Women's Voices in Maternal Health: Autonomy in Prenatal Care amongst Pregnant Women

A Thesis Submitted by

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Submitted to the Department of Economics and Social Sciences in partial fulfillment of the requirements for the degree of Bachelor of Social Sciences in Anthropology

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Declaration

I hereby declare that:

1. The thesis submitted is my own original work while completing my degree at BRAC University.
2. The thesis does not contain material previously published or written by a third party, except where it is appropriately cited through with full and accurate referencing.
3. The thesis does not contain material which has been accepted, or submitted, for any other degree or diploma at a university or other institution.
4. I have acknowledged all main sources of help.

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Approval

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Abbreviations & Acronyms

ANC	Antenatal Care
BAPSA	Association for Prevention of Septic Abortion
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
CRI	Centre for Research and Information
IVP	Intimate Partner Violence
IVPAW	Intimate Partner Violence against Women
KII	Key Informant Interviews
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MNCH	Maternal Neonatal and Child Health
NGO	Non-governmental Organization
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
TFR	Total Fertility Rate
UN	United Nations
USAID	United States Agency for International Development
UNISEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization

Abstract

Bangladesh has made significant progress after independence and is often seen as a development model for other countries, particularly in closing the gender gap. However, one pressing issue that persists is the high maternal mortality rate among women. Despite recent improvements, maternal health remains a concern. A major reason for this is the underutilization of maternal healthcare services. The key to improving maternal health care utilization is women's autonomy. This dissertation explores the perspectives of pregnant women regarding autonomy during prenatal care. It seeks to understand how pregnant women perceive autonomy in maternal health care and their stance within their families when seeking such care. The study also investigates how these perspectives vary across different generations and occupational backgrounds, shedding light on the influence of age and occupation in shaping perspectives. Additionally, the research delves into the impact of social, cultural, and economic factors on these varying perspectives among different groups of pregnant women aiming to uncover why these variations exist. This qualitative study collected primary data through in-person interviews with pregnant women, healthcare professionals, and NGO experts. The findings reveal that a pregnant woman's perception of autonomy is often linked to the degree of autonomy they experience in their lives. When considering occupational and generational differences, unemployed women, typically homemakers, tend to view autonomy as adaptation or adjustment, while employed women see it as a preexisting privilege. The older generation, those above 50 years old, often did not grasp the concept of maternal autonomy during their pregnancies. Furthermore, cultural influences like media, economic factors such as education and employment, social dynamics within families, and the concept of body ownership all play significant roles in shaping these varying

perspectives among pregnant women. To analyze these findings, the study employs Anthony Giddens' theory of "Structuration." This theory helps us understand how women's autonomy is influenced by the rules and resources within a given social structure. Importantly, the study highlights how a woman's autonomy perspective and agency can, in turn, influence these rules and resources. Ultimately, an individual's autonomy can shape their perspective on autonomy itself. Therefore, this dissertation contributes to existing research by focusing specifically on pregnant women's perspectives during prenatal care. It also adds to existing theories by demonstrating how autonomy can be influenced by a structure's rules and resources, and how an individual's autonomy perspective and agency can, in turn, impact these structural elements.

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Chapter 1

Introduction

1.1 Statement of the problem:

Over the past 52 years, Bangladesh has become a role model of development for its great achievements. Bangladesh was the second-poorest nation in the world when it gained independence on December 16, 1971, making its transformation over the ensuing 52 years one of the most remarkable tales (World Bank, 2023). The country has made significant progress in achieving the Millennium Development Goals (MDGs) and is committed to achieve Sustainable Development Goals (SDGs) as well (Hoque, 2022). Bangladesh has made incredible economic progress over the past 52 years despite its limited resources. According to the Centre for Research and Information or CRI (2019), in the most recent ten years, the GDP growth rate has impressively surpassed all previous records and the average annual income has been increasing. Also, it performs among the best in the world at eradicating poverty (CRI, 2019). Among all these success tales, Bangladesh's performance in achieving gender parity stands out, as the nation took first place among south Asian nations as a result of the higher involvement of women in socioeconomic and political activities (CRI, 2019). Despite recent substantial progress, there are still huge gaps that women face in areas including access to healthcare, political representation, employment, and education (Rahman, 2023). Women in Bangladesh continue to have difficulty accessing decent healthcare and reproductive rights due to gender inequality that remains (Rahman, 2023).

