Population Council
Knowledge Commons

Reproductive Health | Social and Behavioral Science Research (SBSR)

2019

Autonomy, intimate partner violence, and maternal health-seeking behavior: Findings from mixed-methods analysis in Bangladesh

Pooja Sripad
Population Council

Sharif M.I. Hossain
Population Council

Charity Ndwiga
Population Council

Charlotte E. Warren
Population Council

Follow this and additional works at: https://knowledgecommons.popcouncil.org/departments_sbsr-rh

 Part of the Demography, Population, and Ecology Commons, Domestic and Intimate Partner Violence Commons, Family, Life Course, and Society Commons, Gender and Sexuality Commons, International Public Health Commons, Maternal and Child Health Commons, and the Medicine and Health Commons

Recommended Citation

Sripad, Pooja, Sharif M.I. Hossain, Charity Ndwiga, and Charlotte E. Warren. 2019. "Autonomy, intimate partner violence, and maternal health-seeking behavior: Findings from mixed-methods analysis in Bangladesh," Ending Eclampsia Country Brief. Washington, DC: Population Council.

This Brief is brought to you for free and open access by the Population Council.

country brief

ENDING Eclampsia

Autonomy, Intimate Partner Violence, and Maternal Health-Seeking Behavior: Findings from Mixed-Methods Analysis in Bangladesh

Photo credit: Sajeda Amin, 2011

JUNE 2019

USAID FROM THE AMERICAN PEOPLE

Made possible by the generous support of the American people through the United States Agency for International Development (USAID).

The Population Council conducts research and delivers solutions that improve lives around the world. Big ideas supported by evidence: It's our model for global change. popcouncil.org

© 2019 The Population Council, Inc.

POPULATION COUNCIL
Ideas. Evidence. Impact.

BACKGROUND

Gendered norms and discriminatory practices often limit women's decision-making power, which over time can lead to social norms that systematically subordinate women. Aspects of empowerment, a multi-faceted construct, were explored in a global evaluation of Demographic and Health Survey (DHS) data that measured how gendered social norms influenced maternal health-seeking behaviors.

Analysis specifically explored associations of women's autonomy and acceptability of intimate partner violence against women (IPVAW) on antenatal care (ANC) use and facility delivery in 63 low- and middle-income countries.

Service utilization is positively associated with increased autonomy and negatively associated with increased acceptability of IPVAW, but variability exists across countries and regions (1). There is need to explore complexities of gender in specific contexts.

In Bangladesh, maternal health-seeking behaviors are influenced by numerous interrelated factors. Little research exists on how gender dynamics and norms, including acceptability of various forms of IPVAW, may influence women's decision-making autonomy, health-seeking behavior, and overall well-being.

The purpose of this study was to explore the relationship between women's autonomy and acceptability of IPVAW and two primary maternal health care utilization outcomes: ANC use and facility delivery. This brief highlights quantitative and qualitative findings on the relationship between women's autonomy and maternal health seeking behaviors in Bangladesh.

METHODS

We applied a mixed methods approach to explore gender dynamics drawing on a secondary analysis of aggregate DHS data in Bangladesh from 2004 to 2014 and 22 in-depth interviews (IDIs) with pre-eclampsia and eclampsia survivors in a tertiary hospital who sought services from different parts of the country between 2014 and 2015.

Scales developed for women's autonomy (6-item) and acceptability of IPVAW (5-item) indicate women's contribution to decision-making around various aspects of their lives and accepting attitudes toward a husband beating his wife for different reasons.

Multivariable logistic regressions estimate associations between these scores and the primary outcomes, controlling for age, wealth, education, marital status, birth order, child sex, urban/rural residence, and quality of care at the individual level and average wealth and educational attainment at the cluster level.

Qualitative analyses involved transcription and translation of interviews, applying an inductively-derived codebook using NVivo, and triangulating findings from the tertiary hospital with DHS results.

