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ABSTRACT

Objectives: The lives of women in low-income countries are characterized by exclusion, which is reflected in poor access to basic health care and services. Women's health outcomes are influenced by this lack of access to health care and women's inability to make their own decisions. Myanmar's 2014 census reported that the country's maternal mortality ratio is the second highest among Southeast Asian countries and that a majority of maternal deaths occurred at home. This study analyzed the association between empowerment among currently married women in Myanmar and barriers in assessing health care.

Setting: 2015-16 Myanmar Demographic and Health Survey (MDHS) data, which included all 15 regions of Myanmar

Participants: 7,759 eligible currently married women age 15-49

Results: A total of 47.6% of currently married women in Myanmar had barriers to accessing health care. The lower the extent of women's empowerment, the more barriers the women experienced in accessing health care. Women with medium and high empowerment scores were less likely to experience barriers in accessing health care compared to women with low scores (OR=0.85, 95% CI 0.73-0.98) (OR=0.55, 95% CI 0.47-0.65) respectively. Women who lived in rural areas were more likely to encounter barriers in accessing health care than those who lived in urban areas (OR=1.41, 95% CI 1.15-1.72). Most regions showed a 27%-77% reduction in the odds of having barriers to accessing health care compared to Kachin State. The women who lived in Chin State were more likely than those in Kachin State to face barriers to accessing health care (OR=1.84, 95% CI 1.38-2.46).

Conclusion: Women's empowerment and regions in Myanmar were important determinants of access to health care, especially in the rural areas. Problems in accessing health care were lower for women age 35 and over, those who had an educated husband, those who had a husband with a white-collar job, and those living with an extended family.

Key words: Women's empowerment, barriers to accessing health care, Demographic and Health Surveys, Myanmar, knowledge, decision power, domestic violence, employment

ACRONYMS AND ABBREVIATIONS

3MDG	Three Millennium Development Goal Fund
CI	confidence interval
DHS	Demographic and Health Surveys
MDHS	Myanmar Demographic and Health Survey
MMR	maternal mortality rate
OR	odds ratio
USAID	United States Agency for International Development

1 BACKGROUND

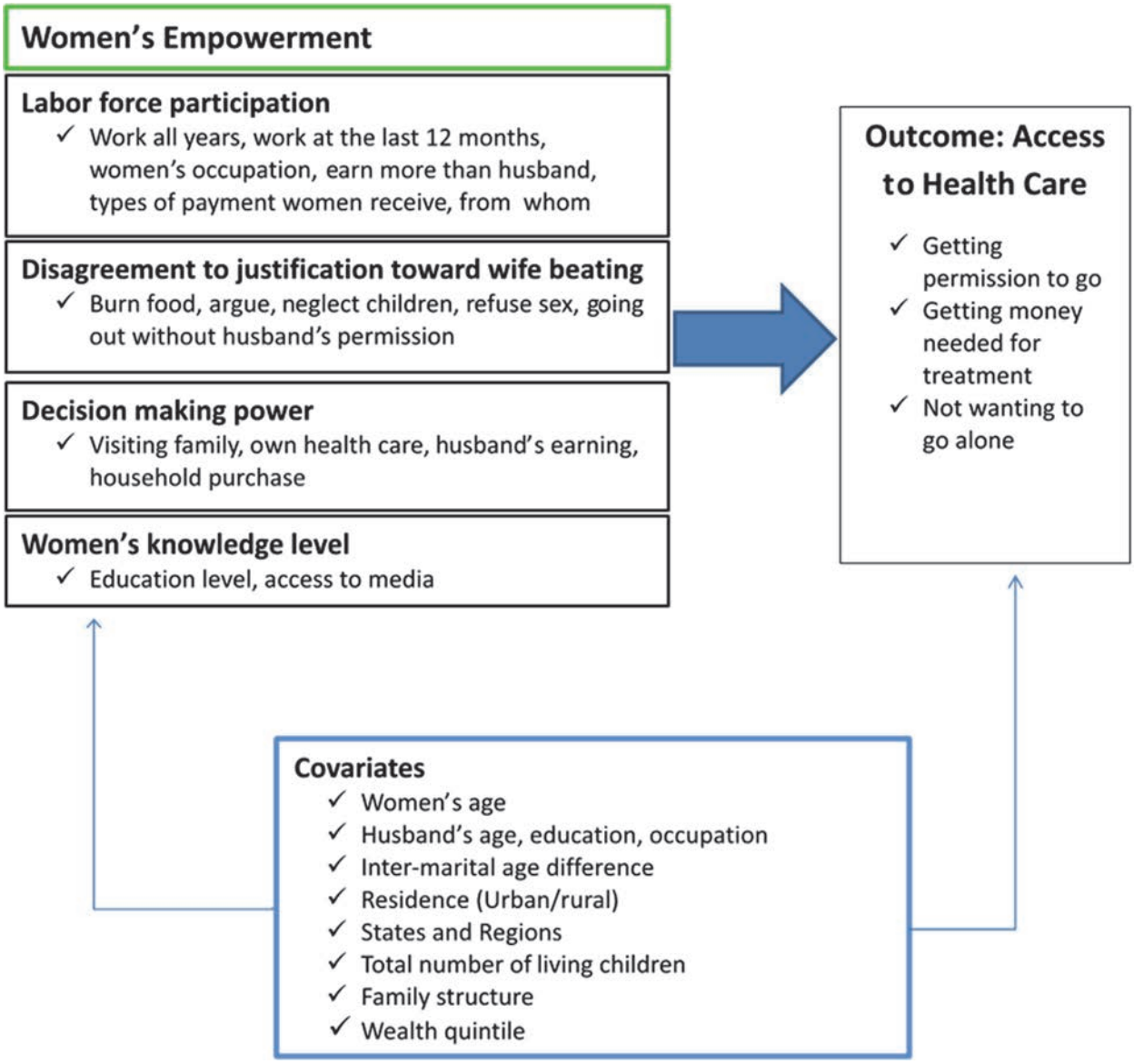
In recent years, women's empowerment has become an important global issue. This empowerment can be defined as women having the ability to make their own decisions in their lives and being able to act accordingly (Upadhyay and Karasek 2010). Women's empowerment is context-specific, and is related to a woman's level of education, employment for cash, extent of media exposure, and difference in age with their spouse (Kishor and Subaiya 2008). There is substantial evidence that the lives of women in low-income countries are characterized by exclusion and lack of empowerment, which is reflected in poor access to basic health care and services. Women's empowerment has a profound influence on the use of health services, which is associated with reproductive health outcomes (Mainuddin et al. 2015).

