PERCEPTION ABOUT HOUSEHOLD DECISION-MAKING PROCESS ON OBTAINING MATERNAL HEALTH SERVICES AMONG THE EMPLOYED WOMEN OF DHAKA CITY

A H M Kishowar Hossain[1]
Gaylan Peyari Tarannum Dana[2]

Abstract

Reducing maternal morbidity and mortality and ensuring maternal and new-born health have been one of the central goals of healthcare system in Bangladesh. In that connection care during and after pregnancy, especially antenatal and delivery, is critical to monitor the status of pregnancy both for mother as well as for expected new-born baby. The role of women's decision-making in reproductive health is crucial one. This study intends to understand the role of household decision-making in obtaining maternal health services- its patterns access and reasons by using qualitative methods. The approaches are employed to explain woman's decision-making process to utilize the service facilities. The findings of the study illustrate that decision-making processes should be understood and recognized in a wider social environment and as a multifaceted process that is closely tangled with local belief systems and social relationships. Combined knowledge of social images, women's requirements and expectations can play an important role in confirming broader and more effective coverage of maternal healthcare, health authorities and to those in charge of maternal care services.

Keywords: Maternal health, decision making process, household, antenatal care (ANC), delivery, postnatal care (PNC), Bangladesh

Introduction

Antenatal care (ANC) service from a qualified person is crucial to monitor the pregnancy status, to diagnose and treat problems to avoid complications that may harm the mother and baby. The main reasons of maternal death are haemorrhage,

[1] **A H M Kishowar Hossain,** Associate Professor, Department of Population Sciences, University of Dhaka, Dhaka-1000, Bangladesh. E-mail: ahmkhossain@du.ac.bd

[2] **Gaylan Peyari Tarannum Dana, PhD,** Associate Professor, Department of Population Sciences, University of Dhaka, Dhaka-1000, Bangladesh. E-mail: tarannum_dps@du.ac.bd

Social Science Review [The Dhaka University Studies, Part-D], Vol. 38, No.2, December 2021
DOI: https://doi.org/10.3329/ssr.v38i2.64463

unsafe abortion and the 'three delays dynamics.' The first delay is the result of deciding to health care professional; the second delay arises from the delay in reaching a medical facility where adequate care is available, and the third delay is related to service centres (lack of adequate human resources and trained personnel). To address these problems, Bangladesh government has taken several measures like developing Maternal and Child Welfare Center (MCWC) and National Maternal Health Strategy 2001 which takes a rights-based approach and The Essential Obstetrics Care (EOC) program through the MCWC. In Bangladesh government has ensured the availability and accessibility of modern health facilities for lower income group people both in urban and rural areas, but the utilization of available health services is considered as a major contributing factor for high maternal mortality. ANC service from a qualified person is significant to screen the pregnancy status, to diagnose and treat problems to avoid complications that may harm the mother and baby. It is important to acknowledge that seeking facility-based care had increased from 29% to 46% percent between 2010 and 2016 (National Institute of Population Research and Training (NIPORT), MEASURE Evaluation, and icddr,b. 2016).

Several studies have shown (National Institute of Population Research and Training and ICF International, 2020; National Institute of Population Research and Training and ICF International, 2016) that women were often not interested to use health facilities, though the facilities were ready to provide services. Despite being familiar with the available services and pregnancy complications one in four pregnant women in Bangladesh did not discuss with family members or decide on a place delivery. Additionally, only one in three pregnant women discussed with their family members about the cost involved in delivery and around 16% discussed regarding the arrangement of transportation (National Institute of Population Research and Training (NIPORT), MEASURE Evaluation, and icddr,b., 2012). Women's decision to utilize health facility was therefore vital though the decision-making process was not straight forward. In Bangladesh like many other developing countries, use of maternal healthcare facilities is interlinked with various psycho-social, cultural and economic aspects of the service receivers (Acharya & Cleland, 2000; Bhatia & Cleland, 1995; Fauveau, Koenig, Chakraborty, & Chowdhury, 1988). In Indonesia, decision making, and utilization of ANC and PNC services depends on the availability, affordability and accessibility of the services. Further, the study argues that if there was awareness among the community people then it would be comparatively easier to reach decision of using ANC, delivery and PNC services in spite of having some other difficulties (Titaley, Hunter, Dibley, &