In recent years, Bangladesh has managed to reduce maternal mortality rate as according to a report of United Nations, maternal mortality in Bangladesh has decreased from 441 deaths per 100,000 live births in 2000 to 123 deaths in 2020, the rate is still extremely high (New age, 2023). Inequitable utilization of maternal health care services is one of the significant factors that are adversely affecting the decline rate of maternal mortality rate in Bangladesh (Haider et al., 2017). In Bangladesh, the utilization of maternity healthcare is significantly influenced by women's autonomy (Abedin et al., 2020; Haider et al., 2017; Haque et al., 2012). Not only maternal morality but also high-risk pregnancy is influenced by women's autonomy, freedom of movement and economic autonomy as 45% women in Bangladesh face high-risk pregnancy issues that are associated with their autonomy (Abedin et al., 2020). According to Haider (2017), women's autonomy is increased by their participation in social and economic activities. Also, female literacy, educational attainment, and the economic status of households are other elements that influence women's autonomy. Even though there is substantial evidence showcasing the beneficial effects of Bangladeshi women's independence on the utilization of maternal healthcare in the studies of Akter et al. (2023); Anwar et al. (2015), Kamal et al. (2016); Methun et al. (2022) and others that have been discussed in chapter 2, a significant number of women continue to encounter societal limitations that restrict their mobility and decision-making power for themselves and their children (Haider, 2017).

However, there is hardly any existing research focusing on how women from different backgrounds perceive autonomy during pregnancy, especially during prenatal care as prenatal care is initial and one of the most important stages of maternal health care (khatun & Khatun, 2018). In this context, this dissertation aims to examine pregnant women's perspective on autonomy during prenatal care; it attempts to understand the difference of those perspectives

among employed, unemployed and older generation of pregnant women and the social, cultural and economic factors that influenced the changes in perspectives.

1.2 Research question:

1. What is pregnant women's perspective on autonomy during prenatal or antenatal health care?
2. How do perspectives on autonomy during prenatal or antenatal health care vary across different occupational and generational groups?
3. Are there any specific social, cultural or economic factors that contribute to the variations in perspectives on autonomy during prenatal or antenatal health care among pregnant women?

1.3 Research objective:

1. To examine a woman's understanding of autonomy, body ownership, self-assurance and their stance in the family while seeking health care services during pregnancy.

2. To find out if women with different economic background, educational background, family background and time period have different perspective on autonomy during pregnancy and prenatal health care.

3. To understand the social, cultural and economic factors that influenced those changes in perspectives and the reason behind no changes in perceptions.

1.4 Methodology:

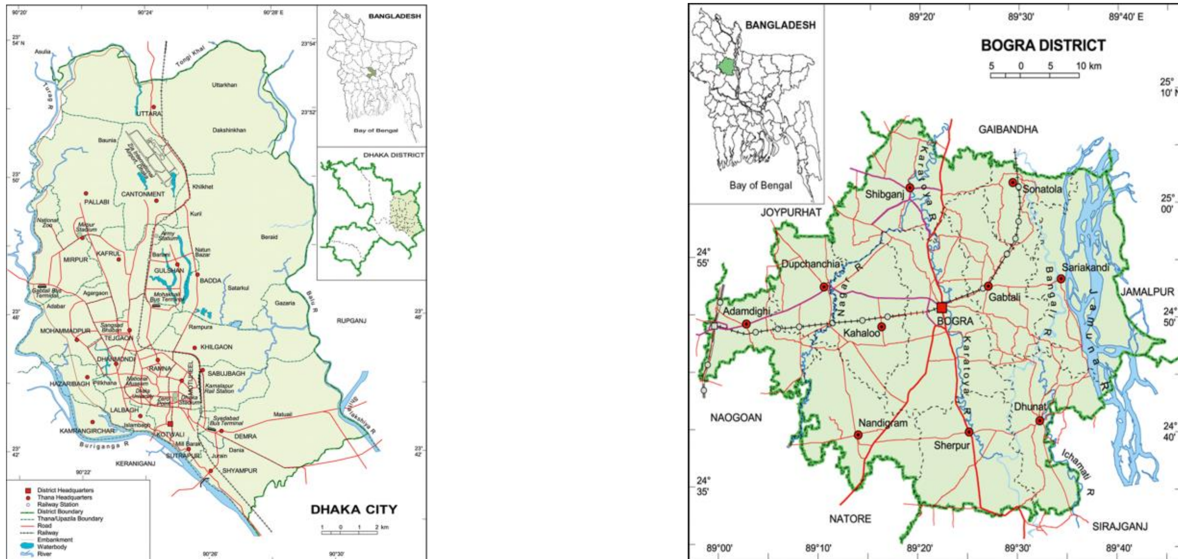
This dissertation is a qualitative study focusing on pregnant women's perspectives on autonomy during prenatal care. Qualitative approach is appropriate for this research as it allows participants

to share their lived experiences and perceptions regarding events in their lives. It also provides researchers with the opportunity to understand the subjective experiences of others and to comprehend the world from their unique perspectives (Austin, 2014). Therefore, this method helps to understand each interviewed woman's unique experience of pregnancy and prenatal care; perspective on autonomy and evaluation of those perspective within different groups. The general objective of this study is to examine a woman's understanding of autonomy and their stance in the family while seeking health care services during pregnancy. The specific objective of this study is to find out if women from different occupational background and generation have varied perspectives on autonomy during pregnancy. Furthermore, another goal of this dissertation is to understand the factors that influenced those changes and the reason behind no changes in perceptions. This study centers its focus on the perspectives of pregnant women, as the utilization of maternal health care is intrinsically linked to the degree of autonomy they possess within their households. Understanding how pregnant women perceive autonomy, particularly in the initial stages of maternal health care such as prenatal care, serves as a foundational step in promoting and safeguarding maternal autonomy throughout the maternal health care journey.

