

GLOBAL JOURNAL OF ENGINEERING SCIENCE AND RESEARCHES WOMEN EMPOWERMENT & ITS IMPACT ON HEALTH STATUS IN BIHAR

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ABSTRACT

Empowering women is an important subject to achieve targets for the sustainable development goals of Bihar. There are several indicators to measure the empowerment of women. Health seeking information is one of the most important indicators in this regard. This study aims at identifying the levels and patterns of women empowerment in relation to health seeking behaviour in Bihar. A total of 45812 women were included in this study. NFHS -4 (National Family Health Survey) data was used for this study. The main emphasis of this study is towards the empowerment of women in terms of Health status and work. The major finding shows that 77.2 % of women were married and 20.2% were never in Union. 84.7% of women were currently working and 15.3% were not working. 86.7% women belong to rural and 13.3% belong to urban. In terms of Decision making of women there were some variables identified like Decision making in terms of spending money, Decision making in terms of health care, For household purchases etc. For analysing the empowerment through Healthcare Prenatal and Antenatal care were utilised also knowledge of Family Planning and methods were considered for this study. Cross tabulation has been performed to showcase the variation of variables by taking different set of variables. The result of this study showed that seeking health information empowered women to promote their self-confidence, filter the information, manage life problems successfully, feel strength against health problems and disabilities, and be encouraged to seek more information.

Keywords: Women empowerment, Decision making, Education, Family planning.

I. INTRODUCTION

A woman's health is her total well-being, not determined solely by biological factors and reproduction, but also by effects of work load, nutrition, stress, war and migration. Women's health issues have attained higher international visibility and renewed political commitment in recent decades. While targeted policies and programs have enabled women to lead healthier lives, significant gender-based health disparities remain in many countries. With limited access to education or employment, high illiteracy rates and increasing poverty levels are making health improvements for women exceedingly difficult. The health of families and communities are tied to the health of women the illness or death of a woman has serious and far-reaching consequences for the health of her children, family and community. Nearly all maternal deaths are preventable through timely prenatal and postnatal care, skilled birth attendance during delivery and the availability of emergency care to deal with complications. Women's health then is about all health issues that affect women. Women's health is about recognising the diversity of women's lives and the diversity that exists among women. Key principles are encouraging women to take control of their bodies (based on a full range of information and access to appropriate health care), education, collaborative decision making between women and their health care providers (with women deciding for themselves what happens to their bodies), and a social model of health (that takes account of more than just body parts and recognises the context of women's lives, e.g. the influence of social factors such as housing and employment on health and well-being). Women's health is based on an all-encompassing view of health whereby, "health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity and has as its starting point personally-defined needs rather than professionally-defined needs.(Kim Johnstone 2001) When talking about why we need women's health, one of the common issues raised is that 'things have changed' and 'it's not like that anymore' ('that' being a situation where women's interests are not taken into account). Indeed, much has changed over the past 20 or so years. Medical power has been, and continues to be, challenged. The over-medicalisation of women's lives is discussed openly in the media and women often refuse certain treatments and seek alternatives.(J. 1996) But we should not forget that the kind of evidence available today about differences between women and men and being able to question the things that we do today are only possible because of 25 years of women's health advocacy, research and services.(D. 1995) Women health is the gender inequality issue but then there are others which also

include the poor healthcare system of the country. Factors are malnutrition, which not only affects the health of the women but also the infants they give birth too (Vydehi n.d.). The health benefits of spacing and limiting births for mothers and children with family planning services are well known. (globalhealth 2012) Of course, all nation states embarking on path of development after Second World War, especially those adopting planned development, did emphasize importance of health and education, but none actually succeeded in ensuring universal healthcare. Roll back of state, cut back on non-plan expenditure and entry of private sector into public space became either limited or costly for a majority of population of India. Health equity concerns not only with health seen in isolation, but it incorporates the larger issues of fairness and justice in social arrangements including economic allocations and paying appropriate attention to the role of human life and freedom from illness and premature death (A. Sen 2002). Earlier the social and economic condition, that act as a setting factor which make people ill and in need of medical care, was thought to be the important determinant of health of the population and medical care was thought to act as a prolonger of survival and improve prognosis after disease (Wilkinson R 2003). According to WHO research, analysing data from 1952 to 1992, income growth is less important for improving health outcomes than the other factors such as access to health technology (Bloom E. David 2001). Access to healthcare services on the one hand is determined by socio-economic differential and on the other hand by public resources. However, socio-economic differences also affect the access to the resources (Mukherjee AN 2008). Therefore, the question is whether presence of appropriate public resources reduces the socio-economic disparity in access to healthcare? If yes, then what are those favourable conditions? These questions have not been addressed by the researcher and academicians. There are studies which have partially touched these issues, like effect of place of residence, poverty, income inequality, employment level or racial profile on access to health (Pickett 2001). It is widely accepted that good provisioning of public health services are key to improving health outcomes in both the developed and developing worlds (Gupta D Monica 2010). For example, the provision of public health services by Japan reduced population's exposure to disease, helped raise labour force productivity and life expectancy, despite lack of rise in the wages and consumption (Johansson 1987). So, it is important to look at the interaction between available collective resources and capabilities in production of equal access to health service. The status of women in Bihar is particularly low because of a lethal combination of feudal, caste and patriarchal oppression. There are various programmes and schemes that are operational with differential outreach and impact on the lives of women. Amidst the continued presence of patriarchal norms and structures, gender stereotypes are less resilient to change. There is an urgent need to upgrade the livelihood opportunities for women workers in Bihar. Given the current situation of the labour market, various avenues to increase income and empowerment opportunities for women need to be explored and strengthened.

II. EMPOWERMENT INDICATORS INFLUENCING WOMEN'S HEALTH

Education: Of all the factors that influence a woman's health and success, education is most important factor that influence women's health. educated women play an important role in the birth process itself. Particularly in poor and remote areas, female midwives may be the only health care provider a pregnant woman sees, and this basic level of care can drastically improve the odds of a safe delivery and a healthy baby. (Walker n.d.) Education plays an important role in women's health by providing them knowledge about the health care services and make them aware about their need for better health care. Educated women are likely to get more aware about their health care. The relationship between education and health is not a one-way street. Girls' health, particularly sexual and reproductive health, is an important issue for their education. Often, girls' sexual and reproductive health problems are related to stigma and discrimination, further creating ostracism in and outside of school. (Gaoshan 2014). Many studies have shown the benefits that education has for girls and women. The studies link education with reduced child and maternal deaths, improved child health, and lower fertility (UNESCO 2010). Women with at least some formal education are more likely than uneducated women to use contraception, marry later, have fewer children, and be better informed on the nutritional and other needs of children (Behrman 2007). Education helps women control how many children they have. Increasing access to education improves maternal health. Increasing girl's education has positive effects on infant and child health. Education decreases a girl's or women's risk for contracting HIV. Education boosts women's earning power (Bureau 2011).

Occupation and work: It provides opportunities to build self-esteem and confidence in women's decision making also, gives social support for otherwise isolated individuals and brings experiences that enhance life satisfaction (Glorian Sorensen 1987). There are both positive and negative impact of occupation on women's health. Women those are working are categorised as self-dependent and they are financially more secured. Working women are more confident and updated about the world. they are more credible about their work. They are more aware about their health care and discover new ways of dealing with the health issues. As women have become more assimilated into the workforce over recent decades, they have realized considerable changes in their work roles which may contribute to health problems and other negative outcomes such as maternal health and other health problems (MD 2008). If the health benefits of employment are due in part to increased income and social support, then one might hypothesize that employment would have a more beneficial effect on health for unmarried women, who do not have a husband as an alternative source of income or social support (Waldron 1989). A number of studies have examined the differential effects that various types of jobs have on the health of employed women. It is important to note that health differences related to occupation may reflect the effects of differences in job characteristics or the effects of differences in the personal characteristics and home situations of women who work in different occupations (Detre 1987).

