EXPLORING THE DECISION-MAKING POWER OF BANGLADESHI WOMEN OF REPRODUCTIVE AGE: RESULTS FROM A NATIONAL SURVEY

Russell Kabir[1], Sayeeda Rahman[2], Dioneia Motta Monte-Serrat[3], S.M. Yasir Arafat[4]

[1]Senior Lecturer, Department for Allied and Public Health, Faculty of Medical Sciences, Anglia Ruskin University, Chelmsford, UK. [2]Lecturer in Clinical Sciences, Faculty of Life Sciences, School of Medical Sciences, Department of clinical sciences, University of Bradford, UK. [3]Lecturer Health and Education, Universidade de Ribeirao Preto, Sao Paulo State, Brazil. [4]Resident, Department of Psychiatry, Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh.

Abstract

Empowerment is personal, multi-dimensional and latent phenomenon that is difficult to measure directly. Bangladesh is a developing country in South Asia and women population of the country is almost equal to the male with the male dominant norms. It was aimed to look into the decision making authority and gender role of Bangladeshi women of reproductive age group. Bangladesh Demographic and Health Survey (BDHS) 2014 data was used for the study. A total of 17,863 women of reproductive age were included in this study. The mean age of the respondents was 31 years. About 23.5% respondents had no education and only 11.6% completed primary education. It was found that 68.5% respondents were working and about 73.6% respondents had no NGO (non-governmental organization) membership. Respondents from richest background were more likely to take their own decisions. Urban residence and with higher educational attainment were more likely to take their own decisions. Working status and membership to NGO are significantly associated with decision making power of women. The study revealed that women from urban area, with NGO membership and employed were more empowered. Poor attainment of primary education, low employment, and few NGO memberships are seemed to be the hindrance in women empowerment in Bangladesh.

Keywords: Women empowerment, Decision-making, Health seeking behavior, BDHS, Bangladesh.

Background

Empowerment is a personal, multi-dimensional latent phenomenon; difficult to measure directly, denoted by autonomy, power, status, agency and such things [1-3]. Empowerment is defined in various ways and aspects. According to few authors, empowering women is defined as a set of characteristics, roles, and behaviour patterns those differentiate women from the men in regards to socially, culturally and in relations of power [4]. These empowering attributes change continuously; differ over time and between different cultural groups because of the constant shifting and variation of cultural and changing of local equilibrium [4]. Multiple studies have shown that there is generally a low status of women in developing countries and gender differences in power and roles have an effect on both physical and mental health, fertility, survival, quality of life, nutrition, and sexuality, and are a source of constraint in material and non-material resources [1, 4-7].

Bangladesh, a highly populous country in South Asia with the density of about 1,063 per sq km and total about 160 million peoples, achieved health related Millennium Development Goals (MDGs) with persistently smart Gross Domestic Product (GDP) growth [8-10]. Women portion of the population is almost equal to the male portion with the patriarchal societal norms [5, 6, 11]. In a country like Bangladesh men are conventionally seem to belief and practices of higher authority and dominance in most of the aspects of family and women are seem to be passive, suppressed, secluded in home making activities, lower social status and lower freedom in decision making [5, 6]. Rural dwellers are in more grave conditions with minimum freedom to make decisions as well as to engage in income generating activities [5, 6, 11]. Without activation of the huge female partner the overall economy as well as development is very difficult to be synchronised [6, 11]. World Bank (WB), United Nations (UN), as well as other international organizations have focused on women empowerment specially in the rural part of Bangladesh [6]. Recently with the limited resources the country started to progress in women empowerment as empowered women have significant role on national progress and overall development [6, 11, 12, 13].

The aim of the study was to examine the decision-making power of Bangladeshi women of reproductive age group in their daily life that can dig out the current state of women empowerment in Bangladesh.

Materials & Methods

Design and Data Sources

This a descriptive cross-sectional study. This research has used Bangladesh Demographic and Health Survey (BDHS) data 2014 [14].

eISSN: 2522-7165
pISSN: 2520-7342

Correspondence: Dr. S. M. Yasir Arafat, Resident, Department of Psychiatry, Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh. Email: arafatdmc62@gmail.com.

