
Women's Autonomy and Reproductive Healthcare-Seeking Behavior in Bangladesh: Further Analysis of the 2014 Bangladesh Demographic and Health Survey

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Abstract: Women's autonomy or empowerment is an important issue to achieve targets for the Sustainable Development Goals (SDGs) of Bangladesh. There are several indicators to measure the women empowerment. Health seeking information is one of the most important indicators in this view. This study aims at identifying women's maternal and child health-care seeking in relation to women empowerment in Bangladesh. Bangladesh Demographic and Health Survey (BDHS) 2014 data was used for the study. A total of 1875 women of reproductive age with complete information on the selected predictors were identified for this analysis by multistage stratified cluster sampling design. Multiple logistic regression and X^2 statistic were used to study determinant factors. A p-value less than 0.05 was considered as statistically significant. Among 1875 women sampled, 87.7% and 88.5% were received antenatal care and postnatal care respectively. Out of women who resided in urban areas, 91.2% women got postnatal care and 93.7% women received antenatal care where as only 83.4% rural women's get antenatal care and 86.6% women got postnatal care respectively. Division, type of residence, respondent's education level, wealth index, decision maker for using contraception, partner's education level, respondent's currently working status, beating justified if wife goes out without telling husband, neglects the children, argues with husband, refuses to have sex with husband, burns the food respectively, women's body mass index and age of 1st birth were found to be statistically significant determinants of receiving antenatal care. Type of residence, wealth index, respondent's currently working status, person who usually decides on visits to family or relatives, beating justified if wife argues with husband were found to be statistically significant determinants of receiving postnatal care. In summary, our analysis highlights concerning continuing healthcare-seeking challenges in Bangladesh. This study explores the factors associated with women's autonomy and reproductive healthcare-seeking behavior in Bangladesh.

Keywords: Women Empowerment, Decision-Making, Health Seeking Behavior, BDHS, Bangladesh

1. Introduction

Empowerment is broadly recognized as a process by which those who have been unnerved are able to increase their self-efficacy, make life-enhancing decisions, and obtain control over resources [1–3]. In addition, empowerment is multi-dimensional – a woman may be empowered in one dimension or sphere (such as financial) but not in another (such as in

sexual and reproductive decision-making). Most countries now acknowledge the importance for girls and women to become more empowered, both as a goal in it, as well as to achieve a more gender equitable society [4].

Women's empowerment can lead to significant positive changes in many domains. The ability of women to make

decisions that affect the personal circumstances of their own lives is an essential aspect of women empowerment and serves as an important contributor to their overall welfare⁵. In recent times, researchers have been assessing the contexts and mechanisms by which empowerment directly or indirectly affect various aspects of women's health [5–7]. Moreover, different studies indicate that association between increased empowerment of women and reduce hindrances of the physical access to health service. In developing countries women empowerment (i.e. control over resources, decision making, autonomy) influence reproductive healthcare seeking behavior and use of prenatal, postnatal care. Likewise in Bangladesh increased empowerment of women is likely to increase their ability to seek out and use health services to better meet their own reproductive health goals, including the goal of safe motherhood and also in child health care seeking behavior [8-9]. The level of education, freedom of choice/movement, power in the household decision making process and involvement in economic activities among women are positively and significantly related to the decision and intensity of utilization of antenatal care in Bangladesh [10]. At present, Bangladesh has progressed in terms of women empowerment. The 2011 Global Gender Gap Index developed by the World Economic Forum, ranks Bangladesh as 69th out of 135 countries in terms of gender equality [11]. According to BDHS, 2014 the proportion of women receiving antenatal care from a medically trained provider increases and similarly, the proportion of women receiving postnatal care within two days of delivery from a medically trained provider also increases. Increased empowerment of women is likely to increase their ability to seek out and use health services from qualified health providers in meeting their own reproductive health goals, including safe motherhood [12].

