures in the parenthesis indicates percentages

Table 2 shows the mean age at marriage of the women was below 18 years. The mean number of child birth per woman was more than three. Almost 60 per cent of the participant's family consisted of two to four surviving children. In addition to this, one fourth of the women recorded child deaths and one fifth of reproductive wastage (induced and spontaneous abortion).

Women were mostly aware of the common family planning methods like, oral contraceptive pills, condom, intrauterine device (IUD), withdrawal and sterilization (both female and male). Spousal communication on family planning issues were not initiated in the early reproductive years. However, women usually got an opportunity to speak their heart out either when they had already attained their desired family size or was under some medical restrictions from future childbirths.

Nearly 70 per cent of the population was adopters of some kind (traditional/modern) of family planning method. Amongst the reversible contraceptives, heavy reliance on the oral contraceptive pill (OCP) method, followed by the traditional method ('calendar' and 'withdrawal') is observed. Use of modern contraceptives like intra uterine device (IUD) and condom were limited and less popular. Irreversible method of contraception was limited to 'tubectomy' and was preferred by almost thirty six per cent of the participants.

There were few (31 one per cent) non adopters of any family planning method. The reasons cited were husband's dislike, religious restrictions and self belief of incapability towards childbearing. However, a strong desire or pressure is also present among the women to bore a male child (heir).

Table 3: Reproductive autonomy of the participants

Decision regarding the number and time of conception	Adopters	Non-adopters	χ2(df), p
self involved	49 (71.0)	5 (7.2)	30.030(2)***
self not involved	18 (26.0)	28 (40.5)	
Decision regarding choosing contraceptive			
self involved	47 (68.1)	9 (13.0)	16.496(1)***
self not involved	20 (28.9)	24 (34.7)	

***p≤0.000

*Figures in the parenthesis indicates percentages

Table 3 depicts the decision and involvement of the participants with their husbands regarding the timing and number of births among the couple. Decisions pertaining to reproductive health issues were either taken by the participants along with their husbands or without the consent of the participants. The women concerned could not exercise their right to reproductive self determination. There was no recorded case of autonomous decision making on family planning or conception solely by the women.

In taking decision regarding the adoption of any family planning method, self (woman) involvement increased (71 per cent) in the adopter group when compared with the non adopter group (7.2 per cent). Those who were adopters of any method had a greater say in this regard. Similarly, it is worthwhile to mention that non involvement (40.5 per cent) in decision increased in the non adopter group than their counterpart (26.0 per cent). Autonomy regarding the choice of the method (contraception), the participants in the adopter group (68.1 per cent) has more say than their non adopter counterpart (13.0 per cent). Non involvement in contraceptive decision is marginally higher among the non adopter group (34.7 per cent).

Case studies

Presented below are some of the case studies taken on women to get an insight of their reproductive life and decision making ability on reproductive health matters. The name of the participants mentioned against each case is not original.

Case 1: Taibun Begum (24), mother of two children, non working, literate up to 2nd standard, married at 20 years.
Taibun Begum after being married for more than one year was unable to embrace motherhood. The fact was troubling her. So she went to the nearby hospital for health check up. Miraculously, she conceived afterwards and gave birth to a healthy baby boy. After their first child, her husband decided to practice withdrawal as a family planning method to avoid children for the time being. It was during this period, when *Taibun* conceived her second child. Her son was then not even a year old; this forced her to think that rearing up two children closely spaced would be tough for her. However, her mother-in-law assured and asked her to carry the pregnancy to term. Now the couple finds their family to be complete. They still practice 'withdrawal' as a birth control method. *Taibun* was never allowed to practice any other contraceptive type.

