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Women's Empowerment and Reproductive Health: Experience from Chapai Nawabganj District in Bangladesh

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Abstract: This study investigate, the various issues of empowerment and reproductive behavior of married women such as health status, decision making of reproductive behavior etc in some selected areas of Chapai Nawabganj district, using the information from 500 ever married women within the reproductive span (15-49 years). Findings reveal that women are found less concerned and deprived to take decision about their own health as well as their child health. The data shows that 55.0% women received antenatal care during their last pregnancy but only 4.5% has participated in decision making about their antenatal care. At postnatal period, 51.65 and 58.78% women took treatment for themselves and their child, respectively but only 5.14%s has participated in decision making about their postnatal care. The logistic analysis shows that respondent's current age, education, occupation, husband's education, per capita yearly income, assistance during delivery and decision for household affairs are mostly associated with antenatal caster seeking behavior of married women.

Key words: Women empowerment, antenatal care, post natal care, logistic regression analysis, Chapai Nawabganj district

INTRODUCTION

The empowerment of women has been recognized through many international, regional and national conferences as a basic human right and also as imperative for national development, population stabilization and global well-being (Hakim *et al*., 2003). Reproductive and sexual health and rights are essential for the empowerment of women and to all quality of life issues concerning social, economic and political and cultural participation by women. Women's empowerment is the process by which unequal power relations are transformed and women gain greater equality with men (Haque, 2005). At the government level, this includes the extension of all fundamental social, economic and political rights to women. On the individual level, this includes processes by which women gain inner power to express and define their rights and gain greater self-esteem and control over their own lives and personal and social relationship. Male participation and acceptance of changed roles are essential for women's empowerment.

Utilization of maternal health care depends not only on the availability of services but also on different other factors such as distance of health care facility; perception of women and their families regarding the need for care; social restrictions on freedom to movement, the opportunity cost of accessing health care and the interaction between the client and the provider of formal health care system. Also as a woman's social status and her health are intrinsically related, her low status often is the cause of poor access to essential healthcare.

Bangladesh is one of the developing countries in the world, the country suffered serious economic and demographic dislocations (Feyistan and Casterline, 2000). Her population is about 14 million of which 48.6% are female and 51.4% are males (BBS, 2003). Now the sex ration is 100:103 that mean the half of the total population are women. But the gender inequality is so high and it is very high especially in the rural areas (Barkat and Murtaza, 2003). So, now a day's women empowerment is a burning issue. Bangladesh society is known to be male-dominated. A married or unmarried woman is identified as the wife or daughter of a man in all social interactions. Most national policy-makers and programme managers involved with health service-delivery, including healthcare providers, employees in

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public and private sectors, community leaders and Members of the Parliament, are male. Women's own decision regarding her reproductive health is mostly negligible and neglected in many developing countries. Thus, research that addresses the empowerment of women is seen as essential.

The aim of research, in this area is to examine the impact of selected women's empowerment factors on the utilization of maternal health care.

MATERIALS AND METHODS

The data were collected from a field survey conducted in the district of Chapai Nawabganj of Bangladesh. These data were collected from both, rural and urban areas of Chapai Nawabganj district. Information was collected of 500 ever-married women by interview method of them 250 were taken from rural areas and 250 from the urban areas, respectively. Respondents were selected by purposive sampling method. For rural areas we had selected three villages under Baroghorian Union and for urban areas we have selected Chapai Nawabganj thana of Chapai Nawabganj District. Data analytic methods envisaged in this study are percentage distribution and logistic regression analysis.

RESULTS

Decision-making of treatment for women's general illness: Decision-making is one of the direct indicators of women's empowerment and it leads to higher self-esteem. If women's decision-making power improves, their empowerment also increases. In Bangladesh, women are deprived to take decision for treatment in their general illness (Aziz and Maloney, 1985). But, like all other major indicators of women's empowerment, it should bring in mind that women would have control over the decision about her health care. Table 1 presents the percentage distribution of decision maker of treatment for general illness. The table indicates that the maximum about 46.0% of the respondent's treatment depend on their husband's decision. That is, husbands are the most dominant persons than that of their better half. The married women who are taking decision for treatment by itself uniquely are 17.80%. Both, the respondents and their husbands about 36.0% is the second highest percentage as decision maker of treatment for general illness. The decision makers including respondent's father, mother, brother etc. who are mainly for divorced or widowed namely other group has a tiny (0.5%) amount.