Previous studies showed that empowerment of patients resulted in favorable health outcomes, such as increased power of decision-making, freedom of making choices and accepting the responsibility. Moreover, the process of empowerment also helped to develop trust in relations; inform choices; facilitate adaptation, well-beings, and hopefulness; increase speed of personal developments and awareness of one's own world; identify one's own strengths and abilities; feel more powerful, higher self-confidence, higher personal satisfaction, higher self-efficiency; and eventually improve quality of life. The benefits of empowerment are not necessarily limited to women themselves, but have the potential to extend to those around her, including – perhaps most prominently – her own children [13]. Empowerment of women is essential for the achievement of sustainable development. Empowered women can more successfully negotiate their reproductive and health related performances with male partners. A better understanding of the situations where greater empowerment is associated with improved health outcomes can assist policy-makers in planning and prioritizing their investments. The impact of women empowerment in utilization of maternal health care is the main aim of this paper. The proper utilization of maternal care depends on the knowledge and decision making power of women. Educated, employed and inde-

pendent women are more concerned about their health care at the time of pregnancy.

2. Methods

Data on 17842 women were extracted from 2014 Bangladesh Demographic and Health Survey (BDHS). This national level survey was designed to provide data on basic indicators of fertility regulation, maternal health, child health, nutritional status of mothers and children, awareness and attitude towards HIV/AIDS, and the prevalence of non-communicable diseases. Enumeration areas (EAs) from the population census 2014 were primary sampling units (PSUs) for this survey, with PSUs designed to produce separate estimates of key indicators for each of the seven divisions such as Dhaka, Chittagong, Rajshahi, Rangpur, Khulna, Barisal and Sylhet. By using the stratified, two-stage cluster design, where, a total of 600 clusters (including 207 clusters in urban areas and 393 clusters in rural areas) were chosen in first stage [12]. In the second stage of sampling, a systematic sample of 30 households (HHs) was selected on average per cluster. Detailed information about the survey can be found in the 2014 BDHS report and all ever married women of the selected households are interviewed by using systematic random sampling technique. [12].

3. Measurement of Variables

3.1. Outcome Variable

Maternal health seeking behavior was indicated by women's use of antenatal care and postnatal care. Dichotomous variables were constructed to measure each of the two dependent variables.

3.2. Explanatory Variables

3.2.1. Demographic Variables

Place of residence (rural, urban) and geographic region based on seven divisions in Bangladesh (Barisal, Chittagong, Dhaka, Khulna, Rajshahi, Rangpur and Sylhet) husband's education level (no education, primary, secondary, higher), respondent age (15-24, 25–34, ≥35), household head (male, female) and wealth index (poor, middle, rich) were included as demographic covariates.

3.2.2. Women's Status Variables

Women's educational status (no education, primary, secondary, higher), women's working status (yes or no), body mass index BMI (<18.5 kg/m², 18.5-24.5 kg/m²) and age of 1st birth (under 18, ≥18), ≥24.5 kg/m²) were included as women's status variables.

3.2.3. Autonomy Variables

In this study the key explanatory variable, women's autonomy, is measured by women's participation in decision making for household, attitudes toward wife beating, attitudes toward refusing sex with her husband, attitudes toward neglecting the children, attitudes toward arguing with husband, attitudes toward burning the food and whether getting per-

mission to seek medical care is a big problem.

4. Statistical Analysis

Univariate and bivariate analyses are used for descriptive measures. Bivariate relationships between dependent and independent variables are examined by using Chi-square test of association. To identify the factors influencing women's empowerment, multiple logistic regression was carried out. Two models were estimated, in the first we estimated receiving antenatal care (yes= 1, no= 0) and in the second model we estimated postnatal care (yes= 1, no= 0) as dependent variable and various independent (demographic, socioeconomic, anatomy and women's status) variables. Multiple logistic regression model is used for the analysis [18]. The coefficients in the analysis represent an increase or decrease in the log odds of being occurrence of an event (versus not occurrence) associated with a unit or category change in an independent variable [14-16].

The mathematical model is expressed as:

$$\ln\left(\frac{p_i}{1 - p_i}\right) = \beta_0 + \beta_1x_1 + \beta_2x_2 + \beta_3x_3 + \dots + \beta_nx_n$$

where, $P(Y_i = 1) = p_i$ and $P(Y_i = 0) = 1 - p_i$; X_i X_i = Independent variables such as woman's demographic, socio economic and program related characteristics, b_0 = Intercept term of the regression model, b_i = Regression co-efficient of the respective variable, representing the effect or association for individual characteristics.