1.4.1 Research Location

For my research, I selected Dhaka and Bogura as my study areas. While I could have focused solely on conducting case studies involving hospitals, clinics, and patients in Dhaka, I opted to include Bogura, a different district, to introduce diversity among the respondents. Additionally, since Bogura is my hometown, it has been more convenient for me to navigate the town and conduct interviews, especially given the limited timeframe for completing my dissertation.

Figure 1: Maps of Research Location



During the initial phase of my fieldwork within Dhaka, I conducted interviews at the BAPSA (Bangladesh Association for Prevention of Septic Abortion) maternity clinic. This choice was driven by my prior experience conducting research with patients at this clinic for my previous dissertation topic (which was cancelled later). Subsequently, during the second phase of data collection, I carried out interviews at two locations in Bogura: the Popular Diagnostic Center and the Regional Labor Office clinic. I preferred clinics over hospitals for this research due to their typically lower patient volume and the increased cooperation of clinic staff. This strategic selection of research locations and the rationale behind it helped streamline my data collection process and contributed to the overall effectiveness of my dissertation research.

1.4.2 Data collection:

To attain the goals of this dissertation, data has been collected through primary and documentary research (secondary resources). The research has been conducted utilizing a qualitative analysis

for the primary data collection. Therefore, this study has conducted the research in 2 methods based on the distinct objectives:

Interviews

In this dissertation, I have conducted Interviews as it allows collecting in-depth and detailed information. This helps in understanding the complexity of participants' experiences, attitudes, and perspectives regarding topic like maternal autonomy. Moreover, interviews offer valuable insights and flexibility and enable to ask follow-up questions or delve into unexpected areas and this has contributed to a comprehensive understanding of the respondent's views on autonomy during prenatal care (Frances & Coughlan, 2016).

As qualitative method has been utilized here, the interviews were semi-structured and the questionnaire was prepared as open-ended so that it helps to clarify their perspectives through their experiences of pregnancy. Furthermore, in-person and semi-structured interviews has been essential as interviews helps to get insights to a person's subjective experiences and opinions (Busetto et al., 2020). Therefore to have a deeper understanding of each participant's perspectives and experiences in-person semi-structured interviews has been conducted.

To understand women's perspective of autonomy and change in perspective among different occupation and generation, this study has conducted one-on-one interviews with 14 women where 11 of them were taking prenatal care. While interviewing, their age and occupation have been emphasized to examine the differences in their experiences. The respondents have been divided into three groups; a group of unemployed pregnant women consisting 5 respondents (under the age of 30 years); another group of employed pregnant women consisting 6 respondents (under the age of 45 years) and the third group of unemployed older women (above

the age of 55 years). For the interviews, the questionnaire has been prepared in a way that focuses on the demography, family details, experience of maternal health care, support system, decision making process, conception about body ownership, relationship with family members, challenges and taboos these women faced during their pregnancy. The interviews have been taken with the help of maternal health care service providers to interview the women who have been taking prenatal health care services in their clinics and hospitals located in Dhaka and Bogura. Here, two different districts have been selected to bring variation in respondents. In terms of interviewing older generation, the respondents have been the mother or another family member of those patients.

Key Informant Interviews:

To understand the factors that influenced the changes in perspectives among employed, unemployed and older generation of women on autonomy during pregnancy, this study has conducted Key Informant Interviews (KII). The respondents have been chosen from the NGOs, clinics and hospitals. Service providers and doctors who provide maternal health care services to pregnant women have been interviewed. Conducting KII with them provided me with the opportunity to have deeper understanding of the reason behind changes or no changes of perspectives among different women.

The KII has enabled a broader discussion that investigated issues regarding women's autonomy during pregnancy. As the service providers and doctors have expertise in these areas, the discussion focused on how age, occupation, educational background and time frame may or may not influence a woman's idea about autonomy, controlling their own body and resources. Also, the discussions have highlighted a woman's struggle to understand their needs during pregnancy;

and the importance of autonomy during pregnancy. Furthermore, it has focused on the factors that may have helped to change a woman's health care seeking behavior within different time frames. The KII has helped to have an overview of women's maternal health care during and the factors that influences their perception of bodily autonomy.