Case 2: Shabana Begum (35), mother of four children, non working, non literate, married at 18 years.
Shabana considered herself to be lucky, because her husband was wise enough in not having children as soon as they were married. Moreover, Shabana's in-laws were settled in Bihar, so she was never under any pressure to give birth to children immediately after marriage. Her husband decided to practice withdrawal just after marriage because he did not have any fixed source of income and even lived in a rented house. He worked as a helper to the driver. Later, her husband learned driving and became a professional driver which gave them a respite in household income. Her husband then decided to have a child. Thus, after two years of marriage she gave birth to a boy child. Later she had two sons and a daughter in quick succession. All these child birth happened according to the wish of the husband. Unfortunately, her daughter died at ten months, which she could not accept. So her husband decided to have another child immediately to cope with the situation and which in turn would help her forget the loss of her daughter. Their last child was a girl and after birth, her husband again switched to withdrawal as a method of family planning.

The excerpts of the above two cases reveal that both the women did not have any say neither in family planning nor in deciding the family size.

Case 3: Sajadi Begum (35), mother of three children, working, non literate, married at 20 years.
Sajadi was married to a '*Masjid Peshnami*' [religious preacher] associated with their local institution. She gave birth to girl child within a year after marriage. Her earliest memory about contraception was of fear. A notion about the relationship between infertility and

contraception was there too. However, the desire of a small family reckoned her but she found herself helpless. There was pressure to give birth to a '*waris*' [heir] as early as possible. Amidst all these events, she with the help of a friend and without the knowledge of her husband started having Oral Contraceptive Pills (OCP). Within a few months she started experiencing frequent vomits, headache and fatigue. Her condition became so severe that she had to stop the medicines, which eventually led her to conceive her second child. After giving birth to a boy child, she was in a favorable position to disclose her intentions of planning their family with her husband, requesting for some method use. Her husband started practicing 'calender' method. This was the only method which was approved by the religion. After six years of successfully practicing the method, she somehow got pregnant for which she wanted abortion. But her husband resisted her citing that 'abortion is a sin'. He further cited that being closely associated with religious activities of the mosque he cannot allow such a heinous crime. Their third child was a girl. They still practice the calendar method but she has increased her days of withdrawal to 22 instead of 20 days post the onset of menstruation. Even after the birth of their third child her husband did not let her wife opt for sterilization, citing similar reasons.
In this case we see that there is a communication between the couples regarding contraceptive use and family planning. However, the wishes of the husbands prevailed.

Case 4: Muslima Bibi (33), mother of two children, non working, non literate, married at 22 years.
Muslima gave birth to a boy child soon after marriage. A local '*Dai Ma*' [local birth specialist] helped her during labour. However, her child died on the second day after birth. This incident made her impatient to embrace motherhood. She conceived for the second time and gave birth to a boy child. Two years later, she gave birth to a girl child. The couple now thought their family is complete, so they started practicing 'calendar method' of birth control and through mutual consent. Muslima was unaware about this family planning method and even had questions about its viability, but her husband reassured her faith.

Case 5: Salma Bibi (37), mother of three children, non working, non literate, married at 10 years
Salma got married at an early age of ten years and attained menarche at fifteen. She gave birth to a boy child when she was seventeen. Neither she nor her husband was aware of any methods of contraception. Months after her first childbirth, she conceived again. So, she went to the nearby hospital for her pregnancy registration. The doctors advised her to rethink her decision of continuance with the pregnancy; given her last child was less than

three months old. She was defiant and said when the baby had already grown up then 'why to take a life'. Soon after her return from the hospital, she started having cramps and bleeding, and was taken to hospital instantaneously. The pregnancy ended up in spontaneous abortion. This whole incident left an agony in her mind. She believes that the administration of an 'injection' [probably tetanus toxoid] at the hospital led to the early termination of the foetus. After six months of this incident she was diagnosed with appendicitis and was operated. Frequent visits to the hospital strained her physical and mental health condition. Yet amidst the circumstances, she conceived for the second time and gave birth to a girl child. After the birth of their daughter's the couple thought that they should stop childbearing for a while and started practicing withdrawal as a family planning method. However, their method failed and she conceived and gave birth to their third child a boy. This time around both of them did not want to take further risk and went for tubectomy post childbirth.

