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Impact of socioeconomic status on reproductive behavior among Bangladeshi women

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IMPACT OF SOCIOECONOMIC STATUS ON REPRODUCTIVE BEHAVIOR AMONG BANGLADESHI WOMEN

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Abstract

Sexual and reproductive health-related illness is a matter of concern in developing countries like Bangladesh. It mostly affects women because of their unawareness, lack of knowledge, and poor socioeconomic status. In poor communities and developing countries, another important risk factor for death and disability is unsafe sex. Proper family planning and healthy sexual and reproductive life can reduce mortality and morbidity of both children and mothers. Improvements in women's socioeconomic status can increase awareness and knowledge about sexual and reproductive life and reduce health-related problems and death. Therefore, this study will examine the impact of socioeconomic status (educational attainment, working status, and wealth index) on reproductive behavior (use of condoms, use of pills, and sexual decision-making) among Bangladeshi women. I analyzed data from the 2014 Bangladesh Demographic and Health Survey, a nationally representative survey of ever-married women ages 15–49 years old. I have analyzed data through multivariate logistic analysis. Results show that women's use of condoms as contraception is significantly associated with their level of education, as higher-educated women are 19.82 times more likely to use condoms than women with no education. The richest women are about 12 times as likely to use condoms as the poorest women. Currently, working women are 19% more ok to refuse sex than women who are not working. The richest women are more than twice as likely to feel it is okay to refuse sex than the poorest women. The results are attenuated but remain significant even when controlling for women's age, place of residence, and media exposure.

Keywords: Socioeconomic status, Women, Reproductive behavior, Bangladesh, Demographic and Health Survey

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Introduction

Bangladesh is a developing country with the highest population density in the world. Its total fertility rate declined from more than six children per woman in 1980 to 1.98 in 2020 (Division 2019). Bangladeshi women live in a patriarchal society, and most of them are economically dependent on the male members of their families. Educational and employment opportunities are increasing among women in Bangladesh, and their socioeconomic status is now being upgraded. Women are now more conscious of their life in the family as well as outside because of the increasing level of education and employment status. The participation of women in the labor force increased in the past ten years, from 29.7% in 2010 to 34.5% in 2020 (World Bank 2022). Different socioeconomic and cultural factors affect women's decision-making power, health-seeking, and reproductive behavior (Mainuddin et al. 2015). Women's lives are affected by their socioeconomic status, and it's an opportunity to study how their reproductive behavior changed as their status has changed in society.

Proper family planning and healthy sexual and reproductive life can reduce the mortality and morbidity of both children and mothers (Hossain et al. 2018). The use of contraception is one of the significant factors of reproductive behavior, and a high contraceptive prevalence rate is expected for controlling birth rates in countries that are experiencing high population growth. The desire for more children is another characteristic of reproduction as it defines family size. Family planning and the use of contraception are necessary for a country like Bangladesh because its large dependent youth population is still one of the major public problems in Bangladesh (Kumar Sarkar, Rahmatullah Imon, and Sarkar 2009). Sexual behavior plays a vital role in the decision of having sexual intercourse, sexual relationships, and healthy sexual behavior (Naved 2013). In Bangladesh,

male domination and sexual violence can have serious consequences on sexual and reproductive health (Fahmida and Doneys 2013).

Increases in women's socioeconomic status (e.g., educational attainment, employment, and wealth) could positively affect their lives and help to maintain healthy sexual life, including proper use of contraception, small family size, sexual decision-making, etc. For example, the current use of contraception is 65.5% among working women and 58.2% among non-working women (Laskar et al. 2006). Exploring women's income-generating activities and reproductive behavior, another study found that working women were three times more empowered than non-working women (Shariful Islam and Mainuddin 2015). Women who received better education have shown lower fertility compared to illiterate women (Islam and Nesa 2009). Educational attainment greatly increased among women of reproduction age in Bangladesh between 1994 and 2014 (Fahmida and Doneys 2013). Female education has direct and indirect effects on fertility by affecting reproductive choices including breastfeeding patterns and contraceptive use (Kundu et al. 2018). Therefore, there might be a change in women's reproductive life. In Bangladesh, reproductive decision-making has been influenced by traditional female roles and women's dependence on men. For example, 18 women out of 30 reported acceptance of their husband's decision of having sex while they didn't want to because of their lack of autonomy and independence from their husband (Naved 2013). Thus, a higher level of education and greater work opportunities for women as well as higher family and socioeconomic status might directly influence decision-making in family life, leading in turn to more effective use of contraception, limited desire for children, and sexual decision-making (Amin, Shah, and Becker 2010).

The purpose of this study is to examine how women's socioeconomic status (e.g., educational level, working status, and wealth index) impacts their reproductive behavior.

Bangladesh provides a unique opportunity to observe how socioeconomic development and fertility change coexist; it is the eighth most populous country in the world and has experienced a dramatic fertility transition in recent decades. I use 2014 Bangladesh Demographic and Health Survey (BDHS) data for this study. A total of 17,863 women of reproductive age were included in the sample. I took the current use of contraception preference of women, their desire to have children, use of birth control pills, and use of condoms as dependent variables to test the hypothesis. I also test whether confounding factors like age, women's reading of newspapers, and exposures to media are influential factors in their private life. The detailed description and analysis of the current survey data will be helpful to identify women's empowerment, reproductive life, and current fertility in the country.

