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Delwar Hossain
Begum Rokeya University

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Socioeconomic Status and Maternal Health-seeking Behavior: A Comparative Study between a Rural Site and an Urban Community in Bangladesh

By Delwar Hossain[1]

Abstract

Maternal health-seeking behavior is not only a crucial public health issue but also a serious women's health concern in Bangladesh. The present study examines the relationship between couples' socioeconomic status and maternal health-seeking behavior in comparison of rural areas and urban communities in Bangladesh. Based on the research objectives, it included 95 rural and 95 urban couples (total 190 couples) randomly selected from purposively selected rural areas and urban communities in Thakurgaon District (north western area of Bangladesh). Results of the present study indicate that the rate of illiteracy was higher in rural sites than in the urban communities (rural: husbands - 25.26% and wives - 13.69%; urban: husbands - 5.26% and wives - 10.52%). The main occupation in rural areas is agriculture for husbands (48.42%) and home making for wives (84.21%) compared to 36.84% urban husbands in services and 75.79% wives in home making. By income, most of the rural couples (47.37%) earn less than Tk. 2000 per month compared to 1.05% in urban area. Data also indicates that 47.37% of rural women did not have medical check-ups during the pregnancy period, 73.69% gave birth at home and 68.42% used a traditional birth attendant (TBA) compared to 20.0%, 38.94% and 33.69% in the urban communities, respectively. The data analysis explores that, both in rural and urban communities, the low rate of maternal health-seeking behavior (e.g., no check-up, child birth at home, and traditional birth attendant) was higher among the husbands with illiteracy, wives only engaged in home-making jobs, and the couples earning less than Bangladesh taka 2000 (1 USD = 83 BDT in currency exchange) in a month. The findings suggest that education, income and particularly women's employment or women's engagement in income generating activities should be taken into account in addressing maternal health issues in Bangladesh.

Keywords: Socioeconomic status, Maternal health-seeking behavior, Rural site, Urban community, Bangladesh

Introduction

Maternal health-seeking behavior is a serious public health issue in Bangladesh and worldwide. Globally about 830 women die each day due to complications of pregnancy and childbirth (WHO, 2016). The term 'maternal health-seeking behavior' refers to the act of women engaging in appropriate health behaviors during pregnancy, childbirth and postpartum period. The

[1]Delwar Hossain, Assistant Professor, Department of Women and Gender Studies, Begum Rokeya University, Rangpur, Bangladesh and educated in the University of Rajshahi, Bangladesh, is a member of the faculty of Social Sciences in the Department of Social Work. He obtained his M. Phil degree from the same university. He has publications in the areas of maternal health, children with disabilities and ethnic culture. He has provided research services to national and international organization. Email: dhossain@brur.ac.bd.

government of Bangladesh has implemented remarkable initiatives to improve maternal health services. Some studies show that the maternal mortality ratio and health care services already improved in Bangladesh due to effective activities and programs (Ali, 2010; Akter & Wohab, 2008; Akter, 2012). Socioeconomic disparities, medical cost, corruption and cultural factor are important barriers to seeking maternal health care during childbirth and the postpartum period (Akter, 2012; Walton & Schbley, 2013a; WHO, 2010; Walton & Schbley, 2013b; Koenig, 2007; Chowdhury et al., 2006; Koenig et al., 2007).

Relevant studies indicate that maternal health and health-seeking behavior have a strong connection with family or couples' socioeconomic status (SES) and show that mothers from higher SES backgrounds enjoy better maternal health services than the mothers from lower SES backgrounds (Hossain & Ilias, 2016; Akter, 2012; Hoang; Le; & Kilpatrick, 2011; Mackenbach et al., 2008, Marmot, 2015). Other studies indicate that socio-cultural settings (i.e., cultural view, social status of women, patriarchal norms) of different environments varies the view and access to health facilities of women during pregnancy and childbirth in different ways (Bale et al., 2003; Rao et al., 2001). Based on the different socio-cultural values or norms, women personalize maternal health-seeking behaviors at the family level and outside of the family. Bangladeshi society (both rural and urban) is a classic patriarchal society with a strict dichotomy between roles for men and women, values and attitude (Kabeer, 1988). Regarding this both rural and urban women are socio-culturally disadvantaged compared to men. On the other hand, women in rural areas are also more disadvantaged than urban women with regard to maternal health due to inequality of health services, low SES, superstitions and cultural barriers. In such situations, two questions are relevant: 1) Are there significant differences in maternal health-seeking behavior and couples' SES between a rural site and an urban community in Bangladesh? 2) Is there a significant relationship between maternal health-seeking behavior and couples' SES? This comparative study is very important to explore and examine differences and relationships of maternal health-seeking behavior and couples' SES between a rural site and an urban community in Bangladesh.