Table 1: Profile of KIIs

KIIs	**Number of Interviews**	**Nature of Interview**	**Reason For Selection**	**Collected Information**
Gynecologists	2	One-on-one	Provides prenatal care to pregnant women and are aware of patient's individual experiences of pregnancy.	Variations among Pregnant women in terms of different backgrounds. Factors related to the variations.
Service provider (NGO Program Manager)	1	One-on-one	Provides health care services to pregnant women and are aware of their challenges.	Discussion on generational differences among pregnant women; the factors influencing the changes and policies related to the issue.

1.4.3 Documentary Research:

Documentary resources have been used as secondary resources in this dissertation for background context. A thorough literature review has been done using journal articles, books, newspapers, NGO reports, and the internet. Primary data and secondary data have been combined to identify the main issues of the research topic. Furthermore, a relatively small number of interviews have been conducted as this is an undergrad thesis. Therefore, it was essential to establish the significance of primary data using information from secondary sources in order to complete this study. The secondary data that have been utilized in this dissertation are

retrieved from World Bank, UNISEF, WHO, UN, BBS (Bangladesh Bureau of statictics), CRI (Central Research Information), and ethnography papers regarding women's health care, maternal health care and maternal autonomy.

1.4.4 Data Analysis:

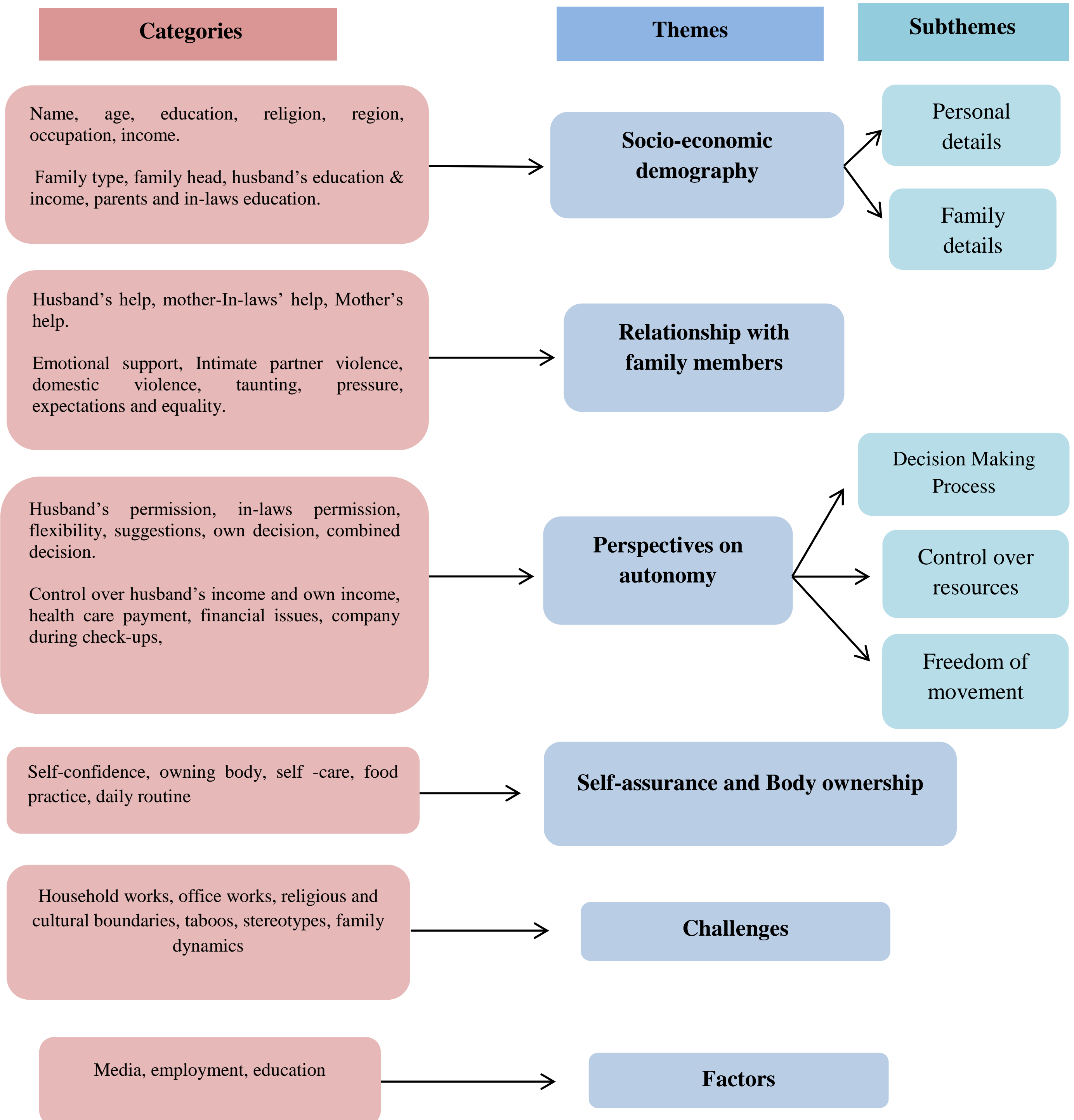
The interviews were conducted in-person and have been recorded. The duration of each recorded interview ranged from 18 to 50 minutes. In addition, there were follow-up in-person interviews that took place later. They agreed to let me record and take notes throughout the interviews so I could utilize the relevant quotes while maintaining their anonymity. Each responder gave their consent voluntarily and was given the freedom to stop at any time. Two of the interviews have been deleted halfway through as the respondents were not comfortable to share their family dynamics. To accurately assess the situations of the respondents and ask additional crucial questions, the interview questionnaire was semi-structured. Throughout the interviews, participant observation helped to have an empathetic understanding of whether they were confortable to talk to me or not.