Background and Significance

Traditional Status of Women in Bangladesh

Women in Bangladesh face inequality in every sector of their professional and personal lives. Women's education, careers, female empowerment, and male domination work as important factors in this situation. In Bangladesh, inequality between men and women persists throughout society. In the past, girls and women were considered reproductive tools of society, and they were encouraged to do only household activities. So, they were active in household work, but they had limited individual socioeconomic status or identity outside the home. Thus, they were largely dependent on their husbands and their socioeconomic status. In the case of family planning and sexual behavior, women had no choice. They were required to do what their husbands wanted. This was the common scenario for Bangladeshi married women of reproductive age.

Female Education

Education is fundamental to human development, enhancing the quality of life and bringing a wide range of benefits for both individuals and society (Salahuddin 2019). Education is essential for empowering women because it closes the gap between men and women in respect of socioeconomic opportunities. It has significant effects on women's reproductive health. Educated women choose to have fewer children, keep themselves and their children healthier, and are more likely to educate their children (Akhter n.d.). Educated women have lower fertility and use more maternal health care, and their children have better health outcomes than those less-educated women (Hahn, Nuzhat, and Yang 2018). Previous studies revealed a positive association between educational attainment and empowerment (Kundu et al. 2018;Axinn and Barber 2001). One study from Bangladesh showed that secondary educated women were 35% more likely to seek their healthcare and 57% more likely to seek their child's healthcare than less-educated women (Kabir et al. 2017). Laskar and colleagues show that women's education has a significant impact on their child health care, purchasing household items, and daily food items (Laskar et al. 2009). Authors of another study found an association between women's status and fertility by examining the realities of matrimonial Garo women in Bangladesh (Laila and Dey 2020). The educational attainment of women is increasing as women in Bangladesh are now more educated than in the past. In 2020, the ratio of women to men in tertiary education in Bangladesh was approximately 77 women for every 100 men enrolled in tertiary (post-secondary) education in Bangladesh (United Nations 2022). This is a tremendous improvement in gender parity since 1970 when only 11 Bangladeshi women were in tertiary education for every 100 men (World Bank 2021).

Women Employment

Women's participation in the workplace and leadership in political and social areas provides further evidence of their independent decision-making power. The income of women outside their husband's income contributes to their autonomy in the family (Anderson and Eswaran 2009). If women achieved a higher degree of education and become employed, the empowerment of households, healthcare, and independent decision-making is likely to be increased gradually (Yasmin et al. 2016). Women who earn an independent income and contribute to family support and those who have cash are less vulnerable to the threat of abandonment and less fearful of the repercussion of contraceptives (Ruth Schuler, Mesbahuddin Hashemi, and Riley 1997). Female labor force participation is increasing in Bangladesh, from 28.8% in 2005 to 32.08% in 2014. More educated women are joining the labor force. They are more independent in their decision-making both in their professional and personal life. They are no longer dependent on their husband's socioeconomic status as they are now stable socioeconomically.

Reproductive Health

According to the World Health Organization (WHO),

> "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health implies that people can have a satisfying and safe sex life and that they can reproduce and have the freedom to decide if, when, and how often to do so." (WHO n.d.)

In the world's poor communities and the developing world, the second most important risk factor for death and disability is unsafe sex (Glasier et al. 2006). Women in Bangladesh have high risk factors for sexual and reproductive behavior (Howlader et al. 2022). Family planning and an understanding of reproductive behavior are needed for Bangladesh to eradicate health-related problems (Shariful Islam and Mainuddin 2015). Women's socioeconomic status is significantly

associated with their desire for children, and educated women desire fewer children than uneducated women (Akram et al. 2020). Since healthy sexual and reproductive behavior has a great advantage for parents and children, the use of contraception is one of the key components of reproductive life, and it can help stave off the poor health of mothers and children (Hossain et al. 2018).

Women's Socioeconomic Status and Reproductive Health

Women's reproductive behaviors in Bangladesh are changing day by day in line with their present socioeconomic status. Family planning, use of contraception, use of oral pills, and other methods of family planning, and the desired number of children are factors influenced by women's educational levels, job status, wealth index, and media exposure. Muhammed and colleagues (Muhammed et al. 2017) showed education and employment status were positively associated with health when controlling for wealth index and age of respondent, region, and religion.

Contraceptive use is one of the most important behaviors in sexual and reproductive life, and several social factors determine access to and use of contraception. The use of contraception varies by place of residence, socioeconomic status, religious status, demographic characteristics, and husband-wife relationship. Researchers have explored the socioeconomic, demographic, and other factors that affect the use of contraception among currently married women of reproductive age. The prevalence of contraceptive use by currently married women is 62.4% (Hossain et al. 2018). They found that the prevalence of contraception use varied across administrative divisions, with a higher prevalence of contraceptive use in urban areas (65.9%) compared with rural areas (62.1%). Muslim women are less likely to use contraception (61.7%) than non-Muslim women (69.4%). A woman's age played a vital role in contraceptive use. Women who are 20–24 years old

use contraceptives more than any other age group. Although women's education had shown no significant association with contraceptive use, employment status had an important relationship. An employed woman had a 26% higher chance of using contraception than an unemployed woman. This study examined many of the possible factors that influence contraception use. It found a significant relationship between women's demographic and socioeconomic status and contraceptive use.

