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Autonomy, intimate partner violence, and maternal health-seeking behavior: Findings from mixed-methods analysis in Ethiopia

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BACKGROUND

Gendered norms and discriminatory practices often limit women's decision-making power, which over time can lead to social norms that systematically disadvantage women.

Aspects of empowerment, a multi-faceted construct, were explored in a global evaluation of Demographic and Health Survey (DHS) data, that measured how gendered social norms influenced maternal health-seeking behaviors. Analysis specifically explored associations of women's autonomy and acceptability of intimate partner violence against women (IPVAW) on antenatal care (ANC) use and facility delivery in 63 low- and middle-income countries. Service utilization is positively associated with increased autonomy and negatively associated with increased acceptability of IPVAW, but variability exists across countries and regions. There is need to explore complexities of gender in specific contexts.

In Ethiopia, maternal health-seeking behaviors are influenced by numerous interrelated factors. Little research exists on how gender dynamics and norms, including acceptability of various forms of IPVAW, may influence women's decision-making autonomy, health-seeking behavior, and overall well-being.

The purpose of this study was to explore the relationship between women's autonomy and acceptability of IPVAW and two primary maternal health care utilization outcomes: ANC use and facility delivery.

This brief highlights quantitative and qualitative findings on the relationship between women's autonomy and IPVAW acceptability and maternal health seeking behaviors in Ethiopia.

METHODS

We applied a mixed methods approach to explore gender dynamics. We drew on a secondary analysis of aggregate DHS data in Ethiopia from 2005 to 2016 and 17 in-depth interviews with women who had experienced and survived pre-eclampsia. We also conducted eight focus group discussions with community men and women in rural and urban areas of Sidama Zone in the Southern Nations, Nationalities, and Peoples Region (SNNPR).

Scales developed for women's autonomy (3-item) and acceptability of IPVAW (5-item) indicate women's contribution to decision-making around various aspects of their lives and accepting attitudes toward a husband beating his wife for different reasons.

Multivariable logistic regressions estimate associations between these scores and the primary outcomes, controlling for age, wealth, education, marital status, birth order, child sex, urban/rural residence and quality of care at the individual level and average wealth and educational attainment at the cluster level.

Qualitative analyses involved transcription and translation of interviews, applying an inductively-derived codebook using NVivo, and triangulating findings with DHS results.

RESULTS

Combined DHS data from the 2005, 2011, and 2016 surveys yielded a sample of 20,882 women and 21,169 births. We found that 16.6% of women had facility-based deliveries and 2.1% received their recommended eight ANC visits (Table 1).

Compared to global maternal health-seeking behaviors, women in Ethiopia are less likely to deliver in facilities and receive their eight recommended ANC visits (60% and 17% of women globally, respectively). Tables 2 and 3 describe the child-level and quality covariates.

Table 1. Descriptive Statistics, Mother-Level Outcomes and Covariates, Ethiopia, 2005, 2011, 2016					
	Mean	**SD**	**No. Cases**	**Min**	**Max**
Mother-Level Outcomes					
Delivery in a health facility (1 = yes)	0.166		3,466		
WHO Recommended 8 ANC Visits (1 = yes)	0.021		439		
Mother-Level Covariates					
Wealth, quintiles	2.620	1.404		1	5
Maternal education, none (1=yes)	0.693		14,471		
Maternal education, primary (1=yes)	0.247		5,158		
Maternal education, secondary (1=yes)	0.043		898		
Maternal education, higher (1=yes)	0.018		376		
Maternal age, years	29.392	7.071		15	49
Marital status (1=married)	0.898		18,752		
Urban (1=yes)	0.122		2,548		
Cluster-Level Covariates					
Average wealth, quintiles	2.612	1.110		1	5
Average education, highest level	0.373	0.411		0	3
N	**20,882**				
Notes: Each observation corresponds to a woman.					