5. Results

A total of 1875 recently married women; aged 15-49 years participated in this study. About 52.3% of the participants were aged 15-24 years old followed by 41.4%, 6.3% aged 25-34 years, and ≥ 35 years respectively. Only 10.5% of the women had no years of formal education. A total of 23.1% had primary education whereas 51.2% had secondary education but higher educated women are only 15.2%. Among the participants, only 24.5% had some sorts of formal work and rest of them (86.7%) were housewives. However, it was noticeable that 66.3% women had power (either by themselves or jointly with their husbands) in deciding their own healthcare seeking. The frequency distributions of the selected covariates are summarized in Table 1.

Table 1. Frequency distribution of the selected covariates.

Variable	Categories	Frequency	Percentage
Demographic variables			
Division	Barisal	191	10.2
	Chittagong	322	17.2
	Dhaka	373	19.9
	Khulna	263	14.0
	Rajshahi	280	14.9
	Rangpur	260	13.9
	Sylhet	186	9.9
Place of residence	Urban	780	41.6
	Rural	1095	58.4
Husband education level	No education	341	18.2
	Primary	505	26.9
	Secondary	640	34.1
	Higher	389	20.7
Household head	Male	1759	93.8
	Female	116	6.2
Wealth index	Poor	552	29.4
	Middle	357	19.0
	Rich	966	51.5
Respondent age	15-24	980	52.3
	25-34	776	41.4
	35+	119	6.3
Women's status variables			
Women's educational level	No education	197	10.5
	Primary	433	23.1
	Secondary	960	51.2
	Higher	285	15.2
Women's working status	No	1416	75.5
	Yes	459	24.5
Body mass index	Under weight	372	19.8
	over weight	451	24.1
	Normal	1052	56.1
Age of 1st birth	under 18	1072	57.2
	18+	803	42.8
Autonomy variables			
Decision maker for using contraception	Respondent	218	11.6
	Husband, partner	150	8.0

Variable	Categories	Frequency	Percentage
Decision maker on respondent's health care	Joint decision	1507	80.4
	Respondent alone	186	9.9
Decision maker on large household purchases	Joint decision	1057	56.4
	Husband alone	632	33.7
	Respondent alone	91	4.9
Decision maker on visits to family or relatives	Joint decision	1028	54.8
	Husband alone	609	32.5
	Mother in low	147	7.8
	Respondent alone	121	6.5
Attitudes toward going out without permission	Joint decision	1037	55.3
	Husband alone	594	31.7
	Mother in low	123	6.6
	Respondent alone	1658	88.4
Attitudes toward neglecting the children	No	217	11.6
	Yes	1621	86.5
Attitudes toward arguing with husband	No	254	13.5
	Yes	1571	83.8
Attitudes toward refusing sex with her husband	No	304	16.2
	Yes	1777	94.8
Attitudes toward burning the food	No	98	5.2
	Yes	1817	96.9
Health seeking variable	No	58	3.1
	Yes	1659	88.5
Received antenatal care	No	231	12.3
	Yes	1644	87.7
Postnatal care	No	216	11.5
	Yes	1659	88.5

The results of the association among postnatal care and antenatal care with different covariates characteristics are presented in Table 2. Besides division, place of residence, husband's education level, wealth index, women's education level, women's working status, body mass index, age of 1st birth, decision maker for using contraception, attitudes toward going out without permission, attitudes toward neglecting the children, attitudes toward arguing with husband, attitudes toward refusing sex with husband and attitudes toward burn-

ing the food had a significant association with women's antenatal care. Postnatal care seems to be significantly associated with their place of residence, wealth index, women's working status, decision maker on visits to family or relatives and attitudes toward arguing with husband. Postnatal care prevalence was comparatively high among working women but prevalence of antenatal care was comparatively low among them. Urban women are more like to receive postnatal care (91.2%) than rural women.

Table 2. Association among postnatal care and antenatal care with different covariates.