The reproductive behavior of women changes according to their income and working status. Contraceptive use among income-generating women was 56% compared with 40.1% among non-participants (Shariful Islam and Mainuddin 2015). The authors' objective of this study was to find out the association between income generating activities of women and their reproductive behavior. Results showed that working women were three times more empowered than non-working women. The use of contraceptives was significantly higher among working women (73.4%) than non-working women. There was no significant relationship between the husband's education and the use of contraceptives. Using contraceptives was 5.6 times higher among working women than non-working women. This study shows that women's involvement in income-generating activities increases empowerment and reduces fertility. They found an association between women's income and reproductive behavior. But a major limitation of this study is it covered a small area of the country (a district) rather than being nationally representative.

Women's education and working status are associated with health-care-seeking behavior. Mainuddin and colleagues found a relationship between women's empowerment and health-seeking behavior in Bangladesh (Mainuddin et al. 2015). Multivariate regression analysis revealed that the husband's education was no longer significantly associated with women's empowerment in mobility to shop alone. Different socioeconomic and cultural factors affect women's mobility

and decision-making patterns. This study shows women's empowerment has positive effects on their choice of health care. One limitation of this study is they investigated one district. Also, the did not consider a full array of other variables for women's empowerment – working status, wealth index, and media access.

Women's sexual and reproductive health is affected by their socioeconomic status. Self-care empowerment is one of the prerequisites for preventing unsafe sexual behavior which can lead to sexually transmitted infections (STI) (Al et al. 2022). These researchers examined the association between women's empowerment and symptoms of STI among currently married women of reproductive age in Bangladesh. They explored the association between women's empowerment and report of STI. Three indicators were significantly associated with genital sores: women's employment status, participation in healthcare decision-making, and women's acceptance of domestic violence. The results show a significant relationship between indicators of women's empowerment and their likelihood of reporting STI. Women who actively participated in joint decision-making with their husbands or partners regarding their family's health care were significantly less likely to report STI. This relationship indicates that women's socioeconomic status influences their reproductive and sexual behavior. Women who have never had any formal education had a higher likelihood of high-risk fertility behavior. The reason for this could be that having no formal education impacts work status and leads to lower income and dependence, all of which affect reproductive life. Women who have higher socioeconomic status and better education are more mindful of sexual and reproductive life and have lower rates of high-risk fertility behavior.

Education of women is the driving factor behind the significant decline in fertility in Bangladesh from 1980–2014 (Bora et al. 2022). In this article, the authors were searching for the

causes of fertility decline in Bangladesh and the effect of female education and family planning programs on the fertility rate. The result of multi-level regression analysis found that the education of females is a more significant driver of the decline in fertility than the family planning indicators.

Bangladesh, an interesting context for studying reproductive behavior of women

Bangladesh is one of the densely populated countries in the world. There are prominent changes of socioeconomic status and fertility decline in Bangladesh. For example, the female literacy rate has increased from 41.8% to 55.7% from 2001 to 2011 (M. Salahuddin 2019). There is a significant association between women's participation of income generating activities and their increasing level of contraceptive use.(Ruhul Amin 1995). Ruhul Amin and others in this article found that after 1980, women involved in credit based programs of various non-government organizations and that created socioeconomic changes and increased use of contraceptives in women (Ruhul Amin 1995). Bangladesh has become an interesting context for the demographers to study fertility and family planning because of its rapid fertility change (Bora et al. 2022). The fertility decline in the past forty years is very significant as it was 6 children per women in 1980 and it decreased to 2 children per women in 2020 (Division 2019). However, Bangladesh has high risk fertility behaviors like narrow birth intervals, maternal and child death among women from 15-49 years of old and these factors are significantly associated with women's socioeconomic status (Howlader et al. 2022).

Much research has examined women's empowerment and decision-making power, socioeconomic status, and use of contraceptives. But these empowering factors and behavior patterns change continuously. Moreover, reproductive behaviors don't mean a single attitude toward the use of contraception. It's related to the overall attitude of one's sexual behavior: desire

for more children, sexual life, health care, and child care (Kabir et al. 2017). Kabir and colleagues explored the decision-making power of Bangladeshi women of reproductive age. They found women who reside in urban areas, have NGO membership, and are employed were more empowered, ensuring further steps toward attainment of primary education that accelerates the decision-making power of women in Bangladesh. We can present the following hypothesis based on previous literature:

Hypothesis 1: Educated women use more contraceptives than uneducated women.

Women's Educational Attainment, Women's Empowerment, and Use of Contraceptives

Women with at least primary education have more empowerment than women with no education (Khan and Raeside 1997). These authors found that women's level of education has a significant impact on their use of contraceptives. This study focuses on factors affecting the most recent fertility rates in urban-rural Bangladesh. They used the 1989 Bangladesh Fertility Survey. Women with more education and those who engaged in employment were less likely to have children and they use more contraceptives (Haq, Sakib, and Talukder 2017). This article searched for sociodemographic factors for contraceptive use in Bangladeshi women. In terms of household wealth quintiles, the result showed that women from middle-income and rich households were more likely to use contraceptives than poor women, and educated women use more contraceptives. Another article found that contraceptive use is higher among employed women (67%) than among unemployed women (61%) (Islam et al. 2016).