However, Following the interviews, the recordings were first transcribed, and then where needed, they were translated into English. Second, each participant had their own case study created from the interviews. Given that the questionnaire was semi-structured and open-ended, it was simpler to learn more about them and consider their experiences. This allowed the respondents to define and frame their challenges from their viewpoints and also helped me to look outside of the intended framework and comprehend the similarities and differences among numerous aspects. Third, the interviews that were conducted were analyzed and used as findings that complemented this dissertation's goals. During the analysis numerous new aspects emerged

because of the interviews as it allowed the respondents to share their experiences without any boundaries.

In the process of analyzing my findings, I initially conducted a coding of the transcriptions to identify distinct categories of data that could be subjected to further analysis. Utilizing coding techniques, I came up with categories and then identified six themes. Some of the themes were extended with several subthemes.

Figure 2 : Thematic Arrangement



1.5 Theoretical framework:

In this dissertation, this theory of "Structuration" by Anthony Giddens have been used to examine how the pregnant women's perspectives on autonomy are shaped and influenced by the social structures they are embedded in, such as their cultural, familial, and societal contexts. The concept of duality of structure have been used to investigate the differences in autonomy perspectives among housewives, jobholders, and the older generation and to find out if there are any specific social structures, norms, or practices within each group that contribute to distinct perspectives on autonomy during prenatal health care. Finally, the theory have been helpful to identify the factors that lead to changes in perspectives on autonomy during pregnancy considering economic background, educational background, relationship dynamics within the family, and how these factors interact with social structures to influence changes in autonomy perspective.

1.5.1 Structuration theory by Anthony Giddens

According to Giddens (1971), an individual's autonomy is influenced by the structure and the structure is influenced, maintained and adopted by the practice of individual's agency. According to Anthony Giddens's structural theory, neither structure nor action/agency can exist on their own as they are closely related, neither one should be favored over the other (Dixon, 2011). With the theory of "Structuration", Anthony Giddens provides us the basis of the identification of the interaction between individuals and the societal factors that influence us. Giddens attempts to balance the role that an individual play with their constrained options for positions in history and in the social fabric they find themselves in. His theory contends that despite people's limited knowledge and partial control over their actions, these factors are what reshape the social order

and bring about social change (Craib, 1992, pg.33; Lamsal, 2012). In this dissertation, the theory of "Structuration" by Anthony Giddens is used in the context of pregnant women's perspectives on autonomy.

