Reproductive Autonomy of Women in Rural Bangladesh

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Abstract

Introduction: Reproductive autonomy confers a women's decision and controls over, matters related to contraceptive use, pregnancy, and childbearing. Rural women of Bangladesh have very little control to shape up their family with their minimum empowerment and are lagging behind in the practice of use of family planning methods.

Objective: To find out the association among rural women's reproductive autonomy and contraceptive behavior.

Materials and Methods: This cross sectional study was conducted among 284 married rural women of reproductive aged in Mohammadpur upazilla, Magura district of Bangladesh from June 2016 to December 2016 selected through simple random sampling. Mixed method approach was introduced for data collection through face to face interview using pretested questionnaire and focused group discussion.

Results: Mean age of the respondents was 26.5±5.7 years with the range of 17 to 45 years. Average monthly family income was 12,561 Taka where majority of the respondents were housewives (83.8%). Education status above primary level was recorded in 23.6%. Early marriage was highly prevalent (77.5%) and mean age of marriage was 17.2±1.7 years. Mean parity was 2.3 per woman. Only 31% of the respondent found to have well reproductive autonomy. Contraceptive use was prevalent in 61.9% of the respondents and only educated women seen to have chance to participate in family planning decision-making. Male participation in contraceptive use was negligible but still men were in main role to give it the final shape to decide about family planning. Women's reproductive autonomy found to be significantly associated with their contraceptive behavior ($p<0.05$). Educational status of the women and age gap with the spouse were significantly associated with their reproductive autonomy ($p<0.05$).

Conclusion: Gender issues were prominent in family planning in rural community and rural women accepted the gender disparity in silence. Policy makers and family planning stake holders should put maximum endeavor to improve women's reproductive autonomy to strengthen their negotiating capacity in fertility control.

Key-words: Reproductive autonomy, Family planning, Rural Women.

Introduction

Bangladesh being the 8th largest countries in the world, having the highest population densities with about 837 inhabitants per square kilometers[1]. However, country has a smaller area compare to its huge population. Bangladesh is having a patriarchal society having strong religious beliefs and social values of the people. In the society, the position of women is at the back and their opinion is generally not taken with due importance. The socio-economic condition of the people is not very well in rural settings. The literacy rate is comparatively poor comparing to many other countries.

Reproductive autonomy is ones have the power to decide and control over the matters related to contraceptive use, and pregnancy. In generally, women's reproductive autonomy is decided by the varying degree of social norms both at the social level and the individual level[2]. Improvement in women's status or their empowerment is a key factor in reproductive preferences and family planning programs. In the world women's decision-making autonomy, like as women's freedom of willing movement, their participation in decision-making, their communication with partner about family planning, and their scope of involvement and control over resources have sometimes been overlooked. Studies have used these direct measures about women's decision-making autonomy revealed that women's decision-making autonomy is influenced by reproductive preferences so strongly that they cannot be ignored[2]. It is important to consider because it helps to explain the issues related to family planning and population control[3].

Women's reproductive autonomy is a factor which gives the ability of the women to control timing, spacing, and the number of pregnancies and birth which ultimately gives the success and achievement of reproductive intentions of women in the society[4]. Factors that influence the women's autonomy most strongly and significantly are poverty and belief systems that devalue such autonomy. The conceptual framework used to develop the reproductive autonomy scale indicates five scales such as decision making ability of women, their communication ability, equitable gender-role attitudes, self-efficacy and management of coercion and unfortunately, all these indicators are poor in regards of the rural context of our country. In this perspective, the study was conducted to describe the current status of rural women's reproductive autonomy in a rational way.

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Materials and Methods

This cross sectional study was conducted among 284 married rural women of reproductive aged in Mohammadpur upazilla, Magura district of Bangladesh from June 2016 to December 2016. These respondents were selected by simple random sampling. In the process of sampling, 284 respondents were randomly taken from rural area from family planning (FP) registration records of upazilla based on the inclusion criteria. Data were collected by trained interviewers by face-to-face interview with a pretested questionnaire. Before finalization of the tool, validity and reliability of the tools were checked. Ethical issue was addressed.