Sample Design

Bangladesh is divided in 7 administrative divisions - Dhaka, Khulna, Chittagong, Rangpur, Barisal, Sylhet and Rajshahi. The BDHS survey used a multi-stage stratified cluster sample where each division was stratified into urban and rural areas and the primary sampling unit for the survey is an enumeration area (EA) developed by the 2011 Population and Housing Census of the People's Republic of Bangladesh [15]. An EA is a geographic area covering an average of 113 households. In the first stage, 600 EAs (207 EAs from urban and 393 EAs from rural areas) were chosen with probability proportional to EA size. A sample of 30 households were selected systematically from per EA to provide a nationally representative sample from urban and rural areas in each division in the second stage. From a total of 17,300 households interviewed, 18,245 ever married women aged 15-49 yrs were identified and 17,863 were interviewed [14].

Data Collection and Analysis

Data was collected using questionnaire. The questionnaires were developed in English and then translated into and printed in Bangla. For this research, women questionnaire was used. Data were analysed using Statistical Software SPSS version 21. Descriptive statistics mainly frequency distributions were calculated for the background characteristics of the respondents. Chi-square analyses were used to estimate the bivariate associations. Logistic regression was used to see the association between dependent and independent variables. Significance level was set at $p<.0.05$ in all analyses.

Variables

The dependent variable of this research is decision making power of women. This variable was constructed by combining variable who usually decides how the money they earn would be used, who usually makes decision about healthcare about themselves, who usually makes decision about making household purchases, who usually makes decisions about visits to their family or relatives and who usually makes decisions about their child health care. The variable was determined by respondent answering 'respondent' to any of the string questions above and it was recoded '0' and 'others' recoded as '1'.

The independent variables of this research were age, education, place of residence, number of living children, current working status, membership to NGO and wealth index.

Age: In this research age of the respondents were categorised as 15-24 years, 25-34 years and 35-49 years.

Education: Respondents indicated the highest level of educational attainment as part of the survey. The categories are –no education, incomplete primary education, complete primary education, incomplete secondary education, complete secondary education and higher education.

Working status: Working status was measured by whether the respondents were employed or unemployed.

Children under the age of 5: This variable was determined by three categories – no children, 1-2 children and 3 and more children in the family.

Wealth Index: The wealth index created by BDHS 2014 and the categories are- poorer, poorest, middle, richer and richest.

Membership to NGO: This variable was constructed by combination of belong to Grameen Bank, belong to Bangladesh Rural Advancement Committee (BRAC), belong to Bangladesh Rural Development Board (BRDB), belong to Association for Social Advancement (ASA), belong to Proshika, belong to mothers' club. If the respondent answering 'yes' to any of these questions it was recoded '0' and 'no' as '1'.

Place of residence: This variable had two categories - urban and rural.

Table 1. Background characteristics of women

Variables	Background characteristics of women	
	F	%
Age of the respondent		
15-24	5184	29.0
25-34	6355	35.6
35-49	6324	35.4
	Mean± SD= 31.02±9.2	
Highest educational level		
No education	4206	23.5
Incomplete Primary	3148	17.6
Complete Primary	2078	11.6
Incomplete Secondary	5645	31.6
Complete Secondary	1077	6.0
Higher	1709	9.6
Place of residence		
Urban	6167	34.5
Rural	11696	65.5
Number of living Children		
0	9170	51.3
1-3	8336	46.7
>3	357	2.0
Working status		
No	12234	68.5
Yes	5624	31.5
Wealth index		
Poorest	3251	18.2
Poorer	3360	18.8
Middle	3621	20.3
Richer	3769	21.1
Richest	3862	21.6
Membership to NGO		
No	13150	73.6
Yes	4713	26.4

Results

Table 1 presents the background characteristics of the respondents. The mean age of the respondents was 31 years. About 23.5% respondents had no education and only 11.6% completed primary education. About 65.5% respondents were from rural area. Approximately 51% respondents had no children. A clear majority of the respondents 68.5% respondents were not currently working and about 73.6% respondents had no NGO membership .

Table 2 shows bivariate analysis between decision making power of women with other independent variables. Chi-square shows that about 41.1% respondents from age group 25-34 yrs can take important decision about family matters. Respondents who were from richest background were more likely to take their own decisions (p<0.00). Respondents from urban area and with

higher educational attainment were more likely to take their own decisions (p<0.00). The results also showed that working status and membership to NGO were significantly associated with decision making power of women.