Table 2. Descriptive Statistics, Child-Level Covariates, Ethiopia, 2005, 2011, 2016					
	Mean	**SD**	**No. Cases**	**Min**	**Max**
Child-Level Covariates					
Birth order	4.184	2.656		1	18
Multiple birth (1 = yes)	0.012		251		
Child sex (1 = male)	0.517		10,796		
N	**21,169**				
Notes: Each observation corresponds to a birth.					

Table 3. Descriptive Statistics, Child-Level Covariates, Ethiopia, 2005, 2011, 2016		
	Mean	**No. Cases**
Quality Covariates		
Checked weight at pregnancy (1 = yes)	0.065	1,376
Checked height at pregnancy (1 = yes)	0	0
Checked blood pressure at pregnancy (1 = yes)	0.319	6,753
Took urine sample at pregnancy (1 = yes)	0.222	4,700
Took blood sample at pregnancy (1 = yes)	0.254	5,377
Told about pregnancy complications (1 = yes)	0.152	3,218
Told where to go for complications (1 = yes)	0.025	529
Health professional checked after delivery (1 = yes)	0.053	1,122
Quality score (0 – 1, percent out of 8)	0.136	2,879
Quality score, prenatal (0 – 1, percent out of 7)	0.148	3,133
N	**21,169**	
Notes: Each observation corresponds to a birth.		

In the Ethiopia sample, 67% of women report involvement in decision-making regarding their own health care utilization, and 60% were involved in household purchases; 73% in visiting relatives; and 16.5% were involved in decisions related to money. Overall, 40.4% of women in Ethiopia report involvement in any decision-making (Table 4).

Relatedly, 54.4% of women believe that a husband is justified in beating his wife for at least one of several reasons (Table 4). Proportions of women's autonomy (measured using decision-making power as proxy) were similar to global estimates (40.1%), while acceptability of IPVAW was higher in Ethiopia (compared to 24.8% of women globally) (1).

Compared to global positive assoiciations, in Ethiopia, the magnitude of autonomy associations are similar; increased women's autonomy increased the likelihood of facility delivery (Ethiopia OR: 1.683, Global OR: 1.3, $p<0.01$) and the receipt of eight WHO-recommended ANC visits (Ethiopia OR: 1.476, Global OR: 1.4, $p<0.01$). Ethiopian associations of acceptability of IPVAW with service utilization were similar to global trends; women in Ethiopia with higher IPVAW scores were less likely than women globally to deliver in facilities (Ethiopia OR: 0.749, Global OR:0.911, $p<0.01$), though slightly more likely to achieve eight ANC visits (Ethiopia OR: 0.857, Global OR: 0.797, $p<0.01$) (Table 5). While some variation in ANC use emerged, younger women (74%), urban women (90%), and women with secondary and above education (94%) tended to express greater senses of empowerment in their own health decision-making (1). Qualitative data corroborate that the majority of women have individual autonomy over their own health care decisions.

"I decide by myself and come to the health facility. Prevously, people have had different ideas, but I do not follow that."

IDI, pre-eclampsia survivor, rural

"Anything that happens to my body affects only me. Therefore, nobody can make decisions on my life. Sometimes [my husband] encourages and helps me… he comes with me, gives me transportation money… [HEWs] encourage and counsel us when we go there for [pregnancy] checkups. They even remind us of checkup days."

FGD, female participant, rural

Descriptions of feeling personally empowered to make health-related decisions were often tempered by significant social influences from spouses, mothers-in-law, family members, HEWs, community members, cultural leaders, and assorted government-supported women's groups. Supportive husbands and women's groups provided encouragement to attend ANC, but traditional wisdom and apprehension from mothers-in-law and community members were frequently seen as a deterrent.