Conceptual Model

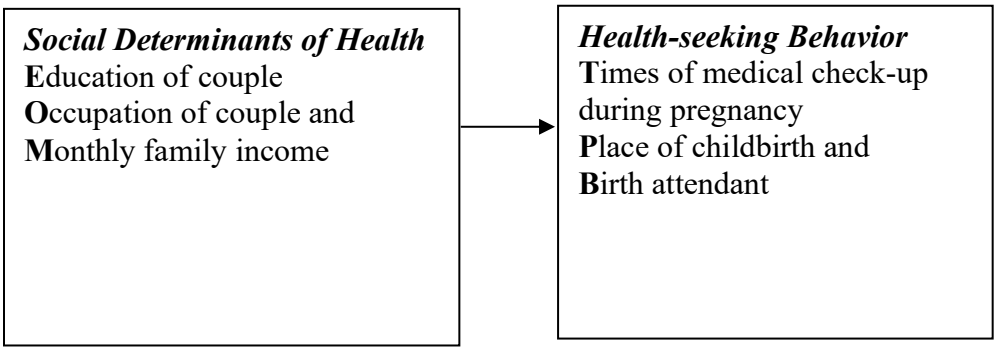
Maternal health-seeking behavior in association with couples' SES is not a new phenomenon in public health research. Over the past few decades sociologists and health researchers in respective fields have developed many theoretical frameworks or models and its methodology to study, understand and explain variation in maternal health-seeking behavior in relation with couples' SES across the individual, groups or in a particular community (Grundy & Annear, 2010).

The term 'health-seeking behavior' includes all meanings and activities a woman and her network engage in as a response to symptoms (Christakis et al., 1994). In this study maternal health-seeking behavior is defined as the seeking behavior of women during pregnancy, childbirth and postpartum period (*e.g., times of medical check-up during pregnancy, place of childbirth and birth attendant*) for the purpose of improving health outcomes. On the other hand, SES is a composite term which includes education, occupation and income that is widely used in social sciences, especially in sociology to study and explain social status and social behavior. Eshleman and Cashion (1985) and others (Miech & Hauser, 2000) defined SES status as an assessment of a person's education, occupation and income position within a particular social system. Many studies have assessed the relationship between SES and maternal health-seeking behavior (Hossain & Ilias, 2016; Akter, 2012; Hoang, Le & Kilpatrick, 2011). However, there seems to be gap in the

literature that reveals how maternal health-seeking behavior and SES vary based on communities (e.g., rural, urban).

The theoretical frameworks reviewed suggest that the Social Determinants of Health Model (SDOH) is more appropriate to study and explain health-seeking behavior of both rural and urban women in Bangladesh. The SDOH perspective emphasized socioeconomic factors (e. g., cultural view, superstitions, social status of women, patriarchal norms and gender) rather than medical care with regard to women's health-seeking behavior. Health Canada (1998), identified income and social status, social support networks, education, employment and working conditions, physical and social environment, biology and genetic endowment, personal health practices and coping skills, healthy child development, healthy services, gender and culture as social determinants of health. We used this model in this study with some modifications. This model, therefore, helps to explore and examine the association between SES and maternal health-seeking behavior among rural and urban women in Bangladesh. The following model was used with some modifications.