Case 6: Husna Banu (25), mother of three children, non working, literate up to 10th standard, married at 19 years.
Husna Banu got married after qualifying her matriculation. During post marriage period the couple did not use any contraceptive; this resulted into conception. She gave birth to a girl child. But Husna and her husband had a strong desire for a male child. However, for the time being she was unable to conceive for the second time. This worried both of them and her husband took her to the hospital for treatment. Within few months she discovered that she was pregnant again. She gave birth to twins (both boys). After the arrival of 'son', both of them felt that their family was complete; hence they would now need contraception to limit their family size. So she started using OCP in consultation with her husband.

Case 7: Alima Bibi (47), mother of five children, working, non literate, married at 15 years.
Alima gave birth to a boy child, who died shortly after birth. Her knowledge about different family planning methods was limited at that time. Initially she did not have the knowledge, that births can be controlled or even the number and spacing of children can be decided. She had a natural spacing of children. The difference between two children was almost three years. After her fourth delivery she thought she had only four *fruits* (children), and she would not conceive again. Seven years later she found to have conceived again and that too in fourth month of her pregnancy. She thought of aborting her pregnancy, but could not succeed because the stipulated time period for abortion exceeded. Alima's husband was unwilling in the process of taking away of an innocent life and she too felt that abortion would be a criminal offence. So, she dropped the idea of induced abortion.

After delivery, the doctor at the hospital advised the couple to choose a permanent (irreversible) method of birth control. So when her daughter was forty days old she went for tubal ligation at the hospital.

Case 8: Asma Begum (37), mother of five children, non working, non literate, married at 10 years.
Asma's mother died during her birth. She got married when she was barely ten years of age. It took her a while to become a mother. At seventeen, she gave birth to her first child. After giving birth to five children, she consulted with her husband about size of the family and future plans. Both of them intended that they should not extend their families and asked her to consult the '*health facility sisters*' [community health providers]. She consulted them, and they suggested her irreversible method options, as they were not interested in having children anymore. Later on, both of them decided and went for tubal ligation at the hospital.
In the cases from 4 to 8, women were involved in decisions related to adopt strategies to limit family size after they reached the desired family size.

Case 9: Faizunnisa Bibi (44), mother of four children, non working, literate up to 7th standard, married at 18 years.
Faizunnisa, after marriage did not think about contraception. She wanted to give birth to children firstly and then think of controlling their size. Her first two pregnancies and childbirth there were no issues regarding the newborn and the mother's health. Problems aroused during her third pregnancy; when she took over the counter medication. The pregnancy resulted into spontaneous abortion followed by Dilation & Curettage. She again met with an accident in her fifth pregnancy, when she had directly fallen on her stomach and had started bleeding profusely. The pregnancy resulted into spontaneous abortion again. Amidst the circumstances she was not using any form of contraception. She started thinking that she should do something about contraception as she cannot go on having children and abortions. In the meanwhile she conceived and gave birth to her fourth child. When she was still at her maternal place post childbirth, she underwent tubal ligation at a private institution and later informed her husband.

Case 10: Zubeida Bibi (42), mother of five, working, literate up to 3rd standard, mother of five children, married at 13 years.
Zubeida came to know about the family planning methods available quite late in life. After giving birth to four children, she thought she would not be able to conceive further. She adopted a strategy to prolong lactation so that she can delay the recommencement of

menstruation. This helped her to maintain birth spacing. Her fifth child was a girl, for which she was very happy. To her dismay, as she grew up she faced problems regarding speech, walking, and learning. Her daughter was not able to carry herself without any help. This moved her deeply and she thought of ending the childbearing process. Without taking any chance whatsoever she went for tubal ligation at the hospital.