Variable	Categories	% Postnatal care		Chi-Square (p-value)	% Received antenatal care		Chi-Square (p-value)
		No	Yes		No	Yes	
Demographic variables							
Division	Barisal	8.4	91.6	9.710 (0.137)	19.4	80.6	23.001 (0.001)
	Chittagong	10.6	89.4		11.2	88.8	
	Dhaka	12.6	87.4		9.7	90.3	
	Khulna	16.3	83.7		6.8	93.2	
	Rajshahi	9.6	90.4		13.9	86.1	
	Rangpur	10.8	89.2		13.1	86.9	
Place of residence	Sylhet	11.3	88.7	9.36 (0.001)	16.7	83.3	45.07 (0.00)
	Urban	8.8	91.2		6.3	93.7	
	Rural	13.4	86.6		16.6	83.4	
Husband's education level	No education	12.9	87.1	1.962 (0.580)	28.2	71.8	134.13 (0.00)
	Primary	12.5	87.5		15.6	84.4	
	Secondary	10.6	89.4		7.2	92.8	
Household head	Higher	10.5	89.5	0.012 (0.53)	2.6	97.4	1.56 (0.132)
	Male	11.5	88.5		12.6	87.4	
	Female	11.2	88.8		8.6	91.4	
Wealth index	Poor	14.1	85.9	8.817 (0.012)	23.7	76.3	114.799 (0.00)
	Middle	13.2	86.8		14.3	85.7	
	Rich	9.4	90.6		5.1	94.9	
Women's age	15-24	11.2	88.8	0.979 (0.613)	12.0	88.0	0.234 (0.89)
	25-34	11.5	88.5		12.5	87.5	
	35+	14.3	85.7		13.4	86.6	
Women's status variables	No education	12.7	87.3	2.597 (0.458)	28.4	71.6	104.39 (0.00)

Variable	Categories	% Postnatal care		Chi-Square (p-value)	% Received antenatal care		Chi-Square (p-value)
		No	Yes		No	Yes	
Women's working status	Primary	12.0	88.0	9.045 (0.001)	19.4	80.6	11.170 (0.001)
	Secondary	11.9	88.1		8.8	91.3	
	Higher	8.8	91.2		2.5	97.5	
	No	12.8	87.2		10.9	89.1	
	Yes	7.6	92.4		16.8	83.2	
Body mass index	Under weight	12.6	87.4	0.902 (0.637)	20.4	79.6	50.45 (0.000)
	over weight	12.0	88.0		4.2	95.8	
	Normal	10.9	89.1		12.9	87.1	
Age of 1st birth	under 18	10.4	89.6	2.82 (0.054)	14.7	85.3	13.56 (0.00)
	18+	13.0	87.0		9.1	90.9	
Autonomy variables							
Decision maker for using contraception	Respondent	12.4	87.6	1.270 (0.530)	17.9	82.1	7.095 (0.029)
	Husband	14.0	86.0		11.3	88.7	
	Joint decision	11.1	88.9		11.6	88.4	
Decision maker on respondent's health care	Respondent alone	10.8	89.2	0.295 (0.863)	14.0	86.0	1.181 (0.554)
	Joint decision	11.4	88.6		11.6	88.4	
	Husband alone	12.0	88.0		13.0	87.0	
Decision maker on large household purchases	Respondent alone	11.0	89.0	0.76 (0.859)	9.9	90.1	3.81 (0.282)
	Joint decision	11.0	89.0		12.4	87.6	
	Husband alone	12.3	87.7		13.6	86.4	
Decision maker on visits to family or relatives	Mother in low	12.2	87.8	8.87 (0.031)	8.2	91.8	7.298 (0.063)
	Respondent alone	19.0	81.0		14.9	85.1	
	Joint decision	11.3	88.7		11.6	88.4	
Attitudes toward going out without permission	Husband alone	11.3	88.7	0.051 (0.446)	14.3	85.7	4.14 (0.03)
	Mother in low	7.3	92.7		6.5	93.5	
Attitudes toward neglecting the children	No	11.5	88.5	1.472 (0.135)	11.8	88.2	3.97 (0.032)
	Yes	12.0	88.0		16.6	83.4	
Attitudes toward arguing with husband	No	11.2	88.8	7.52 (0.005)	11.7	88.3	8.78 (0.003)
	Yes	13.8	86.2		16.1	83.9	
Attitudes toward refusing sex with husband	No	10.6	89.4	1.45 (0.149)	11.3	88.7	9.82 (0.003)
	Yes	16.1	83.9		17.4	82.6	
Attitudes toward burning the food	No	11.3	88.7	1.922 (0.122)	11.8	88.2	7.73 (0.008)
	Yes	15.3	84.7		22.4	77.6	
	No	11.3	88.7		11.9	88.1	
	Yes	17.2	82.8		24.1	75.9	

The multiple logistic regression analysis revealed that there were differences in terms of significant variables and their level of significance (Table 3). Place of residence, husband's education level and wealth index had a significant effect on receiving antenatal care but husband's education is no longer significant with postnatal care.