Decision Making: Women's decision making power plays a significant role in determining maternal health. There is a link between women's decision making and their maternal health services. Women's decision making power has a relationship with the maternal health. Empowering women and increasing their ability to make decisions may increase their uptake of maternal health services (Xiaohui Hou 2012). Studies suggest women's decision making increases the use of ANC and delivery in health facilities. Participation in household decision-making, a common measure used in studies of use of maternal health services, could also be considered a measure of psychological empowerment, although it might also reflect economic and socio-cultural empowerment (Ilene S Speizer 2015). Decision-making power was positively and significantly associated with a range of Maternal Health outcomes: antenatal and postnatal care visits (Afulani 2017). Particularly in patriarchal societies, the health status of women and children suffer especially where women have little control over family finances, little say in decision making and restricted freedom of movement (Taukobong 2016). Education, employment and age are also found to be associated with the level of decision-making power (Shaikh Waqas Hammed 2014). Decision-making capability of women affects healthcare utilisation through various pathways. women's abilities to control earnings and influence household decision-making particularly about healthcare are positive predictors for maternal healthcare utilisation (Edward Kwabena Ameyaw 2016).

Though the life expectancy of females at birth is more than men – 68.2 years for men and 73.2 years for women, in India, however, the life expectancy for both sexes is the same, and yet, there are many reasons as to why women die sooner due to neglect over the years. Women's Health is linked to the status of women in society and the culture that brews within this structure. There are a lot of health issues that mushroom from the socio-economic scenario. There are Women's Health issues that women face which include breast cancer, ovarian cancer, menopause, and others but there are a few health conditions that we tend to ignore or overlook that are killing our women. The Indian society is obsessed with a male child, and hence, women are often forced to get pregnant often for want of a son. Poverty, illiteracy, and superstitions play an essential role in determining the health of a woman. It is estimated that 16% of the population in the rural areas stay more than 10kms away from any medical facilities. Lack of knowledge about dietary pattern during pregnancy and breastfeeding stages is crucial, but in most cases, the women are not aware or ignorant towards maternal and reproductive health. Violence against women is also a health problem, but it is sadly not considered one and ignored. Every five minutes a violent crime is reported against women in India. This is a serious issue because it depletes a woman's emotional and physical strength. (Pharmeasy n.d.)

III. REVIEW OF LITERATURE

Empowerment is a multi-dimensional process which should enable the individuals or a group of individuals to realise their full identity, as well as, powers in all knowledge and resources, greater autonomy in decision-making to enable them to have greater ability to plan their lives to have greater control over the circumstances, which influence their lives and free them from the shackles imposed on them by traditional customs, beliefs and practices.

Empowerment is a self-generating and multi-dimensional process, where involving activity for advancement of women in different fields of life such as economic, political and social empowerment can be considered a change in the context of woman's and man's life that enables her/him increased capacity to lead a human life, characterised by external quality related to health, education, awareness, status and security. During the independence movement, women were visible and active as nationalists, and as symbols of Mother India. Gandhi, in particular, was instrumental in creating space for women through his non-violence mode of protest. The inclusion of women in the nationalist movement was also to debunk the British colonial assertion of needing to save the poor, vulnerable women of pre independence India. As in many nationalist movements, women in India took part in the struggle, in turn propelling a women's rights movement. And, as seen historically in many post-colonial countries, the nationalist women's movement in India was confronted by the rebuilding of a patriarchal nationalist state. Women revolutionaries gave way to their male counterparts who created strong new India. In 1976 the Committee on the status of Women in India was established and published a report recommending an increase in elected women at the grassroots level, which led to the introduction of the 33.30 reservation at the Panchayat level in 1988. It was only in 1993 that an amendment in the constitution made the proposed reservation at the Panchayat a reality.(Mishra 2009). In the last two decades since the reservation for women in elected Panchayat was passed, many studies have been conducted to look at the impact of this policy. A survey conducted in 2008 yielded that women made up close to 500 of all the village councils across the India. The number of women representatives has certainly increased at the grassroots level; however, questions still remain regarding their decision making power within the councils. A study of MIT and IMS Calcutta found that where women Panchayat members were active, there were more robust programs on water, irrigation, and infrastructure. The study conclusively states that in Panchayats where women were absent. A study by The Accountability Initiative also states that in Panchayats with female presidents, the participation of women in the larger council rose closer to 30 in one year. (S. Sen 2000). Women's empowerment in India is heavily dependent on many different variables that include geographical location (urban/rural), educational status, health, economic opportunities and gender-based violence. If we talk about Bihar, the impact of patriarchal structure can be seen in the rural and urban Bihar, although women's empowerment in rural Bihar is much less visible than in the urban areas. This is of particular concern, since much of Bihar is rural despite the high rate of urbanization and expansion of cities. Rural women, as opposed to women in urban setting, face inequality at much higher rates, and in all spheres of life(Domestic violence act (2005) n.d.). Urban women and, in particular, urban educated women enjoy relatively higher access to economic opportunities, health and education, and experience less domestic violence. Women who have some level of education have higher decision making power in the household and the community. Furthermore, the level of women's education also has a direct implication on material mortality rates, and nutrition and health indicators among children(NFHS n.d.). Among rural women there are further divisions that hinder women's empowerment. The most notable ones are education levels and caste and class divisions. Women from lower castes are particularly vulnerable to maternal mortality and infant mortality. They are often unable to access health and educational services, lack decision making power, and face violence. (measurehds n.d.). As a result of a vibrant women's movement in the last 50 years, policies to advance human rights for women in Bihar are substantial and forward thinking, such as the Domestic Violence Act (2005), and 73rd and 74th Amendments to the Constitution that provide reservations for women to enter politics at the Panchayat level. There are multiple national and state level governmental and non-governmental mechanisms such as the women's commission to advance these policies, and the implementation of these policies is decentralized to state and district-level authorities and organizations that include local non – governmental organizations(Behl n.d.).