Figure 1: Conceptual model of couple's SES and maternal health-seeking behavior



Methods of the Study

Study Design

In order to conduct this study, Rathnai village (for rural) and Sarkerpara (ward no.3, for urban) areas of Thakurgaon District in Bangladesh were selected purposefully. The present study was conducted using a two-stage sampling approach. First of all, in both areas there were 450 couples (200 for Rathnai village and 250 for Sarker Para) that were identified who gave birth within five years preceding the survey. Of the total population, 190 couples (95 couples from rural and 95 couples from urban) were finally selected for the study, using simple random sampling, specifically the lottery method. This sampling procedure was more appropriate, un-biased and scientific to select the samples studied.

Variables

Couples' SES statuses were used as the independent variable and was categorized into education, occupation and monthly income. Maternal health care seeking behaviors *(times of medical check-up during pregnancy, place of childbirth and birth attendant)* were used as the dependent variable.

Data collection and analysis

Based on the research objectives, the interview method with questionnaire (both qualitative and quantitative variables) was applied for relevant and reliable data collection (Goodenough, 1980; Pareek & Rao, 1980). Based on the measurement of variables semi-structural questionnaires with open-ended and close-ended questions were designed. The analysis of data was conducted using SPSS 16.0 software. Descriptive statistics were used for presenting profiles of the respondents, frequency distribution of SES and maternal health-seeking behaviors in both rural and urban communities. Pearson Chi-squire test and Cross-tabulation techniques were also presented to compare and examine the data.

Results

Background of the respondents

The study finds some background information about age of the respondents, age at first child delivery, total family members and types of the families, which were more relevant to comprehend the position of women's status in Bangladesh. Planning for marriage and age at first childbirth are still not a central issue for women of the study area. The present study indicates that most of the respondents were 16-20 years old (34.7%) and the highest proportion of age at first childbirth was between 16-18 years (36.8%). The study also finds that 52.6% of the respondents' family members numbered 3-4 and their family types were nuclear (74.7%).

Table 1: Background information of the respondents in Thakurgaon, Bangladesh.

Variable (N=190)	Frequency	Percent
Age of women		
<16 years	2	1.1
16-20 years	66	34.7
21-25 years	41	21.6
26-30 years	23	12.1
31 years and above	58	30.5
Age at first childbirth		
<16 years	62	32.6
16-18 years	70	36.8
19-21 years	24	12.6
22 and Above years	34	17.9
Total family members		
1-2	24	12.6
3-4	100	52.6
5-6	45	23.7
7 and more	21	11.1
Types of family		
Nuclear	142	74.7
Joint	48	25.3

Source: Field survey 2016

Differences in couple's SES

In order to examine the differences of couples' SES between rural and urban communities in the study, settings, education, occupation and monthly income were measured and compared. Education is one of the key indicators of a couple's SES that may influence maternal health care seeking behavior. The data clearly indicate that overall urban couples' educational status was comparatively higher than rural ones. Table 2 shows that most of the rural wives' educational status ranged from 6-10 years (35.79% and 54.73% respectively). On the other hand most of the urban husbands and wives had at least 6-10 years of education (43.15%) and 30.52% respectively).The following table shows that agriculture and its related work was the main occupation of rural husbands (48.42%) while government or private service was the major occupational status of urban husbands (36.84%). Table 2 also shows that most of the rural and urban wives were housewives (84.21% and 75.79% respectively). The study shows (see Table 2) that average monthly income of the urban couples (11000 BDT and above, 32.63%) was higher than the rural ones (<2000 and 2000-5000 BDT, 47.37%).

Results of the Pearson Chi-squire test suggest that these frequency distributions for the couples' education, occupation and family income status for both rural and urban were significantly different at X^2 =35.83 (.000) for husband's education and X^2 =30.18 (.000) for the wife's education; X^2 = 90.56 (.000) and X^2 = 105.95 (.000) differences for husband occupation and monthly family income, respectively at $p<0.05$ and $p<0.01$ level.

Table 2: Results of Chi-squire test of SES by rural and urban communities in Thakurgaon District, Bangladesh.