Hypothesis 2: Educated, currently working and wealthy women are more independent in sexual decision-making than uneducated, non-working and poor women.

Employment of Women, Number of Children, and Reproductive Decision Making

In rural Bangladesh, women's participation in credit programs increases contraceptive use (Ruth Schuler et al. 1997). This article focuses on women's empowerment in participating in credit programs and its effect on their contraceptive use. They used qualitative data to describe how credit programs empowered women and how increased income affects their reproductive life. Their analyses suggest that women who earn an independent income and contribute to family support and those who have cash are less vulnerable to the threat of abandonment and less fearful of the repercussion of contraceptive side effects. They have more control over reproductive decisions. Participation in income-generating projects by poor rural women had been associated with their increased level of contraceptive use, decreased level of fertility, elevated level of desire for no children, and enhanced level of empowerment (Ruhul Amin 1995). Traditionally under patriarchy, the male member had decision-making power. In recent times, women's increased participation in income-generating activities increases their self-confidence outside the home and this affects their household decision-making and fertility behavior. Authors seek the influence of contraceptive use on employment status among Bangladeshi women. The result revealed that current contraceptive use among employed women is significantly influenced by their age, education, and the number of children. They used 2011 BDHS data and found that women's employment status significantly affects their contraceptive behavior. But they didn't examine specifically how the empowerment of women – education, employment status, and economic condition impact the reproductive behavior of women. Kabir and colleagues found lower percentages of respondents with NGO affiliation, which is considered an important indicator of empowerment (Kabir et al. 2017). Their study revealed participation in a credit program is positively associated with women's level of empowerment, defined as a function of their relative physical mobility, economic security, and

ability to make purchases free from domination. Although this study revealed empowerment considering women's wealth index, NGO membership, and education, it didn't examine women's attitudes to their sexual life, especially their reproductive behavior.

Much of the literature has examined women's empowerment and use of contraceptives, while other literature has explored women's income and desire for children. But they didn't focus on women's socioeconomic status and reproductive behavior. There are also limitations of data. Some of them analyze data that is now dated, and some other data represent one district of Bangladesh whereas we need to analyze data from the whole country for a recent period of time.

Methodology

Data

This study employed Bangladesh Demographic and Health Survey (BDHS) data from 2014. Bangladesh is divided into seven administrative divisions: Dhaka, Khulna, Chittagong, Rangpur, Barisal, Sylhet, and Rajshahi. The BDHS data used a multi-stage stratified cluster sample where each division was stratified into urban and rural area sampling units. For the survey, enumerated areas (EA) were developed from the 2011 population and housing census of the People's Republic of Bangladesh. Data were collected using questionnaires. The questionnaire was developed in English and then translated into and printed in Bangla. Women respondents were used for this research. From a total of 17,300 households interviewed, 18,245 ever-married women aged 15–49 years were identified, and 17,863 were surveyed.

Variables

The dependent variable in this study is women's reproductive behavior. I have taken the variables women's current use of pills, use of condoms, and when ok to refuse sex as dependent variables. All three variables are dichotomous. For example, women are asked if they are currently using pills as contraception. The variables are recoded as 1 = yes, women are currently using pills and 0 = no, women are not currently using pills. The variables use of condoms and when okay to refuse sex are also dichotomized in a similar way to indicate whether women use a condom or not and whether women can refuse sex if they want.

The key independent variable is women's socioeconomic status, which is measured by three categorical variables: women's education level, current working status, and wealth index. Women's education levels measure if they ever attended schools and have four categories: no education, primary level, secondary level, and higher secondary level of education. Women's current working status indicates whether the respondent worked recently (i.e., was currently working, was on leave from a job in the past 7 days, or worked in the past year). There are four categories for working status: currently working, not working, has a job but on a leave, and worked in the past year. The wealth index refers to the relative wealth of the household women live in. The wealth index is a composite measure of a household's cumulative living standard. The wealth index is calculated using easy-to-use data on a household's ownership of selected assets, such as televisions and bicycles; materials used for housing construction; and types of water access and sanitation facilities. Women are placed into quintiles based on their wealth index: poorest, poorer, middle, richer, and richest. Control variables include three other demographic and socioeconomic factors: women's age, place of residence, and media exposure.

Analytic Approach

For analysis, this study shows descriptive statistics of dependent and independent variables. This study used multivariate logistic regression to see the relationship between independent variables and dichotomous dependent variables. Table 3, 4, and 5 indicate logistic regression between dependent variables and socioeconomic independent variables. To further investigate whether women's reproductive behavior varies by age, place of residence, and wealth index, I used multivariate logistic regression analysis. Table 6 indicates whether and how the result changes when controlling for women's age, place of residence, and wealth index.

Results

Descriptive Statistics

Table 1 shows the percentage distribution of women's sexual and reproductive behavior in Bangladesh. This includes women's use of pills as current fertility preference, use of condoms as current fertility preference, and when okay to refuse sex. Responses are recorded as 25.2 percent of them use pills, 6.2 percent use condoms, and 90.4 percent of them okay to refuse sex when their husband has sexually transmitted infections.