RESULTS

Combined DHS data from the 2004, 2007, 2011 and 2014 surveys yielded a sample of 21,837 women and 22,030 births. We found that 22.7% of women had facility-based deliveries and 4.9% received their WHO-recommended eight ANC visits (Table 1).

Table 1. Descriptive Statistics, Mother-Level Outcomes and Covariates, Bangladesh, 2004, 2007, 2011, 2014

	Mean	SD	No. Cases	Min	Max
Mother-Level Outcomes					
Delivery in a health facility	0.227		4,957		
WHO Recommended eight ANC Visits	0.049		1,070		
Mother-Level Covariates					
Wealth, quintiles	2.913	1.422		1	5
Maternal education, none (1=yes)	0.240		5,241		
Maternal education, primary (1=yes)	0.299		6,529		
Maternal education, secondary (1=yes)	0.388		8,473		
Maternal education, higher (1=yes)	0.073		1,594		
Maternal age, years	25.397	6.172		15	49
Marital status (1=married)	0.981		21,422		
Urban (1=yes)	0.228		4,979		
Cluster-Level Covariates					
Average wealth, quintiles	2.893	1.000		1	5
Average education, highest level	1.277	0.491		0	3
N	**21,837**				

Notes: Each observation corresponds to a woman.

Table 2. Descriptive Statistics, Child-Level Covariates, Bangladesh 2004, 2007, 2011, 2014					
	Mean	**SD**	**No. Cases**	**Min**	**Max**
Child-Level Covariates					
Birth order	2.518	1.682		1	14
Multiple birth (1 = yes)	0.008		176		
Child sex (1 = male)	0.515		11,345		
N	**22,030**				
Notes: Each observation corresponds to a birth					

Table 3. Descriptive Statistics, Prenatal and Postnatal Quality Covariates, Bangladesh 2004, 2007, 2011, 2014		
	Mean	**No. Cases**
Quality Covariates		
Checked weight at pregnancy (1 = yes)	0.350	7,711
Checked height at pregnancy (1 = yes)	0.047	1,035
Checked blood pressure at pregnancy (1 = yes)	0.380	8,371
Took urine sample at pregnancy (1 = yes)	0.240	5,287
Took blood sample at pregnancy (1 = yes)	0.182	4,009
Told about pregnancy complications (1 = yes)	0.340	7,490
Told where to go for complications (1 = yes)	0.117	2,578
Health professional checked after delivery (1 = yes)	0.318	7,006
Quality score (0 – 1, percent out of 8)	0.246	5,419
Quality score, prenatal (0 – 1, percent out of 7)	0.236	5,199
N	**22,030**	
Notes: Each observation corresponds to a birth.		

Compared to global maternal health-seeking behaviors, women in Bangladesh are less likely to deliver in facilities and receive their WHO-recommended eight ANC visits (60% and 17% of women globally, respectively). Tables 2 and 3 describe the child-level and quality covariates.

In the Bangladesh sample, 56.8% of women report involvement in decision-making regarding their own health care utilization; 56.8% were involved in household purchases; 58.5% in visiting relatives; and 14.8% were involved in decisions related to money. Overall, 39.4% of women in Bangladesh report involvement in any decision-making (Table 4).

Relatedly, 10% of women believe that a husband is justified in beating his wife for at least one of several reasons (Table 4). Proportions of women's autonomy (measured using decision-making power as proxy) were similar to global estimates (40.1%), while acceptability of IPVAW was lower in Bangladesh (compared to 24.8% of women globally) (1).

Compared to global positive associations, in Bangladesh, increased women's autonomy was not associated with facility delivery (Bangladesh OR: 0.955 ns, Global OR: 1.3, $p<0.01$), while it increased the likelihood of receiving the WHO-recommended eight ANC visits (Bangladesh OR: 1.458, Global OR: 1.4, $p<0.01$) (Table 5).

Bangladeshi associations of IPVAW with service utilization were lower than global trends; women in Bangladesh with higher IPVAW scores were less likely than women globally to delivery in facilities (Bangladesh OR: 0.684, Global OR: 0.911, $p<0.01$) and achieve the WHO-recommended eight ANC visits (Bangladesh OR: 0.729, Global OR: 0.797, $p<0.01$) (Table 5).