SES *(N=95 for rural, 95 for urban)*	**Rural**		**Urban**		**X^2**
husband's education	F	Percent	F	Percent	
no education	24	25.26	5	5.26	35.83*
1-5 years	32	33.69	18	18.94	*(.000)*
6-10 years	34	35.79	41	43.15	
11-12 years	1	1.05	8	8.42	
13 & above years	4	4.21	23	24.21	
education of wives					
No Education	13	13.69	10	10.52	
1-5 years	29	30.52	30	31.58	30.18*
6-10 years	52	54.73	29	30.52	*(.000)*
11-12 years	1	1.05	15	15.79	
13 &above years	0	-	11	11.58	
husband's occupation					
service	6	6.31	35	36.84	
agriculture	46	48.42	6	6.31	90.56*
small business	4	4.21	28	29.48	*(.000)*
day laboring	33	34.73	8	8.42	

rickshaw/van puller	3	3.15	10	10.52	
others	3	3.15	8	8.42	
occupation of wives					
service	3	3.15	16	16.84	
home making job	80	84.21	72	75.79	14.19*
small business	0	-	2	2.10	*(.003)*
day laboring	12	12.63	5	5.26	
family income (Bangladesh Taka)					
<2000	45	47.37	1	1.05	
2000-5000	45	47.37	25	26.31	105.95*
5000-8000	4	4.21	25	26.31	*(.000)*
8000-11000	1	1.05	14	14.73	
11000>	0	-	31	32.63	

Source: Field survey 2016

Differences in maternal health-seeking behavior

Medical check-ups are one of the most important needs of a pregnant mother. Table 3 shows that most of the rural women did not have medical check-ups during their pregnancy (47.37%). This study indicates that 73.69% of the respondents gave birth to their last child at home (either at parent's house or husbands' house) in rural areas while in urban settings, 38.94% of respondents gave birth to their last child at home. Normally, according to the Bangladeshi culture, for the first delivery, women go to a parent's house and the mother makes the decision about how the delivery will proceed. Besides, distance of health facilities, financial conditions, lack of knowledge about maternal mortality and non-cooperation behaviors of government hospitals, most rural women decided to give birth at home. In general, there is a lack of trained birth attendants in rural Bangladesh. The data shows that 26.31% respondents were assisted by trained birth attendants such as a doctor/nurse, while 68.42% were assisted by a traditional birth attendant (TBA) in rural areas. Due to tradition, lack of knowledge about safe motherhood, financial conditions and gender norms most of the rural women had to give birth at home by a TBA. On the other hand, 54.73% were assisted by a specialist doctor or nurse and 33.69% by TBA in urban areas. Results of Pearson Chi-squire test suggest that the frequency distributions of medical check-up, place of child birth and birth attendant were significantly different between rural and urban women ($X^2 = 50.17$, p= .000; $X^2 = 26.05$, p= .000; $X^2 = 22.94$, p= .000) at $p<0.01$ and $p<0.05$ level).

Table 3: Results of Chi-squire test for maternal health-seeking behaviors (medical check-up during pregnancy, place of childbirth and birth attendant) by rural and urban areas in Thakurgaon District, Bangladesh.

N= (rural= 95, urban=95)	Rural		Urban		X^2
	F	Percent	F	Percent	
Medical check-up during pregnancy					
No checkup	45	47.37	19	20.00	
1-2 times	38	40.00	17	17.89	50.17*
3-4 times	10	10.52	42	44.21	*(.000)*
5-6 times	2	2.1	17	17.9	
Place of childbirth					
At home	71	74.7	37	38.94	
Govt. hospital	14	14.73	27	28.42	26.05*
Private clinic/hospital	10	10.52	31	32.63	*(.000)*
Birth attendant					
Doctor/nurse	25	26.31	52	54.73	
SBA/CSBA/FWV	5	5.26	11	11.58	22.94*
TBA	65	68.42	32	33.69	*(.005)*

Source: Field survey 2016

Cross-tabulation result between couples' SES and Maternal Health-seeking Behavior

Cross-tabulation results on maternal health-seeking behaviors (e.g., medical check-up during pregnancy period, place of childbirth and birth attendant) varies in association with couples' SES (e.g., education, occupation and income) in Thakurgaon District, Bangladesh (Table 4). The table indicates that, both in rural and urban communities, the low rate of maternal health-seeking behavior (e.g., no check-up during pregnancy period, birth at home, and TBA) was higher among the husbands with illiteracy (15.3%), wives only engaged in home-making jobs (80%) and the couples earning less than BDT 2000 (24.2%) in a month.

