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FAMILY PLANNING PRACTICE AND WOMEN'S FERTILITY DECISION-MAKING POWER

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This paper investigates the effects of family planning practice on fertility decision-making power in South Korea. The log-linear analysis of the 1981 survey data by the Institute of Population and Health Services Research, Yonsei University, Seoul, Korea, shows that those urban and rural women who practice family planning or have experienced abortion exercise greater influence on couple's fertility decision-making than those who do not practice family planning or have had no abortion experience. In addition, there is an interactive effect of abortion experience and contraceptive use on fertility decision-making among urban women. This finding is significant because regardless how birth control becomes available in a society, birth control use enhances women's decision power concerning fertility.

This paper explores the relationship between fertility control behaviors and the pattern of couples' fertility decision-making pattern in South Korea. Do women who use contraceptives and/or have had at least one abortion have greater decision-making power on reproductive issues than those who do not? In the developed countries, birth control and abortion have been acquired as reproductive rights through various phases of the feminist movement. Hence, an individual woman's use of contraceptives and/or decision for abortion is more likely to be an expression of her control over her own body. In the developed countries, women who have personal awareness of reproductive freedom and rights will exercise greater influence on the fertility decision-making process in the family than women without this awareness.

In the developing countries, however, the use and advocacy of birth control and abortion are more closely related to the issue of population control rather than as an expression of women's reproductive freedom. Birth control and abortion became available through population control policies. The implementation of national family planning policies in the Third World countries coincided with the neo-Malthusian foreign policy perspective of advanced industrial countries. The U.S., as well as other advanced countries, expressed enthusiasm for Third World population control as an anti-poverty and pro-development measure (Dixon-Mueller 1988). Both technologically and financially the U.S. supported population control policies and programs in Third World countries which emphasized limiting family size (e.g., "Stop At Two" campaigns), often

meeting quantitative goals at the expense of quality of reproductive health services. New contraceptive technologies, such as IUDs, were tested experimentally on women in the Third World. Third World governments rarely regard birth control as a feminist issue, and feminist groups have rarely participated in population control programs to represent women's interests. Thus, population control programs focus on women's excessive fertility without considering sociocultural patriarchal systems which engender gender inequality(Tangri 1976).

South Korea is a good case in point. The Korean family planning programs have been cited as one of the more successful in the world. Since the inception of the national policy of family planning in 1962, the program has been supported technically, financially, and ideologically by the government, as well as foreign donor agencies. The percentage of married women who practice contraception has increased from 9 percent in 1960 to nearly 72 percent in 1987. Abortion was legalized *de facto* in 1973 and was widely practiced often as birth control.[1] The average number of induced abortions of married women in Korea was 2.2 (Hong 1988). While the Korean Family Planning Programs are evaluated to be successful as public population control policy, Korean feminist scholars argue that the Programs neglect women's concerns and interests (Cho 1979). The Programs'excessive preoccupation with quantitative goals in service delivery rather than quality often damaged women's health. Women were mostly excluded from the decision-making process, their main role being on the local level as field workers. In the absence of strong feminists' influence or involvement in the Programs and due to the lack of the government's commitment to the enhancement of women's rights, Korean women became a target for population control, instead of being the main initiator.

Women in developing countries are often perceived as a target or an object of population control. Health workers impose family planning programs on women in order to meet an assigned quota. Family planning programs, such as China's one-child policy, often constrain women's reproductive freedom of having a child and sometimes threaten the survival of female children. The difference in the channels through which birth control and abortion became available in developed and developing countries makes one curious about the relationship between family planning experiences and women's fertility decision-making power, especially in developing countries. Do women in developing countries who practice contraception and/or have had an abortion have more power in a couple's fertility decision-making?

[1]Under this law, a doctor can legally perform an abortion when "continuation of the pregnancy is likely to damage the health of the mother". Since there is no detailed instruction interpreting this clause, especially terms like "damage" and "health", the doctor can exercise considerable discretion.

In general, family planning practice is believed to enhance women's status. Birdsall and Chester (1987) argue that accessibility to contraception enhances women's status by allowing women to control the timing and spacing of childbearing, which, in turn, increases women's educational and economic opportunities. However, with regard to the specific relationship between family planning practice and women's fertility decision-making power, the existing literature presents inconsistent research findings. Kar and Talbot (1980), in their cross-cultural study, find a nonsignificant correlation between current contraceptive use and conjugal power regarding family planning in Venezuela, but a significant correlation in Kenya. They argue, that in a traditional society like Kenya, women who use contraceptives tend to have greater autonomy in decisions and actions, and greater freedom to discuss issues concerning family planning than those women who do not use contraceptives. This research examines whether Korean women who currently use contraceptives and/or have had at least one induced abortion have greater influence on couples' fertility decision-making. The hypotheses examined here are: (1) those women who have an abortion experience exercise greater influence on couples' fertility decision-making than those who have not had an abortion experience; and (2) those women who currently use contraceptives have greater influence on couples' fertility decision-making than those who do not use contraceptives.

