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Correlates of unmet need for contraception in Bangladesh: does couples' concordance in household decision making matter?☆

Jalal Uddin[a,*], Mohammad Habibullah Pulok[b,1], Md Nasim-Us Sabah[c,2]

[a]Department of Sociology, University of Alabama at Birmingham, Birmingham, AL 35233, USA
[b]Centre for Health Economics Research and Evaluation (CHERE), University of Technology, Sydney (UTS), Sydney, Australia
[c]Department of Finance, Rawls College of Business, Texas Tech University, Lubbock, TX 79409, USA

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Abstract

Introduction: A large body of literature has highlighted that women's household decision-making power is associated with better reproductive health outcomes, while most of the studies tend to measure such power from only women's point of view. Using both husband's and wife's matched responses to decision-making questions, this study examined the association between couples' concordant and discordant decision makings, and wife's unmet need for contraception in Bangladesh.
Methods: This study used couple's data set ($n=3336$) from Bangladesh Demographic and Health Survey of 2007. Multivariate logistic regression was used to examine the likelihood of unmet need for contraception among married women of reproductive age.
Findings: Study results suggested that couples who support the equalitarian power structure seemed to be more powerful in meeting the unmet demand for contraception. Logistic regression analysis revealed that compared to couple's concordant joint decision making, concordance in husband-only or other's involvement in decision making was associated with higher odds of unmet need for contraception. Wives exposed to family planning information discussed family planning more often with husbands, and those from richest households were less likely to have unmet need for contraception.
Conclusion: Couple's concordant joint decision making, reflecting the concept of equalitarian power structure, appeared to be a significant analytic category. Policy makers in the field of family planning may promote community-based outreach programs and communication campaigns for family planning focusing on egalitarian gender roles in the household.

Keywords: Contraception; Women's power; Household decision making; Concordance; Family planning

1. Introduction

Expansion of access to family planning (FP) and meeting the identified unmet need for contraception have become two key challenges to improving maternal and reproductive health in the developing world. Unintended pregnancy, often occurred due to poor access to contraceptive services, often results in abortion-related morbidity and mortality [1]. Globally, recent estimates suggest that the use of contraceptive averted almost 270,000 maternal deaths in 2010 [2]. In Bangladesh, contraceptive prevalence rate has fairly been stagnant over the last decade [3]. Although maternal mortality has substantially declined, many Bangladeshi women still die from pregnancy-related causes [4].

Bangladesh is a Muslim-majority country, where women's lives remain constrained by religious values and patriarchal family structure. Typically, the Muslim institution of *purdah* (female seclusion) and patriarchal family structure challenge women in acquiring higher status and agency relative to men within the household. Although changing, the practice of *purdah* is still socially valued. The *purdah* system, which enforces a strict separation between men and women, often restricts women's freedom of movement and access to educational and labor market opportunities [5]. In addition, traditional Muslim family law gives men the right to unilateral divorce, double share of inheritance and guardianship over

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* Corresponding author. Tel.: +1 2054131917.
E-mail addresses: jalal@uab.edu (J. Uddin), mohammad.pulok@chere.uts.edu.au (M.H. Pulok), nasim.sabah@ttu.edu (M.N.-U. Sabah).
[1] Tel.: +61 424136347.
[2] Tel.: +1 806 834 4970.

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wife and children. These structural forces tend to give men more power and authority in the household and systematically put women in weaker position within the intrahousehold power hierarchy. Given the cultural context of Bangladesh, it is particularly important to critically understand the intrahousehold decision-making process as a power relation between wives and husbands.

A growing body of empirical literature focused on women's status, gender power and their impact on fertility, reproductive health and FP outcomes [6–9]. A common impression brought by these studies is that women with higher status and greater agency are more likely to control their fertility and reproductive choices. More recently, much effort has been extended to measuring women's autonomy as an important multidimensional construct reflecting women's relative power, especially in the household decision-making domain. Typically, most of the studies tend to measure such variable using only women's report of how they themselves perceive their participation in the decision making [10–12]. Relatively less attention has been given to employing husbands' and wives' perspectives together. Recently, a number of couple studies examined the association between various health outcomes and couples' household decision-making dynamics [13–15]. These studies commonly used the analyses of decision making as a proxy measure of either women's relative power [13,14] or women's autonomy [15]. Using these measures, studies tend to argue that concordant joint decision making is favorable for better maternal health outcomes than male-dominated or women-dominated decision making [13].

The use of couple-level measures on decision making has two advantages in examining the association between women's power and use of contraception. First, methodologically, it yields better reliability in estimates of the pattern of household decision making and better captures the existing gender roles within household. Second, it helps examining several theoretical assumptions in relation to women's power and control over their reproductive choices. One theoretical assumption is that strong communication and shared control over resources, as reflected in couple's concordance in joint decision makings, have potential to overcome husband's opposition to contraceptive use when husbands disagree on regulating child birth [7]. Another assumption is that a couple's approval of wife's freedom of movement, authority to use financial resources and practice of taking care of their own or children's health facilitate wives to get access to FP information and meet their contraceptive demand [16].

Using the matched married couples sample from Bangladesh, this study makes two contributions to the existing literature on FP and reproductive health. First, using the operationalization of couple's decision makings recently used by Story and Burgard [13], we attempt to measure couple's decision makings by matching husbands' and wives' concordant and discordant responses to a set of household decision-making questions. A couple's concordant responses would include whether both wife and husband agree that they jointly make the decision, or wife alone makes the decision, or husband alone makes the decision, or someone else with them take part in the decision, and discordant responses would include whether wife and husband disagree about who makes the decision [13]. Second, using the couple-level decision-making measures, and controlling for women's status, and demand- and supply-side factors of contraception use derived from literature on FP and reproductive health, we examine the association between couples' concordant and discordant decision-making patterns and women's unmet need for contraception in Bangladesh.

2. Methods

2.1. Data and sample

This study used data from the Bangladesh Demographic and Health Survey (BDHS) of 2007. BDHS is a nationally representative household survey that collects detailed information on maternal and child health, mortality, fertility and FP from the eligible household members. Following a multistage stratified sampling procedure, BDHS conducts standardized separate surveys for ever married women and men [17]. In BDHS of 2007, a total of 10,996 women aged 15–49 years (98.4% response rate) and 3771 men (92.6% response rate) were interviewed. For the purpose of this study, we used the couple data set of 2007. The 2007 couple data set included 3336 respondents who identified as husband and wife through the matching process used by DHS. DHS interviewed all eligible women from the sampled households, whereas the men's survey was conducted among a subsample of households (usually every second household) selected for the women's survey. As such, the couple sample is nationally representative.

2.2. Outcome variable

2.2.1. Unmet need for contraception

There is a concept of "unmet need for contraception" of women who do not want to become pregnant but are not currently using contraceptives. In other words, unmet need for contraception is the discrepancy between a woman's stated desire to limit or space childbearing and her actual use of contraceptives. The BDHS of 2007 defined unmet need using a conventional algorithm developed based on a set of standardized survey questions. These questions were asked to eligible women to determine whether they desired to either terminate or postpone childbearing. This study used a binary measure of unmet need for contraception measuring whether a married woman had any unmet need for contraception (both for spacing and limiting childbearing). The detail calculation procedures of the conventional measure and recently instituted revisions are reported elsewhere [18].