India is one of the world's fastest growing economies, with women mainly from the middle class increasingly entering the workforce. In Bihar, women's economic opportunities remain restricted by social, cultural and religious barriers. Most notably inheritance laws embedded in Hindu and Shariat civil codes continue to marginalize women in the household and the larger community. Rural women, have the lowest literacy rates, and therefore do not have the capacity to negotiate pay or contracts and most often engage in the unorganized sector, self-employment, or in small scale industry. Self help groups are widely practised model for social and economic mobility by NGOs and the government. (IBID n.d.). Bihar's economy has allowed for many women to enter the workforce, and while poor and rural women have little access to education and training, there is a high demand for domestic workers in urban cities. Domestic workers are mostly illiterate, with little or no negotiating power for wage equity, and are highly vulnerable to exploitation and humiliation. Women are also very visible in the construction sector in Bihar, and like domestic

workers are largely unorganized and rely on daily wagers. Women construction workers are mostly poor and illiterate and have little negotiating power. This sector is also unregulated and highly vulnerable to exploitation. Women workers also earn significantly less than men, although women are the ones who do most of the backbreaking work like carrying bricks and other heavy materials on site. (Articlebase n.d.) Empowerment IS a multi-dimensional process which should enable the individuals or a group of individuals to realise their full identity, as well as, powers in all knowledge and resources, greater autonomy in decision-making to enable them to have greater ability to plan their lives to have greater control over the circumstances, which influence their lives and free them from the shackles imposed on them by traditional customs, beliefs and practices.(Rani 2014). Women empowerment and economic development are closely related, in one direction, development alone can play a major role in driving down inequality between men and women; in the other direction, empowering women may benefit development(Duflo 2012). Women's empowerment expands the freedom of choice action to shape women's lives. Women empowerment is considered as a necessary condition for development, although it is not a sufficient condition. Women empowerment has several dimensional focuses and envisages greater access to knowledge, social and economic resources, and greater participation in economic and political decision-making processes. It seeks change in the sexual division of labour, equal access to food, healthcare, education, employment opportunities, owner-ship of land and other assets, and access to the media. Evidences show that women lag behind men in many aspects of development such as educational attainment, employment, social and political power, and exposure to the media(Md. Nazmul Hasan 2011).

Need for study in Bihar

Bihar is more than twice densely populated than the country as a whole, but has one of the lowest urbanisation; its per capita income was nearly half of the national average and about one third of Haryana and Punjab. Bihar has the fourth highest concentration of poverty among the states. In terms of literacy rates too Bihar stand at the bottom in comparison to other major fifteen states. It has lowest life expectancy (60) compared to the India average 65 years. Similarly profiling the health sector all the indicators of health achievement like Infant mortality rates, life expectancy, nutritional attainment, women's health it ranked at the bottom among the major fifteen states. However, in last several years, there has been progress on several indicators such as the overall decline in childhood mortality, maternal mortality and preventive diseases. Still Bihar is backward as compared to even some of the least developed countries. Therefore, the sheer population pressure and poor development status in Bihar leads to huge discrepancy in all the sectors in general and women's health in particular. The health outcomes across regions and districts with a few districts reflect a cluster of poor inputs and equally poor output. Outcome indicators and therefore also reflecting the regional disparity in the state. The per capita expenditure on health is among the lowest across states and has stagnated in real terms over the last decade and a half. Bihar is one such state which characterises all the features and pattern of inequality in its most glaring form. Given such a gloomy situation of the state in general and health sector in particular there were very few studies on Bihar. Some of the studies which are there mainly focused on the state level analysis that too in terms of general unequal distribution in the entire sectors i.e. education, health, income and employment etc. Bihar, the third most populous state in India, has recorded the highest decadal growth during the nineties and around 40% of its population is below poverty line. The major health and demographic indicators of the State like infant mortality rate, maternal mortality ratio, total fertility rate, etc. are much higher than the all India level and reflect a poor health status in the State. Amongst the major States, the Human Development Index in Bihar has been the lowest for the last three decades. In Bihar, there are substantial gaps in sub-centres, primary health centres, and a very large gap in community health centres along with shortage of manpower, drugs and equipment's necessary for Primary Health Care and woefully inadequate training facilities. Other factors affecting the health status include: very high fertility rate; low level of institutional deliveries and a high level of maternal deaths; very low coverage of full immunization; low level of female literacy; and poor status of family planning programme. The above indicators that has been used in this study can provide a better picture in terms of empowerment of women and impact on health status.

Socio Economic condition

Bihar is the second largest state in India with respect of population and eleventh largest in area. It supports 8.8 per cent of country's population with only 2.8 per cent of land mass. The state experienced unprecedented socio-economic changes during last decade. Among major states of the country, Bihar recorded the highest growth in

population (25%) and population density (1102 /sq.km.) during the last decade. It is the least literate state (64%) in the country but girl's enrolment in school increased by more than two fold during last four years (K.M. Singh 2012). Presently Bihar is the least urbanised state of India, Bihar, in terms of levels of output, has been one of the smallest among all the major states in India. Not only in terms of economic output, but also in terms of almost each and every indicator of relevance, the Human Development Index, access to infrastructure, healthcare, education, law and order, the gap between Bihar and India's achievements have been so large (Kumari 2014). Women are considered as back bone of economy. Women conditions started deteriorated mainly after the early Vedic era & became worsened in later Vedic area. These were continued till the mid nineteenth century. After that gathering started for women's rights & all those related issues like equality, voting rights etc. people are little bit more conventional & society is very unacceptable to any change. Conditions have been improved since past. Male child are prioritised here over girl child in most of the aspects of life like in education, freedom etc.(Pramila prasad 2009). Bihar is one state which bears high population pressure along with very low social and economic development. It has a very high birth rate and low life expectancy at birth among the major fifteen states of India. Bihar is performing poorly not only in demographic indicators but also in all indicators

of development. It has the highest concentration of poor across the Indian states. Its per capita expenditure on health is amongst the lowest across states in India. There are only few studies focusing on Bihar regarding health sector. Studies in health economics mainly look at health services only and none has seen utilization of health services in relation to availability, affordability, acceptability and utilization of health services. Health is intrinsically and instrumentally important. Now it is well accepted that any development programme is incomplete if it fails to improve health standard of any country. The question of empowerment of women with respect to Health status in Bihar has not received adequate attention in the development literature. Of course, there are some studies for India, but this issue has not been examined either in context of interaction between demand and supply or at a much disaggregated sub national level. Moreover, its linkages with health are absolutely un – researched one. Bihar is one state which has very critical role in terms of shaping overall development outcome of India, which is in itself in a very poor shape. It is often said that India cannot develop by ignoring Bihar. Least known about status of women and also determinants of health of women of Bihar, despite it being one of the crucial state of NRHM. Therefore, a study attempts to showcase the attempts by carrying out this exercise for Bihar at a disaggregate level.

Research Question

The present study is an attempt to explore the status of women in Bihar especially in terms of empowerment with respect to their health and work. Thus the explicit research questions answered in this piece of work are as follows-

- What explains empowerment of women in Bihar?
- How women empowerment is associated with health status?
- What is the health status of women in Bihar? How do they access health care?

Source of data

Data from 45,812 women aged 15-49 years residing in Bihar state of India who participated in the NFHS – 4. Bihar is spread up to an area of 94,163 sq. km. and a population of 103.8 million. There are nine divisions, 38 districts, 101 subdivisions, 533 blocks and 45,098 villages. It has population density of 1102 per sq. km. (as against the national average of 382). The decadal growth rate of the Bihar is 25.07 (against 17.64 percent for the India). The population of Bihar has been continued to increase as much faster rate than the country rate. This study is purely based on secondary data source. This study has been based on the data set of NFHS – 4 (Bihar).

Variable used

Antenatal Care (ANC), Prenatal Care (PNC) to strengthen reproductive and child health care. ANC provided by different sources like Government and Private sources has been analysed. Awareness of health scheme and programmes among currently working women and educated and uneducated women has been analysed.

IV. METHODOLOGY

The community based cross sectional study was conducted on women of Bihar which includes selected indicators like Health status of women, currently working women, Awareness among women, Educational status. This study is based on the secondary data source as named above. For calculating and analysing data, following methods has been used:

- The data has been coded into different sets and on account of which the responses has been calculated;
- The multiple response has been taken from the samples of the desired research questions. The percentages has been used to show the multiple responses;
- Cross tabulation has been performed by using the SPSS analytical software to show the variations among different variables;
- Empowerment of women is assessed by integrating with Health and Work variables.
- Basic information about respondent

Finding and Interpretations

Table 1.