Case 11: Salma Bibi (40), mother of three children, non working, literate up to 4th standard, age at marriage 12.
Salma was married to a person who already had a family. This was not known to her prior to marriage. Salma had her first child when she was only fifteen years old; and it was a girl. Her daughter had certain abnormalities which restrained her from leading a normal life. They were not using contraception which resulted in consequent and frequent births. She gave birth to seven children and out of them, three are surviving. Afterwards, she started using OCP but had to discontinue it very shortly as it did not suit her. Complications like headaches and vomiting forcing her to stop it midway resulting into unwanted pregnancies. Three induced abortions were done in 8th, 9th and 10th pregnancies – two using surgical technique and one using oral abortifacients. These decisions were taken by her solely Salma. To support her family in the absence of her husband's monetary contribution, she works as a domestic help. Whenever her husband cohabits, she takes up abortifacients as and when necessary since other methods do not suit her.
In the above cases, women solely took reproductive decisions. The women representing these cases received a minimum level of education. Faizunnisa (Case 9) and Zubeida (case 10) went for tubal ligation on her own. In Salma's case, she took the decisions of undergoing induced abortions and in choosing contraceptive types on her own.

Discussion
The patriarchal social system marginalizes women form equal access to basic resources like nutrition, education, income and health care; from choices related to marriage, age at marriage, number of children, workload, sexual relations, and contraception; from decision making regarding the household, their own children and themselves. Thus, women are exposed to early marriage, several pregnancies, excessive workload, inadequate nutrition, and lack of timely and adequate health care interventions, unsafe deliveries – all of which contributes to poor reproductive health status (Saha and Saha 2010).
Reproductive health is not just a major health issue, but it is also an issue of human rights and human development. Reproductive rights are central to human rights, especially the human rights of women. They derive from the recognition of the basic right of all individuals and couples to make decisions about reproduction free of discrimination,

coercion or violence. They include the right to the highest standard of health and the right to determine the number, timing and spacing of children. Despite the recent international consensus on reproductive rights during the Beijing and Cairo summits, locating reproductive rights within a human rights framework continues to be a work in progress. The key reproductive rights include the *right to reproductive health care,* including family planning and the right to reproductive self determination.

Reproductive rights must be protected, promoted and fulfilled if the outcome of sexual and reproductive health is to be improved. A rights perspective highlights the importance of empowering women to take their own decisions about their sexual and reproductive lives. The increased choices and opportunities, especially for women, that come from better and more accessible sexual and reproductive health services and education have led millions of people in many countries to opt for smaller families.

It appears from the present study that more than half of the participants, who are from Muslim community received education from non-formal schools (religious texts); majority of them got married before their legal age; one in every three women experienced reproductive wastage; majority of the child delivery were not institutional; oral contraceptive pills and withdrawal remained the most preferred family planning method; general apathy towards vasectomy and condom usage has also been observed; decisions regarding choosing family planning types were mostly made by husbands; significant association has been found between both working status and decision making ability of the participants and adoption of family planning; and role of women in health care decision making was negligible.

The socio demographic profile of the Muslim women in India is not encouraging. The Prime Minister's High Level Committee (PMHLC) in the year 2006 brought some facts which were alarming. In India, Muslim constitutes the second largest religious community. The population of this community is over 138 million as enumerated by the 2001 Census which is exceeded only by Indonesia's and close to the Muslim population of Bangladesh and Pakistan. The growth rate has been close to 30 per cent in each of the four intercensal period (1961-2001). The spatial distribution of the population is uneven throughout the country; the majority residing in West Bengal, Bihar, Maharashtra and Uttar Pradesh. Although the Muslim community shows a better sex ratio, but they are predominantly rural but the level of urbanization is higher than the population. The women have lower educational attainments than men and their counterparts of other community. Around 60 per cent of the women are non literate. Less than 17 per cent of Muslim women completed 8 years of schooling. Low socio-economic status and a low level of educational attainments are consistent with early marriage for Muslim girls. Women are mostly self employed in home based work. The work participation rate (14 per cent) is low among