Table 4. Distribution of Autonomy and Acceptability of IPVAW Covariates, Bangladesh, 2004, 2007, 2011, 2014		
	Mean	**No. Cases**
Autonomy		
Respondent involved in decisions over money (1 = yes)	0.148	3,232
Respondent involved in decisions over own healthcare (1 = yes)	0.568	12,403
Respondent involved in decisions over household purchases (1 = yes)	0.568	12,403
Respondent involved in decisions over daily purchases (1 = yes)	0.283	6,180
Respondent involved in decisions over visiting relatives (1 = yes)	0.585	12,775
Respondent involved in decisions over cooking food (1 = yes)	0.212	4,629
Woman autonomy score (0 – 1, percent out of 6)	0.394	8,604
Acceptability of IPVAW		
Beating justified if wife goes out without telling husband (1 = yes)	0.125	2,730
Beating justified if wife neglects children (1 = yes)	0.131	2,861
Beating justified if wife argues with husband (1 = yes)	0.163	3,559
Beating justified if wife refuses sex (1 = yes)	0.059	1,288
Beating justified if wife burns food (1 = yes)	0.021	459
Women's acceptability of IPVAW score (0 – 1, percent out of 5)	0.1	2,184
N	**21,837**	
Notes: Each observation corresponds to a woman.		

Table 5. Odds Ratios of Facility Delivery and Antenatal Care Use, Bangladesh 2004, 2007, 2011, 2014		
Variables	**(1) Facility Delivery**	**(2) Antenatal Care (WHO Recommended 8 Contacts)**
Main Exposures		
Woman's autonomy score	0.955 (0.815-1.120)	1.458*** (1.233-1.724)
Women's acceptability of IPVAW score	0.684*** (0.556-0.841)	0.729*** (0.593-0.896)
Covariates		
Wealth Quintile 2	1.005 (0.858 - 1.177)	1.101 (0.947 - 1.279)
Wealth Quintile 3	1.363*** (1.164 - 1.597)	1.114 (0.960 - 1.291)
Wealth Quintile 4	1.867*** (1.601 - 2.177)	1.336*** (1.140 - 1.566)
Wealth Quintile 5	3.277*** (2.753 - 3.901)	2.106*** (1.764 - 2.514)
Education, Primary	1.456*** (1.265 - 1.675)	1.122 (0.976 - 1.291)
Education, Secondary	2.206*** (1.894 - 2.569)	1.578*** (1.370 - 1.816)
Education, Higher	4.774*** (3.932 - 5.795)	2.792*** (2.306 - 3.380)
Marital Status (1=yes)	1.093 (0.798 - 1.498)	1.634 (1.153 - 2.316)
Birth Order	0.613*** (0.580 - 0.647)	0.826*** (0.790 - 0.863)
Child Sex (1 = male)	1.114*** (1.034 - 1.201)	1.044 (0.965 - 1.129)
Urban (1 = yes)	1.477*** (1.293 - 1.688)	1.618*** (1.419 - 1.844)
Average wealth score	1.168*** (1.075 - 1.269)	0.998 (0.915 - 1.088)
Average schooling	1.689*** (1.460 - 1.955)	1.496*** (1.295 - 1.729)
Quality score		48.84*** (40.49 - 58.91)
Constant	0.0323*** (0.00500 - 0.208)	1.07e-08 (-)
N	**21, 837**	**21,799**
*** p<0.01, ** p<0.05, * p<0.1		

Notes: The unit of observation is the birth. Odds ratios are presented with 95% confidence intervals in the parentheses below. Delivery in a facility (column 1) reports whether the mother delivered the birth in a health facility or not. ANC contacts (column 2) reports whether the mother received at least 8 ANC contacts for the birth. Results are from logistic regressions that include cluster, mother, birth, and quality of care controls. Cluster-level covariates are the average wealth index value of mothers in the cluster, and the average educational attainment of mothers in the cluster. Mother controls include the household wealth index (in quintiles), educational attainment of the mother (no education, primary, secondary, higher), age of the mother (in 5-year age groups), mother's marital status, and mother's place of residence (urban/rural). Birth level controls include birth order. For Column 2, quality of care controls include the 7-point average quality score that was generated for the birth. Standard errors are clustered at the primary sampling unit (DHS cluster) level.

