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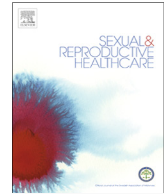

Effects of women's autonomy on maternal healthcare utilization in Bangladesh: Evidence from a national survey

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ABSTRACT

Objectives: This study aims to construct an index of women's autonomy to analyze its effect on maternal healthcare utilization in Bangladesh. Empirical modeling of the study used instrumental variable (IV) approach to correct for possible endogeneity of women's autonomy variable.
Methods: Data from the Bangladesh Demographic and Health Survey (BDHS) 2011 was used for the study. Women's autonomy variable was obtained through factor analysis of variables related to autonomy in decision making regarding healthcare, financial autonomy and freedom of movement. Conditional mixed process (CMP) models were fitted for three maternal healthcare indicators: at least four antenatal care (ANC) by trained personnel, institutional delivery and postnatal care (PNC) by trained personnel.
Results: Study sample consisted of 8753 women with 5.5 mean years of schooling. Women with no formal education, of Islamic faith, from poorest wealth quintile, residing in rural areas and with low autonomy used the maternal healthcare least. Marginal effect shows that if women's autonomy score is increased by one unit, probability of maternal healthcare utilization will increase by 0.14 for ANC, 0.14 for institutional delivery, and 0.13 for PNC.
Conclusions: Women's autonomy is an important driver of maternal healthcare utilization in Bangladesh. Results suggest that women participating in social and economic activities enhances their autonomy. Other factors affecting women's autonomy are female literacy, educational attainment and households' economic status.

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Introduction

World Health Organization (WHO) defined maternal mortality as the deaths of women while pregnant or within 42 days of termination of pregnancy, resulting from complications arising due to pregnancy or its management [1]. In 2015, it was estimated that about 300 thousand mothers died due to causes related to pregnancy and childbirth, a significant decline from half a million deaths in 2000 [2]. United Nations (UN) adopted Millennium Development Goal 5 (MDG-5) in 2000 that set the target of reducing maternal mortality ratio (MMR) by to about 143 per 1000 live births by 2015. If the rate of decline of MMR observed over the years 1990 to 2010 continued after 2010, Bangladesh should have achieved the MDG 5 target [3].

Although reducing MMR by two-thirds over a period of 25 years is a significant accomplishment, this reduction, in part, is attributable to the fall of Total Fertility Rate (TFR) in Bangladesh. The MMR in Bangladesh remains relatively high compared to other developed and transitional countries of the world and although direct causes of MMR declined rapidly, indirect causes of MMR did not decline as much as the overall decline rate [4]. Further improvements will require addressing the indirect obstetric causes of MMR [5], which will require greater focus on equity in maternal health outcomes. Inequitable utilization of maternal healthcare services is an important contributing factors adversely affecting the rate of decline of MMR in Bangladesh [6].

At the end of the MDG era UN has adopted a new set of Sustainable Development Goals (SDGs) for all nations. In SDG, the MMR target for Bangladesh has been set at 70 per 100,000 live births

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by 2030 [7]. From the current level of MMR at about 180 per 100,000 live births, achieving the new target will require comprehensive approaches for improving maternal health. Supply-side interventions, such as improving access to maternal health services, is unlikely to improve MMR significantly without addressing the social and health disparities. Maternal healthcare utilization, e.g., accessing antenatal care (ANC), delivery care, and postnatal care (PNC), are important indicators to better understand the system-wide issues and concerns as it related to further improvements in MMR. At least four ANC visits are recommended by WHO to ensure that health care providers are assessing mother's and fetus's wellbeing during pregnancy (WHO) on a timely basis. ANC visits are also instrumental in future planning of delivery place and attendants. Institutional delivery is recommended for better pregnancy outcomes and PNC care by skilled personnel within two days of birth is needed to avert potential complications that may arise after the delivery of the babies.

Although the term "women's autonomy" is used widely in the literature, there is no all accepted definition of the term. Women's autonomy is a broad multi-dimensional concept which entails control over resources and ideologies; it requires self-confidence to overcome external barriers through the process of interaction among women and other stakeholders [8]. Women's autonomy, therefore, emphasizes women's ability to decide course of actions, ability to meet her requirements which depends on the degree of control she has over material/financial resources and her ability to move freely in the community in which she lives [9]. Women's autonomy is often measured by combining a number of dimensions of autonomy and independence including her decision making capabilities, control over finances, and freedom of mobility [10–12].