Table 2 shows the percentage distribution of women's socioeconomic status in Bangladesh. Among women from 15-49 years of age, 23.6 percent have no education, 29.3 percent have primary education, 37.6 percent have secondary education, and 9.6 percent of them are from a higher education level. Considering working status, 68.8 percent of them are not currently working, 31.3 percent are currently working. The wealth index of women shows that 18.2 percent of them are in the poorest category, 18.8 percent are poorer, 20.3 percent are middle, 21.1 percent are richer, and 21.6 percent are richest.

Multivariate Analysis

Logistic regression is used to measure the relationship between women's socioeconomic status and reproductive behavior. Results are presented as odds ratio. Table 3 shows the impact of women's socioeconomic status (education level, work status, and wealth index) on the use of pills. Table 4 shows the impact of women's socioeconomic status on their use of condoms. Table 5 shows the impact of women's socioeconomic status on when okay to refuse sex. To see if the relationship between women's socioeconomic status and reproductive behavior changes when controlling for age, place of residence, and media exposure, I used multivariate logistic regression in Table 6. These results are presented through the odds ratio in three nested models.

Table 3 shows the association between women's use of pills and socioeconomic status (education level, work status, and wealth index). Logistic regression was used to show the impact of socioeconomic status on the use of pills, and results are presented as odds ratio. The relationship between women's level of education and the current use of pills is statistically significant. Women with no education is considered as the reference group to show the relationship how women's use of pills changes according to their level of education. Women with a primary level of education are 43% times more likely to use pills than women with no education, and women with a secondary level of education are 85% more likely to use pills than women with no education. Women who have a higher secondary level of education are 36% more likely to use pills than uneducated women. The relationship between women's work status and the use of pills is not statistically significant. Women's wealth index has a significant relationship with the use of pills and the poorest group is the reference group among the five groups- poorest, poorer, middle, richer, richest. The results shows that among five groups (poorest, poorer, middle, richer, richest), the richest

women are 8% less likely to use pills than the poorest group. Women from middle wealth group use 15% more pills than the poorest group. The result indicates the impact of socioeconomic status on women's reproductive behavior is significant.

Table 4 presents a significant association between socioeconomic status and the use of condoms. Women with no education is the reference group among the four groups- no education, primary level, secondary level, higher secondary level of education. Women who have a primary level of education are 2.07 times more likely to use condoms than women with no education. Women with a secondary level of education are 5.55 times more likely to use condoms than women with no education. Women with a higher secondary level of education are 19.82 times more likely to use condoms than women with no education. Women's use of condoms increases in a graded fashion as their level of education increases.

The association between women's work status and the of use condoms shows a significant association. The reference group for the analysis is the women who are not working. The result shows that women who are currently working or doing a paid job are 28% less likely to use condoms than women who are not working. This result shows a negative association between women's use of condoms and their work status. This result is statistically significant. The wealth index of women has a significant impact on their current use of condoms. The reference group among the five wealth groups is the poorest group of women. The result shows that poorer women are 1.41 times more likely to use condoms than poorest group, women from the middle wealthy group are 2.96 times more likely to use condoms than women from the poorest group, women from the richer group are 4.59 times more likely to use condoms than poorest group and women from the richest group are 12.15 times more likely to use condoms than the poorest group.

Table 5 shows that there is a significant relationship between women's socioeconomic status and their independent decision-making. I take the variable 'When okay to refuse sex' when they know their husband has a sexually transmitted infection. Among the four groups, the group-women with no education are the reference group to see the association. The result shows that women with a primary level of education are 1.36 times more likely to feel it's okay to refuse sex than women with no education. Women with secondary level of education are 1.57 times more likely to feel it's okay to refuse sex than women with no education. Women with a higher secondary level of education are 2.05 times more likely to say it's okay to refuse sex than women with no education. This shows that the more women become educated, the more they can make independent decision in their sexual life. Working status of women and the independent decision making in sexual life is positively associated. Women who are not currently working is considered as the reference group to show the association between women's okay to refuse sex and work status. The result shows that women who are working are 19% more likely to feel it's ok to refuse sex than women who are not working. The wealth index of women and when okay to refuse sex is statistically significant. Amon the five wealth groups of women, the poorest group is the reference group. It shows that poorer women are 4% less likely to refuse sex than the poorest group, women from the middle group are 17% times more likely to refuse sex than the poorest group, women from the richer group are 1.38 times more likely to refuse sex than women from poorest group and richest women are 2.35 times more likely to okay to refuse sex than the poorest group.

Table 6 presents the association between women's socioeconomic status (education level, work status, and wealth index) and women's reproductive behavior (use of pills, use of condoms, and when okay to refuse sex) when controlling for age, place of residence, and media exposure. Results are shown as odds ratio in three separate models. The first three models show the

significant relationship between women's use of pills and socioeconomic status when controlling for age, place of residence, and media exposure. Model 1 shows there is a significant impact of women's education level on the use of pills when controlling for age, place of residence, and media exposure. The reference group is the women with no education to see the result. It shows that women with a primary level of education are 1.18 times more likely to use pills than women with no education and women with a secondary level of education are 1.32 more likely to take pills than uneducated women when controlling for age, place of residence, and media exposure. Younger women (ages 15-24 and 25-34) are 4% less likely to take pills than older women (35-49).