Muslim women. Among employed women, the largest proportion is in wage worker/ employee category followed by self-employed women (PMHLC 2006). Our study also corroborates with the existing literature.
Even today, Muslim women in India have lower contraceptive use and higher fertility rates when compared with their counterparts of other religions. The reason behind this anomaly is yet to be found. Apart from socioeconomic and religious influence, there are some vital factors which control the complicated family decision. In our study, husband's influence on reproductive decision making was very pronounced and women were not free to decide on contraception, the number and spacing of their children. They lack decision making ability in family planning. In the study by Sathar and Kazi (1997), it was found that women's age and family structure are the strongest determinants of women's authority in rural Punjab, Pakistan. The same study also shows that older women and women in nuclear `households were more likely than other women to participate in family decisions. In our study it was found that with increase in age women were more likely to be considered in decision making regarding health care practices.
Increase in women's education and participation in labor force enhances women's status by offering opportunities to control their own resources as well as their power to take decisions regarding fertility (Riley 1997; Hindin 2000; Becker et al. 2006; Acharya et al. 2010); our study corroborates with these findings.
A couple's reproductive decision-making process is influenced by many factors like, couples perceptions, evaluations, norms and attitudes towards fertility choices (Hollerbach 1983 and Hull 1983). Additionally, a couple's decision making is affected by the government programmes, which not only make modern contraceptives available, but also actively encourage the acceptance of fertility limitation (Easterline 1978, Freedman 1979, Lesthaeghe 1980, Simmons and Phillips 1992 and Watkins 1987). The Indian Government's heavy reliance on terminal methods of contraception resulted in the perception among most of the Indian couples, that family planning is a means of stopping childbearing rather than a means of spacing births, despite the well-established fact that birth spacing not only reduces fertility but also benefits the health of both mothers and children (Rajaretnam and Deshpande 1994 and Jejeebhoy 1989). The policy has created a vacuum, which hinders the acceptance and practice of Reproductive and Child Health Services (RCH). This situation has changed somewhat in recent years after the International Conference on Population and Development (ICPD) in the year 1994. The top-down targets for family planning were officially abandoned, and the government has been making greater efforts to promote temporary methods (Narayana 1998). The government of India has officially renounced its target system approach and adopted

Target Free Approach (TFA). This new approach has placed women's need on the forefront (Murthy et al.2002).

Religious opposition is also a frequently cited barrier to adoption of family planning among Muslim in India (Caldwell and Caldwell 1988, Mishra et al. 1999, Bhende et al. 1991). In our study, the opposition was restricted to only few methods such as vasectomy, intra uterine device (IUD). However, religious opposition to family planning was not observed in our study. One of the first comprehensive studies on Indian Muslim however reveals that there is "substantial demand from the community for fertility regulation and for modern contraceptives". Very little consideration has been given to understanding practices, preferences, and in ensuring access to diverse family planning methods that meet diverse needs (PMHLC 2006). According to the NFHS-3 survey, Muslim has the highest per cent of overall unmet needs for contraception (18.8 per cent) as compared to all other surveyed populations (IIPS and Macro International 2007).

Conclusion

There are limited resources on the Muslim community's reproductive health practices. The present research reveals married Muslim women's reproductive health practices in general and their position in matters relating to family planning. It is solely the right of the women to decide on these issues. These rights are guaranteed by our national and international instruments of law. However, a contradictory picture is discovered, where women play negligible role in decision making. Husbands predominantly overpower their counterparts, thus leaving no individual entity of the women. Decision making assessment can be done by accumulating various aspects of freedom. In our study, we only took the reproductive (timing and spacing of births) and contraceptive (choice) for consideration. Future studies encompassing the other aspects of decision making would provide valuable information when explored and tested in differential socioeconomic and sociopolitical situations across geographical diversification.

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