Type of place of resident		%
Urban	6096	13.3
Rural	39716	86.7
Age of Respondent		
15-25		30.2
25-35		44.2
35-49		25.5
Respondent currently working		
No		84.7
Yes		15.3
Current marital status		
Never in Union		20.2
Married		77.2
Widowed		2.1
Divorced		0.10
No longer living together/separated		0.4
Respondent's Occupation		
Not in work force/no occupation		13
Professional/ technical		0.3
Clerical		0.1
Sales		0.1
Agriculture		1.8
Services/household		0.4
Manual/skilled/unskilled		0.4
Don't know		19.4

Bihar with a population of 104 million is the second most populous state in India, next only to Uttar Pradesh. Despite efforts in the last few decades to stabilize population growth, the state's population continues to grow at a much faster rate than the national population in terms of decennial growth. The state is densely populated with 880 persons per square kilometre. In this study the main emphasis has been given towards the women of Bihar and their status of Health. The above table 1 is showing the basic information about the respondents. From the table the findings is coming out to be clear that there are 13.3 % are Urban and 86.7% are Rural residents. Also, 44.2 % lies

in the age group of 25-35 years and 25.5% are in the range of 35-49 years. In the case of marital status, there are 77.2% married and 20.2 % never in Union. And, findings on occupation shows that 13% are not in the workforce and 3.1 % are currently working. These information brings light towards the current status of women in terms of Occupation which is very low. The participation of women in the work is very low in Bihar. The result shows that only 3.1 % of women are currently working and in which more are in the agricultural segments and less are skilled. This shows that most of the women are not literate and that is why they are not in some professional jobs also due to less educational attainment they are not skilled and only agricultural jobs are left in their hands.

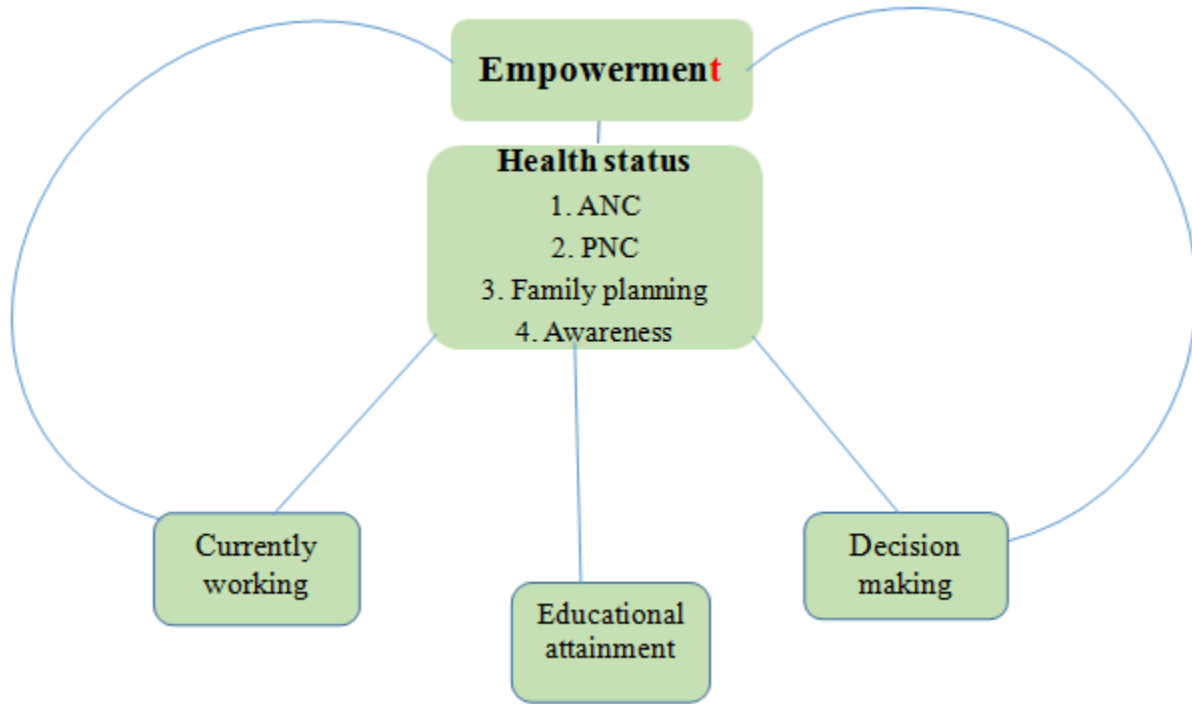


Figure 1: Women empowerment and health status linkages

1. Assessing Health with Educational attainment of women

Educational attainment in Prenatal care (multiple response)

Table 1. a.

G o v e r n m e n t C e n t r e	Prenatal Care	Educational Attainment			%
		No Education	Primary	Secondary	
	Doctor	19	30.7	46.2	70.7
	Dai/Traditional	1	0.7	0.7	0.6
	Anm/nurse	25.1	27.7	31	29.3
	Community centre	0.6	0.5	0.3	0.3
	Anganwadi/icds	8.5	9	6.6	2.3
	Asha	5.2	4.8	3.4	0.8

	Private Centres	0.1	0.1	0.2	0.1
Private	By no one	51.3	40.6	28.3	12
No One					

The finding of the study has been broken down into three categories on the basis of which all the analysis has been showcased. The above hierarchy is showing the indicators which has been considered for this study. The centre point of this study is Health of women and how health of women has a relationship and how much relationship with the other different indicators such as Occupation of women, Educational attainment and Decision making. Table 1. a. shows the Prenatal care and Educational attainment of women. The main aim is to find out how Prenatal care related to Educational attainment of women. Shows the multiple response of the women in the table. There are categories of Public facilities like Government centres and Private centres where women usually go or prefer to go most. The crosstabulation result is showing that 59.4% of Uneducated women prefer Government centres for Prenatal care. Whereas, 73.4% of women who choose government centres have done their primary level of education. On the other hand, 88.2% of women go to government centres have their secondary education. And, rest are higher educated. In case of Private education, the picture is different and only 0.1% to 0.2 % prefer this option for Prenatal care.

Status of Antenatal care in terms of educational attainment of women

Table 1. b.

Antenatal Care %	Educational attainment			
	% No education	primary	secondary	higher
Respondent's Home	18.4	16.3	16.3	13.5
Govt./municipal hosptl.	6.5	6	7.1	6.3
Govt. dispensary	0.8	1.1	0.4	0.4
Anganwadi/icds	36.6	29.3	19.7	7.1
Other public facility	0.3	0.3	0.3	0.9
Private health centres	23.4	35.8	44.9	64.2

Table 1. b. shows the antenatal care preference of women in terms of educational attainment. The results shows that there are 62.6% women prefer the government/public services and 23.4% prefer Private facilities who don't have Education. Following that 53% of women prefer government/public facilities and 35.8% like to go to private centres are Primary educated. Whereas, 43.8% women go to government facilities and 44.9% go to private centres are secondary educated. While in higher education 28.2% go to government centres and 64.2% go to private centres for Antenatal care. This clarifies that women who are not educated accessing public hospital due to reasons like low cost of treatment and trust. Whereas, women who are literate and know about that are quite low in terms of going for checkups in government centres.

Table 1. c.