Heywood, 2010). Therefore, higher level of awareness would have been helpful to change the generation gap of perception regarding service utilization decision making. It is found that decision related to utilization of ANC service was very much influenced by the decision of mothers-in-laws as they play an important in decision making (Akhter, S., Dasvarma, G. L., & Saikia, U. 2020; Simkhada, Porter, & Van Teijlingen, 2010). The perception of mothers-in-law about the importance of ANC was formed from their own experience for which they felt that medical interventions were not important for their daughters-in-law (Zakaria, Khan, Ahmad, Cheng, & Xu, 2021; Simkhada et al., 2010).

The utilization of maternal healthcare services was associated to the availability, accessibility, affordability and quality of services, along with to the social system, health presuppositions and individualities of the service users (Zakaria, Khan, Ahmad, Cheng, & Xu, 2021; Amin, Shah, & Becker, 2010; Awusi, Anyanwu, & Okeleke, 2009; Bulatoo & Ross, 2000; Chakraborty, Islam, Chowdhury, & Bari, 2002; Organization, 2001). In order to increase the acceptance of ANC, delivery and PNC services, it was therefore important to comprehend the issues that underlie the decision of pregnant women of using available services for their babies as well as for themselves. This study, therefore, conducted to understand how women in Bangladesh make decisions at household level on using maternal health services.

Research Methodology

This research employed phenomenological approach utilizing qualitative data. A purposive sample of 41 married women aged 15-49 participated in this study. The purpose of this sampling technique was to document how women make decisions in household level on obtaining maternal health services. The data collection process was guided through in-depth interview. Table 1 gives and overview of the interview participants. The study was carried out in the heart of Dhaka in December 2019 to February 2020. All of the data were verified in the field to confirm that all the data was properly collected and recorded. The data analysis was processed by using NVIVO 2012. Our thematic data analysis related to household decision-making on obtaining maternal health services of the interview have been divided into three parts: (1) ANC; (2) delivery; and (3) PNC. During and after data collection, the maintenance of privacy and confidentiality was very strict. The respondents were free to terminate the interview at any time.

Table 1: Demographics of Interview Participants

Characteristics	Respondent Number
Age	
25-30	20
31-35	6
36-40	5
41-45	4
46-50	6
Education	
Below Secondary School Certificate (SSC)	15
SSC and above	26
Employment	
Housewife	22
Officers	8
4 grade Employee	11

FINDINGS

Household Decision-Making on Obtaining Antenatal Care

During discussion concerning respondents' opinions of the knowledge and significance of prenatal programs and services, it became obvious that the benefits stated by the women were varied and related to expressed needs. One of the perceived benefits of prenatal care was that it acts as a vehicle for enhanced knowledge (Table 2 theme 1). Prenatal period provides the opportunity to learn about self-care and important new-born care issues (nutrition, stress reduction, exercise, breastfeeding, bathing) which turn to make their decision easier. According to majority mothers-in-laws pregnancy is a normal so there was no need for ANC services until complications occurred. These traditional believe created a mindset that it is not important to receive ANC services (Table 2theme 2). About 30 women reported that their family treated them like childbearing machines, and they discontinued the antenatal examinations when the result of the first examination indicated that the fetus was well (Table 2 theme 3). Twenty women did not make a decision to use prenatal care because of personal difficulties at home. The important reasons stated for dissent to prenatal care was rooted to the responsibility of social roles of a woman (mother, wife, housewife, homemaker, among others) (Table 2 theme 4). Women did not make a decision on obtaining

prenatal support for distrust. If there is doubt, fifteen women pretended themselves vulnerable, so if a woman does not arrange to have prenatal care it's because she doubts either herself or others. Other women did not like to visit the doctor every month, or every other month. It was because they did not like it or did not like have check-up by male doctors. As one third of the women had this taboo (Table 2 theme 5). Although husbands' interest levels and attempts to support pregnancy health were fairly high, but little knowledge regarding pregnancy seemed to pose a significant barrier for active involvement in decision making. Overall, it was observed that women's knowledge surrounding pregnancy was inadequate, especially about complications or danger signs during pregnancy and delivery. Wives, in general, describe the husbands as being less educated or uneducated or misinformed about pregnancy related health. About eighteen women alleged that their husband was reluctant about their pregnancy, and they did not show their interest in wives' decision-making process (Table 2 theme 6).