Women's reproductive autonomy was revealed through 14 itemed scale which was previously used by Upadhyay et al[3] and this tool was grouped into 3 subscales: freedom from coercion; communication; and decision-making which was validated. To assess FP knowledge of respondents dichotomous types of questions were used. FP attitude tool was constructed based on Likert scale. Except FP knowledge, Cronbach's Alpha (α) were >0.70 for all the scales. Data processing and analyses were done by using Statistical Package for Social Sciences (SPSS) version 20. Frequencies, percentage, mean and standard deviation (SD) were used for descriptive statistics. To reveal significance of predictors on women's reproductive autonomy hierarchical regression model was used.

Results

Average age of the respondents was 26.5 years with SD of 5.7 years and their age range was 17 to 45 years. More than half (53%) of the respondents were in the age group of 20-29 years and around 10% were still adolescent. More than two-thirds (68.3%) of the respondents had their monthly family income about 10,000 Taka with average income of 12,561 Taka. In this study, respondent's minimum monthly family income was 4000 and maximum was 60,000 Taka. Here more than half of them (54.6%) had primary level education. Among the respondents Muslims (88.4%) were predominant and 83.8% were housewives. Almost two-thirds (62.7%) had joint family. About 43% of the respondents had ≤ 4 family size and their average family size was 4.9 with ±1.9 SD. Their maximum family size was13 and minimum was 2.

Maximum respondents (77.5%) had history of marriage before 18 years and mean age of marriage was 17.2 years with their SD of 1.7 years. Among the respondents around one-third (34.5%) had history of delivery more than two times and 2.3 was average parity with SD of ±1.2. Almost half (49.3%) regularly used contraceptives and 12.3% gave history of irregular use. 44.6% used oral contraceptive pills (OCP), where 21.7% had chosen injections, 3.4% used implant and only 4 % had chosen Copper-T as their contraceptive method. Among the users, barrier method, condom was used in 7.4% cases, only 8% had the history of using permanent methods of contraceptives either tubal ligation or vasectomy and natural methods were chosen by 10.9% (Table-I). Mean score of women's reproductive autonomy was 33.9 (±7.5). Only a few rural women (14.8%) showed well reproductive autonomy. Average FP knowledge score was 7.1 (±1.4). Although almost all of them heard about OCP but overall FP knowledge was not satisfactory. Only 13.4% women had good FP knowledge. Average FP attitude score was 21.4 (±4.2). Less than one-fourth rural women (23.2%) showed well FP attitude about using FP methods (Table-II).

Among the 284 respondents, the mean of reproductive autonomy scores was 32.8 for the illiterate respondents, 34.2 for the respondents who were educated up to primary level and 34.9 for the respondents having educational level more than primary school. It was found that there is a strong association with education and reproductive autonomy with value of $p<0.05$ and $F=2.034$ (Figure-1). It was revealed that the mean of reproductive autonomy score was 33.5 for the family with lower income i.e. monthly income up to Tk 10,000.00, the mean of reproductive score was the highest i.e. 34.9 when the monthly family income was between Tk. 10,000.00 to Tk. 20,000.00 and the same started declining up to 34.3 when the monthly family income was more than Tk. 20,000.00. It was found that there was no statistical significant association between reproductive autonomy and family income with value of $p<0.05$, $F=2.043$ (Figure-2). It was also revealed that among the respondents, means of reproductive autonomy score was 33.20 for the respondents having age gap more than 9 years. It was 33.9 when the age gap was 3-8 years and score was 35.6 where the age gap was less than 2 years. It was found that there was no statistical significant association between reproductive autonomy and age gap of the couple with the value of $F= 0.791$ and $p>0.05$ (Figure-3).

Among 284 respondents, 62% respondents were the contraceptive users and 38% were non-users. It was also found that among the poor reproductive autonomy respondents, 28.4% respondents were contraceptive users and 41.7% respondents were non-users, among the average reproductive autonomy respondents, 35.2% respondents were contraceptive users and 35% respondents were non-users and among the well reproductive autonomy respondents, 71.9% respondents were contraceptive users and 28.1% respondents were non-users. It was found that, there was statistical association between reproductive autonomy and contraceptive behavior with the $\chi 2 = 16.8$; $p<0.05$ (Table-III).