There is a positive association between the work status of women and use of pills when controlling for women's age, place of residence, and media exposure. The reference group is the women who are not currently working. Model 2 shows that women who are currently working are 1.14 times more likely to use pills than women who are not working when controlling for age, place of residence, and media exposure. Younger women (15-24 and25-34) are 0.96 times more use pills than 35–49-year-old women. Women who watched TV at least once a week are 1.13 times more likely to take pills than women who didn't watch TV. Model 3 shows the significant relationship between women's wealth index and the use of pills. The poorest group is the reference group to see the relationship. The result indicates richest women are 15% less likely to take pills than the poorest women and poorer women are 12 % more likely to take pills than the poorest group. Again, younger women (15-34) take 0.99 times more pills than older (35-49). Watching tv has a significant impact on taking pills as women who watched tv once a week are 1.19 times more likely to take pills than women who didn't watch tv.

Women's use of condoms and their socioeconomic status has significant association as the analysis shows. Table 6 shows whether the association changes or not if controlling for age, place

of residence, and media exposure. For the relationship between the use of condoms and women's level of education when controlling for age, place of residence, and media exposure, Model 1 shows a statistically significant association. Women with no education is considered the reference group to see the relationship. Women with a primary level are 1.85 times more likely to use condoms than women with no education, women with a secondary level of education use 4.26 times more likely to use condoms, and women with a higher secondary level of education are 12.18 more likely to use condoms than women with no education when control for other variables. Women who live in urban areas are twice as likely to use condoms than women from rural areas. Those who watched tv at least once a week are 66% more likely to use condoms than women who didn't watch TV.

Working status has a significant impact on the use of condoms. Women who are currently not working is considered the reference group to see the relationship. Model 2 shows women who are currently working are 0.80 times more likely to use condoms than non-working women even controlling for age, place of residence, and media exposure. Younger women (15-34) are 3% less likely to use condoms than 35-49-year-old women and those who watched TV once a week are 1.36 times more likely to use condoms than women who didn't watch TV. Considering the place of residence women who live in urban areas are 2.28 times more likely to use condoms than women who live in rural areas.

The wealth index is positively associated with women's use of condoms when controlling for age, place of residence, and media exposure. The poorest group is considered the reference group to see the association. Poorer women are 1.42 times more likely to use condoms than the poorest women, middle group women are 2.62 times more likely to use condoms than poorest women, richer women are 3.54 times more likely to use condoms than the poorest group and richest

women are 8.52 times more likely to use condoms than the poorest group. The result indicates the use of condom increase among women as their wealth index increases even controlling for age, place of residence, and media exposure. Younger women (15-34) are 4% less likely to use condoms than 35–49-year-old women and women from urban areas are 1.50 times more likely to use condoms than women from rural areas. Women who watched TV once a week are 1.27 times more likely to use condoms than those who didn't watch TV at all.

There is a positive association between women's socioeconomic status (education level, work status, and wealth index) and sexual decision-making 'when okay to refuse sex' when controlling for age, place of residence, and media exposure. For examining the association between level of education and okay to refuse sex, women with no education are considered the reference group. Model 1 shows that women with a primary level of education are 1.31 more likely to okay to refuse sex than women with no education, women with a secondary level of education are 1.40 times more okay to refuse sex than women with no education and those who are higher educated are 1.52 times more likely to okay to refuse sex than uneducated women even when controlling for age, place of residence and media exposure. The living place (Rural or Urban) is significantly associated with sexual decision-making as the result shows women from urban areas are 1.54 times more likely to okay refuse sex than rural residents. Media exposure (Watching TV) is positively related to the okay to refuse sex as women who watched TV at least once a week 1.44 times more and women who watched tv at less than once a week are 1.45 times more likely to refuse sex if they want compared to women who didn't watch TV at all.

Working status is positively associated with the okay to refuse sex when controlling for age, place of residence, and media exposure. Women who are currently not working is considered as the reference group to see the relationship. Women who are currently working are 1.23 times

more okay to refuse sex than women who are not working. Women from urban areas are 1.56 times more okay to refuse sex than rural residence women. Women who watch TV once a week are 1.57 times and women who watched tv less than once a week are 1.49 times more likely to refuse sex than women who didn't watch TV at all.

The wealth index of women has a significant association with the okay to refuse sex when controlling for age, place of residence, and media exposure. For the analysis, the poorest group of women is considered as the reference group. The richest women are 1.52 times more likely to refuse sex than the poorest women. Women from urban areas are 1.39 times more likely to okay to refuse sex than women from rural areas. Women who watched TV once a week are 1.41 times and women who watched tv less than once a week are 1.48 times more okay to refuse sex than those who didn't watch TV at all.

Discussion

This study examines the impact of socioeconomic status on reproductive behavior among Bangladeshi women. Though previous studies investigated the socioeconomic status and sexual and reproductive health of Bangladeshi women, they did not examine the impact of socioeconomic status on reproductive behavior such as the use of pills, the use of condoms, and when okay to refuse sex. This study is the first approach to examine how socioeconomic status (education level, work status, and wealth index) impacts the reproductive behavior of Bangladeshi women. In Bangladesh, women's choice of life changes both in public and private life, and this change can occur for various reasons such as progress in education, working status, or wealth index. Currently, women's empowerment and women's independence are important issues across the world and in Bangladesh. Women's contributions are considered a major part of society as well as a necessary

condition for sustainable development. Although Bangladesh is a male-dominated country, women are now more independent than in the past, especially in their intimate life.