Research conducted primarily in Asia showed that women's empowerment is associated with contraceptive use (Hasan and Uddin 2016; Morgan and Niraula 1995), lower fertility (Hindin 2000), and longer birth intervals (Upadhyay and Hindin 2005). In Ghana, some aspects of household decision making, perceptions of spousal abuse, and spousal age differences were associated with women's use of health care. A lower spousal age difference was found to have a positive effect on women's joint decision making (Kishor and Subaiya 2008). One study in Accra, Ghana, revealed that the higher the level of empowerment, the greater the rate of health-care-seeking behavior and the lower the incidence of illness for women and sociomedical barriers such as domestic violence (Nartey 2014).

In the 2014 Myanmar census, the maternal mortality ratio (MMR) was 282 per 100,000 live births, which was the second highest among Southeast Asian countries. The majority (62%) of maternal deaths occurred at home, while 14% died on their way to hospital due to late referrals, primary delays, and long travel distances (UNFPA Myanmar 2010). A 2013 study conducted in camps for internally displaced persons in Kachin State, Myanmar, highlighted gender inequity issues, and found that women's lack of empowerment and inability to make their own decisions on contraceptive usage increased barriers to their reproductive health care (Kachin Women's Peace Network and the Gender Equality Network 2013).

In Myanmar, there is a limited understanding of the correlation between the empowerment of women and married women's use of health services for reproductive, maternal, and child health. This study explores the level of women's empowerment, and the effect of that empowerment on barriers to accessing health care. The study used a comprehensive, conceptually driven index of women's empowerment among currently married women in Myanmar that utilized data from the 2015-16 Myanmar Demographic and Health Survey (MDHS). The conceptual framework is shown in Figure 1 below. The results of the study will contribute to policies that increase the use of health care services and strategies for women's empowerment, which ultimately aim to improve maternal, child, and reproductive health.

Figure 1 **Conceptual framework of the relationship between women's empowerment and access to health care**