Qualitative data corroborate that acceptance of women's subordinate positions in households renders most unable to independently make health care-seeking decisions.

Spouses/intimate partners, mothers-in-law, and other family members play critical roles in determining whether and/or where the women seek skilled care for ANC, delivery, and postnatal care (PNC). These relationships affect a woman's decision-making ability to seek care given her restricted religious and cultural practices.

"We didn't go there [facility/ANC clinic] before that [the PEE condition]. My husband said no interception over Allah! ...he has been working in Dhaka-the capital city... I called him at today morning and told him to come see me and the child. He asked me by whose permission we took to come to Dhaka. I answered that I was here because the condition was worsening...he responded that 'interruption on Allah is not needed, everything will happen in its way'."

IDI, pre-eclampsia survivor,

The emotional toll of gender dynamics during pregnancy and postnatally manifest variably; for example, spousal sternness burdened the woman with balancing household needs and her need for medical attention, compelling some women to over-work to sustain their households and maintain a peaceful and supportive home environment while preparing for birth.

Even when women receive ANC, spousal neglect often intersects with poverty status as influences on service use.

"I had no ANC checkup. You see I am garmet worker how I can afford such money for the ANC checkup. My husband is a "boundel", "Badmaish" (meant bad). I needed money for the checkup. In addition, I had no time to go there. Every day I had duty [work]."

IDI, pre-eclampsia survivor

CONCLUSIONS & RECOMMENDATIONS

Quantitative and qualitative findings suggest that gender dynamics, alongside other factors, affect women's empowerment to seek maternal health services in Bangladesh.

While incongruencies between decision-making capacity of women with respect to their health, mobility, and use of household finances were observed across methods, concurrence around household power dynamics and normalized IPVAW effects - that manifest as restricted socio-cultural mobility and dependence on spousal permissions – limit women's ability to reach care.

Less information emerged organically in qualitative interviews about the influence of IPVAW, though this is likely given the lack of specified focus on this in the formative study. Consistent quantitative findings were observed using Bangladesh's programmatic guideline for the recommended four ANC visits. We recommend further research around maternal mental health as relates to conditions like pre-eclampsia. Additionally, explicit gender equity-promoting and socio-economically supportive policy and programming should be put into place to enable women to mitigate intra-household dynamics and empower them to use necessary maternal health care.

REFERENCES

1) Pooja Sripad, Charlotte E Warren, Michelle J Hindin, & Mahesh Karra, (2018). Assessing the role of women's autonomy and acceptability of intimate partner violence in maternal health-care utilization in 63 low- and middle-income countries. International Journal of Epidemiology, dyy299, https://doi.org/10.1093/ije/dyy299

CONTACT

Pooja Sripad, Associate, Population Council
psripad@popcouncil.org

Sharif Hossain, Associate, Population Council
sharifhossain@popcouncil.org

Charity Ndwiga, Program Officer, Population Council
cndwiga@popcouncil.org

Charlotte Warren, Senior Associate, Population Council
cwarren@popcouncil.org

The Ending Eclampsia project seeks to expand access to proven,underutilized interventions and commodities for the prevention, early detection, and treatment of pre-eclampsia and eclampsia and strengthen global partnerships.

USAID FROM THE AMERICAN PEOPLE

Made possible by the generous support of the American people through the United States Agency for International Development (USAID).

The Population Council conducts research and delivers solutions that improve lives around the world. Big ideas supported by evidence: It's our model for global change. popcouncil.org

© 2019 The Population Council, Inc.

POPULATION COUNCIL
Ideas. Evidence. Impact.