		Educational attainment			
		%			
		No education	Primary	Secondary	Higher
method type	No method	75.6	78.2	83.5	83.5
	Traditional	0.5	0.5	0.7	2.0
	Modern	23.9	21.3	15.8	14.5
Total		100.0	100.0	100.0	100.0

Table 1. c. shows the variation of use of family planning method among educated and uneducated women in Bihar. There are different categories in the method of family planning like traditional, modern and no method. The results shows that 23.9% of not educated women uses modern family planning method and 0.5% are using traditional method. 21.3% women who are primary educated uses modern method and 0.5% uses traditional method. 15.8% women who are secondary educated uses modern method and 0.7% uses traditional method. Whereas, 14.5% women who are higher educated uses modern method and 2 % uses traditional method of family planning. This contradicts the expectation that compared to low educated women with more education using less family planning method.

Awareness about health problems/disease and Role of Educational attainment

Table 1. d.

Awareness		Educational attainment			%
		No education	Primary	Secondary	
Ever heard of a sexually transmitted infection (STI)	No	66.9	51.7	37.7	9.5
	Yes	33.2	48.3	62.3	90.5
Heard of Tuberculosis	No	23.2	15.7		6.6
	Yes	76.8	84.3	11.2	93.4
Ever heard of AIDS	No	71.6	57		10.7
	Yes	28.4	43	40.5	89.3
				59.5	

Ever heard of HIV	No	78.3	64.1	48.2	14.9
	Yes	21.7	35.9	51.8	85.1

Table 1. d. shows the results of awareness among women about diseases and health issues with respect to their educational level. In this category few diseases like Sexually transmitted disease, Tuberculosis, AIDS and Ovulatory knowledge has been considered with the educational attainment of women. For, sexually transmitted infection only 33.2% women knows that and they are not educated. 48.3% primary educated women knows about sexually transmitted infection. 62.3% of secondary educated women knows about sexually transmitted infection. 90.5% of women who are highly educated knows about sexually transmitted infection. On the other hand, 76.8% of women who are not educated heard of tuberculosis and 84.3% primary educated women knows about that and 88.8% secondary educated women knows about tuberculosis and only 93.4% highly educated women heard of tuberculosis. Asking about AIDS, 28.4% of women who are not educated knows about AIDS. 43% of primary educated women knows about the same. 59.5% of secondary educated women knows about AIDS. And, 89.3% of highly educated women knows about AIDS. When asked about HIV 21.7% not educated women having heard of that, 35.9% women who are primary educated heard of HIV, 51.8% secondary educated women heard of HIV, and 85.1% highly educated women heard of HIV. This trend shows that educated women are more aware about these diseases, this shows that how education opens the door of awareness among women. There were less number of women who were highly educated but large number of women were only primary educated and in between they left education. There may be reasons like they got married or their family don't want them to go for studying. Therefore, as the women is illiterate they become unaware about the health issues and as they get education they tend to grab knowledge also.

Awareness of programs and schemes in terms of education and currently working women

		Educational attainment			
		%			
Health Insurance type	No education	Primary	Secondary	Higher	
	a. Central government health scheme	No	99.4	99.6	99.6
	Yes	0.6	0.4	0.4	0.8
b. Rashtriya swasthya Bima Yojana	No	92.1	92.7	94.7	96.7
	Yes	7.9	7.3	5.3	3.3
c. State Insurance scheme	No	99.5	99.6	99.6	99.6
	Yes	0.5	0.4	99.7	0.4
				0.3	

d. Private mode	No	99.2	99.1		98.8
	Yes		0.9	99.3	1.2
		0.8		0.7	
1. Know programme in this area that give loans to women to start or expand a business	No	No education	Primary	Secondary	Higher
	No	72.7	67.4	67.1	59.3
	Yes	27.3	32.6	32.9	40.7
2. Has bank/saving account	No	75.5	74.8	70.6	49.3
	Yes	24.5	25.2	29.4	50.7
3. Has mobile phone	No	65.5	57.4	57.5	31.6
	Yes	34.5	42.6	42.5	68.4
		Educational attainment %			
		No education	Primary	Secondary	Higher
Covered by health insurance	No	90.7	91.3	93.6	92.1
	Yes	9.3	8.7	6.4	7.9

Table 1. e. shows the awareness of health schemes and programs among women on the basis of their educational attainment. The result shows that 9.3% women are covered by health insurance are not educated also 90.7% not educated women are not covered by health insurance. In terms of literacy 8.7% Primary educated, 6.4% secondary educated and 7.9% highly educated women are covered by health insurance. On the other hand, the distribution of Health insurance type shows some more details about the number of using different methods of insurance. Women who are not educated having 0.6% pursuing central government health insurance and 0.5% not educated women prefer state insurance type. 0.8% not educated women prefer private mode of insurance. Considering educated (primary, secondary and higher) women, there are 0.4% primary educated, 0.4% secondary and 0.8% highly educated women prefer Central government insurance scheme. In terms of state insurance type the mean of educated (primary, secondary, higher) is 0.36% prefer this option. And, 0.93% women prefer private insurance mode. Moving on to the awareness programs like how many women know about program which give loans to women and how many women have bank account and how many women use mobile phone. The result shows that 27.3% not educated women know about loan programs and mean of educated (primary, secondary and highly) educated women know about loan programs is 35.4%. There are 24.5% of not educated women have bank account and mean of educated (primary, secondary and highly) women have bank account is 35.1%. Considering mobile phone, 34.5% not educated women have mobile phone and mean of educated (primary, secondary and highly) educated women have mobile phone as their medium of communication is 51.16%. This finding shows that women who are literate is more aware in comparison with not educated women. This shows that literacy plays a crucial role in making women aware

2. Assessing Health with Currently working women
Prenatal and working women (multiple response)

Table 2. a.

Prenatal Care %	Respondent currently working %	
	Not working	Working
Doctor	32.40	24.20
Dai/Traditional	0.9	0
Community centre	0.4	1.4
Anganwadi/icds	7.5	10.4
Asha	4.3	3.6
Anm/nurse	28.1	26.9
Private Centre	0.1	0
No One	40.2	45.3

Table 2. a. show the distribution of currently working and not working women in terms of Prenatal care. The result shows that 32.4% not working women go to doctor and 24.2% working women go to doctor. 0.9% not working women go to dai. 0.4% not working women and 10.4% working women go to anganwadi centres. 4.3% not working women and 3.6% working women go to Asha. 28.1% not working women and 26.9% working women go to anm/nurse. 0.1% not working women and 0% working women go to private centres. About 40.2% not working women don't go to anyone and 45.3% working women don't go to anyone.

Antenatal care among currently working women

Table 2. b.

Antenatal care %	Respondent currently working %	
	Not working	Working
Respondent's Home Yes	15.8	17.1
	84.2	82.9
No		
Govt./municipal hospntl Yes	7.6	6
	92.4	94
No		
Govt. dispensary Yes	0.7	0.5
	99.3	99.5
No		
Anganwadi/icds Yes	26.8	34.2
	73.2	65.8
No		
Other public centres Yes	0.2	0
	99.8	100
No		
Private health centres Yes	39.4	28.6
	60.6	71.4
No		

Table 2. b. shows the Antenatal care among currently working women. The finding shows that 15.8% not working women prefer their home. 7.6% not working women prefer government/municipal centre. 0.7% not working women go to government dispensary. 26.8% not working women go to anganwadi centres. 0.2% not working go to private health centres. Whereas 17.1% working women prefer their home. 6% working women prefer government centre. 0.5% working women prefer government dispensary. 34.2% working women prefer anganwadi centres. And preference of private centres by working women are negligible.