Table 2: Qualitative Interview Data Representing Household Decision on Maternal Healthcare Seeking Behaviour

	Theme	Title	Quote from interview data
ANC	Theme 1	Prenatal care as a vehicle for enhanced knowledge	If we are informed before about the facilities, available services like choices about delivery, cost of hospital and how to manage with things especially when we have more children…..then it would have been stress and easier for us afterwards. (Age 30, uneducated, unemployed).
	Theme 2	Traditional believes of mother-in-law	My mother-in-law told me, childbirth is natural for all women and all my children were delivered at home without any complication. So, there is no need for good foods and ANC during pregnancy. (Age 25, not-educated, employed). According to my mother-in-law there was no need for ANC visits in earlier days. Furthermore, she added that all her children were born healthy without any ANC visits. So, she asked me why various foods and ANC is required for pregnant women. That's why I didn't go. (Age 31, educated, employed).
	Theme 3	Good condition of fetus changes women's decision	If there is no complication found in first check-up and the baby is fine, then there is no point of having ANC check-ups from a doctor during pregnancy. (Age 22, not-educated, unemployed).
	Theme 4	Workload of pregnant women	Once I was confirmed about my pregnancy in my last pregnancy, I did go for any ANC visits as I had to do all the household work did not have enough time for myself (Age 27, educated, unemployed).
	Theme 5	Negative attitudes about male medical practitioners	I went to a male gynaecologist, but I did not feel comfortable. It was very uncomfortable and embarrassing for me to do the test by male medical persons. So decided not to go for any antenatal check-ups as there were male doctors (Age 30 not-educated, unemployed).
	Theme 6	Low level of husband's knowledge and his less consciousness on pregnancy health	My husband being educated did not have any knowledge about health, nutrition and immunization. So, they did not ask us to go for the antenatal check-ups. So, we believe that husbands should know what they have to what type of care required during pregnancy, otherwise they will not be able to take any decision. (Age 36, educated, employed).