Table 3. Adjusted association between antenatal care and postnatal care and their covariates, Bangladesh, 2014.

Variable	Categories	Antenatal care		Postnatal care	
		Estimate	Odds Ratio (p-value)	Estimate	Odds Ratio (p-value)
Demographic variables					
Division	Barisal	-0.414	0.661 (0.181)	0.361	1.435 (0.325)
	Chittagong	0.031	1.032 (0.916)	0.025	1.025 (0.937)
	Dhaka	0.262	1.300 (0.371)	-0.340	0.712 (0.247)
	Khulna	0.797	2.218 (0.021)	-0.507	0.602 (0.094)
	Rajshahi	0.176	1.193 (0.552)	0.071	1.073 (0.827)
	Rangpur	0.388	1.474 (0.205)	-0.018	0.982 (0.954)
Place of residence	Sylhet (ref)	-	-	-	-
	Urban	0.525	1.690 (0.008)	0.377	1.458 (0.033)
	Rural (ref)	-	-	-	-
Husband's education level	No education	-1.420	0.242 (0.001)	0.093	1.098 (0.769)
	Primary	-0.911	0.402 (0.028)	0.041	1.042 (0.884)
	Secondary	-0.449	0.638 (0.266)	0.162	1.175 (0.516)
Household head	Higher (ref)	-	-	-	-
	Male	-0.702	0.495 (0.063)	-0.031	0.969 (0.924)
	Female (ref)	-	-	-	-
Wealth index	Poor	-0.597	0.550 (0.009)	-0.514	0.598 (0.021)
	Middle	-0.570	0.565 (0.017)	-0.407	0.666 (0.065)
	Rich (ref)	-	-	-	-
Women's age	15-24	-0.471	0.624 (0.170)	0.318	1.374 (0.310)
	25-34	-0.441	0.644 (0.184)	0.275	1.316 (0.363)
	35+(ref)	-	-	-	-

Variable	Categories	Antenatal care		Postnatal care	
		Estimate	Odds Ratio (p-value)	Estimate	Odds Ratio (p-value)
Women's status variables					
Women's education level	No education	-1.311	0.270 (0.010)	-0.208	0.812 (0.595)
	Primary	-0.906	0.404 (0.060)	-0.280	0.756 (0.402)
	Secondary	-0.472	0.624 (0.304)	-0.326	0.722 (0.242)
	Higher (ref)	-	-	-	-
Women's working status	No	0.278	1.321 (0.101)	-0.687	0.503 (0.001)
	Yes (ref)	-	-	-	-
Body mass index	Under weight	-0.349	0.706 (0.045)	-0.092	0.912 (0.636)
	over weight	0.818	2.267 (0.002)	-0.158	0.854 (0.406)
	Normal (ref)	-	-	-	-
Age of 1st birth	under 18	0.089	1.093 (0.611)	0.414	1.513 (0.012)
	18+ (ref)	-	-	-	-
Autonomy variables					
Decision maker for using contraception	Respondent	-0.353	0.703 (0.107)	-0.098	0.907 (0.681)
	Husband	-0.108	0.898 (0.721)	-0.196	0.822 (0.454)
	Joint decision (ref)	-	-	-	-
Decision maker on respondent's health care	Respondent alone	-0.359	0.699 (0.241)	0.224	1.251 (0.470)
	Joint decision	0.078	1.081 (0.714)	-0.023	0.977 (0.910)
	Husband alone (ref)	-	-	-	-
Decision maker on large household purchases	Respondent alone	0.658	1.932 (0.306)	1.043	2.838 (0.055)
	Joint decision	-0.126	0.881 (0.776)	0.695	2.003 (0.060)
	Husband alone	0.218	1.244 (0.623)	0.561	1.753 (0.127)
	Mother in low (ref)	-	-	-	-
Decision maker on visits to family or relatives	Respondent alone	-1.203	0.300 (0.048)	-1.810	0.164 (0.001)
	Joint decision	-0.723	0.485 (0.174)	-0.995	0.370 (0.036)
	Husband alone	-0.784	0.457 (0.136)	-0.785	0.456 (0.098)
Attitudes toward going out without permission	Mother in low (ref)	-	-	-	-
	No	-0.107	0.898 (0.691)	-0.356	0.701 (0.226)
	Yes (ref)	-	-	-	-
Attitudes toward neglecting the children	No	-0.066	0.936 (0.806)	-0.002	0.998 (0.995)
	Yes (ref)	-	-	-	-
Attitudes toward arguing with husband	No	0.121	1.129 (0.609)	0.557	1.745 (0.017)
	Yes (ref)	-	-	-	-
Attitudes toward refusing sex with husband	No	0.270	1.310 (0.459)	-0.095	0.910 (0.809)
	Yes (ref)	-	-	-	-
Attitudes toward burning the food	No	0.228	1.257 (0.597)	0.403	1.497 (0.377)
	Yes (ref)	-	-	-	-