DATA AND METHOD

Data analyzed here were originally collected in 1981 by the Institute of Population and Health Services Research, Yonsei University, Seoul, Korea, to compare social and psychological characteristics of women who use contraceptives with those women who do not use contraceptives. The study was limited to women who were currently married, were under 45 years in age, were at the risk of pregnancy, and who did not want more children. A two-stage sampling method was employed: cluster sampling and representative random sampling. Two regions were chosen for cluster sampling: an urban subregion of Seoul and a rural subregion of Chungnam Province. From each cluster, representative random samples were drawn. The total for each group of urban user and urban non-user was fixed at 100. For each group of rural user and rural non-user the total was fixed at 200 by the design.[2] The mean age of the respondents was 35.81. Over 85 percent of the respondents were over 30 years in age and had been married over 10 years. Almost 70 percent of the respondents had more than 3 children. There were some socio-demographic differences between rural and

[2]Since the urban and the rural sample were analyzed separately, there is no need to include the two-factor effect relating region and contraceptive use in the models to be considered.

urban respondents. Rural respondents were on average 2 years older, had longer marriages, and had one more child than urban respondents. (See Ahn *et al.* (1985) for the detailed description of the data set.)

Three variables were included in the analysis: fertility decision-making power, abortion experience, and current contraceptive use. Respondent's fertility decision-making power was measured by the question, "When you don't want to have a child any more and your husband wants to have more children, what would you do?" A scale composed of three items was given to respondents:(1) comply with him; (2) try to persuade him and not to have a child; (3) not to have a child regardless of his opinion. Both abortion experience and current contraceptive use were dichotomous variables.[3] Table 1 presents a 3x2x2 contingency table composed of those variables. The log-linear analysis method was employed to analyze the contingency table.

TABLE 1. THREE-WAY TABULATION FOR FERTILITY DECISION-MAKING BY CONTRACEPTIVE USE AND ABORTION EXPERIENCE FOR URBAN AND RURAL WOMEN

Region	Abortion	Contraceptive Use	Fertility Decision-Making		
			Husband	Both	Wife
Urban	Yes	Yes	1	17	27
		No	4	7	24
	No	Yes	5	19	28
		No	13	32	19
Rural	Yes	Yes	7	13	69
		No	5	11	38
	No	Yes	10	25	75
		No	28	27	85

ANALYSIS AND FINDINGS

Table 2 reports various log-linear models fitted to data in Table 1 and their goodness-of-fit statistics. In Models 2, 3, 6, and 7, the fertility decision-making variable is treated as a linear variable. Model 8 tests the null hypothesis that abortion experience and contraceptive use are independent of fertility decision-making, controlling for the association of the two independent

[3]Initially three categories of contraceptive users were used, i.e., male-control contraceptive user, female-control contraceptive user, and non-user. Since the decision-making patterns found among female-control contraceptive users and male-control contraceptive users were similar, those two categories were combined.

TABLE 2. LIKELIHOOD-RATIO CHI-SQUARE VALUES FOR SOME LOG-LINEAR MODELS PERTAINING TO TABLE 1

Model	d.f.	X^2	p-value
Urban			
1. [AC] [AD] [CD]	2	6.9310	.0312
2. [AC] [AL$_d$] [CL$_d$] [ACL$_d$]	3	5.8062	.1209
3. [AC] [AL$_d$] [CL$_d$]	4	8.0471	.0896
4. [AC] [CD]	4	16.8710	.0023
5. [AC] [AD]	4	12.6712	.0129
6. [AC] [AL$_d$]	5	12.8450	.0246
7. [AC] [CL$_d$]	5	17.7265	.0035
8. [AC] [D]	6	23.9261	.0007
9. [A] [C] [D]	7	26.4026	.0006
Rural			
1. [AC] [AD] [CD]	2	1.7942	.4078
2. [AC] [AL$_d$] [CL$_d$] [ACL$_d$]	3	2.4885	.4764
3. [AC] [AL$_d$] [CL$_d$]	4	2.6439	$>.5$
4. [AC] [CD]	4	5.9866	.1998
5. [AC] [AD]	4	6.9305	.1394
6. [AC] [AL$_d$]	5	6.9307	.2255
7. [AC] [CL$_d$]	5	6.8016	.2355
8. [AC] [D]	6	12.7875	.0462
9. [A] [C] [D]	7	24.9866	.0010

[A] : Abortion Experience.
[C] : Contraceptive Usage.
[D] : Fertility Decision-Making.
[L$_d$]: Fertility Decision-Making as Linear Variable.

variables. Considering L^2 and the degree of freedom, the null hypothesis can be rejected for both urban and rural sample.

For the urban sample, Model 2 is the best-fitted model.[4] Abortion experience and current contraceptive use have linear effects on the fertility decision-making pattern, respectively. In addition, there is an interactive effect of abortion and contraceptive use on decision-making. Those women who currently use contraceptives are more likely to have greater influence on couples' decision concerning having a child. Likewise, women who have had at least one

[4]The strategy of finding the "best" fitted model is a choice or negotiation between Type I error and Type II error. Frequently, the probability of a Type I error between 1.10 and 0.35 is used for a decision for a best-fitted model (Knoke and Burke 1980:31). Models with higher probability levels may involve "too good a fit," that is, include unnecessary parameters (Bishop *et al.* 1975:324).