Delivery	Theme 7	Predetermined decision on institutional birth	I have always wanted that my baby should be born in hospital not at home though people around me considered home delivery. So, it was hard for me to stick to my decision to have baby in hospital. (Age 40, educated, employed).
	Theme 8	Comfortable to have delivery at home	It was my sole decision to have delivery at home because I had proper understanding from listening from others how to have a delivery at home and how it was done in medical centres. Since I feel comfortable when my relatives are around me at the time of delivery. So, I had my baby at home, and I did not encounter any problem during my delivery. (Age 28, not-educated, employed).
	Theme 9	Persuasive health workers	I was given only a choice of two hospitals not even asked if wanted to have delivery at home. Since I was familiar with maternity clinic as I where I had an ANC check-up. I was pleased with their care and had no reason to change and go to a different clinic. (Age 23, not-educated, unemployed). The health works who visited me gave me all the information regarding the benefits of institutional delivery me and encouraged me to go to hospital. (Age 23, educated, unemployed).
	Theme 10	Silent or argumentative role of husbands	My husband always agreed with my decisions about antennal check-ups, so we never discussed just went to the hospital (Age 37, educated, employed). Me and my husband never discussed about which hospital to go because we knew where to go when time comes. So, it was not something we needed to discuss, as we were sure where we would be going. (Age 29, not-educated, employed) My husband and I had an argument about the decision where to have the delivery. Since he does not have enough knowledge on these matters. It was hard for me to convince him. (Age 29, not-educated, employed).
	Theme 11	Influential role of the neighbour	My neighbour had her babies at home and did not face any problem during delivery everything was normal, so I thought to have my baby at home. (Age 24, not-educated, employed).
	Theme 12	Dominant role of mother-in-law	My delivery took place at a maternity. It was my mother-in-law's decision. But my husband preferred (name of the government hospital) and wanted me to see the same lady whom I was visiting lately and get it done with. However, I refused because that would have been very expensive, which is quite true. Since the expenses would be exorbitant, I declined to visit the same lady doctor. As she is attached with a clinic, she would prefer me to pay a visit in her chamber that would have been costly for my family. My mother-in-law preferred a maternity since all her children were delivered there. This sounds fine to me. That's the reason I had to visit there. Otherwise, my husband's preference was (name of the government hospital) for my upcoming delivery. Yes, my mother-in-law preferred (name of the government hospital) since it was closer to home and there were lots of facilities to be had from (name of the government hospital) as well. There were no questions about visiting a place farther from home to have my delivery done. Since my husband was unemployed, we had to be very careful about our expenses. I was looking forward to getting my delivery done at (name of the government hospital). Everything there was free…… They had even provided with 'iron' tablets.
	Theme 13	Husband is the final decision maker	I was having a prolonged labour and needed to go to the hospital. My husband finally gave me approval of going to the health centre. (Age 26, not-educated, unemployed).
	Theme 14	Fear of surgical instruments in hospitals	I believe in clinic doctors forced to undergo surgery and I am afraid of surgery. I am scared if the stiches were unhealed then it would affect my regular household activities and my sexual relationship with husband. So had my baby at home without any difficulties. (Age 35, not-educated, employed).

PNC	Theme 15	No need to go for postnatal check-up	Since everything was normal then why would I go to the health centre for PNC services? (Age 25, not-educated, employed). After recovering from infection, I did not go for any further check-up, but I went to the clinic once when mild bleeding came out from my wound. (Age 27, educated, employed).

Household Decision on Obtaining Delivery Care

Women who received any kind of ANC services fixed their decision where they would give birth. Twenty women assumed that the hospital or health centre was the appropriate place for delivery (Table 2 theme 7). On the contrary, fifteen women told that they took the decision to have home delivery based on the following reasons: first, after hearing from various sources on how birth delivery takes place at hospital they were sceptical about going to the hospital; second birth delivery at home was comfortable as it was close to relatives which gave them the scope to visit the women; third when the women found out that the condition and position of the fetus was quite good, they did not feel any urge to go to hospital (See Table 2 theme 8). About eleven women precisely mentioned that their health workers encouraged them to make decision to go to a particular health centre (Table 2 theme 9). There was a clear variation between women planning to have delivery at home and those planning an institutional delivery with regard to their husband's participation in the decision-making process. Women who had decided to have delivery at home discussed the issue with their husbands. Sixteen women reported their husbands to be very encouraging of their choice of home delivery choice. Eleven women said that they did not discuss about the place of birth with their spouse. Five of the women said they had an argument about it (Table 2 theme 10). The sway of neighbours put into women who were planning to have delivery at home. Majority of them stated someone known shared their positive experience of home delivery that had influenced or inspired them to pursue their delivery at home (Table 2 theme 11). Some women said that their mother-in-laws took the decision where the delivery would take place since they control the financial issues in the houses. They agreed with her because the cost of having delivery at private clinic is higher than that of at government services. The health centres which were operated by NGOs were comparatively cheaper than private clinic (Table 2 theme 12). Social scale of power at household played an important role in deciding where women gave birth. Despite the fact, care during motherhood appeared to be a negligible concern in the conflict of power, most of the women had any say over whether they could have institutional delivery because of their socio-economic and customary dependence on men (Table 2 theme 13). Women's decision whether to seek delivery care from the health centre was influenced by the hospital fear

and surgery. As some women considers hospitals or health centre were generally a place for treating serious diseases. So, having delivery in hospitals would assume that 'something abnormal' had happened to their bodies when pregnancy is normal for women (Table 2 theme 14).