From the table 3 it was observed that, the negative value of the coefficients (log odds ratio) for mother's education relating to postnatal care or antenatal care suggests that decreasing level of education decreased the odds of being seek the postnatal care or antenatal care. Similarly, household head, wealth index, decision maker in using contraception or visiting relatives, attitude towards going outside or neglecting children were negatively associated with seeking antenatal care and postnatal care. Furthermore, husband education, women's age was positively associated with postnatal care bur negatively with antenatal care. Not working women were significantly less (OR=0.503, $p<0.001$) likely to seek their postnatal care than working women. Women's education, body mass index had a significant impact seeking antenatal care. Urban women appeared to be more likely (OR=1.690, $p<0.001$ and OR=1.458, $p<0.001$) to seek antenatal care and postnatal care respectively child healthcare compared to rural.

6. Discussion

In this study analyzed the relationship between women's autonomy and reproductive healthcare seeking behavior of women in Bangladesh in a recent nationally reproductive

survey from Bangladesh. From the bivariate analysis of BDHS, 2014data, it was found that division, place of residence, husband's education level, wealth index, women's education level, women's working status, body mass index, age of 1st birth, decision maker for using contraception, attitudes toward going out without permission, attitudes toward neglecting the children, attitudes toward arguing with husband, attitudes toward refusing sex with husband and attitudes toward burning the food had a significant association with women's antenatal care. Postnatal care seems to be significantly associated with their place of residence, wealth index, women's working status, decision maker on visits to family or relatives and attitudes toward arguing with husband. Two measures of women's reproductive health seeking behavior were considered: antenatal care and postnatal care. This measured women's autonomy by women's participation in domestic decision making for own health care or using contraception or visiting relatives etc, attitudes toward wife beating, attitudes toward refusing sex with husband etc.

Khulna has higher odds of getting antenatal care. Individuals from urban area have higher likelihood of having antenatal care and postnatal care. Husband's education level is significantly associated with antenatal care—the proportion of

getting antenatal care among individuals whose husbands having education levels more than 'No education,' are significantly high. It also found evidence that the prevalence of male head forces women to switch from 'having antenatal care' state. However, it has no significant impact on the occurrence of getting antenatal care. Poor people have significantly lower odds of getting antenatal and postnatal care.

Maternal education is considered the most important factor in determining women's delivery care seeking behavior [17]. The findings from this study as shown that maternal education have significant influence on getting antenatal care. Women with no education were less likely to utilize health care facility compared to higher educated women. Employment can increase women's economic autonomy and reproductive health status. This may be because it raises their awareness and provides new ideas and opportunities through interaction with other people outside the home and community [18-20]. In this study, unemployed women had a significant negative influence on the utilization of maternal health care. Working women were significantly more likely to use of health facility.

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 various purchases on their own freedom from domination and violence within the family, political and legal awareness, and participation in public protests and political campaigning [21]. In our study, ability to make various purchases on their own freedom from domination has a positive impact on getting health care.

7. Conclusion

This study examines the relationship between women's empowerment in health seeking behavior as well as socio-economic variable. The results of this study indicate the importance of women empowerment in their health care. From the above discussion, this observe that higher educated women, women in urban areas, and working women are more empowered in decision-making which helps them to seek health care. All possible efforts must be made to increase women's educational level. Government efforts should be made to enhance the employment of women and should encourage women to participate in NGO activities.

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