Table 2. c.

%		Not working		Working	
		No	Yes	No	Yes
Currently diabetes	has	No	97.90	98.7	
		Yes	1.8	1.1	
		Don't know	0.3	0.2	
Currently asthma	has	No	97.90	98.8	
		Yes	1.9	1.1	
		Don't know	0.2	0.1	
Currently has heart disease	has	No	97.60	96.3	
		Yes	1.8	3.3	
		Don't know	0.5	0.3	
Currently has cancer	has	No	98.90	99.7	
		Yes	0.9	0.1	
		Don't know	0.3	0.2	
Currently thyroid disorder	has	No	98.60	98.3	
		Yes	1.2	1.6	
		Don't know	0.3	0.2	

Table 2. c. shows the distribution of results of diseases among currently working women. In this table there are few diseases which have been mentioned like Diabetes, Asthma, Heart disease, Cancer and Thyroid disorder. In this response the results have been drawn among the currently working women. There are 97.9 % not working women who don't have diabetes and 1.8% not working women have diabetes. Whereas 98.7% working women don't have diabetes and 1.1% working women have diabetes. About 97.9% not working women who don't have diabetes and 98.8% working women who don't have Asthma. And, 1.9% not working women and 1.1% working women have Asthma. There are 97.6% not working women have heart disease and 96.3% working women don't have heart disease. 1.8% not working women have heart disease and 3.3% working women have heart disease. On the other hand, 98.9% not working women don't have cancer and 99.7% working women don't have cancer. 0.9% not working women has cancer and 0.10% working women has cancer. Also, 98.6% not working women don't have thyroid disorder and 98.3% working women don't have thyroid disorder. About 1.2% not working women has thyroid disorder and 1.6% working women has thyroid disorder. This finding shows that women who are not working has significantly high rate of disease and who are working are quite lower in terms of disease. Among all the four listed disease, there are large percentage of women who are suffering from heart disease. After that asthma is the major problem the women of Bihar are suffering from. This can be due to pollution from household like cooking from traditional ways and outside sources also. One more reason is their inappropriate way of lifestyle and their traditional thinking towards their life as well. And, not getting nutritional food habit is also a reason behind the occurrence of diseases like this. Heart disease and Thyroid is higher among currently working women. Whereas, diabetes and asthma is higher among those who are not working.

Awareness of schemes among currently working women

Table 2. d.

%		Respondent currently working	
		No	Yes
1. Covered by health insurance	No	85.20	14.80
	Yes	79.30	20.70
Health Insurance Type			
a. Central govt. Scheme	No	84.70	15.30
	Yes	85.30	14.70
b. State govt. Scheme	No	84.70	15.30
	Yes	69.60	30.40
c. Rashtriya Swasthya Bima Yojana	No	85.10	14.90
	Yes	79.20	20.80
d. Private Scheme	No	84.70	15.30
	Yes	90	10
2. Has Bank/Savings account	No	86.70	13.30
	Yes	79.40	20.60
3. Has mobile phone	No	84.90	15.10
	Yes	84.20	15.80

Table 2. d. shows the awareness of scheme among currently working women. The finding shows that about 85.2% not working women aren't covered by any health insurance and 79.3% not working women are covered by health insurance. Also, 14.8% working women aren't covered by health insurance, whereas, 20.7% working women are covered by health insurance. Moving on towards the type of health insurance, the finding shows that 85.3% not working women prefer central government schemes and 14.7% working women prefer central government scheme. 69.6% not working women prefer state government scheme and 30.4% working women prefer state government scheme. Whereas, 90% of private scheme has been preferred by not working women, as well as 10% is being preferred by working women. Also, it shows that 79.4% of not working women has Bank account and 20.6% working women has bank account. Also, 84.2% of not working women has mobile phone and 15.8% working women has mobile phone facility.

Family planning and Currently working

Table 2. e.

%		Respondent currently working		%
		No	Yes	
Use of method type	No method	78.2	71.2	77.1
	Traditional method	0.8	1.0	0.8
	Modern method	21.0	27.8	22.0
Total		100.0	100.0	100.0

Table 2. e. shows the distribution of family planning method used by currently working women. There are some categories which are assigned for family planning methods like, Traditional method, modern method. The finding show that 78.2% not working women use no methods and 0.8% not working women uses Traditional method, whereas, 21% not working women use modern method of family planning. On the other hand, 71.2% working women uses no method, 1% uses traditional method whereas 27.8% women uses modern method. This finding shows that women who are working has slightly higher preference of modern method of family planning. Whereas, women who are not working has the slightly lower rate of using modern method of family planning.

4. Assessing Health with Decision making among women
 Prenatal and Decision making (Multiple response)

Table 3. a.

Prenatal%	Person who usually decides how to spend respondent's earnings			
	Respondent alone	Respondent and husband/partner	Husband/partner alone	Someone else
Doctor	26.2	23.4	18	40
Anm/nurse	27.9	32.6	10	20
Community health	1.6	0	2	0
Anganwadi/icds	11.5	9.8	12	0
Asha	4.9	2.2	4	0
No one	44.3	41.8	62	40
Person who usually decides on respondent's health care				
Doctor	31.7	34	25.4	36.3
Anm/nurse	29	28.3	27.9	29.2
Dai/Traditional	0.3	0.9	0.7	0.9
Community health	0.7	0.5	0.6	0
Anganwadi/icds	7.9	8.5	6.6	8
Asha	5.2	4.8	3.1	3.5
Private	0.3	0	0.1	0.9
No one	39.3	38.5	45.5	38.9
Person who usually decides on large household purchases				
Doctor	31.9	34.3	24.5	35.8
Anm/nurse	23.9	28.6	28.6	30.7
Dai/Traditional	0.5	0.9	0.8	0
Community health	0.5	0.5	0.7	0
Anganwadi/icds	6.4	8.6	6.6	9.5
Asha	6.4	4	4.2	4.4
Private	0.5	0.1	0	0.7
No one	43.1	38.8	44.4	38

Table 3. a1

%Prenatal	Has money that respondent alone can decide how to use	
	No	Yes
Doctor	30.3	33.3
Anm/nurse	27.1	29.7
Dai/Traditional	0.9	0.4
Community health	0.4	0.7
Anganwadi/icds	7.7	8.3
Asha	4.3	4
Private	0.1	0.1
No one	42.3	38.1

Table 3. a2

% Prenatal	Usually allowed to go to the market		
	Not at all	Alone	With someone else only
Doctor	33.4	28.7	33.1
Anm/nurse	23.1	28.9	29.1
Dai/Traditional	0.6	1	0.5
Community health	0.2	0.6	0.5
Anganwadi/icds	4	8.8	8.5
Asha	2.9	4.1	4.7
Private	0.2	0.2	0
No one	45	41.7	38.4