Household Decision On Obtaining Postnatal Care

Majority woman said that there was no need to go for postnatal check-up as everything was normal. Women did not go for any post-natal check-up particularly for normal delivery but those who had complication or caesarean baby, they went to doctors or health centres only once or twice for post-natal check-up (Table 2 theme 15).

Discussion

Decision-making is recognized as multifaceted procedure strictly knotted with social belief and relations, so it requires to be analysed in the wider social context. Findings of other study shows that most trustworthy sources related to pregnancy information mothers, mother-in-law, female relatives, friends and neighbour. As knowledge to pregnancy was rooted with mothers' experiences that handed down between generations and gathered over experience differences with convincing information and guidance given by midwives, health workers and doctors (El-Nemer, Downe, & Small, 2006; Ginsburg & Rapp, 1991; Maimbolwa, Yamba, Diwan, & Ransjö-Arvidson, 2003; Withers, Kharazmi, & Lim, 2018). Therefore, childbirth should not be seen exclusively as medical phenomena but as a combined knowledge that highlights social connections and kinship bonds, corroborate a woman's status and individuality and attach her to the past.

The data suggest that there is a link between cultural beliefs about pregnancy and women's use of maternal care services. The opinions of the informants regarding the specific choice arise from a multifaceted set of situations and cultural conditions that is in line with other studies that. mentioned that cultural assumptions, cultural childbirth practices and beliefs influence women decision making about ANC and delivery (Akhter, S., Dasvarma, G. L., & Saikia, U. 2020; Withers et al., 2018; Rahman, M. M., Tabassum, T., Rahman, M. S., Uddin, A. N. M. M., Ahmad, M., Ferdousi, S. S., & Wahab, M. A. 2018; Maimbolwa et al., 2003). Some women identified the necessity for prenatal care and the possible benefits, including enriched knowledge, social assistance, and mental safety. The causes that stopped several women from observing to maternal care revealed rudiments particular mindsets: women did not give importance to the health problems of their children

nor their own, women faced problems to fulfil their needs, and women mentality were pervaded by emotions of shame and fear. The social images they embrace also showed qualities of a nature sketched by social rubrics that allocate certain characters to women, advancing gender difference. The finding revealed that careless about pregnancy, household activities and childcare were also regarded as causes for low uptake of maternal care which was similar to the findings of other studies that showed women prioritize their family and motherhood on the expense of their own health (Rahman, M. M., et.al., 2018; Choudhury et al., 2012; Gatrad, 1994; Liamputtong, Yimyam, Parisunyakul, Baosoung, & Sansiriphun, 2005).

This qualitative study showed that in Bangladesh mothers-in-law competed a significant part in the decision to receive ANC services and institutional delivery. Her hierarchy position in the family unimpeded her active participation in decision-making. In maximum examples, it was found that mothers-in-law did not support ANC visits and facility-based delivery. However, in few cases, knowledgeable mothers-in-law were encouraging and supported institutional deliveries. Mothers-in-law's own pregnancy experience and perceptions prejudiced to change their daughters-in-law's decisions regarding maternal healthcare. This attitude for not allowing to seeking support was due to sallow awareness about the significance of precautionary care as all mothers-in-law are in low level of education or were mostly uneducated (Mahumud, R. A., Alamgir, N. I., Hossain, M., Baruwa, E., Sultana, M., Gow, J., ... & Khan, J. A. 2019; Matsuyama & Moji, 2008).

In present study, women preferred to have female doctors, health technicians and nurses in maternal healthcare system, since women felt easier to communicate with them, both in terms of approachability and uncovering their figures during the physical examination. The finding was similar to other studies where it was found that choice for female doctors considered as an important barrier to service utilization (Mahumud, et al., 2019; Nigenda et al., 2003). The results would recommend that midwives were comfortable with freely giving out information about facilities-based services. Few research have mentioned that mid-wives view childbirth in a medical fashion while others feel that midwives fear being blamed (Kirkham, 1999; Olsson, Jansson, & Norberg, 2000) and were therefore disempowered. Traditionally, women's pregnancy was taken care within the boundaries of the family, and delivery was done by a female, so, the whole process was guided by females in general. With the discloser of medicine, pregnancy came to be part of the domain of science, an object of medical science, which was originally dominated by male professionals.

