NATIONAL INSTITUTE OF STATISTICS

POLICY BRIEF

EMPOWERMENT OF WOMEN IN UNION AND USE OF REPRODUCTIVE HEALTH SERVICES IN CAMEROON

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The objective of this note is to examine the relationship between the empowerment of women in union and the use of reproductive health services. From the analyses of the 2004, 2011 and 2018 DHS data used, it appears that the percentage of autonomous women increased over the 2004-2018 period in Cameroon. The analysis of the use of modern contraceptives, use of antenatal care by a skilled provider, antenatal visits during the first term of pregnancy, effectiveness of at least four antenatal visits, delivery in a health establishment or use of postnatal care within two days after childbirth, shows that the level of use of reproductive health services gradually increases as empowerment of women in union increases. In addition, conventional variables for measuring the status of women (notably education and employment status) have emerged as important factors positively associated with the use of reproductive health services in Cameroon.

I. INTRODUCTION

Reproductive health is recognised as a right in most countries in the world. For the World Health Organization (WHO), reproductive health is the condition of physical, mental and social welfare related to the reproductive system. It enables people to benefit from healthy sexuality and to freely decide if and when they wish to have children and how often. It gives the possibility to have access to appropriate health services, enabling women to be followed up during pregnancy by providing them and their children the opportunity to be healthy. The low use of reproductive health services in developing countries is usually associated with very high levels of maternal mortality.

In Sub-Saharan Africa, the objectives of reducing the level of maternal mortality are still far from being achieved. In Cameroon, the results of

the fifth Demographic and Health Survey (CDHS V, 2018) show that the pregnancy-related mortality ratio is 467 maternal deaths per 100,000 live births, while the agenda of the Sustainable Development Goals (SDGs) targets lower than 70 maternal deaths per 100,000 live births worldwide by 2030.

The statement of consensus on targets and strategies to end preventable maternal death by the World Health Organization (WHO) stipulates that to achieve the goal of maternal health, universal coverage for sexual, reproductive and maternal health care should be ensured.

The SDGs place particular emphasis on the issue of women empowerment and reproductive health. SDG 3 (target 3.7) on good health and welfare highlights universal access to sexual and reproductive health services, including family planning, information and education. In addition, SDG 5 (target 5.6) addresses the various factors of gender inequality and, more particularly, it aims at ensuring universal access to sexual and reproductive health care.

At the national level, Cameroon's health sector strategy for the 2016-2027 period considers family planning, antenatal consultation and delivery attended by a skilled health care provider as pillars of the reduction of maternal mortality. However, it should be noted that the modern contraceptive prevalence among women in union (from 16% to 15% between 2011 and 2018), coverage of antenatal care (from 85% to 87% between 2011 and 2018) and percentage of births in health facilities (from 61% to 67% between 2011 and 2018) have stagnated in recent years.

The objective of this study is to examine the relationship between women empowerment and use of reproductive health services in Cameroon, in order to contribute to the reflection on this theme in Cameroon and to provide the Government and its development partners with information to better guide sexual and reproductive health policy actions.

II. METHODOLOGY

Data used for analyses come from the last three Cameroon Demographic and Health Surveys (CDHS): CDHS III 2004, CDHS-MICS 2011 and CDHS V 2018. These are national household surveys with results that are representative up to the regional level and by residential areas. Sample sizes range from approximately 11,000 to 15,000 households; in each sample household, women and men in union aged 15 to 49 were interviewed on their employment status, women's participation in income and in various household decisions.

Study variables were identified through a literature review. Three aspects of the use of sexual and reproductive health services were retained for multivariate analyses in order to highlight the most determining factors of the use of sexual and reproductive health services. These include the current use of contraceptives, use of antenatal care by a skilled provider and delivery in a health facility.

This study is based primarily on 2018 CDHS-V data from which a sub-sample (weighted) of 7,463 women aged 15-49 years in union for the analysis of the relationship between empowerment and the use of modern contraceptives on the one hand, and 6,926 women in union aged 15-49 years and who had a live birth in the five years before the survey, for the analysis of the relationship between empowerment and the use of antenatal care and delivery in health facilities on the other hand.