Table 2. Bivariate analysis of decision making power of women and other independent variables

Variables	Decision Making Power	
	Percentage	*p*-value
Age of the respondent		
15-24	31.1	
25-34	41.1	
35-59	39.7	<0.00
Children 5 and under		
0	37.9	
1-2	38.1	
3+	24.1	<0.00
Wealth Index		
Poorest	30.7%	
Poorer	34.5%	
Middle	35.8%	
Richer	39.1%	
Richest	46.8%	<0.00
Educational Attainment		
No Education	33.8	
Incomplete Primary	34.0	
Complete Primary	38.5	
Incomplete Secondary	38.6	
Complete Secondary	44.6	
Higher	45.8	<0.00
Place of Residence		
Urban	42.4	
Rural	35.2	<0.00
Currently working		
No	44.8	
Yes	22.2	<0.00
Membership to NGO		
No	37.5	
Yes	38.3	<0.00

Table 3. Logistic regression showing association between decision making power of women and background characteristics

Variables	Decision Making Power		
	Odds Ratio	95% CI	p-value
Age of respondent			
15-24	1	1	
25-34	0.539	0.496-0.585	<0.00
35-59	0.527	0.480-0.578	<0.00
Children 5 and under			
0	1	1	
1-2	0.951	0.889-1.018	<0.14
3+	2.018	1.565-2.602	<0.00
Wealth Index			
Poorest	1	1	
Poorer	0.882	0.792-0.982	<0.02
Middle	0.878	0.789-0.977	<0.01
Richer	0.800	0.717-0.893	<0.00
Richest	0.715	0.633-0.808	<0.00
Educational Attainment			
No Education	1	1	
Incomplete Primary	0.989	0.792-0.982	<0.83
Complete Primary	0.820	0.789-0.977	<0.00
Incomplete Secondary	0.823	0.717-0.893	<0.00
Complete Secondary	0.774	0.633-0.808	<0.00
Higher	0.661	0.577-0.758	<0.00
Place of Residence			
Urban	1	1	
Rural	1.147	1.065-1.236	<0.00
Currently working			
No	1	1	
Yes	3.095	2.871-3.331	<0.00
Membership to NGO			
No	1	1	
Yes	0.852	0.791-0.917	<0.00

The association between decision making power of women and characteristics of women were examined using logistic regression analysis (Table 3). Women with no children were likely to have more empowerment than women with children. Women who belonged to richer family were more likely to take their own decisions than comparing to women from other wealth index groups. The analysis also revealed that women from urban area, with NGO membership and currently employed were more empowered than from women of rural area, NGO membership and unemployed women.

Discussion

Empowerment is a process that occurs over time and women empowerment may change over the course of

her life as a natural process of advancing age, improved income, or as a response to familial, social, political and other circumstantial changes [7]. Currently women empowerment is a burning issue across the globe as women are considered as major source in the society as well as it is considered as necessary condition for achieving the sustainable development [5, 6, 11, 12].

Bangladesh is a male dominant populous developing country [5, 6, 8-11] and it was aimed to look into the decision-making power of Bangladeshi women of reproductive age group in their daily life. The result revealed that about 41% of the respondents had educational attainment below the primary level among them 23.5% respondents had no education, 51% respondents had no children, 68.5% respondents were not currently working and about 73.6% respondents have no NGO membership (Table 1). Previous multiple studies revealed linear relationship between educational attainment & empowerment [3, 4, 11, 12, 16]. Previous study from Bangladesh revealed that secondary completed educated women were 1.35 times more likely to seek their own healthcare and 1.57 times more likely to seek child healthcare than those of non-educated women [12]. In a different study in Bangladesh, Mainuddin et al. mentioned women education had significant impact on deciding child healthcare, purchasing large household items and daily food items [11]. In a study in Ethiopia, Lailulo et al. found significant correlation of empowerment with maternal education, employment status, as well as media exposure [4].

The study revealed education and employment status were positively associated with health, wealth index and age of respondent, region, and religion [4]. Another study revealed that women with at least primary education, implying that they are at a higher level of empowerment than women with no formal education [3]. This study revealed less percentage of respondents with NGO affiliation (Table 1) which is considered as an important indicator of empowerment [12]. Studies found that participation in credit programs is positively associated with a women's level of empowerment defined as a function of their relative physical mobility, economic security, ability to make purchases on their own freedom from domination and such aspects [12]. In another study in Bangladesh women empowerment was empirically examined, primarily with respect to its relationship with access to financial services [2].