Table 3. a. shows the distribution of different categories of decision making indicators and relationship with the health indicators among women of Bihar. The distribution shows that relationship of person who usually decides how to spend respondent’s earnings with prenatal care. The finding shows that 26.2% to doctor, 27.9% to anm/nurse, 1.6% to community health, 11.5% to anganwadi, 4.9% to asha and 44.3% to no one are taking the decision to go these places solely by their own decision. By husband/partner alone the percentages are 18% to doctor, 10% to anm/nurse, 12% to anganwadi, 4% to asha and 62% to no one respectively. The second decision making variable is Person who usually decides on respondent’s health care with the Prenatal care. The result shows that 31.7% to doctor, 29% to anm/nurse, 0.3% to dai/traditional, 0.7% to community health, 7.9% to anganwadi, 5.2% to asha, 0.3% to private and 39.3% to no one is decided by the respondent alone to go to these places. On the other hand, 25.4% to doctor, 27.9% to anm/nurse, 0.7% to dai/traditional, 0.6% to community health, 6.6% to anganwadi, 3.1% to asha, 0.1% to private and 45.5% to no one is decided by the Husband/partner of the respondent alone. from Table 3. a1, The other variable of decision making is, has money that respondent alone can decide how to use with the prenatal. The finding shows that respondent who alone decide how to use the money alone are 33.3% go to doctor, 29.7% go to anm, 0.4% to traditional, 8.3% to anganwadi, and 0.1% prefer private centres for prenatal care. Moving on to the other decision making variable that is, is respondent usually allowed to go to market? The finding shows that respondent who are not at all allowed to go has 33.4% to doctor, 23.1% to anm, 0.6% to traditional, 0.2% to community health, 4% to anganwadi, 2.9% to asha, and 0.2 to private centre for the prenatal care. In the category, where the respondent allowed to go to market alone includes 28.7% to doctor, 28.9% to anm, 1% to traditional, 0.6% to community health, 8.8% to anganwadi, 4.1% to asha and 0.2% to private centres for prenatal care. The finding shows that decision making for women is not given so much importance in areas like Bihar. Women alone are not allowed to make decisions about their health also. This clears the picture that still some sorts of patriarchal exists in the areas like Bihar. It can be eradicated by education and awareness among the people.

Table3. a3.

% Prenatal	Usually allowed to go for the health facility		
	Not at all	Alone	With someone else only
Doctor	37.3	29.5	31.1
Anm/nurse	22.7	28.8	28.8
Dai/Traditional	0.8	1.1	0.5
Community health	0	0.7	0.5
Anganwadi/icds	3.5	8.2	8.9
Asha	3.2	3.6	5
Private	0.3	0.1	0.1
No one	41.3	42.2	39.7

Table 3. a3. Shows the respondent usually allowed to go for the health facility. The finding shows that 37.3% visiting doctor, 22.7% visiting anm, 0.8% visiting traditional, 3.5% visiting anganwadi, 3.2% to asha and 0.3% to private are not at all allowed to go for the health facility. In case of Alone, 29.5% to doctor, 28.8% to anm, 1.1% to traditional, 0.7% to community health, 8.2% to anganwadi, 3.6% to asha and 0.1% to private are allowed to go alone.

Antenatal care with Decision making among women

Table 3. b.

Antenatal %	Person who usually decides how to spend respondent's earnings			
	Respondent alone	Respondent and husband/partner	Husband/partner alone	Someone else
Respondent's Home	20.6	16.8	15.8	0
Govt./municipal hosptl	11.8	8.4	10.5	0
Govt. dispensary	0	0.9	0	0
Anganwadi/icds	26.5	34.6	26.3	0
Other public facility	0	0	0	0
Private health centres	32.4	31.8	21.1	90
	Person who usually decides on respondent's health care			
Respondent's Home	18.2	15.9	15.5	14.5
Govt./municipal hosptl	8	8.1	6.4	4.3
Govt. dispensary	0	0.7	1.1	0
Anganwadi/icds	29	27.2	29.3	26.1
Other public facility	0	0.2	0.2	0
Private health centres	34.7	40.6	31.3	49.3
	Person who usually decides on large household purchases			
Respondent's Home	17.8	15.6	16.9	14.1
Govt./municipal hosptl	9.3	8.1	5.7	7.1
Govt. dispensary	0.9	0.8	0.6	0
Anganwadi/icds	21.5	26.6	32.2	25.9
Other public facility	0	0.2	0.2	0
Private health centres	30.8	42	28.6	49.4

Table 3. b. shows the distribution of decision making in terms of antenatal care. The result shows that respondent who decides alone prefer antenatal at home are 20.6%, 11.6% to government hospital, 26.5% to anganwadi, 32.4% to private centres. Considering husband alone shows that 15.8% to their home, 10.5% to government hospital, 26.3% to anganwadi, 21.1% to private centres. The other variable of decision making is person who usually decides on respondent's health care shows that 18.2% to doctor, 8% to government, 29% to anganwadi, 34.7% to private centres are decided by respondent alone. Whereas, 15.5% to their home, 6.4% to government, 1.1% to dispensary(govt.), 31.3% to private centres is decided by Husband alone for antenatal care. Person who usually decides on large household purchases includes 17.8% to their home, 9.3% to government, 21.5% to anganwadi, 30.8% to private centres are decided by respondent alone for antenatal care. Whereas, 16.9% to their home, 5.7% to government, 32.2% to anganwadi, 28.6% to private centres are decided by husband of respondent alone.

Number of Antenatal visits during pregnancy with Decision making
 3. c. Table

% ANC visits	Person who usually decides on respondent's health				
	Respondent alone	Respondent and Husband/partner	Husband/partner alone	Someone else	Other
No. of Antenatal visits during pregnancy					
0 No visits	39.3	38.6	45.5	38.9	39.4
1 – 5	54.1	54.3	49.2	54.9	51.5
6 – 10	6.3	6.9	4.5	6.2	7.5
More than 10	0	0.1	0.5	0	0
Don't know	0.3	0.1	0.2	0	1.6

Table 3. c. shows the number of antenatal visit in terms of decision making. Person who usually decides on respondent's health has been taken into consideration for this variable. The finding shows that 39.3% no visits are decided by respondent alone. 54.1% are visiting 1 to 5 times are decided by respondent alone. 6 to 10 visits are having only 6.3% which are decided by respondent alone. on the other hand 45.5% of no visits are decided by husband/partner alone, 1 to 5 number of visits are 49.2% which are decided by husband/partner alone. 4.5% of 6 to 10 times is decided by husband alone for antenatal visits. This result shows that still patriarchy is holding its grip among deciding health care of women in Bihar.

Family planning and Decision making

Table 3. d.

% use by method type		Person who usually decides on respondent's health					%
		Respondent alone	Respondent and husband/partner	Husband/partner alone	Someone else	Other	
	No method	70.5	67.2	75.6	82.5	87.0	
	Traditional method	0.8	1.5	0.5	1.6		
	Modern method	28.7	31.4	23.9	15.8	13.0	
Total		100.0	100.0	100.0	100.0	100.0	

Table 3. d. shows the distribution of method of family planning with respect to the decision making among women of Bihar. The finding shows that 70.5% no method is decided by respondent alone. 0.8% traditional method is decided by respondent alone. 28.7% modern method is decided by respondent alone. 75.6% of no method is decided by husband/partner alone, 0.5% traditional method is decided by husband alone, 23.9% of modern method is decided by husband alone. This finding shows that still husband play a dominant role in deciding which method to use in family planning. Which means that patriarchy still exists in deciding family planning also.