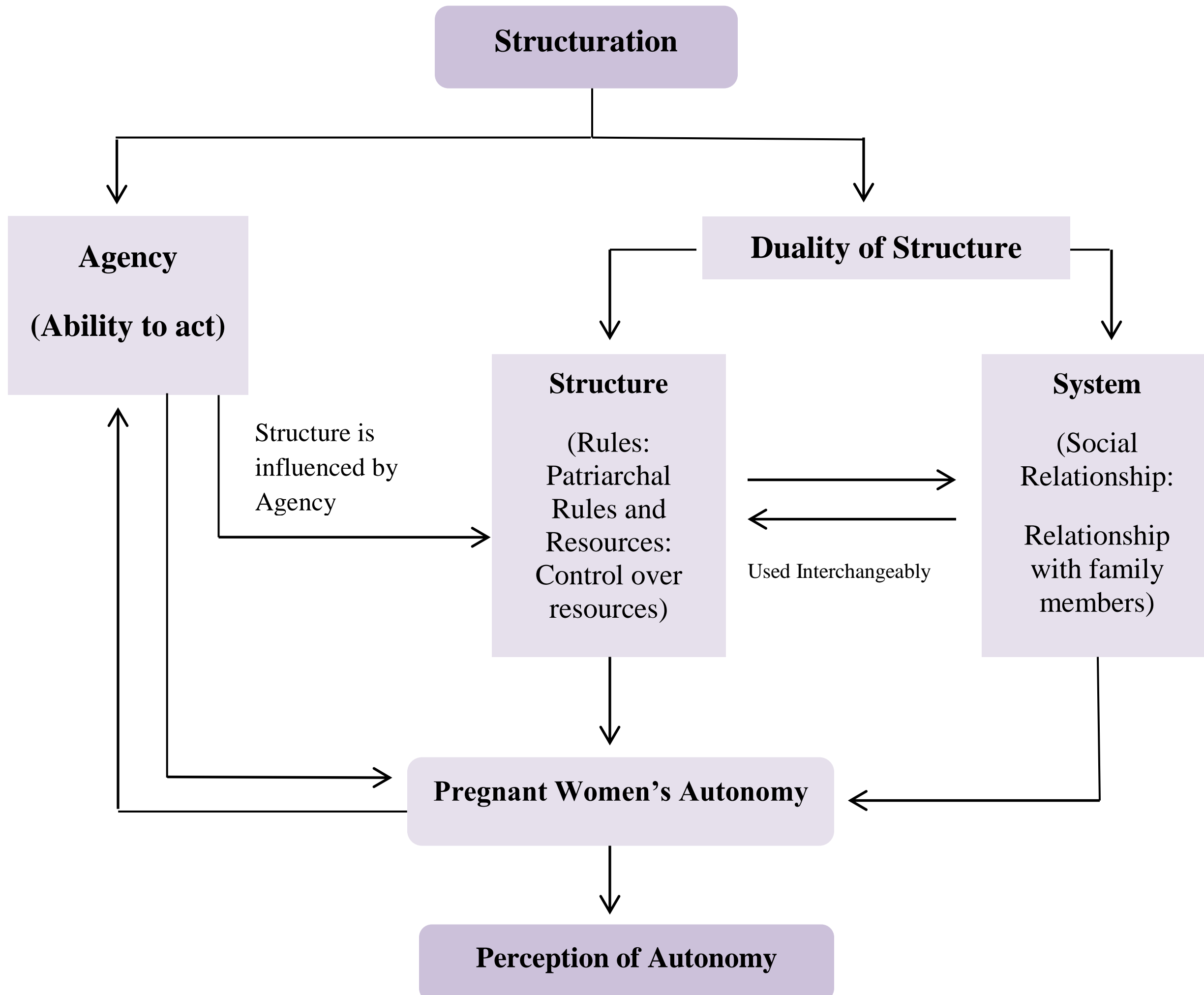
Anthony Giddens is one of the prominent British sociologists who first came up with the term "structuration" or talked about the "structuration theory" in his 1976-1977 book "New Rules of Sociological Method and in Functionalism" which was influenced by Durkheim's work named "The Rules of Sociological Method" (Clark, 1986; Fuentes & Lataza, 2008). In this book, Giddens reverse Durkheim's idea of "Social Facts" and argues that individual and society complete each other as society influences people and people construct support and change the society (Horne & Jary, 2004). He also adds that every individual is an active component of society as they are able to go against the constraints imposed on them by the society and they change their social situation with their knowledge. Moreover, to him human behavior cannot be predicted and the structural forces of society alone cannot determine human behavior (Fuentes & Lataza, 2008). Therefore, Anthony Gibbens in his theory of "Structuration" basically argues that even though actions of people are influenced by the society as their knowledge about it is restricted, they are the elements of the society that influence social structure and social changes (Lamsal, 2012). The summation of the theory is divided into two in his work "The Constitution of Society" in 1984; one is ontology that included concepts like structure and agency, knowledge and motivation, time and space, norms and power. The other one is epistemology that includes theoretical measurement of the qualities and dynamics of different kinds of institutions and social systems (Giddens, 1981 and 1985; Lamsal, 2012; Stones, 2020).

In the “Structuration” theory, according to Giddens, structure and agency cannot be separated and to connect these two together he came up with the term “Duality of Structure” (Lamsal, 2012; Fuentes & Lataza, 2008; Horne & Jary, 2004). Here, by structure Giddens means the virtual existence of two elements; “rules” and “resources” that is used or altered in a people’s daily life (Dixon, 2011). Rules and resources together create “Social Reality” and individually they are the properties of practical actions that have real effects but they exist in “memory traces” (Horne & Jary, 2004). Moreover, Giddens suggests structure as traditions, institutions, moral codes and other sets of expectations that are generally constant; they may alter as a result of unintended consequences (Lamsal, 2012). There are three components of structures such as power, meaning, and norms (Giddens, 1976, 118-26, 161;1979, 81-94, Stones, 2020). However, in Giddens’s theory, “structure” and “system” are used interchangeably. Here, system refers to the patterns of social relationship in society and these relationships are considered as macro features of society whereas the structure is rules and resources that help an actor to produce or reproduce the society. Here, rules are used contextually in daily life, sometimes codified, some are unwritten. Also, resource is of two kinds; allocative resources (material resources) that enables people to get things done and authoritative resources (non-material factors) that enables people to have authority over others. To Giddens, resource provides human with power that helps human to achieve the ability bring change in their life and social circumstances (Fuentes & Lataza, 2008). Therefore, rules are a composite of meanings and norms, and resources refer to power (Stones, 2020).