FGD findings: Focus Group Discussion (FGD) data was studied and it was found that FGD data enhanced the depth of the study findings of the quantitative data. During the FGD, it was found that women's reproductive autonomy was hard to describe in male dominant society. Where early marriage is very common, family planning decision making was too tough for the young girls, their say in this regard mostly remained underestimated and adolescent pregnancy

made them even more vulnerable. Male participation in contraceptive use was almost nil and rural women used to take the whole practice in line with the traditional norms even in presence of any health related issues. It came out that only educated women or women with personal income had chance to participate in decision-making but still men were in main role to give it the final shape.

Table-I: Reproductive characteristics of respondents (n=284)

Reproductive characteristics	Frequency	Percentage
Age at 1st marriage of respondents (years)		
≤15	30	10.6
16-17	189	66.9
≥18	65	22.5
Mean (SD)	17.2(±1.7)	
Min-Max	15-24	
Number of delivery		
0	27	9.9
1	47	16.2
2	111	39.4
>2	99	34.5
Mean ± SD 2.3±1.2; Range: 0-5		
Use of contraceptives		
Not using	108	38.4
Irregular	35	12.3
Regular	141	49.3
Types of contraceptives (*n*=175)		
OCP	77	44.6
Injection	39	21.7
Norplant	5	3.4
Copper-T	8	4.0
Condom	14	7.4
Vasectomy / ligation	13	8.0
Natural method	19	10.9

Table-II: Status of women's reproductive autonomy, family planning knowledge and attitude (n=284)

Variables	Percentage			Mean ±SD	Cronbach's alpha (α)
	Poor	Fair	Good		
Family planning knowledge	28.2	58.4	13.4	7.1±1.4	0.64
Family planning attitude	48.6	28.2	23.2	21.4±4.2	0.84
Reproductive autonomy	35.6	49.6	14.8	33.9±7.5	0.82

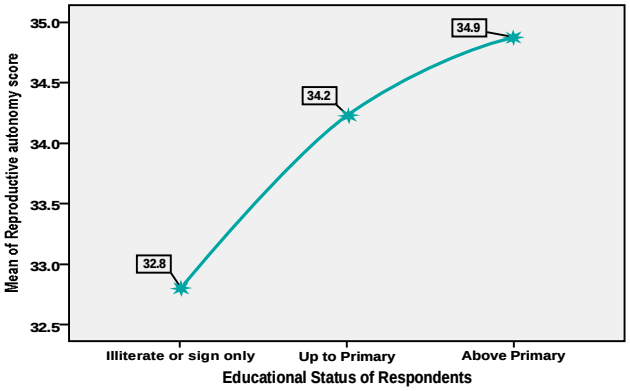

Figure-1: Educational status and reproductive autonomy

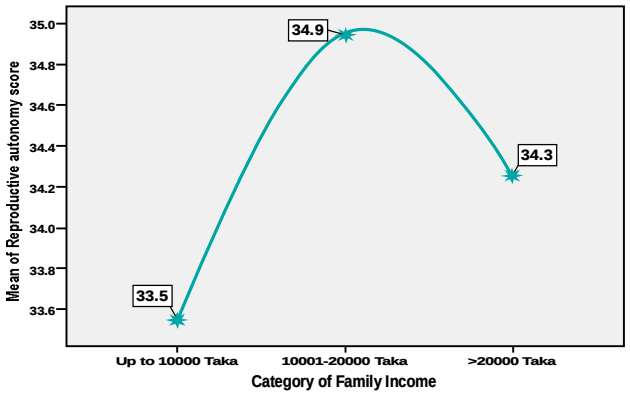

Figure-2: Family income and reproductive autonomy

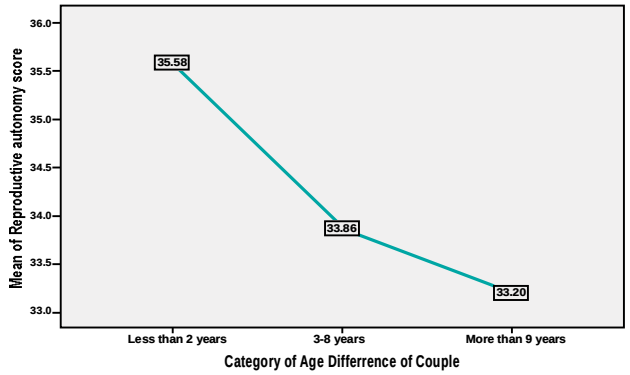

Figure-3: Age gap and reproductive autonomy

Table-III: Reproductive autonomy and contraceptive behavior (n=284)