Data were analysed using SPSS version 24 software for both bivariate and multivariate analyses. Firstly, a description of the socio-demographic characteristics of the population studied was made and the profile of women in union aged 15-49 years meeting the criteria of empowerment was brought out. A chi-square test was performed to test the association between each dependent variable and each independent variable. The variables were then retained for the multivariate analysis based on the association at the bivariate level ($p < 0.05$).

Secondly, multivariate logistic regressions were performed to identify the associations of explanatory variables with the independent variables, providing odds ratios (ORs) and 95% confidence intervals (CIs).

III. FINDINGS

a. Trends in indicators of the empowerment of women in union from 2004 to 2018

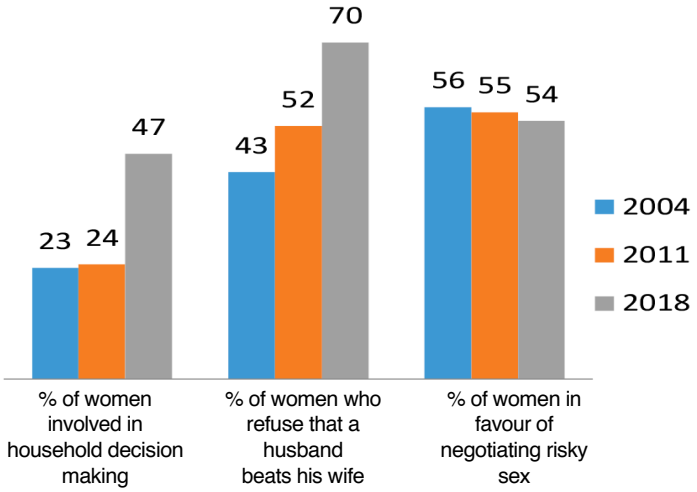
Globally, from 2004 to 2018, there was an improvement in the indicators of the empowerment of women in union aged 15-49 years.

The percentage of women participating in household decision-making doubled between 2004 and 2018. In 2018, 47% of women in union aged 15-49 years participated in household decision-making , as against 23% in 2004 *(Graph 1).*

In addition, the percentage of women in union aged 15-49 years who believe that a husband is not justified in beating his wife under any of the five reasons has increased, from 43% in 2004 to 70% in 2018.

Regarding women opinions about refusal of risky or unprotected sex with their sexual partner, the percentage of women in union aged 15-49 years who think that a woman has the right to refuse to have sex with her husband has not changed between 2004 and 2018. This percentage was 56% in 2004, 55% in 2011 and 54% in 2018.

***Graph 1**: Trends in indicators of the empowerment of women in union from 2004 to 2018*

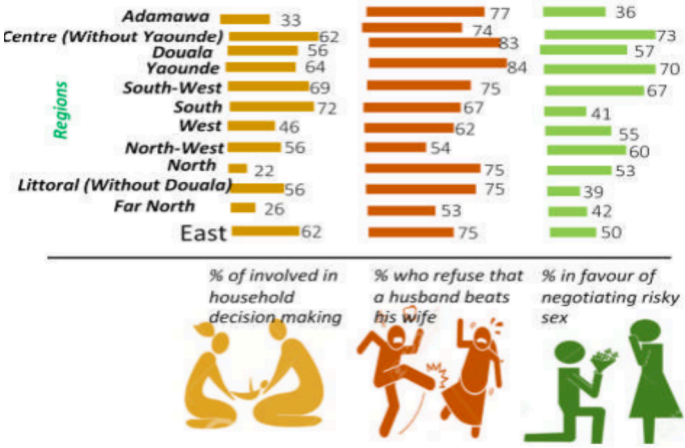


Sources: CDHS III 2004; CDHS-MICS 2011 and CDHS V 2018

b. Socio-demographic characteristics of empowered women in 2018

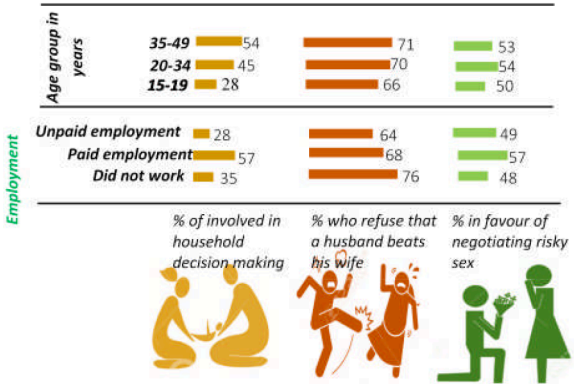
The analysis of socio-demographic characteristics shows that living in an urban area, increasing the level of education, paid employment and an age above 19 years are in favour of the empowerment of women in union aged 15-49 years *(Graph 2, 3 and 4)*.