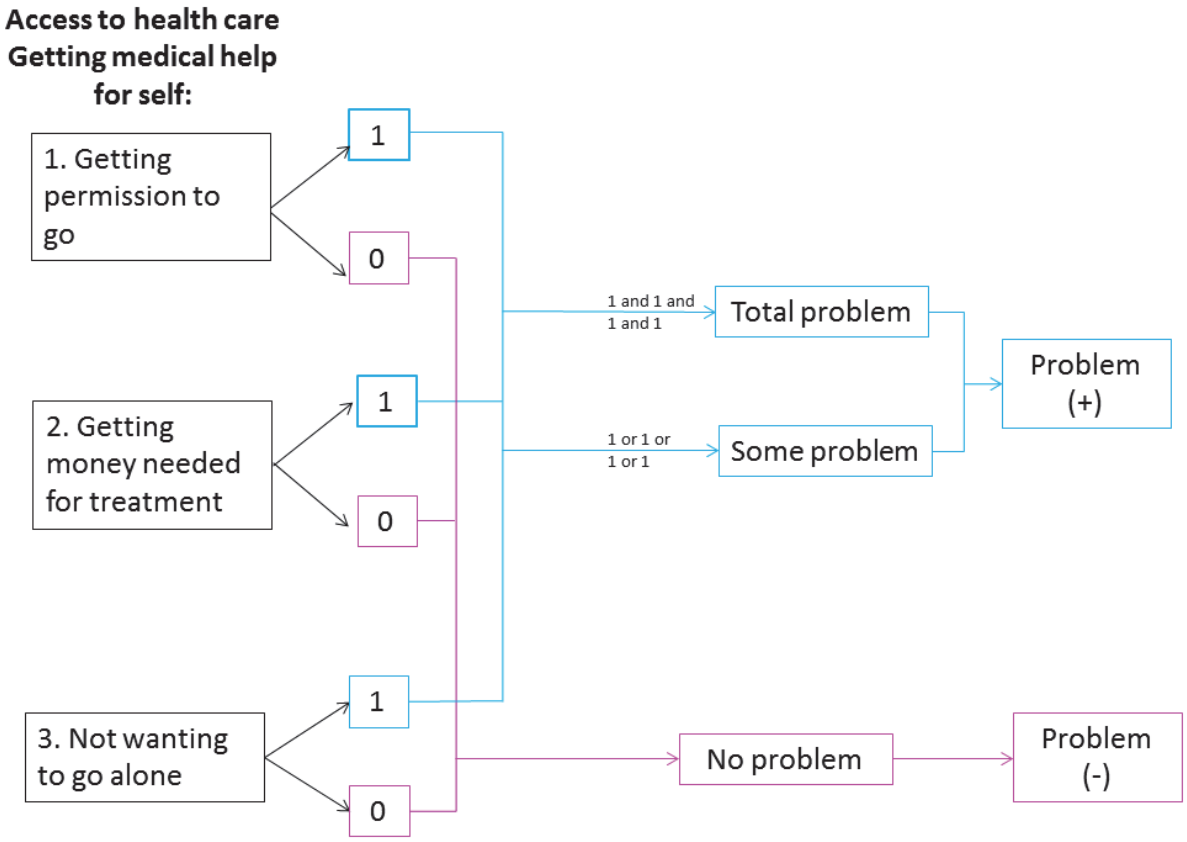
2 METHODS

This study used the dataset from the first MDHS conducted between 2015 and 2016. The MDHS was a nationally representative, cross-sectional survey of demographic and health indicators of women and members of their households, which was implemented by the Ministry of Health and Sports, Myanmar, with technical assistance from ICF in Rockville, Maryland, USA. The methodology and data collection procedures have been published elsewhere. A two-stage cluster sampling design (441 clusters, 30 households per cluster) was stratified by urban and rural status in 15 states and regions by country-specific geographic or administrative regions. A standardized questionnaire was used to collect data on demographic, social, and behavioral indicators, including health status and reproductive health of all men and women age 15-49 in the selected households. The focus of the analysis was 7,759 eligible currently married women age 15-49. The sample was restricted, however, because some indicators used to calculate women's empowerment are only available for currently married women. Decision-making power and some labor force participation factors (relative to husbands) are not available for unmarried women. The study results include descriptive statistics, and the estimation of the odds ratio (OR) and 95% confidence interval (CI) calculated with multivariable logistic regression analyses and a confounders' adjustment for the survey sampling design.

2.1 Outcome Variable

The outcome variable was barriers to accessing health care. In the 2015-16 MDHS, all women were asked, "When you are sick and want to get medical advice or treatment, is each of the following a big problem or not? (1) Getting permission to go to the doctor? (2) Getting money needed for advice or treatment? (3) The distance to the health facility? (4) Not wanting to go alone?" The outcome variable was recategorized by recoding "yes" responses to the items "getting permission to go to the doctor," "getting money for advice or treatment," and "not wanting to go alone." Those women who encountered all or some problems in these three areas were categorized as having barriers in accessing health care, as shown in Figure 2, while those who did not encounter any problem in the three domains were categorized as having no barriers. The distance to the health facility was not considered in this analysis of barriers because physical proximity to health facilities may be determined by factors other than women's empowerment.