Place of treatment for women's general illness: Place of treatment plays an important role for the patients especially for a woman. Most people of our country are poor and less educated. They prefer the treatment place where they get treatment with a cheap cost and easily like as government hospital, village doctors etc. Though, government hospitals have comparatively better treatment facilities, but in our country these types of facilities have no proper utilization. Village doctors have not enough training for quality treatment. Consequently poor and less educated people of our country are deprived from their treatment right. Table 2 presents the percentage distribution of respondent's place of treatment for their general illness. The table indicated that, the highest, about 48.0% respondents go to the government hospital for treatment of their general illness. The remaining 21.7, 23.7 and 6.8% respondents go to clinic, village doctors and others places (Homio-doctors, Kobiraj etc.), respectively.

Table 1: Percentage distribution of decision maker of treatment for general illness

Decision maker	Percentage
Own	17.8
Husband	45.9
Both	35.8
Others	0.5
Total	100.0

Table 2: Percentage distribution of respondent's place of treatment

Place of treatment	Percentage
Government hospital	47.8
Clinic	21.7
Village doctor	23.7
Others	6.8
Total	100.0

Impact of empowerment on utilization of maternal health care: The two components of maternal care that is antenatal care and post natal care are taken as dependent variable separately.

Women empowerment and antenatal care: Antenatal care especially medical check up during pregnancy is an umbrella term used to describe the medical procedures and pregnancy related care provided by doctor or a health worker in a medical facility or at home. The overall aim of antenatal care is to produce healthy mother and baby at the end of the pregnancy. But there are no substantial unified criteria about what exactly constitutes antenatal care. There is a considerable variation in the content of antenatal care (Royston *et al*., 1989). Antenatal care has strong link with medical check up during pregnancy, decision-making of medical check up during pregnancy and assistance during pregnancy complications. Medical check up during pregnancy is necessary for every pregnant woman. Women in Bangladesh still feel hesitation to take medical check-up during pregnancy. They also avoid it due to their poverty, lack of proper pregnancy knowledge, lack of awareness about

Table 3: Percentage distribution of empowerment of women and antenatal health care check up

Characteristics	Percentage
Medical check up	
Yes	54.4
No	33.3
Did not Conceive	12.3
Decision maker for medical check up at the time of pregnancy	
Own	4.48
Husband	35.34
Both	58.08
Others	2.10
Assistance at pregnancy complications	
Expectation of assistance	
Yes	79.48
No	20.52
Type of assistance	
Husband	35.7
Mother-in-Law	13.9
Health Worker	46.1
Others	4.4
Respondent's knowledge about pregnant complicacy	
Severe headache	54.6
Convulsions	36.4
Vaginal bleeding during pregnancy	19.0
Fever more than three days	42.0
Bad smelling vaginal discharge	22.6
Other	1.2
Discussed with health professional about pregnancy related complications	
No	76.2
Yes	23.8

pregnancy and lack of such medical center etc. But, now a day some NGOs associated with government are trying to give such types of facilities in a cheap and sometimes free of cost from various organizations like Maternity Center, Maternity Clinic and Urban Primary Health Care Center etc. From the Table 3 we see that 33.3% mother did not take any medical check up during their antenatal period. But 54.4% women are more conscious about medical check up as well as antenatal care for the betterment of them and 12.3% surveyed women had no need medical check up because they did not conceive.