***Graph 2**: Percentage of women aged 15-49 currently in union based on their opinion about household decision-making and by region of residence in 2018*



Sources: *CDHS V 2018*

***Graph 3**: Percentage of women aged 15-49 currently in union based on their opinion about household decision-making and some socio-demographic characteristics in 2018*

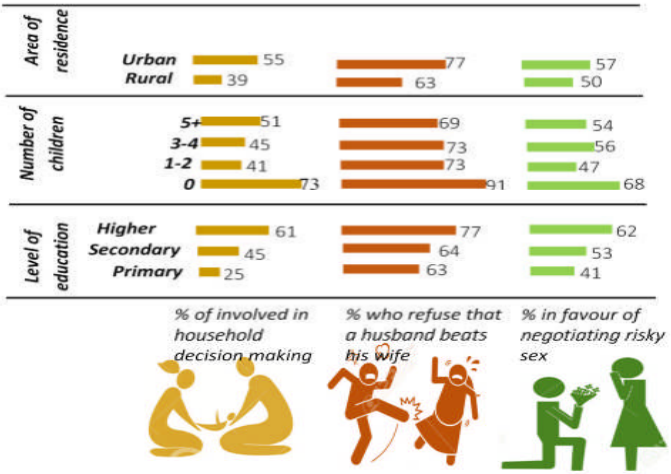


Sources : CDHS III 2004 ; CDHS-MICS 2011

Women in union aged 15-49 years with secondary or higher education, those living in urban areas, those in paid employment and those aged 35-49 years have greater propensity to participate in decision-making in the household, to reject all the reasons why the husband might be

justified in beating his wife and to approve negotiation of sex with partner/husband. These women are considered as the most empowered.

***Graph 4**: Percentage of women aged 15-49 currently in union based on their opinion about household decision-making and some socio-demographic characteristics in 2018*



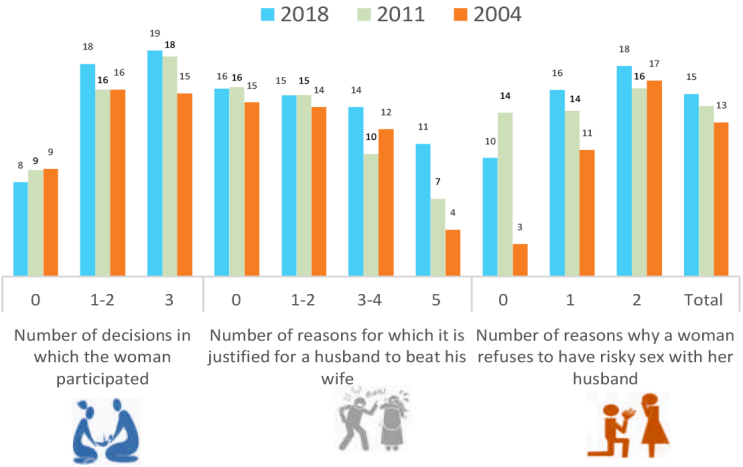
Sources : CDHS III 2004; CDHS-MICS 2011

However, the least empowered women in union aged 15-49 years are those with no education, those who are unemployed, those aged 15-19 years, those living in rural areas, and those from Adamawa, North and Far North regions.