Figure 2 Composite outcome: Access to health care



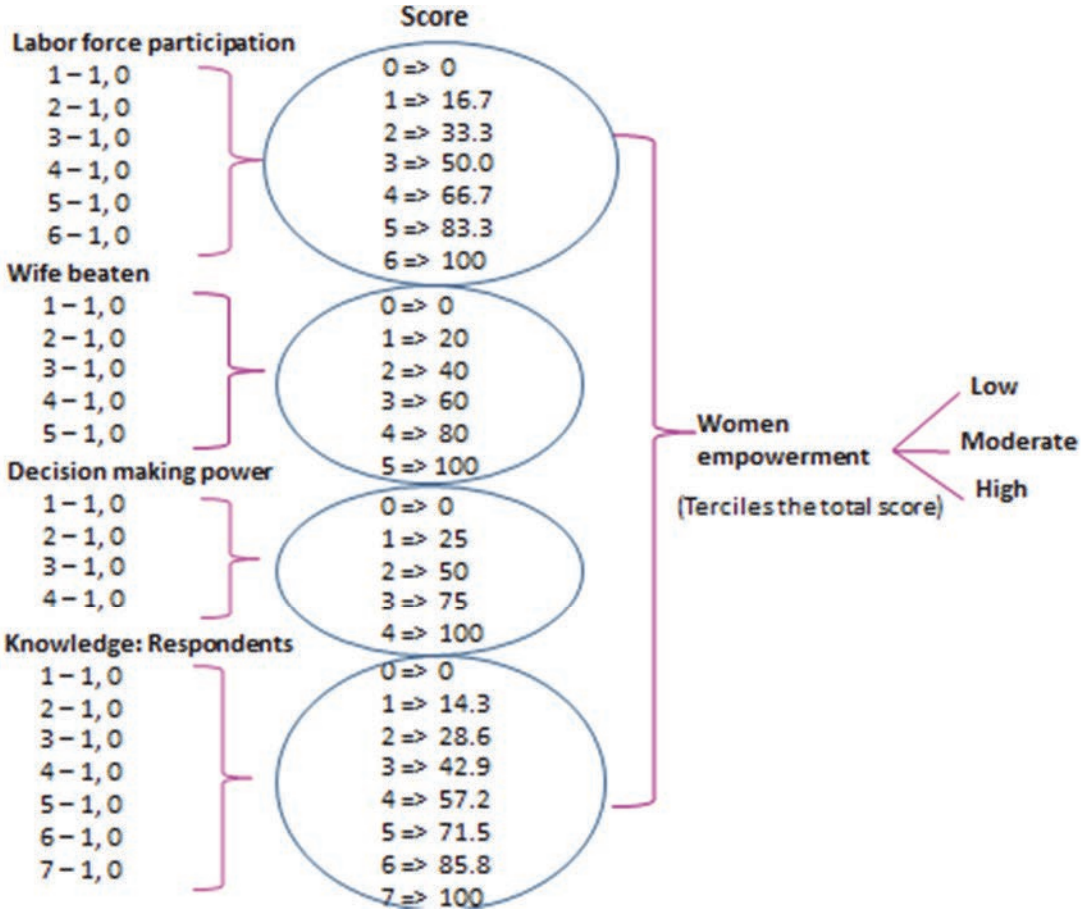
2.2 Study Variables

The composite variable of the women's empowerment index was constructed from 17 indicators selected from the previous literature (Sebayang, Efendi, and Astutik 2017) that categorized and recoded the indicators into four domains: women's labor force participation, decision-making power, women's disagreement with the justification of wife beating, and women's knowledge. The labor force participation of women was measured by six indicators: work in the previous 12 months (work or not), for whom the woman works (not working, works for family members, works for someone else, or self-employed), woman's occupation (not working, unskilled labor, skilled labor, professional, or self-employed), types of payment (not working, not paid, paid in cash and in kind, paid in cash only), work throughout the year (not working, works occasionally, works seasonally, or works all year), and earns more than the husband (not working or not paid in cash, earns less than husband, earns about the same as husband, or earns more than husband).

Women's disagreement with the justification of wife beating was evaluated in five areas: neglecting children, going out without husband's permission, arguing with husband, refusing sex, and burning food. Decision-making power was assessed with four questions about who made decisions about women's health care, household purchases, visits to family members, and husband's earnings. All decisions were categorized into a decision made by the husband or another person, or a decision made by the woman jointly or alone. The women's knowledge component includes two variables: formal educational level with four

categories (no education, primary, secondary, and higher) and access to media, with three response options (no access, access to some media, and access to all types of media). The summative index of the domain was calculated to obtain the scores of each domain. The index for each domain was divided by the number of its contents. Thus, each domain is equally weighted in the single, composite index of women's empowerment. The total score of the composite index was then divided into terciles of low, medium, and high levels. See Figure 3.

Figure 3 Scoring for the women's empowerment index



2.3 Strengths and Limitations of the Study

- Since the secondary data analysis in the study used the 2015-16 MDHS nationally representative data, the results cannot be generalized across Myanmar.
- Other influencing factors on women's empowerment such as cultural dimensions could not be explored in the study.
- The finding about the influence of family structure on health care access contradicts other existing findings.
- There remains a need to assess providers' perspectives on the factors that decrease women's access to health care.