Decision-making of medical check up during pregnancy is important indicator that ultimately leads empowerment of women. To increase empowerment of women in our patriarchal society, we should improve women's decision-making power. But they often feel shy about medical check up as antenatal care during pregnancy. Almost, all of them do not decide of their own about such type of needs. They take the decision from their closely related persons. Table 3 presents the percentage distribution of decision-maker for medical check up during pregnancy. From the table we see that among the women who have been taken medical check up during pregnancy only 4.48% are making decision uniquely for medical check up during pregnancy, which is very low compared with their counterparts (35.34%).

Pregnancy complications are very touching matter of women, because at pregnancy period, mental and physical depression do enforce on her mentality. Consequently, she emerge assistance during this period from her close relatives such as husband, mother, mother-in-law, health worker etc. Table 3 presents the percentage distribution of respondents who expect assistance at pregnancy complications for the last birth. About 12% of the total surveyed women did not conceive their pregnancy. So, among the conceive women, 79.48% expect assistance at pregnancy complications and rest of them did not expect any assistance. Table 3 also shows, the percentage distribution of type of assistance that is expected by women. From the table we see that, among the women who expect assistance at pregnancy complications, most of them (46.1%) expect health worker as assistance followed by their husband as assistance (35.7%). The remaining 13.9 and 4.4% expect their mother-in-law and others like mother, sister, sister-in-law etc. as assistance at pregnancy complications, respectively. Pregnant women need to talk to health professional about their complications aroused during pregnancy, but from our study we find that only 23.8% respondents talked to the health professional. Regarding pregnancy related complications most women have the knowledge about several headache followed by vaginal bleeding and convulsion.

Women empowerment and postnatal care: A crucial component of safe motherhood is postnatal care. It is important for mother's treatment of complications arising from delivery, especially for birth that occurs at home. Postnatal check up provides opportunities to assess and treat delivery complications and to counsel mothers on how to care for themselves and their newborns. Postnatal care is strongly associated with the treatment after delivery for mother and child and mother's decision-making of treatment after delivery. From Table 4 we see that approximately 52% women receive postnatal care checkup.

Delivery system is an important part of reproductive health. In general, delivery is commonly of two types such as normal and caesarean delivery. Caesarean delivery is more common among first births of urban women than that of rural. Table 4 presents the percentage distribution for last birth by type of delivery. The findings show that, most of the deliveries are normal. About 90.0% deliveries of surveyed women are normal and the rest are taking place by caesarean delivery.

This is also important for our study, because it is related with women's empowerment. Table 4 elucidates

Table 4: Percentage distribution of decision maker for postnatal health care check up

Characteristics	Percentage
Receive post natal care	
Yes	51.65
No	48.35
Types of delivery	
Normal	90.27
Caesarean	9.73
Decision maker for types of delivery	
Own	5.14
Husband	36.64
Both	55.38
Others	2.24
Child treatment after delivery	
Yes	58.78
No	41.22
Discussed with husband about her own health and the baby's health	
No	34.8
Yes	65.2

the percentage distribution of decision maker for treatment after delivery. From the table we found that, about 18.0% of the respondents did not produce child and/or did not take treatment after delivery. Among the respondents who took treatment after delivery for her own and/or their child, maximum, 55.38% decision own, which are very low compared with their counterparts, 36.64%. Like mother, treatment of child after delivery is also important for our study. Table 4 presents the percentage distribution of respondents who took treatment for child after delivery. The findings shows that, about 12.0% respondents did not produce child, so they have no need take treatment for child. Among the child produced respondents, maximum (about 58.78%) took treatment for their after delivery. From our study, we also find that 65.2% respondents talked to husbands about her own health and the baby's health.

Factors affecting of respondent's decision-making of medical check up during pregnancy: The examination of decision-making for medical check up during pregnancy is an important phenomenon that effects women's empowerment. Different characteristics have demonstrated uniquely in the incidence of decision-making across reproductive health cares such as decision-making of treatment for general illness and treatment after delivery, medical check up during pregnancy etc. Previously we explored the various important indicators of reproductive health care for women, but decision-making of medical check up during pregnancy is the most important among them. This indicator may be influenced by some others indicators combined and independently. To examine the combined impact of the several variables to this indicator, the multivariate analysis has to be needed. For this circumstance, we apply logistic regression analysis to estimate the effects of some selected socio-economic, demographic and geographic factors on decision-making for medical check up during pregnancy.