Multivariate analysis shows that socioeconomic status has a significant impact on reproductive behavior among Bangladeshi women. The analysis finds that there is a significant association between women's socioeconomic status and reproductive behavior. Tables 3, 4, and 5 show the significant association between women's education level, work status, wealth index, and reproductive behavior. Women who have at least a primary level of education are 1.43–1.85 times more likely to take pills than uneducated women. Women with a higher secondary level of education are 19.82 times more likely to use condoms as a current fertility preference than women with no education. Educated women use more contraceptives (condoms and pills) than uneducated women, and this supports the first hypothesis. After controlling for age, place of residence, and media exposure, women who are higher educated use 12.18 times more condoms than uneducated women. Women's work status and use contraceptives shows an interesting result as there is no significant association between women's work status and their use of pills. Again, there is a negative association between women's use of condoms and work status. The work status of women has a significant association with the use of condoms as the result shows women who are currently working are 28% less likely to use condoms than those who are not working. However, women's work status and reproductive behavior (use of pills, use of condoms and when okay to refuse sex) has positive association when controlling for age, place of residence and media exposure. In the table 6, model 2 shows that women who are currently working are 1.14 times more likely to use pills than women who are not working when controlling for age, place of residence, and media exposure. Currently working women are 0.80 times more likely to use condoms than non-working women even controlling for age, place of residence, and media exposure. With the control

variables, women who are currently working are 1.23 times more okay to refuse sex than women who are not working. The women with secondary level of education take 1.85 times more pills than uneducated women and the richest women use 12.15 times more condoms than the poorest women. These values remain significant even when controlling for their age, place of residence, and media exposure.

I found women's educational level affects their own choice of refusing to have sex when their husband has sexually transmitted infections. Their working status, age, wealth index, and place of residence played a vital role in their reproductive behavior. The result showed women with higher secondary levels of education are 2.05 times more likely to feel it's okay to refuse sex than women with no education. The richest women are 1.52 times more likely to feel it's okay refuse sex than the poorest women. Although, women's work status and use of contraceptives shows an inconsistent result, there is positive association between women's work status and their independent decision making in sexual life. Women who are currently working are 19% more likely to feel it's okay to refuse sex than women who are not working. Thus, education level, work status and wealth index have a significant impact on independent decision-making power and it supports the second hypothesis. Similar results are seen in the studies of (Haque, Iqramul 2014), (Hossain, Khan 2018) , (Shariful, Mainuddin 2014) though they didn't focus on women's reproductive behavior specifically (use of pills, use of condoms, and when it is okay to refuse sex) as reproductive behavior. For example, (Haque and Iqramul 2014) found that there is a significant association between contraceptive use and sociodemographic factors in Bangladesh. Likewise, (Shariful and Mainuddin 2014) found that income-generating activities among rural women have an impact on their contraceptive use.

This study found that women's socioeconomic status has a significant association with their sexual decision-making power: when okay to refuse sex if the husband has a sexually transmitted infection. Women who are educated, wealthy, and currently working are more independent in decision-making in sexual life than those who are uneducated, poor, and currently not working. A study about women's sexual decision-making (Fahmida, Philip 2013) found that women couldn't get the decisions as their husbands had the right and authority to have sex. However, this study didn't show the association between women's socioeconomic status and sexual decision making. Our paper found that women can make sexual decisions as their socioeconomic status upgrades. Women who are educated, wealthy, and currently working are more okay to refuse sex if they want than women who have no education, are unemployed, and are poor.

When controlling for women's age (15-49), place of residence (Urban versus Rural), and media exposure (TV watching) we found that the association between socioeconomic status and reproductive behavior remains significant. Young women (15-34) are more likely to use condoms and more likely to take pills than older women (35-49). Women who live in urban areas are more likely to take pills, use condoms, and are more okay to refuse sex than women from rural areas. In Bangladesh, socioeconomically stable women live in urban areas. Therefore, this relationship is significant. Media exposure is another factor that has a relationship with women's reproductive behavior. The result shows that women who watched TV at least once a week or less than once a week are more likely to use pills, use condoms, and feel more okay to refuse sex them women who didn't watch TV at all.

Limitations

This study has some limitations of this study. This study focused on women in Bangladesh in 2014 and we didn't include women's husband's income or any savings in bank accounts of women as socioeconomic status. We also didn't include other reproductive behavior like the use of injections, abortion, etc. The situation could be explained by women with no children, currently doing business or any specific job, and their attitude to other fertility methods. I did not include women with specific salary group or their income statuses. I also did not include healthcare preferences and the number of living children in this study. This study reveals women with higher educational levels, rich and working status, and age groups differ in their attitude to reproductive life and their socioeconomic status creates an impact on their sexual attitude. Women are not asked questions about exposure to the internet as media exposure and it may have a significant association.