3 RESULTS

3.1 Background Characteristics

Table 1 shows the background characteristics of the sample population of currently married women age 15-49. Forty-seven percent of the currently married women had a primary education level, and 73.9% were living in rural areas. For the respondents' occupation, 29.3% of women were not working, while only 4.5% of women were working in professional, technical, or managerial careers. Regarding familial and marital composition, half of the women were in a nuclear family, while 49.1% lived in an extended family. Among married couples, most wives were younger than their husbands. The education level of respondent's husband showed that 40.0% had primary education, and 37.6% secondary education. Fewer than 10% of the husbands were white-collar workers, with more than 90% blue-collar workers.

Table 1 Background characteristics of currently married women

Background characteristics	Levels	Weighted percent	Weighted number	Unweighted number
Age	15-19	2.93	228	235
	20-24	10.74	834	859
	25-29	16.22	1,258	1,299
	30-34	19.40	1,505	1,486
	35-39	19.10	1,482	1,474
	40-44	16.53	1,283	1,326
	45-49	15.07	1,169	1,191
Total number of living children	No children	11.81	917	879
	3 children	70.08	5,437	5,279
	4 and more children	18.11	1,405	1,712
Residence	Urban	26.06	2,022	2,057
	Rural	73.94	5,737	5,813
Region	Kachin	3.07	238	505
	Kayah	0.52	40	468
	Kayin	2.59	201	494
	Chin	0.84	66	481
	Sagaing	0.67	828	606
	Taninthayi	2.25	174	438
	Bago	10.05	780	588
	Magway	8.27	642	560
	Mandalay	10.80	838	525
	Mon	3.58	278	474
	Rakhine	5.85	454	535
	Yangon	13.43	1,042	584
	Shan	11.61	901	521
	Ayeyarwaddy	13.95	1,083	601
	Naypyidaw	2.51	194	490
Education	No education	15.38	1,197	1,203
	Primary	47.14	3,656	3,622
	Secondary	29.46	2,285	2,432
	Higher	8.01	621	613

Continued...

Table 1—Continued

Background characteristics	Levels	Weighted percent	Weighted number	Unweighted number
Occupation	Not working	29.33	2,270	2,398
	Professional/technical/managerial	4.54	351	405
	Clerical	1.05	81	82
	Sales	17.52	1,356	1,370
	Agricultural-self employed	9.67	748	840
	Agricultural employed	5.78	447	428
	Household and domestic	0.18	14	13
	Services	0.60	46	46
	Skilled manual	5.93	459	402
	Unskilled manual	25.40	1,987	1,886
Polygyny	No other wives	94.38	7,321	7,447
	Have other wives	5.40	420	406
	Don't know	0.22	18	17
Family structure	Nuclear	50.91	3,942	3,970
	Extended	49.09	3,817	3,900
Wealth quintile	Poorest	20.90	1,622	1,685
	Poorer	20.44	1,586	1,620
	Middle	20.05	1,555	1,608
	Richer	19.45	1,509	1,554
	Richest	19.16	1,487	1,403
Inter-marital age difference	Wife is older	21.47	1,665	1,617
	Equal age	10.54	818	826
	Wife is younger	67.99	5,276	5,425
Husband education	No education	14.80	1,152	1,157
	Primary	40.01	3,103	3,048
	Secondary	37.59	2,915	3,052
	Higher	6.32	490	494
	Don't know	1.28	99	119
Husband occupation	White collar	8.63	661	728
	Blue collar	91.37	7,098	7,142
Barriers to health care access	Present	52.43	4,068	3,942
	Absent	47.57	3,691	3,928
Women's empowerment measures				
Labor force participation	None	29.26	2,270	2,398
	1 – 3	17.70	1,373	1,594
	>3	53.05	4,116	3,878
	None	1.98	152	161
Disagreement to wife beating	1 – 3	27.16	2,085	2,065
	>3	70.87	5,522	5,644
	None	3.05	239	249
Decision making	1 – 3	34.60	2,684	2,734
	>3	62.35	4,836	4,887
	None	7.55	587	619
Knowledge	1 – 3	57.54	4,464	4,466
	>3	34.91	2,708	2,785

3.2 Women's Empowerment

Four domains of women's empowerment were categorized into three groups of none, one to three, and more than three factors. Regarding labor force participation, 29.26% of women did not participate in the labor force, while 53.05% participated in more than three factors in the domain. With wife beating, 1.98% of women agreed with the justification of this practice, as opposed to 98.02% of women who disagreed with

the justification. Among the 98.02% of women who disagreed, 70.87% disagreed with the justification of wife beating with more than three factors, while 27.16% disagreed with one to three factors. The majority of women had one to three and more than three decision-making factors. A small percentage of women (3.05%) did not have any decision-making factors. For knowledge, the majority (57.54%) had one to three knowledge factors, 34.91% had more than three factors, and 7.55% did not have a single knowledge factor.