Table 4. Distribution of Autonomy and Acceptability of IPVAW Covariates, Ethiopia, 2005, 2011, 2016

	Mean	No. Cases
Autonomy		
Respondent involved in decisions over money (1 = yes)	0.165	3,446
Respondent involved in decisions over own healthcare (1 = yes)	0.671	14,012
Respondent involved in decisions over household purchases (1 = yes)	0.606	12,654
Respondent involved in decisions over daily purchases (1 = yes)	0.248	5,179
Respondent involved in decisions over visiting relatives (1 = yes)	0.733	15,307
Respondent involved in decisions over cooking food (1 = yes)	0	0
Woman autonomy score (0 – 1, percent out of 6)	0.404	8,436
Acceptability of IPVAW		
Beating justified if wife goes out without telling husband (1 = yes)	0.564	11,777
Beating justified if wife neglects children (1 = yes)	0.598	12,487
Beating justified if wife argues with husband (1 = yes)	0.546	11,402
Beating justified if wife refuses sex (1 = yes)	0.455	9,501
Beating justified if wife burns food (1 = yes)	0.557	11,631
Women's acceptability of IPVAW score (0 – 1, percent out of 5)	0.544	11,360
N	**20,882**	

Notes: Each observation corresponds to a woman.

Table 5. Odds Ratios of Facility Delivery and Antenatal Care Use, Ethiopia, 2005, 2011, 2016

Variables	(1) Facility Delivery	(2) Antenatal Care (WHO Recommended 8 Visits)
Main Exposures		
Woman's autonomy score	1.683 (1.301 - 2.177)***	1.476 (1.163 - 1.875)***
Women's acceptability of IPVAW score	0.749 (0.651 - 0.863)***	0.857 (0.752 - 0.976)**
Covariates		
Wealth Quintile 2	1.517 (1.277 - 1.804)***	1.174 (1.009 - 1.365)**
Wealth Quintile 3	1.231 (1.014 - 1.493)**	1.198 (1.011 - 1.419)**
Wealth Quintile 4	1.700 (1.409 - 2.052)***	1.423 (1.184 - 1.710)***
Wealth Quintile 5	2.215 (1.700 - 2.656)***	1.286 (1.016 - 1.629)**
Education, Primary	1.539 (1.371 - 1.728)***	1.203 (1.079 - 1.341)***
Education, Secondary	2.739 (2.271 - 3.303)***	1.435 (1.183 - 1.741)***
Education, Higher	4.656 (3.146-6.892)***	1.185 (0.900 - 1.560)
Marital Status (1=yes)	0.742 (0.626 - 0.879)***	0.966 (0.824 - 1.132)
Birth Order	0.820 (0.790 - 0.851)***	0.936 (0.909 - 0.964)***
Child Sex (1 = male)	1.041 (0.956 - 1.134)	0.937 (0.860 - 1.020)
Urban (1 = yes)	2.471 (1.856 - 3.289)***	0.766 (0.598 - 0.982)**
Average wealth score	1.470 (1.322 - 1.635)***	1.188 (1.083 - 1.302)***
Average schooling	2.524 (2.027 - 3.143)***	1.672 (1.411 - 1.980)***
Quality score		407.0 (317.4 - 521.9)***
Constant	0.00849 (0.00381 - 0.0189)***	0.0224 (0.0103 - 0.0487)***
N	**20,882**	**20,851**

*** p<0.01, ** p<0.05, * p<0.1

Notes: The unit of observation is the birth. Odds ratios are presented with 95% confidence intervals in the parentheses below. Delivery in a facility (column 1) reports whether the mother delivered the birth in a health facility or not. ANC visits (column 2) reports whether the mother received at least 8 ANC visits for the birth. Results are from logistic regressions that include cluster, mother, birth, and quality of care controls. Cluster-level covariates are the average wealth index value of mothers in the cluster, and the average educational attainment of mothers in the cluster. Mother controls include the household wealth index (in quintiles), educational attainment of the mother (no education, primary, secondary, higher), age of the mother (in 5-year age groups), mother's marital status, and mother's place of residence (urban/rural). Birth level controls include birth order. For Column 2, quality of care controls include the 7-point average quality score that was generated for the birth. Standard errors are clustered at the primary sampling unit (DHS cluster) level.