The logistic model is fitted by considering medical check up during pregnancy as the dependent variable which we dichotomized by assessing 1, if the respondents can participate decision-making for medical check up during pregnancy and 0 for otherwise. The explanatory variables considered in the model are respondent's current age, education, religion, place of residents, age at marriage, husband's education, household educational status (average years of schooling), per capita yearly income, type of family and assistance at pregnancy complications, daily household expenditure, decision for household work and equal rights existing in the society.

From the results of the logistic regression analysis, it appears that current age is the most important factor affecting of decision-making for medical check up during pregnancy among married women and it has strong significant association with medical check up during pregnancy. From the study, we see that, women age group 40 and above years are 0.150 times less likely to go for medical check up during pregnancy than the women who are at age group up to 19 years. So, we can say that married women aged at low level are much concourse than that of older for medical check up during pregnancy. Education is also strong and positive effects on medical check up during pregnancy for married women. The result shows that women with primary, secondary and higher education are 1.625, 3.282 and 35.867 times more likely to go for medical check up during pregnancy than the women who are illiterate (reference group), respectively. Husband's education has also strong and significant effects on medical check up during pregnancy for married women. The result shows that women's husband with primary, secondary and higher education are 1.941 times, 2.201 times and 1.829 times more likely to medical check up during pregnancy than the women whose husband has no education (reference group), respectively. Per capital yearly income has also strong and positive significant on medical check up during pregnancy for married women. The per capita yearly income of Tk. 30000 and above are found to be 3.305 times more likely to take medical checkup. The result also shows that, women who have married at age group 20 and above years are 1.528 times more likely to go for medical check up during pregnancy than the women who have married at age group up to 15 years as reference group. The results also elucidates that urban respondents are more likely to receive medical checkup than their rural counterparts. The result shows that, non-Muslim women are 1.692 times more likely to go for medical check up during pregnancy than their Muslim counterpart (reference group).

Table 5: Logistic regression of medical check up during pregnancy on some selected socio-demographic characteristics

Characteristics	Coefficient β	Significance level	Odds ratio
Place of residence			
Rural (Ref)	-	-	1.000
Urban	0.244	0.327	1.277
Age of respondent			
Up to 19(Ref)	-	-	1.000
20-29	-0.739	0.093	0.478
30-39	-1.402	0.002	0.246
40 and above	-1.900	0.000	0.150
Respondent's education			
Illiterate (Ref)	-	-	1.000
Primary	0.484	0.039	1.623***
Secondary	1.188	0.000	3.282***
Higher	3.580	0.000	35.867**
Husband's education			
Illiterate (Ref)	-	-	1.000
Primary	0.663	0.006	1.941
Secondary	0.789	0.005	2.201
Higher	0.604	0.116	1.829**
Respondent's occupation			
House wife (Ref)	-	-	1.000
Service (govt.)	-2.426	0.003	0.088
Service (non-govt.)	-1.241	0.040	0.289
Business	-1.116	0.061	0.328
Labor	0.587	0.549	1.798
Religion			
Islam (Ref)	-	-	1.000
Others	0.526	0.209	1.692
Household educational status (Average year of schooling)			
<5 (Ref)	-	-	1.000
5-10	-0.163	0.509	0.849
>10	0.449	0.326	1.567
Per capita income (Yearly)			
<15000 (Ref)	-	-	1.000
15000-30000	0.260	0.210	1.297**
>30000	1.195	0.013	3.305***
Age at marriage			
Up to 15 (Ref)	-	-	1.000
15-20	-0.010	0.952	0.990
20 and above	0.424	0.263	1.528
Assistance at pregnancy complications			
No (Ref)	-	-	1.000
Yes	0.485	0.019	1.624
Daily household expenditure			
No (Ref)	-	-	1.000
Yes	0.217	0.222	1.243**
Decision for household affairs			
No (Ref)	-	-	1.000
Yes	0.981	0.000	2.667**
Equal rights existing in society			
No (Ref)	-	-	1.000
Yes	0.168	0.389	1.183*