3.3 Barriers to Health Care Access

In this study, there were three questions about possible barriers to the health care access of currently married women: "getting permission to access health care," "getting money needed for treatment," and "not wanting to go alone." Table 1 shows that 47.57% of currently married women had barriers to accessing health care. Table 2 shows the distribution of barriers in accessing health care among currently married women across independent variables. A total of 24.94% of the women with high empowerment experienced some barriers, while 40.60% of women with low empowerment index scores experienced greater barriers in accessing health care. The lower the women's empowerment, the more the women experienced barriers in accessing health care. Women with medium and high scores had 0.85 and 0.55 odds, respectively, compared to the women with low empowerment scores. The experience of encountering barriers in accessing health care varied by the respondent's age, educational level, and wealth quintiles. Women living in rural regions (51.34%) experienced barriers versus 36.87% of those living in urban areas. Women whose husbands had lower educational and occupational status faced more barriers. With family structure, 52.25% of women from nuclear families had barriers while 42.77% of those from extended families faced similar barriers.

Table 2 Barriers to accessing health care with women's empowerment and covariate factors

Background characteristics	Levels	Weighted number	Barriers to health care access	No barrier in health care access
Women's empowerment	Low	2,650	1,499 (40.60)	1,151 (28.29)
	Medium	2,555	1,272 (34.46)	1,283 (31.53)
	High	2,554	920 (24.94)	1,634 (40.18)
Respondent's age	15-19	228	119 (52.54)	109 (47.46)
	20-24	834	418 (50.11)	416 (49.89)
	25-29	1,258	610 (48.44)	648 (51.56)
	30-34	1,505	721 (47.90)	784 (52.10)
	35-39	1,482	687 (46.32)	795 (53.68)
	40-44	1,283	601 (46.87)	682 (53.13)
	45-49	1,169	535 (45.77)	634 (54.23)
Respondent's education	No education	1,197	738 (61.86)	459 (38.14)
	Primary	3,656	1,908 (52.19)	1,748 (47.81)
	Secondary	2,285	912 (39.89)	1,373 (60.11)
	Higher	621	131 (21.13)	490 (78.87)
Respondent's occupation	Not working	2,270	1,060 (46.71)	1,210 (53.29)
	White collar	433	133 (30.64)	300 (69.36)
	Blue collar	5,057	2,485 (49.34)	2,572 (50.66)

Continued...

Table 2—Continued

Background characteristics	Levels	Weighted number	Barriers to health care access	No barrier in health care access
Region	Kachin	238	144 (60.63)	94 (39.37)
	Kayah	40	22 (55.80)	18 (44.20)
	Kayin	201	117 (58.45)	84 (41.55)
	Chin	66	48 (73.14)	18 (26.86)
	Sagaing	828	254 (30.64)	574 (69.36)
	Taninthayi	174	80 (46.01)	94 (53.99)
	Bago	780	287 (36.80)	493 (63.20)
	Magway	642	325 (50.56)	317 (49.44)
	Mandalay	837	327 (39.05)	511 (60.95)
	Mon	278	95 (34.22)	183 (65.78)
	Rakhine	454	245 (53.84)	209 (46.16)
	Yangon	1,042	476 (45.69)	566 (54.31)
	Shan	901	489 (54.24)	412 (45.76)
	Ayeyarwaddy	1,083	676 (62.42)	407 (37.58)
	Naypyidaw	194	106 (54.43)	89 (45.57)
Residence	Urban	2,022	746 (36.87)	1,276 (63.13)
	Rural	5,737	2,945 (51.34)	2,792 (48.66)
Husband's occupation	White collar	661	198 (30.00)	463 (70.00)
	Blue collar	7,098	3,433 (49.06)	3,665 (50.94)
Husband's education	Incomplete primary and none	2,813	1,535 (56.65)	1,278 (43.35)
	Complete primary and some secondary	4,224	1,938 (45.89)	2,286 (54.11)
	Complete secondary and higher	722	171 (23.63)	551 (76.37)
Wealth quintile	Poorest	1,622	1,131 (69.72)	491 (30.28)
	Poorer	1,586	903 (56.94)	683 (43.06)
	Middle	1,555	710 (45.64)	845 (54.36)
	Richer	1,509	569 (37.70)	940 (62.30)
	Richest	1,487	378 (25.44)	1,109 (74.56)
Polygyny	No other wives	7,321	3,436 (46.94)	3,885 (53.06)
	Have other wives	420	242 (57.72)	178 (42.28)
	Don't know	18	13 (73.38)	5 (26.62)
No. of living children	No child	917	399 (43.49)	518 (56.51)
	1-3	5,437	2,512 (46.20)	2,925 (53.80)
	4 and more	1,405	781 (55.54)	624 (44.46)
Inter-marital age difference	Same age	818	375 (45.89)	443 (54.11)
	Husband>wife	5,276	2,554 (48.44)	2,722 (51.56)
	Wife>husband	1,665	759 (45.60)	906 (54.40)
Family structure	Nuclear	3,942	2,060 (52.25)	1,882 (47.75)
	Extended	3,817	1,626 (42.77)	2,191 (57.23)