Table 4: Cross-tabulation result between couple's SES and maternal health-seeking behavior

N= 190, Percent (%)	***Women's Health-seeking Behavior***									
Socioeconomic Status	Medical Check-up During Pregnancy				Place of Childbirth			Birth Attendant		
Education of Husbands	*No check-up*	*1-2 times*	*3-4 times*	*5- 6 times*	*Home*	*Govt.Hos*	*Private Clin*	*Doctor/ Nurse*	*SBA/CSBA /FWV*	*TBA*
No Education	6.3	5.3	3.7	-	11.6	2.1	1.6	3.2	.5	11.6
Primary	11.1	6.3	8.4	.5	17.4	4.2	4.7	8.4	1.6	16.3
Secondary	12.6	15.3	8.9	2.6	23.2	10.0	6.3	14.7	4.2	20.5
Higher Secondary	1.1	1.1	4.7	5.8	2.1	1.6	1.1	2.6	1.1	4.7
Higher Education	2.6	1.1	4.7	5.8	2.6	3.7	7.9	11.6	1.1	1.6
Education of Wives										
No Education	7.4	1.1	3.7	-	8.9	2.6	.5	3.2	-	8.9
Primary	12.1	9.5	8.4	1.1	18.9	6.3	5.8	10.5	2.6	17.9
Secondary	13.2	17.9	9.5	2.1	26.3	8.9	7.4	15.3	5.3	22.1
Higher Secondary	1.1	.5	2.6	4.2	2.6	2.1	3.7	5.8	.5	2.1
Higher Education	-	-	3.2	2.6	-	1.6	4.2	5.8	-	-
Occupation of Husbands										
Service (Govt./Private)	4.2	3.7	7.9	5.8	6.8	5.8	8.9	15.3	2.1	4.2
Agricultural Work	8.9	11.1	6.3	1.1	19.5	2.6	5.3	8.9	2.1	16.3
Small Business	2.6	4.2	7.9	2.1	7.4	6.8	2.6	8.4	1.1	7.4
Day laboring	12.6	6.3	2.1	.5	15.8	3.7	2.1	4.7	1.1	15.8
Rickshaw/van puller	1.6	2.6	2.1	.5	3.7	1.6	1.6	1.6	1.6	3.7
Others	3.7	1.1	1.1	3.7	3.7	1.1	1.1	1.6	.5	3.7
Occupation of Wives										
Service (govt./private)	3.7	1.6	2.6	2.1	4.2	1.6	4.2	6.3	-	3.7
Home making jobs	22.6	26.3	23.2	7.9	45.8	18.4	15.8	31.1	7.9	41.1
Small business	-	-	1.1	-	-	-	1.1	1.1	-	-
Day laboring	7.4	1.1	.5	-	6.8	1.6	.5	2.1	.5	6.3
Family Income (BDT monthly)										
<2000	17.4	6.8	-	-	20.5	2.1	1.6	4.2	-	20.0
2000-5000	8.9	15.7	10.0	2.6	23.2	5.8	7.4	10.5	4.7	21.1

5000-8000	1.6	4.7	7.4	1.6	5.8	6.8	2.6	8.9	1.6	4.7
8000-11000	2.6	-	4.7	.5	3.2	2.6	2.1	3.7	1.6	2.6
11000 and above	3.2	2.6	5.3	5.3	4.2	4.2	7.9	13.2	.5	2.6

Source: Field survey 2016

Discussion

Patterns of maternal health-seeking behavior in relation with the couples' SES is an important discourse in Bangladesh. According to current research reports, such behavior is associated with low SES, gender inequality, patriarch and negative attitudes of health facilitators. There are significant policy-implications as a result and a need for proper evaluation for couples. Couples living in poverty and disadvantaged situations, especially lower SES, are always busy maintaining their livelihoods, and they cannot spend needful money and time during pregnancy, childbirth and the postpartum period. As a result, most of the women, especially in rural areas, are reluctant to pursue medical check-ups and treatment during pregnancy, childbirth and after delivery.