Agency is another important concept of Anthony Giddens “Structuration Theory”. According to Giddens, 'Agency' refers to two fundamental human abilities: 'acts' and 'activities.' 'Acts' are

individual actions that occur step by step, while 'activities' are the ongoing engagements of independent individuals (Cloke, 1991, pg. 99)..

Figure 3: Theoretical Framework



According to structuration theory, human agency, which is the ability to act, is always influenced by power dynamics. This theory suggests that agency is the key element in bringing about any kind of change in society (Lamsal, 2012). Giddens also talks about "the dialect of control" which

means the power one person has over another depends on the power held by the other person. Power is not unlimited, and no single person possesses absolute power while others are powerless. This means that people are never entirely helpless when someone else exerts control over them (Fuentes & Lataza, 2008).

Globalization and time-space is another significant concept that is related to Ginddens's theiry of Structuration. According to Giddens, Globalization has profoundly impacted various aspects of our lives, from economic and political ties to social and cultural frameworks. It has transformed the way we interact, gain knowledge, and conduct business. The internet, exemplified by Wikipedia, has revolutionized knowledge-sharing and expanded actors' influence on world affairs through remote interactions and virtual spaces. Giddens' Structuration theory has been instrumental in understanding how routine behaviors shape society's structure, introducing the concept of time-space geography. Globalization, a widely recognized phenomenon, has significantly altered daily routines, with technology replacing traditional marketplaces. People now unconsciously navigate virtual spaces through constant connectivity to communication sources, blending with physical space and time. Overall, globalization's impact, though debated, is undeniable, fundamentally altering the way we experience and interact with the world (Fuentes & Lataza, 2008; Lamsal, 2012).

Giddens theory of "Structuration" has been used widely by many authors around the world in their papers. For example, authors such as Barley and Tolbert, 1997; Bastien et al. 1995; Jones et al. 2000; Poole and Desanctis, 1993; Riley, 1983; Smith, 1983; Witmer, 1997; have used structuration theory in their organizational papers related to Business. Moreover, Farrall and Bowling, 1999; have used this theory in criminology and Browning, 1994; Gambetta, 1987;

Layder et al., 1991 used this theory in Education. Also, in sectors like housing and land-use development, family and women, migration and social development, authors like Burman, 1988; Apyter and Garnsey, 1994; Halfacree, 1995 and Carlsnaes, 1992 (Phipps, 2001).

This theory has proven to be instrumental in the analysis of the research objectives, providing a more profound understanding of the dissertation's subject matter.

1.6 Significance of the Research:

In Bangladesh, maternal mortality rate (MMR) is still considered to be high although there has been huge transformation in last 10-15 years. According to Bangladesh Bureau of Statistics (BBS) (2007), in 2007, the MMR has been 348 per 100,000 live births which reduced to 144 per 100,000 live births by 2015 and later in 2020, the rate dropped down to 123 deaths per 100,000 live births (world Bank, 2023). Despite this improvement, the rate is higher because of the low maternal health care utilization; service accessibility, demographic, and socioeconomic factors (Haque et al., 2012). The major reason of lower utilization of maternal health care and High-risk pregnancy is women's autonomy as Bangladesh is a highly patriarchal society, where traditional gender paradigms exist and women are considered as subordinate to men in almost all aspects of their lives that influences the use of pregnancy care services (Abedin et al., 2020; Haider et al., 2017; Haque et al., 2012). There are numerous studies that talk about the importance of women's autonomy for the proper utilization of maternal health care in Bangladesh and handful of literature that discuss women's and midwives perception on antenatal care and post natal care yet there is barely any research that examines women's idea of autonomy during pregnancy and prenatal health care service. Therefore, this dissertation is going to contribute data for future research and add more to existing literature focusing on pregnant women's individual conception

of autonomy during prenatal health care and overall maternal health care. This thesis aims to conduct a qualitative research with in-person interviews and highlight a woman's perspective on autonomy during their pregnancy and the occupational and generational differences of those perspectives. Here, the outcome of this study will significantly contribute to find out if pregnant women in Bangladesh are aware of the idea of autonomy during pregnancy and the importance of autonomy for betterment of their own body and their children. This will also help future research to find out the strategies following which women in Bangladesh can participate in decision making in their families and strengthen their rights as only 42 per cent married women in Bangladesh participate in decision making process regarding health care whereas 19 per cent do not even have that autonomy in any aspect of their lives (Haider, 2017). Moreover, as the dissertation will focus on factors that changed women's perspectives, it will contribute to in figuring out the ways to improve maternal health care in Bangladesh based on the factors.