Despite considerable evidence demonstrating the positive impact of women's autonomy on maternal healthcare utilization, most women in Bangladesh still face societal restrictions on their movement and ability to make decisions for herself and her children. Only 42 percent of married women were found to be active in household decision making processes related to their own healthcare, child healthcare, major household purchases and visiting family and relatives, while 19% do not participate in any of these aspects of decision-making [13].

It has been well documented that women's autonomy is an important driver behind the utilization of maternal healthcare services in developing country settings. The Programme of Action chalked out in 1994 International Conference on Population and Development in Cairo, Egypt, formally acknowledged the importance of improved women's status, which enhances their decision making capability, especially where reproductive behavior is concerned [14]. Given the patriarchal household structure in the Indian subcontinent, autonomy of women is severely curtailed by the society and the consequences of this low autonomy are high child mortality, slow rate of fertility decline and poor overall reproductive health status [15].

When women's autonomy is impaired through restrictions on movement, having limited or no decision making authority and being financially dependent, consequences are often early age of marriage, and relatively low utilization of reproductive care [16]. Several studies have explored the effect of women's autonomy on reproductive health outcomes in Bangladesh [10–12,17–19]. These studies indicate that lower family size and desired fertility are observed among women with higher levels of autonomy [11]. Similarly, higher rates of institutional deliveries were observed among women with higher levels of autonomy [17]. Despite these few attempts to link women's autonomy with maternal health care utilization and outcomes, more rigorous analysis is needed to better understand different dimensions of women's autonomy and its effect on utilization of maternal care services. This study aims to find out the relationship between women's autonomy and maternal care utilization in Bangladesh.

Materials and methods

Conceptual framework

For this study we followed the framework proposed by Jejeebhoy for estimating women's empowerment [20]. According to Jejeebhoy, women's empowerment is determined by demographic status (women's age), economic status (asset quintile), social status (women's schooling), and media exposure. Women's empowerment has four dimensions: self-esteem, control of resources, decision making, and mobility. The dimension of self-esteem is difficult to measure and often not considered in the analysis of women's autonomy [21]. Some authors conceptualize this dimension by considering the relevant information possessed by women and use of the information towards household decision making [22]; some stress the importance of access to material and social resources [23] while others emphasize decision-making authority over financial matters, freedom of movement and possessing equal power in the family [24]. In this study, we posit that last three dimensions represent women's autonomy because decision making authority is the central issue of women's autonomy [25] (Fig. 1).

In general, women's freedom of movement, control of resources, and decision making authority increase with age. Similarly, higher educational attainment and exposure to mass media can have positive influence on women's empowerment and autonomy. Effect of household wealth status on women's autonomy is ambiguous: it can decrease the freedom of movement of women but decision making related to the use and control of financial resources may improve [26].

In the BDHS data collected some information which can be used to construct women's autonomy measure. The relevant variables are: decision-making on own health, on children's health, on major household purchases and visiting family and relatives. The first two variables show the decision making authority regarding health matters, while the third indicates the degree of control women have over household resources. The last variable reflects the freedom of movement of women in the household.

For assessing maternal healthcare utilization, we have followed Andersen's behavioral model [27]. According to the model, healthcare utilization is determined by predisposing, enabling, and need based factors. In this study, predisposing factors include maternal age and education, husband's age and education, and religion, while enabling factors include wealth quintile and residence. Perceived need includes birth order, media exposure, and women's autonomy. Andersen proposed that predisposing characteristics affect enabling resources, which in turn, shapes the needs of the population in question. All these factors together determine the use of healthcare services, including the use of maternal healthcare.

Data source

This study uses BDHS 2011 dataset for exploring the relationship between women's autonomy and utilization of maternal health services. Like other Demographic and Health Surveys, this survey also collected information on household characteristics, reproductive and child health utilization, knowledge, attitude and behavior regarding HIV/AIDS and women empowerment vis-à-vis health outcomes by interviewing ever married women of reproductive age (15–49 years) and also ever married men aged 15–54 years. BDHS is a nationally representative survey and the

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