Some community members and health providers expressed concern that cultural pressure for home birth and the quality of a woman's relationship with her husband could negatively impact her ability to use ANC, though these concerns were not always echoed by pregnant women.

"Development leaders in the community through One-to-Five leaderships help and push all pregnant women to visit health facilities for check-ups… In the household, my husband encourages me to go to the health facilities. However, my husband's family [i.e. elders] do not encourage me to go to the health facilities for check-ups. In the community, women development army representatives encourage us."

IDI, pre-eclampsia survivor, rural

In Ethiopia, spouses/intimate partners, mothers-in-law, and other family members play critical roles in determining whether and/or where women seek skilled care for ANC, delivery, and postnatal care (PNC). These relationships affect a woman's decision-making ability to adhere to treatment regimens and seek care. Husbands were described as both potential barriers and as enablers to motivating their wives' seeking health services.

"The primary one who motivates her to go to the health institution are HEWs…They follow up the pregnant mother from the beginning up to the time of delivery. The second one is the husband and it is a must for him. He is responsible to motivate her to go there. The neighbors are secondary… they should motivate and follow up this way."

FGD, male participant, urban

Qualitative data elucidate manifestations of women's experiences of IPVAW and suggest plausible influences of these factors on access to maternal health services. Intimate partner dynamics occur in rural and urban settings, though were more pronounced in urban settings, where women experienced increased vulnerabilities to HIV, marital dispute, and potential separation and divorce. Some women describe sexual and physical violence during pregnancy, often describing consumption of alcohol as related to these acts.

"There are some husbands who even kick her while she is pregnant. Those husbands do not know the woman or the baby in her womb may get affected by their actions... there are two types: the one who assists [in getting to care] and beats that do not assist."

FGD, male participant, rural

"

I wasn't interested to have sexual intercourse with my husband while I was pregnant and he told me he wanted to. Then I told him that he couldn't force me into doing it. Then I turned away and slept on the bed, telling him not to touch me. He begged me, but I refused. Then he insulted me and threw me out of the bed."

FGD, female participant, urban

CONCLUSIONS & RECOMMENDATIONS

Women in Ethiopia demonstrate some degree of decision-making power and autonomy. Although quantitative associations between women's autonomy and facility-based delivery and ANC use are statistically insignificant, qualitative evidence suggests that women, particularly young and urban women, have a strong sense of their personal autonomy and are willing to take charge of their health decision-making.

These women may however also be prey to gendered oppression by instances of IPVAW. The negative association between increased acceptability of IPVAW and ANC and delivery service utilization was stronger in Ethiopia than globally, in part due to higher proportions of women reporting normalized acceptable attitudes toward IPVAW.

Qualitative evidence corroborates complex gender dynamics, including the persistent influence of husbands, community members, and mothers-in-law on women's health seeking behavior despite women's aspirations to make their own health-related decisions. Intimate partner violence reports from community members suggest that these dynamics may indirectly influence women's sense of safety and subsequent empowerment to seek necessary health care.

To further explore and understand the nuances of complex interpersonal and social dynamics, further research around maternal mental health as relates to perceptions and experiences of IPVAW is needed.

Explicit gender equity-promoting and socio-economically supportive policy and programming should be explored to mitigate consequences of IPVAW and traditional social pressures, and empower women to use necessary maternal health care.

REFERENCES

1) Pooja Sripad, Charlotte E Warren, Michelle J Hindin, & Mahesh Karra (2018). Assessing the role of women's autonomy and acceptability of intimate partner violence in maternal health-care utilization in 63 low- and middle-income countries. International Journal of Epidemiology, dyy299, https://doi.org/10.1093/ije/dyy299

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