Conclusion

Women in Bangladesh are progressing in social and economic life. This study reveals how this improvement in socioeconomic conditions creates a positive impact on their reproductive behavior (Kabir et al. 2017). Although the study has a few limitations, this study has several strengths. BDHS is a nationally representative survey with information on women's reproductive behavior from Bangladesh. This study might create a positive impact on healthy sexual life as it reveals the positive association between women's socioeconomic status and their sexual behavior. Previous studies show that women's empowerment has the greatest impact on reproductive health. Socioeconomic status can not only affect women's reproductive life but also their consciousness and knowledge of sexual life. Therefore, socioeconomic status has a significant impact on

reproductive behavior among Bangladeshi women. Female education, working status, and wealth index can change the lifestyle and sexual behavior of women as their status can be upgraded. Through these studies, policymakers, health care providers, and other organizations in Bangladesh can take necessary steps to increase consciousness among women so that they become educated and employed and get a healthy sexual life. In this way, the upgraded social and economic status of women can impact their sexual and reproductive behavior.

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Table 1: Percentage distribution of women's sexual and reproductive behavior in Bangladesh.

Variables	Percentage
Use of Pills	
Yes	25.2
No	74.8
Use of condoms	
Yes	6.2
No	93.8
When okay to refuse sex	
Yes	90.4
No	8.7

Source: Bangladesh Demographic and Health Survey 2014

Table 2: Percentage distribution of socioeconomic status of women in Bangladesh.

Variables	Percentages
Education level	
No education	23.6
Primary	29.3
Secondary	37.6
Higher	9.6
Working status	
Not working	68.8
Currently working	31.3
Wealth Index	
Poorest	18.2
Poorer	18.8
Middle	20.3
Richer	21.1
Richest	21.6

Source: Bangladesh Demographic and Health Survey 2014

Table 3: Logistic Regression between Use of Pills and other Independent Variables.

Independent Variables	Odds ratio	P-value
Education Level		
No education	Ref	
Primary Level	1.43	<0.001
Secondary Level	1.85	<0.001
Higher Secondary Level	1.36	<0.001
Work status		
Currently working	1.00	0.81
Not working	Ref	
Wealth Index		
Poorest	Ref	
Poorer	1.12	0.05
Middle	1.15	<0.05
Richer	1.11	0.05
Richest	0.92	0.15

Source: Bangladesh Demographic and Health Survey 2014

Table 4: Logistic Regression between Use of Condoms and other Independent Variables.

Independent Variables	Odds ratio	P-value
Education Level		
No education	Ref	
Primary Level	2.07	<0.001
Secondary Level	5.55	<0.001
Higher Secondary Level	19.82	<0.001
Work status		
Not Working	Ref	
Currently working	0.72	<0.001
Wealth Index		
Poorest	Ref	
Poorer	1.41	0.06
Middle	2.96	<0.001
Richer	4.59	<0.001
Richest	12.15	<0.001

Source: Bangladesh Demographic and Health Survey 2014

Table 5: Logistic Regression between when okay to refuse sex and other independent variables.

Independent Variables	Odds ratio	P-value
Education Level		
No education	Ref	
Primary Level	1.36	<0.001
Secondary Level	1.57	<0.001
Higher Secondary Level	2.05	<0.001
Work status		
Not Working	Ref	
Currently working	1.19	0.01
Wealth Index		
Poorest	Ref	
Poorer	0.96	0.68
Middle	1.17	<0.05
Richer	1.38	<0.001
Richest	2.35	<0.001

Source: Bangladesh Demographic and Health Survey 2014

Table 6: Odds Ratio of Education level, Work status, Wealth Index on Use of pills, use of condoms and when okay to refuse sex with control variables

	Use of pills			Use of condoms			When ok to refuse sex		
Variables	Model 1	Model 2	Model 3	Model 1	Model 2	Model 3	Model 1	Model 2	Model 3
Education level									
No education	Ref			Ref			Ref		
Primary	1.18**			1.85***			1.31***		
Secondary	1.32***			4.26***			1.40***		
Higher	1.01			12.18***			1.52***		
Work status									
Not working		Ref			Ref			Ref	
Currently working		1.14***			0.80***			1.23***	
Wealth index									
Poorest			Ref			Ref			Ref
Poorer			1.12*			1.42			0.83
Middle			1.08			2.62***			0.98
Richer			1.0000			3.54***			1.02
Richest			0.85*			8.52***			1.52***
Age									
15–24	0.96***	0.96***	0.96***	0.99	0.97***	0.96***	1.00	0.99	0.99
25–34	0.96***	0.96***	0.96***	0.99	0.97***	0.96***	1.00	0.99	0.99
35–49	Ref	Ref	Ref	Ref	Ref	Ref	Ref	Ref	Ref
Place of residence									
Rural	Ref	Ref	Ref	Ref	Ref	Ref	Ref	Ref	Ref
Urban	0.94	0.93	0.99	2.00***	2.28***	1.50***	1.54***	1.56***	1.39***
TV watching									
Not at all	Ref	Ref	Ref	Ref	Ref	Ref	Ref	Ref	Ref
Once a week	1.09*	1.13**	1.19***	1.66***	2.24***	1.27*	1.44***	1.57***	1.41***
Less than once	1.00	1.02	1.03	1.10	1.36	0.92	1.45***	1.49***	1.48***

Source: Bangladesh Demographic and Health Survey 2014