Ref = Reference category, Here ***, ** and * indicates $p<0.001$ (highly significant), $p<0.01$ (significant) and $p<0.05$ (less significant)

Decision for household affairs is an important factor influencing the medical check up during pregnancy for surveyed women and it has strong and positive significant impact. The result shows that, women who have decision-making power for household affairs are 2.667 times more likely to go for medical check up during pregnancy than that having no such power. Expectation of assistance at pregnancy related complications has strong and positive significant effects on medical check up during pregnancy for married women. The table shows that, women who expect assistance at pregnancy related complications are 1.624 times more likely to go for medical check up during pregnancy than those do not expect assistance. Control over daily household expenditure has insignificant impact on medical check up during pregnancy for married women. The result shows that, women having control over daily household expenditure are 1.243 times more likely to go for medical check up during pregnancy than that having no such facility (reference group). Equal right of male and female existing in the society has no significant effects on medical check up during pregnancy. The result shows that women who agree equal rights male and females existing in the society are 1.183 times likely to go for medical check up than that who does not agree (Table 5).

DISCUSSION

Women empowerment and their reproductive behavior is much publicized concern among both the developed and developing nations and recently it has become a major topic of socio-economic and demographic research. Considering its importance, an attempt has been made in this study to investigate the various issues of empowerment and reproductive behavior of married women such as health status, decision making of reproductive behavior etc in some selected areas of Chapai nawabganj district. From the results, only 17.8% of the respondents may take decision for the treatment of their general illness. For the last birth, about 55.0% women received antenatal care and among them only 4.5% is the self decision maker. Among the women who expect assistance at pregnancy complications, 46.1% expect health worker corresponding 35.7% expect their husband as assistance. At postnatal period, 51.65 and 58.78% women took treatment for themselves and their child after delivery, respectively but among them only 5.14% are decision maker. This indicates that most of the women are conscious about their health care for the betterment of them and their child but they are to wait for their husband's decision. On the other hand, this study also indicates that a large number of women terminate their pregnancy unsafely because they do not check up in the period of pregnancy. In socio-economic and demographic impact on decision making of medical check up during pregnancy, the study shows that women who are relatively young are much conscious than that of their older counterparts for medical checkup during pregnancy. The study also shows that education has strong and positive significant impact on medical check up at the time of pregnancy and as at the women's education level

improves; their tendency for medical checkup also increases. Women's decision making for household affairs has also strong significant effect on. The results elucidates that women who can make decision for household affairs are more likely to check up at the time of pregnancy than those women who do not get such opportunities. Among other's factors women's occupation, husband's education, per capita yearly income and assistance at pregnancy complications have also found significant e\effects on medical check up during pregnancy.

Women's empowerment policy could be made on women's mobility, a limited role in household as well as society based decision making, a limited control over all knowledge about their reproductive health. Considering this points, the study findings lead to the following policy implications.

- Inform and empower girls to delay pregnancy until they are physically and emotionally mature.
- Enable women to exercise their rights to control their own fertility and their right to make decision concerning reproduction, discrimination and violence.
- Improve the quality of reproductive health services and implement commitments to reducing the tragedy of maternal mortality.
- Increase gender equality and equal opportunities for women in all spheres of employment.
- Provide education and training that enable women to catch up and adapt to changing economic conditions
- Improve communication between men and women on issues of sexuality and reproductive health and the understanding of their joint responsibilities so that they are equal partners in public and private life.

There is a more radical approach would aim at directly meeting women's strategic gender needs for greater influence over their own empowerment and reproductive behavior. Such an approach, would involve action a multiple levels to increase women's access to resource of various types, through both strengthened informal rights and extended formal rights (legislation and state provision in women's interest).

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