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Microfinance participation and contraceptive decision-making: results from a national sample of women in Bangladesh

N.S. Murshid*, G.E. Ely

School of Social Work, University at Buffalo, State University of New York, United States

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ABSTRACT

Objectives: Our objective was to assess whether microfinance participation affords greater contraceptive decision-making power to women.
Study design: Population based secondary data analysis.
Methods: In this cross-sectional study using nationally representative data from the Bangladesh Demographic and Health Survey 2011 we conducted multinomial logistic regression to estimate the odds of contraceptive decision-making by respondents and their husbands based on microfinance participation. Microfinance participation was measured as a dichotomous variable and contraceptive decision-making was conceptualized based on who made decisions about contraceptive use: respondents only; their partners or husbands only; or both.
Results: The odds of decision-making by the respondent, with the reference case being joint decision-making, were higher for microfinance participants, but they were not significant. The odds of decision-making by the husband, with the reference case again being joint decision-making, were significantly lower among men who were partnered with women who participated in microfinance (RRR = 0.70, $P < 0.01$).
Conclusion: Microfinance participation by women allowed men to share decision-making power with their wives that resulted in higher odds of joint decision-making.
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Introduction

In Bangladesh approximately 61% of women report the use of contraceptives but little is known about how contraceptive decision-making takes place among married couples. An understanding of what goes into the decision-making process regarding contraceptives is important because women may face heath risks based on contraceptive patterns, especially when they do not have control over these decisions – including contracting sexually transmitted diseases and unwanted pregnancy, which in turn may further compromise their sexual and reproductive health.

Women are often solely responsible for making contraceptive decisions; others share that decision-making with their partners; while, others have partners or husbands who

* *Corresponding author*. Tel.: +1 617 9552549.
E-mail addresses: nadinemurshid1@gmail.com, nadinemu@buffalo.edu (N.S. Murshid).
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make contraceptive decisions for the couple.[1] However, such decision-making is difficult to map. Research indicates that contraceptive use, like condom use, may vary based on men's preference even when women choose it as their preferred method of contraception.[2] There are four ways in which women's own decisions or preferences regarding contraceptive may be overridden. First, women may be conditioned to being passive in their sexual relationships that may make them non-assertive about contraceptive use.[3] Second, women experiencing intimate partner violence may have less control over their reproductive and sexual rights than they would want.[4,5] Third, women's own religious and cultural beliefs surrounding contraceptive use may out-weight their personal health concerns.[6–8] Finally, women with a history of unwanted sexual outcomes – such as unwanted pregnancy or sexually transmitted diseases – may make decisions to prevent such outcomes in the future irrespective of their desires.[7,9]

All of these factors, research suggests, connect to economic resources. Much of the literature on decision-making, including contraceptive decision-making, focus on who has economic control in the household, suggesting that men as heads of household often have greater say in decision-making. This is because men, as income-earners, have economic control over the household, which perhaps allows them to assert themselves more, use violence as a tool to maintain control in some situations and uphold their religious and cultural beliefs that they instill in their partners.[10–13]

Similarly, others suggest that women's lack of economic resources may preclude them from using contraceptives due to their inability to afford them, while making it difficult for them to assert themselves in the household.[14,15] This is particularly true in cultures that uphold patriarchal norms and sexual division of labour that dictate that men are income-earners while women are homemakers.[16] In Bangladesh, this problem of limited economic access for women, particularly women from low socio-economic backgrounds, have been met with solutions from microfinance institutions (MFIs) that provide women with a host of financial resources, the most acclaimed of which is the microloan program. By availing microloans women create micro enterprises from which they potentially earn an income, which in turn, allow them to garner more economic control over their households.[17] However, studies suggest that women do not always benefit from microfinance participation; instead, they hand over their loans to their husbands, thus relinquishing any positive individual benefits that they may have experienced, including decision-making power in various domains, including contraceptive decision-making.[18,19]

The objective of the present study, then, was to assess how increased economic resources, as conceptualized by microfinance participation, affect contraceptive decision-making, if at all, given the contradictory evidence on the role of microfinance participation on women's decision-making in various countries.[18,20] This study uses data from a nationally representative sample of women from the 2011 Bangladesh Demographic and Health Survey (BDHS). We hypothesize that current microfinance participants are more likely to report contraceptive decision-making power than non-participants of microfinance. Based on studies that indicate that women who are HIV literate (i.e. aware of how HIV is transmitted), women with media exposure, women who do not desire more children, and women who already have young children are at increased odds of using contraceptives, we control for these factors, in addition to demographic factors, age, education, employment status, urban dwelling, and wealth assets.[1,2,7,9,12,15]

Methods

This cross-sectional study employed a population based secondary data analysis approach with a sample of 7325 women between the ages of 15 and 49 years.

Data and sampling

Data from the nationally representative Bangladesh Demographic and Health Survey were used in the present study. Data documents reveal that the survey utilized a two-stage stratified sampling process to generate the sample of households from which respondents were selected. The first stage involved selection of 600 enumeration areas with 207 clusters in urban areas and 393 in rural areas. The household list from the selected enumeration areas was deemed the sampling frame for the second stage of the sampling that involved the selection of household. In the second stage of sampling 30 households were selected per enumeration area, on average. Interviews were conducted at 17,141 households, which accounted for 98 percent of all the occupied households, in which 18,222 ever-married women aged 12–49 years were identified in these households, of which 17,842 were interviewed.

The present study, however, restricts the data to those who responded to questions on microfinance participation, contraceptive decision-making, and control variables. This resulted in a sample of 7325 women between the ages of 15 and 49 years.

Measures

The measurement of contraceptive decision-making was based on a question that asked women about who made decisions regarding contraceptive use. Women who indicated that they were using contraception reported who makes decisions about contraceptive use. Responses were grouped into three categories: (1) women who indicated 'Respondent Only' were categorized as women who made contraceptive decisions without their partner's influence; (2) women whose response was 'Partner Only,' were categorized as those whose husbands/partners made contraceptive decisions; and (3) women whose response was 'Jointly with Partner/Husband,' were categorized as those who made such decisions together.

Microfinance participation was measured based on women's responses to a question about their participation in the following microfinance institutions: Grameen Bank; Brac; ASA; Proshika; BRDB; Mother's Club; and other. Responses were categorized into two categories: (1) women who indicated that they participated in at least one of these organizations were categorized as microfinance participants; and (2) women who did not indicate that they participate in any

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