c. Empowerment and use of reproductive health services

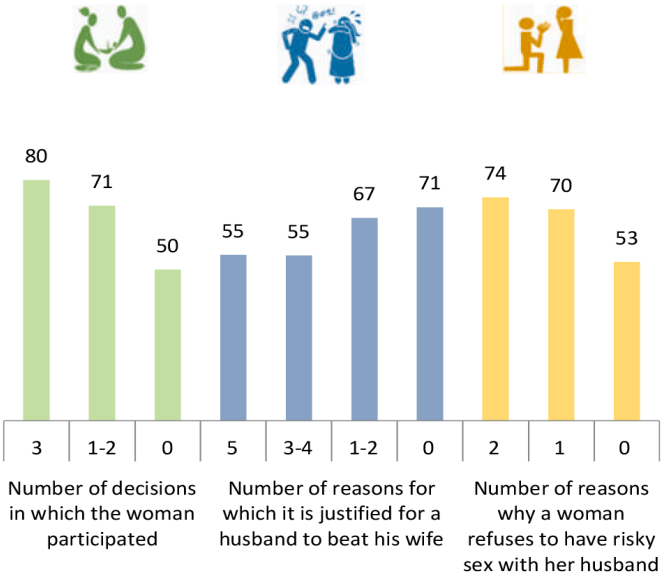
In Cameroon, women in union aged 15-49 who meet the criteria for autonomy generally use reproductive health services more than other women. The analysis of the use of modern contraceptives, use of antenatal care by a skilled provider, antenatal visits during the first term of pregnancy, effectiveness of at least four antenatal visits, delivery in an establishment or use of postnatal care within two days after childbirth, shows globally that the level of use of reproductive health services gradually increases as empowerment of women in union increases.

***Graph 5**: Distribution (%) of women in union aged 15-49 years using modern contraceptives by empowerment indicator from 2004 to 2018*



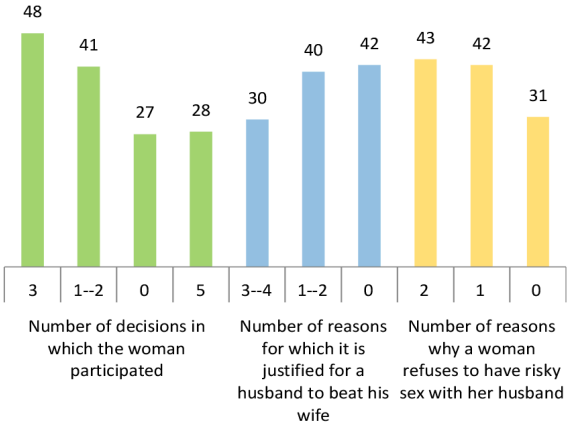
Sources : CDHS III 2004; CDHS -MICS 2011, CDHS V 2018

***Graph 6**: Distribution of women who received antenatal care from a skilled provider in 2018*



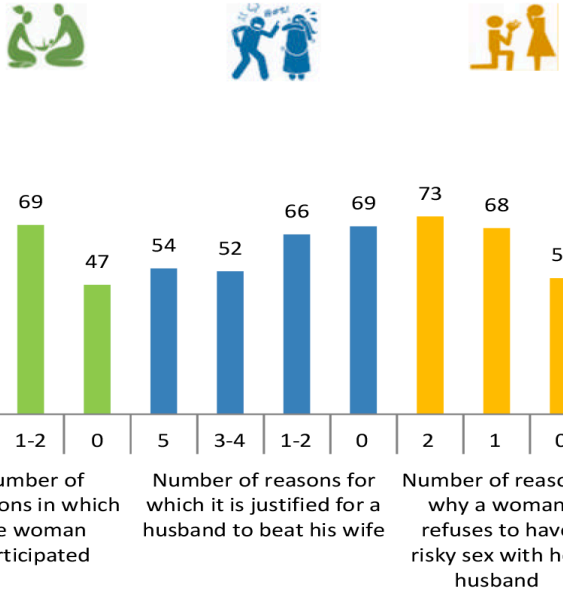
Sources : 2018 CDHS-V

***Graph 7**: Distribution (%) of women who went for an antenatal visit for the first time during the first trimester of pregnancy, by empowerment indicator in 2018*



Sources : 2018 CDHS-V

***Graph 8**: Distribution (%) of women whose delivery took place in a health facility, by empowerment indicator in2018*



Sources : 2018 CDHS-V

d. Factors explaining the use of reproductive health services by women in union

Some binary logistic regression models were estimated to determine the associations between, on the one hand, the degree of women empowerment and, on the other hand, the use of modern contraceptives, use of antenatal care by a skilled personnel and delivery in a health facility.