Though the average age was 31 year but respondents without any child were 51% that seems quite contradictory to the authors (Table 1) in respect of the socioeconomic tradition of Bangladesh. The situation could be explained by women with no children were found to have more empowerment than women with children and they might delay their childbirth (Table 3). Respondents who are from richest background are more likely to take their own decisions and respondents from urban area and with higher educational attainment are more likely to take their own decisions (Table 2). The results also revealed that working status and member-ship to NGO are significantly associated with decision making power of women (Table 2). Women from richer family are more likely to take their own decisions than comparing to women from other wealth index groups. This is consistent with another research from Pakistan [17]. The analysis revealed, women from urban area, with NGO membership and employed were more empowered.

Conclusion

Bangladesh is progressing rapidly in health and wealth but poor attainment of primary education, low employment of females, and few NGO memberships are seemed to be the hindrance in women empowerment as well as overall development of Bangladesh as about half of the population is women. The study revealed that women from urban area, with NGO membership and employed were more empowered. Ensuring further steps to endure the 100% attainment of primary education can accelerates the decision making power of females in Bangladesh.

Conflict of Interest: None

Funding: Self funded

References

1. Kwagala B, Wandera SO, Ndugga P, Kabagenyi A. Empowerment, partner's behaviours and intimate partner physical violence among married women in Uganda. BMC Public Health. 2013;13:1112.
2. Mahmud S, Shah NM, Becker S. Measurement of Women's Empowerment in Rural Bangladesh. World Dev. 2012;40(3):610–9.
3. Kawaguchi L, Abdel N, Fouad M, Chiang C, Helmy I, Elshair H, et al. Dimensions of women's empowerment and their influence on the utilization of maternal health services in an Egyptian village: A multivariate analysis. Nagoya J Med Sci. 2014;76:161–71.
4. Lailulo YA, Susuman AS, Blignaut R. Correlates of gender characteristics, health and empowerment of women in Ethiopia. BMC Women Health. 2015;15(116):1–9.
5. Zaman UR, Rahman MM, Hussain SMA, Zaki M. Women Empowerment in Different Household Issues of Bangladesh. Bangladesh Med J. 2008;37 (2):45–9.
6. Chowdhury T, Kowsari M, Begum J, Khan M, Haque S, Wahid T. Employment and empowerment of rural poor women in Mymensingh District of Bangladesh. Progress Agric. 2016;27(3):301–10.
7. Davis LM, Schensul SL, Schensul JJ, Verma RK, Nastasi BK, Singh R. Women's empowerment and its differential impact on health in low-income communities in Mumbai, India. Glob Public Health. 2014;9(5):481–94.
8. Arafat SMY. Doctor Patient Relationship: an Untouched Issue in Bangladesh. Int J Psychiatry. 2016;1(1):2.

9. Arafat SMY. Suicide in Bangladesh: a Mini Review. J Behav Health. 2017;6(1):66–9.
10. Arafat SMY. Anti-Ulcerants: The Driving Force of the Pharma Market of Bangladesh. Int J Perceptions Public Health. 2016;1(1):1–2.
11. Mainuddin A, Begum HA, Rawal LB, Islam A, Islam SSM. Women empowerment and its relation with health seeking behavior in Bangladesh. J Fam Reprod Health. 2015;9(2):65–73.
12. Hasan MN, Sheikh M, Uddin G. Women empowerment through health seeking behavior in Bangladesh: Evidence from a national survey. South East Asia J Public Health. 2016;6(1):40–5.
13. Kabir M, Rashid M, Kabir R. Food Security and Nutrition status of mothers and under five children of Chittagong Hill Tracts. South Asian J Popul Health 2008:1(1):12-23.
14. National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. Bangladesh Demographic and Health Survey 2014. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT, Mitra and Associates, and ICF International, 2016.
15. Bangladesh Bureau of Statistics (BBS). Statistics Division, Ministry of Planning. Population & Housing Census: Preliminary Results, 2011. Dhaka, Bangladesh: BBS.
16. Kabir R, Khan HTA. Utilization of antenatal care among pregnant women of urban slums of Dhaka City, Bangladesh. IOSR J Nurs Health Sci. 2013;2 (2):15-19.
17. Ferdous N, Kabir R, Khan HT, Chowdhury MR. Exploring the relationship of Domestic violence on Health Seeking behavior and Empowerment of Women in Pakistan. Epidemiol Biostatistics Public Health. 2017:17:14(1).