TABLE 3. ESTIMATES OF EXPECTED FREQUENCIES UNDER PREFERRED MODELS(MODEL 2 FOR URBAN: MODEL 3 FOR RURAL) FOR THE DATA IN TABLE 1.

Region	Abortion	Contraceptive	Decision-Making		
			Husband	Both	Wife
Urban	Yes	Yes	2.35	14.31	28.35
		No	1.88	11.24	21.88
	No	Yes	4.61	19.79	27.61
		No	14.17	29.66	20.17
Rural	Yes	Yes	6.01	13.77	69.23
		No	6.02	10.18	37.80
	No	Yes	12.63	20.97	76.40
		No	25.35	31.08	83.57

TABLE 4. THE ODDS RATIOS BASED ON EXPECTED FREQUENCIES.

Region	Abortion	Contraceptive	Decision-Making		
			Husband	Both	Wife
Urban	Yes	Yes	1	1	1
		No	1	.9818	.9647(=.9818^2)
	No	Yes	1	1	1
		No	1	.4876	.2377(=.4876^2)
	Yes	Yes	1	1	1
		No	1	1	1
	No	Yes	1	.7050	.4965(=.7050^2)
		No	1	.3501	.1223(=.3501^2)
Rural	Yes	Yes	1	1	1
		No	1	.7380	.5451(=.7380^2)
	No	Yes	1	1	1
		No	1	.7384	.5450(=.7384^2)
	Yes	Yes	1	1	1
		No	1	1	1
	No	Yes	1	.7246	.5251(=.7246^2)
		No	1	.7250	.5250(=.7250^2)

abortion have greater decision power. Women who currently use contraceptives and have experienced abortion have the greatest decision power concerning reproduction. Table 4 shows the odds ratio computed from the expected frequencies shown in Table 3.

According to Table 4, regardless of the abortion experience, not using contraceptives decreases the odds relative to husbands' decisions by a factor of 0.98 and $0.96(0.98^2)$ from wives' low to high decision-making power. Regardless of the contraceptive usage, no abortion experience decreases the odds relative to husbands' decisions by a factor of 0.70 and $0.50(0.70^2)$ from wives' low to high decision-marking power. It is interesting to note that abortion experience has greater effects on decision-making than contraceptive use. Furthermore, among those with no abortion experience, not using contraceptives decreases the odds relative to husbands' decisions by a factor of 0.49 and $0.24(0.49^2)$. For the rural sample. Model 3 is the best-fitted model. Model 2, while still citting the data, does not significantly improve Model 3. According to Model 3, whereas both abortion experience and contraceptive use have linear effects on couples' fertility decision-making, there is no statistically significant interactive effect of abortion and contraceptive use on decision-making. Women who currently use contraceptives and have had abortion exercise greater influence on fertility decision-making. As shown in Table 4, regardless of the abortion experience, not using contraceptives decreases the odds relative to husbands' decision by a factor of 0.74 and $0.54(0.74^2)$ from wives' low to high decision-making power. Regardless of the contraceptive use, no abortion experience decreases the odds relative to husbands' decision by al factor of 0.72 and 0.52 (0.72^2) from wives' low to high decision-making power. Unlike the pattern found in the urban sample, abortion effects are almost comparable with contraceptive effects. On the other hand, the effects of contraceptive use on fertility decision-making is greater among rural women than among urban women, while abortion effects are almost similar in urban and rural sectors. In other words, not using contraceptives decreases wives' decision making power to a greater degree among rural women than among urban women. Unfortunately, due to the limitation of data, the specific three-way interaction effects among region, abortion experience and/or contraceptive use, and decision-making cannot be statistically tested or examined.

DISCUSSION AND CONCLUSION

The results of the analysis lead to the conclusion that both contraceptive use and abortion experience influence wives' fertility decision-making power in both urban and rural South Korea. Those women who use contraceptives and/or have had at least one abortion experience are more likely to follow their own decisions concerning further child bearing than those women who do not. This finding is significant in that regardless of the way through which birth control becomes available in a society, birth control use enhances women's decision power concerning fertility. Although contraceptive measures and abor-

tion in Korea have been available through public policies of population control which do not have any feminist cause and offer no overall program for improving women's status, the availability of birth control measures and liberalization of abortion do enhance Korean women's awareness of their right of control over their own bodies and fertility decision-making power.

Cho's study(1979) reports that the attitude toward women's status and role of those women who practice family planning is little different from that of those women who do not. She argues that women's family planning practices do not affect their view of women's rights in general. However, according to this analysis, family planning practice significantly influences women's fertility decision-making power.

Birth control and easy access to abortion are in a way a mixed blessing for Korean feminism. Family planning practices may have a tendency to worsen an individual woman's health condition due to side effects of inadequate contraceptive use and possible over-frequent abortion procedures. On the otherhand, however, practicing family planning has been shown to enhance women's consciousness of their reproductive freedom and rights.

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