Reproductive autonomy	Contraceptive use		χ^2	p
	Yes n (%)	No n (%)		
Poor	50(28.4)	45(41.7)	7.24	0.027
Average	62(35.2)	38(35.2)		
Well	64(71.9)	25(28.1)		

Discussion

This study was conducted to find out the socioeconomic disparity and gender awareness in rural area. In patriarchal structures of our society, to execute women's empowerment is challenging. The study findings upon age, income, religion, family size, parity etc. showed the result of similarity with Bangladesh Health and Demographic Survey (BDHS) of 2011 and in few cases, it differed due to regional variation and also for the study process. We found that early marriage was a very common scenario in our rural community which was little higher in this study in comparison with the BDHS of 2011[5]. In respect to recent BDHS context, little bit higher percentages (77.5%) revealed in case of history of early marriage which was more prevalent in 20-24 years age group. Social security was a major concern in marriage before maturity. In educated and economically stable rural family, early marriage was not uncommon which was also explained in study of Parveen S et al done in rural area[6].

Bangladesh is progressing day by day in women's education. Strong association was found between education and reproductive autonomy; which indicated that women's reproductive autonomy was significantly associated with contraceptive behavior. Among them only around 32% were well empowered with majority in the poor empowerment group. It was slightly better than previous study findings of Parveen S et al[6] in 2004. Like many other studies educations was in significant state with women empowerment. Role of employment was found significant in recent study of Afrin Sultana done in Khulna division of Bangladesh[7]. Economic access and household decision were in strong correlation with women empowerment but mobility was still restricted in the study of Parveen S et al[6].

We revealed a statistically significant association between age gap of couples and contraceptive use; that means when the age gap was less, the communication between husband-wife would be better. This can also be correlated with the findings of Eretria where the author found that there was a very strong direct association between husband-wife discussion on family planning and ever-use of family planning[8]. It was found that, there was statistical association between reproductive autonomy and contraceptive behavior. This was similar to another study, which showed; that the women with higher autonomy were significantly more likely to use any contraceptive method; and were more preferred to adopt modern methods and traditional method over non-use, than women with low autonomy[9]. As the women with well reproductive autonomy could decide on fertility issue, their contraceptive behavior was also better.

In the study conducted by Shireen J[10] in 2002 revealed that women were not in empowered position even in gender empowerment state and it was very hard to describe in real picture which was similar to this study. We also revealed that most of the cases the rural women did not have good understanding about their reproductive autonomy. Sometimes they were happy at current situation and in few cases; they want more empowerment about family planning. Another study conducted in the Muslim community of Murshidabad revealed that acceptance of dowry, under valuation and gender inequity were still encouraged hidden to avoid familial disharmony which were similar to this findings[11]. We found that social security was an important issue which added with male dominancy in crisis of women's autonomy. This is also similar to the findings which was studied in Indian sub-continent[12,13].

Conclusion

Women's control over their fertility behavior and contraceptive use is undoubtedly an important issue, which dominated in the context of male ascendancy in countries like Bangladesh where the family settings are mainly patriarchal. Gender discrimination is very common and the autonomy of a woman in her family to practice the family planning methods is poor in most instances. Very few women had a good knowledge about family planning methods or satisfactory attitude towards using these methods. The status of reproductive autonomy was also seen very negligible in most cases. Improvement in women's status or their empowerment is a key factor in reproductive preferences and family planning programs. Population control is the direct indicator of stabilizing the economic development of a country and women's active participation in decision making about fertility control is a strong determinant to increase the use of family planning methods.

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