V. CONCLUSION

The study concluded that though the situation of women in Bihar is needs a lot of improvement, there is scope for upgradation in the areas of decision making, education, health and opportunities as well. Better education, opportunities for employment and a shift in the attitude of society in general towards women will lead to their empowerment. Education of women should be made national priority. Women work play an important role in accessing health care services. Currently working women accessing family planning services higher than those who are not working. This indicates women's work as an indicator of Empowerment is positively influencing in utilisation of health care services. Men often ignore women's issues. Empowerment of women will go a long way in improving the health and quality of life of women and families and will lead to accelerated development of our society. This study based on beyond the individual factors and searched the effects of community and regional level factors on the utilization of maternal health services. An urban area was consistently associated with an increased likelihood of the utilization of maternal health services. Sufficient amount of variation at community of residence and region of residence on each of the mentioned indicators of the utilization of maternal health services. There was a large significant variation in utilization of ANC services and PNC services has been observed. The usage of maternal health services revealed interesting outcomes in affecting factors. The findings also showed that literacy affects the utilization of health services of women. Therefore, promoting women's education will yield greater outcome in increasing the health of women. There is a need to focus on vulnerable section of the community and regional interventions. There is a need of future investigation of those determinants that account the unexplained community and regional variations in the usage of maternal health. Long-term and sustained improvements in women's health require rectification of the inequalities and disadvantages that women and girls face in education and economic opportunity. Several positive actions can be taken to reduce these inequalities and empower women. For education, these include making schooling more affordable by reducing costs and offering targeted scholarships, building secondary schools close to where girls live, and making schools girl-friendly. Additionally, the content, quality, and relevance of education must be improved through curriculum reform, teacher training, and other actions aimed at transforming attitudes, beliefs, and gender-biased social norms that perpetuate discrimination and inequality. For enhancement of economic opportunity, governments need to guarantee women effective and independent property and inheritance rights, especially to land and housing, both in law and in practice. Because gender inequality is deeply rooted in entrenched attitudes, societal institutions, and market forces, political commitment at the highest international and national levels is needed to institute these policies and to allocate the resources necessary for gender equality and women's empowerment to improve female health.

REFERENCES

1. Afulani, Patience. 2017. "Conceptualizing pathways linking women's empowerment and prematurity in developing countries." *BMC Pregnancy and Childbirth*.
2. n.d. *Articlebase*.
<http://www.articlesbase.com/careersRarticles/attitudeRofRcorporateRindiaRtowardsRworkingRwomenR>.
3. Behl, Monisha. n.d. "Women suffer most: Armed conflict and women's right." *North East Network*.
4. Behrman, Jere. 2007. "What determines Post School Skills." *World Development Report*.
5. Bloom E. David, P River, Frang K. 2001. "Social technology and human health." *Human Development Report*.
6. Bureau, Population Reference. 2011. "Girls education fact sheet." *Population Reference Bureau*.
7. D., Broom. 1995. "Generating health, sexing illness, challenging society for women's health." *Australian Government Publishing Service*.
8. Detre, K. M., Feinleib, M., Matthews. 1987. "The Federal women's study." *N.I.H workshop, New York*.
9. n.d. "Domestic violence act (2005)." *DLHS*.
10. Duflo, Esther. 2012. "Women Empowerment and economic development." *Journal of Economic Literature*
11. Edward Kwabena Ameyaw, Augustine tanle, Kwaku Kissah, Joshua Amo. 2016. "Women's Health Decision Making Autonomy and Skilled Birth in Ghana." *International Journal of reproductive Medicine*.
12. Gaoshan, Junjian. 2014. "Why is Girls's education important for Public Health?" *United Nations Population Fund*.

13. globalhealth. 2012. Kerala women. <http://keralawomen.gov.in/index.php/health/190-the-importance-of-women-s-health>.
14. Glorian Sorensen, Lois M. Verbrugge. 1987. "Women, Work, and Health." *Annual Review Public Health* .
15. Gupta D Monica, B R Desikchari, Rajendra Shukla, T V somanathan, kk Datta. 2010. "How might India's Public Health Systems be Strengthened?" *Economic and Political Weekly*.
16. IBID. n.d. "IBID." MIT.
17. Ilene S Speizer, Peter Lance, Ravi Verma. 2015. "Descriptive study of the role of household type in UP, India." *US National Library of Medicine, National Institute of Health*.
18. J., Astbury. 1996. "the making of women's madness." *Oxford university press*.
19. Johansson, Sheila Ryan and Carl Mosk. 1987. "Exposure, Resistance and Life Expectancy: Disease and Death During the Economic Development of Japan." *Population Studies*.
20. K.M. Singh, R.K.P. Singh, Abhay Kumar. 2012. "Dimensions of Rural Poverty in Bihar." *Munich Personal RePEc Archive*.
21. Kim Johnstone, Sarah Brown, Marilyn Beaumont. 2001. "Why women's health?" *Women's Health Victoria*.
22. Kumari, Reena. 2014. "Development and Disparity in Bihar." *Journal of Regional Development and Planning*.
23. MD, Dwenda Gjerdingen. 2008. "Women's Work Roles and their Impact on Health." *Taylor & Francis Online*.
24. Md. Nazmul Hasan, M Sheikh Giash Uddin. 2011. "Women empowerment through health seeking behaviour in Bangladesh." *South East Asia Journal of Public Health* .
25. n.d. [measurehds. http://www.measuredhs.com/pubs/pdf/FRIND3/14Chapter14.pdf](http://www.measuredhs.com/pubs/pdf/FRIND3/14Chapter14.pdf).
26. Mishra, Vandita. 2009. "New Lok Sabha will have most women MPs ever." *May* .
27. Mukherjee AN, Karmakar K. 2008. "Untreated Morbidity and Demand for Health care in India." *Economic and Political weekly*.
28. NFHS. n.d. NFHS. <http://www.measuredhs.com/>.
29. Pharmeasy. n.d. Health of women. <https://www.google.co.in/url?sa=t&rct=j&q=&esrc=s&source=web&cd=8&cad=rja&uact=8&ved=2ahUKEwikze-a5KTgAhVMWisKHc4zBEYQFjAHegQIBRAB&url=https%3A%2F%2Fpharmeasy.in%2Fblog%2Fwhat-is-killing-our-womens-health%2F&usq=AOvVaw00Ilt-S0nvkTs00HqdHz0L>.
30. Pickett, K. E and M. Pearl. 2001. "Multilevel analyses of neighbourhood socioeconomic context and health outcomes ." *Journal of Epidemiology and Community health* 111-122.
31. Pramila prasad, mamta kumari, A.K. Poddar. 2009. "A study on socio-economic status, health and hygiene of rural women of Godda ." *Asian Journal of Home Science* .
32. Rani, Asha. 2014. "Empowerment of women in rural Bihar." *Indian Journal of Public Administration*.
33. Sen, Amartya. 2002. "Why Health Equity ." *Health Econ.* 659-666.
34. Sen, Samita. 2000. "Towards a feminist politics? Historical perspective." *Poverty Reduction and Economic Management Network*.
35. Shaikh Waqas Hammed, Syeed Khurram Azmat, Moazzam Ali. 2014. "Women's empowerment and contraceptive Use." *PLoS ONE*.
36. Taukobong, Hannh F.G. 2016. "Does addressing gender inequalities and empowering women and girls improve health and development ." *Health Policy and Planning*.
37. UNESCO. 2010. "Education Counts: Towards the Millennium Development Goals ." *UNESCO*.
38. Vydehi. n.d. "Women Health in India." *Institute of medical sciences & research centre*.
39. Waldron, I., & Jacobs, J. A. 1989. "Effects of Labour force participation on women's health." *Journal of Occupational Medicine*.
40. Walker, Dilys. n.d. "What factor influences women's health most?" *Big think*.
41. Wilkinson R, Marmot M (Ed.). 2003. "Social Determinants of Health ." *International Centre for Health and Society, WHO*.
42. Xiaohui Hou, Ning Ma. 2012. "The effect of women's decision making power on maternal health." *World Bank*.