3.4 Barriers to Accessing Health Care and Women's Empowerment and Covariate Factors

Table 3 presents the result of the regression analysis that examined the relationship between women's empowerment and barriers to accessing health care. Women who had either medium or high levels of empowerment had lower odds (0.15 and 0.45 times lower, respectively) of having barriers to accessing health care, when controlling for other factors. Women older than age 35 faced fewer problems in accessing health care compared to the younger women. Women age 40-44 had a 34% reduction in encountering

barriers to health care access in contrast to women age 15-19. By residence, women who lived in rural areas had 1.41 times higher odds of encountering barriers to accessing health care than those living in urban areas. By region, most showed a 27%-77% reduction in the odds of having barriers to accessing health care compared to those in Kachin State, with all other factors held constant. Women in Chin State had 1.84 higher odds of encountering barriers to accessing health care than those in Kachin State.

The husband's education is also a significant factor in the likelihood of women having barriers to health care access. Compared with women whose husbands have no or incomplete primary education, there are lower odds of experiencing barriers to health care access among those whose husbands have either secondary or tertiary education. Women whose husbands hold white-collar jobs experienced a 29% reduction in the odds of having barriers to accessing health care. By family structure, the women who lived in an extended family had a 26% reduction in experiencing barriers to health care access compared to those who lived in a nuclear family. A significant association was found with the unadjusted regression analysis. Although polygyny and the number of living children were significantly associated with barriers to health care access in the unadjusted model, this is not the case in the adjusted regression model controlling for other factors.

Table 3 Association between women's empowerment and barriers to health care access adjusted for covariates

		Barriers to health care access					
Variables	**Levels**	**Crude OR (95% CI)**			**Adjusted OR (95% CI)**		
Women's empowerment	Low	1			1		
	Medium	0.76***	0.66	0.88	0.85*	0.73	0.98
	High	0.43***	0.37	0.51	0.55***	0.47	0.65
Respondent's age	15-19	1			1		
	20-24	0.91	0.65	1.27	0.83	0.58	1.19
	25-29	0.85	0.62	1.16	0.76	0.54	1.06
	30-34	0.83	0.60	1.15	0.72	0.50	1.04
	35-39	0.78	0.56	1.08	0.70*	0.49	0.99
	40-44	0.80	0.57	1.10	0.66*	0.47	0.94
	45-49	0.76	0.54	1.07	0.67*	0.47	0.96
Region	Kachin	1			1		
	Kayah	0.82	0.56	1.20	0.81	0.57	1.16
	Kayin	0.91	0.64	1.31	0.81	0.58	1.13
	Chin	1.77***	1.32	2.36	1.84***	1.38	2.46
	Sagaing	0.29***	0.21	0.36	0.23***	0.17	0.32
	Taninthayi	0.55**	0.39	0.78	0.52***	0.37	0.72
	Bago	0.38***	0.28	0.51	0.35***	0.26	0.47
	Magway	0.66*	0.47	0.95	0.62**	0.44	0.88
	Mandalay	0.42***	0.30	0.57	0.40***	0.29	0.54
	Mon	0.34***	0.22	0.51	0.31***	0.20	0.47
	Rakhine	0.76	0.55	1.03	0.60**	0.44	0.81
	Yangon	0.55***	0.40	0.75	0.67**	0.49	0.90
	Shan	0.78	0.52	1.14	0.71**	0.48	1.04
	Ayeyarwaddy	1.10	0.74	1.58	0.95	0.65	1.39
	Naypyidaw	0.78	0.57	1.05	0.73*	0.54	0.98
Residence	Urban	1			1		
	Rural	1.81***	1.50	2.18	1.41**	1.15	1.72
Husband's occupation	Blue collar	1			1		
	White collar	0.44***	0.35	0.57	0.71**	0.56	0.89

Continued...