This study shows the existence of a significant and positive association between the level of empowerment of a woman in union and the use of modern contraceptives, as well as the use of antenatal care from a skilled provider. The number of decisions in which women participated remained significant and positively associated with the use of modern contraceptives and the use of antenatal care from a skilled provider; which corroborates the results of some studies carried out in the context of developing countries (Yohannes Dibaba Wado, 2017).

The women employment status, which is one of the conventional variables for the measurement of women condition, is significantly associated with the use of modern contraceptives. Women with a paid employment are 22% more likely to use modern contraceptives compared to their counterpart who have not worked in the past 12 months.

More than employment status, the number of reasons why a husband is justified in beating his wife has emerged as an important factor associated with the use of reproductive health services, notably the use of antenatal care from a skilled provider and delivery in a health facility.

Education - another measurement of women status- is also crucial for the use of reproductive health care. This confirms the results of some studies carried out in developing countries (Furuta and Salway 2006; Mistry, Galal and Lu 2009).

A woman's age is a factor associated with the use of reproductive health services. The odds ratios favour younger women when it comes to modern contraceptive use and delivery in a health facility. The odds

are rather in favour of older women for the use of antenatal care from a skilled provider. Compared to their 15-19-yearold counterparts, women aged 20-34 years are 61% more likely to seek antenatal care from a skilled provider. Women aged 35-49 years are 4.47 times more likely.

A woman's area of residence is also an important factor associated with the use of reproductive health services. Odds ratios for the use of these services by women are higher for those in urban areas compared to those in rural areas.

IV. OBSERVATIONS AND RECOMMENDATIONS

With regard to the results summarised above, the empowerment of women in union is positively associated with the use of reproductive health services by women.

At the end of this study, factual findings suggest the following recommendations which are formulated mainly with regard to public authorities.

Observation n°1: Educated women are often the most exposed to the media or Internet and thus to information and knowledge about modern health care. It is also important to increase the level of education of women, notably the youngest ones, to ensure proper use of reproductive health services through sexual health education.

Observation n°2: The observed relationship between paid employment and modern contraceptive use shows that interventions aimed at improving women employment opportunities may also generate reproductive health benefits. Improving girls' education and women employment status can play a dual role in improving the empowerment of women in union and health-seeking behaviour.

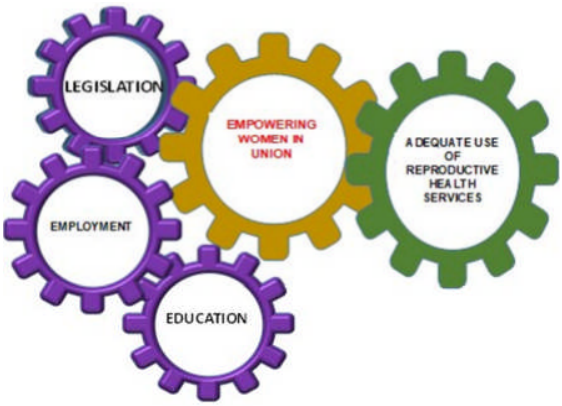
Recommendation n°1: Action should be stepped up for the education of young girls and for the promotion of women's access to paid employment, which are important factors in their appropriate use of reproductive health services.

Observation n°3: Results underscore the need for initiatives to improve the condition of women in Cameroon, notably by ensuring the need to protect women's rights and by achieving gender equality, ensuring women's participation in decision-making at all levels and in particular within the household.

Recommendation n°2: To promote the protection of women's rights and gender equality as well as their participation in decision-making at all levels and in particular within the household, for example through appropriate legal and legislative changes. This will improve women's empowerment and propensity to use health care in line with SDG 5.

Observation n°4: Significant disparities exist in the use of reproductive health services regarding the wealth quintile and area of residence.

Recommendation n°3: To take appropriate measures to correct disparities in access to reproductive health services, for example by improving incomes in rural areas and developing health infrastructure in rural and semi-rural areas, to ensure access to basic health services for the poorest populations.



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