Conclusion

The social images sketched by the respondents who participated in this study intertwined cultural, emotional, social, and household features. The informants stated that gestation was not always a pleasant stage in their lives, given the undesirable moods that come about when getting maternal services. Fear of the unforeseen events indicated an adverse social image of maternal care among women. Their dialogues disclosed that seeking maternal support involved notions associated with the healthy birth of a child, as revealed by terrors of miscarriage or anxiety about their children being born physically challenged because of appropriate care. Thus, pregnant women should be given the chance to articulate their needs, additionally varied meaning of the pregnancy episode that have been developed in their journey of lives. Similarly, common and scientific information should be conveyed together so as to function in a complete way. This would permit healthcare experts to convey the exclusivity of pregnancy and childbirth and to offer supportive care on mother's health. Since pregnancy is influenced by cultural, biological, social, economic and religious aspects it is recommended that a human approach to healthcare should be promoted. These features should be addressed in the guidelines of the publicly funded program for humanization of maternal healthcare, which is based on the assumption that prenatal, delivery and postnatal assistance were human rights. Since a mutual fact of social images and women's desires and expectations can play an important role in safeguarding extensive and more effective coverage of maternal healthcare, health authorities and to those in charge of maternal care services should pay special attention on these issues.

Reference

Acharya, L. B., & Cleland, J. (2000). Maternal and child health services in rural Nepal: does access or quality matter more? *Health policy and planning, 15*(2), 223-229.

Akhter, S., Dasvarma, G. L., & Saikia, U. (2020). Reluctance of women of lower socio-economic status to use maternal healthcare services–Does only cost matter? *Plos one*, *15*(9), 1-14.

Amin, R., Shah, N. M., & Becker, S. (2010). Socioeconomic factors differentiating maternal and child health-seeking behavior in rural Bangladesh: A cross-sectional analysis. *International journal for equity in health, 9*(1), 1-11.

Awusi, V., Anyanwu, E., & Okeleke, V. (2009). Determinants of antenatal care services utilization in Emevor Village, Nigeria. *Benin Journal of Postgraduate Medicine, 11*(1), 21-26.

Bhatia, J. C., & Cleland, J. (1995). Determinants of maternal care in a region of South India. *Health transition review*, 5(2), 127-142.

Bulatoo, R., & Ross, J. (2000). Rating maternal and Neonatal Health Programs in Developing Countries. *Chapel Hill, NC: MEASURE Evaluation Project, University of North Carolina, Carolina Population Centre*.

Chakraborty, N., Islam, M. A., Chowdhury, R. I., & Bari, W. (2002). Utilisation of postnatal care in Bangladesh: evidence from a longitudinal study. *Health & social care in the community, 10*(6), 492-502.

Choudhury, N., Moran, A. C., Alam, M. A., Ahsan, K. Z., Rashid, S. F., & Streatfield, P. K. (2012). Beliefs and practices during pregnancy and childbirth in urban slums of Dhaka, Bangladesh. *BMC Public health, 12*(1), 1-6.

El-Nemer, A., Downe, S., & Small, N. (2006). 'She would help me from the heart': an ethnography of Egyptian women in labour. *Social Science & Medicine, 62*(1), 81-92.

Fauveau, V., Koenig, M. A., Chakraborty, J., & Chowdhury, A. (1988). Causes of maternal mortality in rural Bangladesh, 1976-85. *Bulletin of the World Health Organization, 66*(5), 643-651.

Gatrad, A. (1994). Attitudes and beliefs of Muslim mothers towards pregnancy and infancy. *Archives of disease in childhood, 71*(2), 170-174.

Ginsburg, F., & Rapp, R. (1991). The politics of reproduction. *Annual review of Anthropology, 20*(1), 311-343.