Table 3—Continued

Variables	Levels	Barriers to health care access					
		Crude OR (95% CI)			Adjusted OR (95% CI)		
Husband's education	Incomplete primary and none	1			1		
	Complete primary and some secondary	0.65***	0.56	0.76	0.76***	0.66	0.86
	Complete secondary and higher	0.24***	0.18	0.31	0.41***	0.31	0.54
Wealth quintile	Poorest	1					
	Poorer	0.57***	0.47	0.70			
	Middle	0.36***	0.30	0.44			
	Richer	0.26***	0.21	0.33			
	Richest	0.15***	0.12	0.19			
Polygyny	No other wives	1					
	Have other wives	1.54**	1.20	1.98			
	Don't know	3.12	0.79	12.29			
No. of living children	No child	1					
	1-3	1.12	0.95	1.32			
	4 and more	1.62***	1.33	1.98			
Inter-marital age difference	Same age	1					
	Husband>wife	1.11	0.92	1.33			
	Wife>husband	0.99	0.81	1.21			
Family structure	Nuclear	1			1		
	Extended	0.68***	0.61	0.76	0.74***	0.66	0.84

*** p<0.0,001, ** p<0.001, *p<0.05

4 DISCUSSION

4.1 Women's Empowerment

Women's empowerment was determined by four domains: labor force participation, disagreement with a justification of wife beating, decision-making power, and women's knowledge level. One-third of the women did not participate in the labor force. The 2014 Myanmar census report found similar findings that among the unemployed population, most were women (Department of Population 2015). The majority of women had more than one of the seven knowledge factors. Almost all women were involved in decision making, and almost all disagreed with the justification of wife beating. Among those women, approximately 70% strongly disagreed. In the 2015-16 MDHS, half of the women agreed with wife beating (MoHS and ICF 2017). Our findings differ, which might be due to the inclusion of only currently married women. With these findings, we conclude that the main contributor to low empowerment might be labor force participation. These findings contradict other studies (Hasan and Uddin 2016; Dhaher, Mikolajczyk, Maxwell, and Kramer 2010) that showed that low decision-making power and low knowledge might be strongly associated with low empowerment.

4.2 Barriers to Health Care Access

Nearly half of the women in this study had barriers while attempting to access health care despite the exclusion of geographical difficulties. This finding was similar to other research (Hossen and Westhues 2011a; Hossen and Westhues 2011b). Barriers to health care access differed by background characteristics. The lower the respondent's age, educational level, and wealth quintile, the greater number of barriers faced when accessing health care. This finding was found in a similar study conducted in Bangladesh (Hasan and Uddin 2016).

Women from Chin State encountered the most barriers when attempting to access health care. Although we excluded distance from health facilities in the calculation of barriers, women from rural areas still faced more barriers compared to the women from urban areas. Thus, geographical and transportation difficulties do not appear to be the only causes of barriers to accessing health care in different states and regions. Other factors, including women's empowerment, might influence the health-seeking behavior of women (Hossen and Westhues 2011a). Women whose husbands had lower educational and occupational status experienced more barriers (Mainuddin et al. 2015; Assaf and Davis 2018). Women with more than four children also experienced more barriers, which may be due to the fact that women in this group use health services more frequently than other groups of women. Women from nuclear families also experienced more barriers than women from extended families.

4.3 Women's Empowerment and Barriers to Accessing Health Care

In this study, there was a negative association between the level of women's empowerment and the experience of encountering barriers when attempting to access health care. Few women with high scores on the empowerment index encountered barriers in accessing health care. Older women could access health care services more easily than younger ones. In this study, the access to health care of married women is better if they are married to educated, employed husbands. As found in other research, the education and employment status of the husband had influence on the wife's access to health care (Mainuddin et al. 2015).

More women in rural areas faced barriers in accessing health care than those in urban areas. Similarly, more women from the Chin State experienced barriers to health care compared to those who lived in Kachin State. Sagaing Region, Bago Region, and Mon State showed fewer barriers in accessing health care. This may be due not only to road conditions, but also to weather, ethnicity, and cultural beliefs and taboos. This finding is consistent with other studies (Hossen and Westhues 2011a). The women who lived in extended families had barriers to accessing health care in contrast to those lived in a nuclear family (Debnath 2015). Existing evidence shows that most women had female family members as companions while seeking health care, especially in developing countries (Debnath 2015; Pletcher, Tice, Pignone, and Browner 2004).

4.4 Conclusion

This study focused on the association between women's empowerment and barriers to accessing health care. Women's empowerment is an important determinant of a woman's ability to access health care, especially in rural areas. Regions influence barriers to accessing health care in the Myanmar context. Barriers to access to health care are reduced when the woman is over age 35, has an educated husband and a husband with a decent job, and lives in an extended family. Therefore, we believe that the findings could contribute to the policy formulation in reducing health inequity and increasing women's empowerment, while at the same time contributing to achieving universal health coverage by 2030.

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