The overall results suggested that differences in maternal health-seeking behavior in relation with couples' SES was a major influential factor among the women in both rural and urban areas of Thakurgaon district, Bangladesh. The results of the frequency distribution suggest that the SES of rural couples was comparatively lower than urban couples. Hence, this study supports the previous study of the Bangladesh Demographic and Health Survey 2014 showing that there are sharp differences of SES between urban and rural people in Bangladesh.

Data indicate that the rate of illiteracy was higher in rural sites than in the urban areas (rural: for husbands 25.26% and for wives 13.69%; urban: for husbands 5.26% and for wives 10.52%). The main occupation in rural sites for husbands is agriculture and its related work (48.42%) and homemaking for wives (84.21%) compared to 36.84% urban husbands in services and 75.79% wives in homemaking. It is interesting to note that most of the wives in both rural areas and urban sites were engaged in home-making activities. According to income, most rural couples (47.37%) earn less than BDT 2000 per month compared to 1.05% in urban areas. Data also indicates that 47.37% rural women did not have medical check-ups during pregnancy, 73.69% gave birth at home and 68.42% used a traditional birth attendant (TBA) compared to 20.0%, 38.94% and 33.69% in the urban community, respectively. A body of previous studies indicated that maternal health-seeking behaviors have a strong connection with family or couples' socioeconomic status (education, occupation, and income) and show that mothers from higher SES backgrounds enjoy better maternal health services than mothers from lower SES backgrounds (Hossain & Ilias, 2016; Akter, 2012; Hoang, Le & Kilpatrick, 2011).

In addition, the result of cross-tabulation analysis indicates that both in rural and urban communities, the low rate of maternal health-seeking behavior (e.g., no check-up, birth at home, and TBA) was higher among the husbands with illiteracy, wives only engaged in home-making jobs, and the couple earning less than BDT 2000 in a month.

The findings of the present study may be useful for both integrating and rethinking constructs that would allow for an improvement in health-seeking behaviors of women in Bangladesh. Regarding this, the government of Bangladesh needs to create income generating opportunities for both men and women, especially for rural women, so they can fulfill their daily needs and also bear the costs of treatment. Besides, governmental and non-governmental organizations need to create special programs for poor and deprived couples to ensure safe motherhood.

Conclusion

The present study finds that SES has a strong connection with women's healthcare-seeking behaviors in both rural and urban areas. The study also finds SES of rural couples was comparatively worse than urban couples. In turn, maternal healthcare-seeking behavior among rural women is extremely low (fewer medical check-ups, childbirth at home, and traditional birth attendant). These results are also supported by several researches abroad and in

Bangladesh.

The researcher hopes that the present study contributes to the field of health-seeking behaviors for women, to enhance maternal health facilities by improving their socioeconomic status. This research contributes valuable insights about how to change the present situation and offers policymakers suggestions for rethinking maternal health policies. Further research is essential to fully understand the implications of gender as a social determinant of health, particularly as an influential factor in shaping maternal health-seeking behavior in Bangladesh.

Recommendations

Based on the findings, the study recommends some strategies and interventions to improve maternal health services as well as health care seeking behaviors among women, especially in rural areas. The following action plans are recommended at governmental policy, implementation and community levels.

Governmental policy level	***Implementation level***	***Community level***
● The government should establish adequate services, low cost and corruption free quality health care services.	● The Ministry of Health and Family Welfare of Bangladesh can form a tracking and monitoring system for pregnant women throughout pregnancy to ensure safe motherhood.	● Community level awareness campaigns and maternal education should be conducted to upgrade the knowledge and perception of both man and woman about reproductive health issues.
● The government should create income-generating activities for rural women as they can earn money to bear treatment costs during pregnancy and daily life.	● The Ministry of Health and Family Welfare of Bangladesh should improve the quality of maternal health services by providing essential equipment and instruments.	● A strong women network group should be established to empower of women as well as ensuring safe motherhood.
● The government should adopt equity approach to ensure maternal health care services between rural and urban areas.	● The Ministry of Health and Family Welfare of Bangladesh can form a train health staff for maternal health services only.	

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