Kirkham, M. (1999). The culture of midwifery in the National Health Service in England. *Journal of Advanced Nursing, 30*(3), 732-739.

Liamputtong, P., Yimyam, S., Parisunyakul, S., Baosoung, C., & Sansiriphun, N. (2005). Traditional beliefs about pregnancy and child birth among women from Chiang Mai, Northern Thailand. *Midwifery, 21*(2), 139-153.

Mahumud, R. A., Alamgir, N. I., Hossain, M., Baruwa, E., Sultana, M., Gow, J., ... & Khan, J. A. (2019). Women's preferences for maternal healthcare services in Bangladesh: evidence from a discrete choice experiment. *Journal of clinical medicine*, *8*(2), 132-152.

Maimbolwa, M. C., Yamba, B., Diwan, V., & Ransjö-Arvidson, A. B. (2003). Cultural childbirth practices and beliefs in Zambia. *Journal of Advanced Nursing, 43*(3), 263-274.

Matsuyama, A., & Moji, K. (2008). Perception of bleeding as a danger sign during pregnancy, delivery, and the postpartum period in rural Nepal. *Qualitative health research, 18*(2), 196-208.

National Institute of Population Research and Training (NIPORT), MEASURE Evaluation, and icddr,b. (2012). *Bangladesh Maternal Mortality and Health Care Survey 2010.* Dhaka, Bangladesh: NIPORT, MEASURE Evaluation, and icddr,b.

National Institute of Population Research and Training (NIPORT), International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b), and MEASURE Evaluation. (2017). *Bangladesh Maternal Mortality and Health Care Survey 2016: Preliminary Report*. Dhaka, Bangladesh, and Chapel Hill, NC, USA: NIPORT, icddr,b, and MEASURE Evaluation.

National Institute of Population Research and Training & ICF International. (2020). *Bangladesh Demographic and Health Survey, 2017-2018*. Dhaka, Bangladesh, and Rockville, Maryland, USA.

Nigenda, G., Langer, A., Kuchaisit, C., Romero, M., Rojas, G., Al-Osimy, M., . . . Ba'aqeel, H. (2003). Womens' opinions on antenatal care in developing countries: results of a study in Cuba, Thailand, Saudi Arabia and Argentina. *BMC Public health, 3*(1), 1-12.

Olsson, P., Jansson, L., & Norberg, A. (2000). A qualitative study of childbirth as spoken about in midwives' ante-and postnatal consultations. *Midwifery, 16*(2), 123-134.

Organization, W. H. (2001). *Advancing safe motherhood through human rights*. Retrieved from https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/RHR_01_5/en/ (Accessed on 22 May 2019)

Rahman, M. M., Tabassum, T., Rahman, M. S., Uddin, A. N. M. M., Ahmad, M., Ferdousi, S. S., & Wahab, M. A. (2018). Perceptions of Decision-making in Accessing Reproductive Healthcare Services of Urban Women. *Journal of Armed Forces Medical College, Bangladesh*, *14*(1), 15-20.

Simkhada, B., Porter, M. A., & Van Teijlingen, E. R. (2010). The role of mothers-in-law in antenatal care decision-making in Nepal: a qualitative study. *BMC pregnancy and childbirth, 10*(1), 1-10.

Titaley, C. R., Hunter, C. L., Dibley, M. J., & Heywood, P. (2010). Why do some women still prefer traditional birth attendants and home delivery?: a qualitative study on delivery care services in West Java Province, Indonesia. *BMC pregnancy and childbirth, 10*(1), 1-14.

Withers, M., Kharazmi, N., & Lim, E. (2018). Traditional beliefs and practices in pregnancy, childbirth and postpartum: A review of the evidence from Asian countries. *Midwifery, 56*, 158-170.

Zakaria, M., Khan, A. K. M., Ahmad, M., Cheng, F., & Xu, J. (2021). Women's perception of male involvement in antenatal, childbirth and postnatal care in urban slum areas in Bangladesh: A community-based cross-sectional study. In *Healthcare 9*(4), 473-483. Multidisciplinary Digital Publishing Institute.