1.7 Organization of the thesis:

This dissertation studies women's perspectives on autonomy during pregnancy and occupational and generational difference of those perspectives among employed, unemployed and older generation. This thesis is structured in 5 chapters. Chapter 1 covers background context, including research question and objectives, methodology, theoretical framework, significance of the research and organization of the thesis. In Chapter 2, the review of prior research and the identification of research gap are discussed. Chapter 3 presents the findings from case studies and key informant interviews (KII) that have gathered regarding the factors that changed the perspectives among different women. In chapter 4, I have analyzed the finding and connected it with the existing literature and KIIs. Since the findings are based on in-depth interviews, they

will enhance the data and offer evidence for previous studies in this field. Finally, in Chapter 5, conclusion with overall summary, recommendations, limitations, and a further research section is provided.

Chapter 2

Literature review

2.1 Women's health Care:

Initially, it is important to concentrate on the general situation of women's health care in Bangladesh in order to gain a deeper knowledge as one of the goals of this study is to comprehend pregnant women's understanding of autonomy during prenatal or antenatal health care services. Understanding the state of women's health care would provide us a better understanding of their access to health care services, gender-related health care challenges, and the availability of health care services for women in the Bangladesh. In this part, women's health conditions that are directly or indirectly connected to maternal health care have been highlighted and emphasized.

It has been crucial to strengthen women's health care services across the nation as the government makes every effort to safeguard women's overall development and achieve MDGs

(Millennium Development Goals) 2015. The maternal mortality rate has decreased by more than 66 per cent over the past 20 years, and maternity leave has been increased from four to six months (CRI, 2019). A 2013 study by various UN organizations projected Bangladesh's MMR to be 170 per 100,000 live births. Though, according to UNICEF (2021), there were 176 deaths per 100,000 live births in 2019. This high rate is primarily attributed to the poor quality of care and limited access to healthcare services, especially in rural areas (Chowdhury et al., 2020). Moreover, by 2030, the present administration wants to lower the MMR to 63 per 100,000 live births. Furthermore, primary health care services are being provided by community clinics to rural, marginal and vulnerable women. A voucher package for three antenatal checks, a safe delivery with trained birth attendants, one post-natal checkup, and transportation costs is offered through maternal health voucher programs (CRI, 2019).

For Bangladeshi women, malnutrition is a serious health concern as many of the women are undernourished. Bangladesh has one of the highest rates of malnutrition in the world, with 36.1% of women of reproductive age being underweight, according to a World Bank study (World Bank, 2021). Numerous health issues, such as anemia, stunting, and unfavorable pregnancy results, can be brought on by malnutrition.

Anemia is a common health issue among Bangladeshi women, with an estimated 51% of women between the ages of 15 and 49 suffering from the condition (UNICEF, 2021). Anemia can have detrimental effects on both maternal and child health, increasing the chance of maternal mortality, causing low birth weight, and impairing children's cognitive growth. Another major health issue caused by malnutrition in Bangladesh is stunting. The situation known as stunting occurs when a child's height is below the average for their age as a result of poor nutrition. The

World Bank estimates that 31.4% of Bangladeshi infants under five have stunted growth (World Bank, 2021). Stunting can have long-term effects on a child's health and development, including hampered cognitive growth and an elevated chance of developing chronic diseases in later life. Malnutrition is also linked to poor pregnancy results in Bangladeshi women. Undernourished women are more likely to experience pregnancy complications, like premature birth and low birth weight infants, which could have a long-term negative impact on the child's health (UNICEF, 2021).

Bangladesh also has a high prevalence of reproductive health problems, such as early marriage, unintended pregnancy, and illegal abortion. With 51% of females getting married before they turn 18, the nation has one of the highest rates of child marriage in the world (UNICEF, 2021). In Bangladesh, a sizable percentage of maternal deaths are caused by unsafe abortions.

However, the sufferings of women in Bangladesh do not end with these diseases or health issues rather it extends to a point where they face gender related problems. It is believed that Bangladesh has worked really well closing gender gap but gender inequality affects women's access to healthcare services in Bangladesh. For example, Bangladeshi women have limited access to healthcare facilities because of obstacles related to distance, transportation, and cost. In addition, there are numerous social and cultural obstacles that prevent women from getting healthcare, including mobility restrictions, lack of female healthcare professionals, and requirements for male guardianship (Afsana & Rashid, 2016). Also, due to a variety of factors, including a lack of knowledge, inadequate schooling, and the belief that healthcare services are irrelevant to their requirements, women in Bangladesh frequently neglect healthcare services (Hossain, Ross, & El Arifeen, 2018). Another problem is that Bangladeshi women have little

control over their health, which limits their ability to use healthcare facilities. When it comes to making choices about their health, including when and where to seek medical attention, women frequently rely on male family members (Biswas & Kabir, 2015). Furthermore, healthcare professionals in Bangladesh discriminate against woman, which limits their access to high-quality medical treatment. Discrimination can take many different forms, including removing information, ignoring their health needs, and giving them poor treatment (Rahman & Haque, 2018).

However, in order to address serious health problems, the Government of Bangladesh and numerous non-governmental organizations (NGOs) are working to provide healthcare services to women in Bangladesh. For example, Maternal and Child Health services that focuses on antenatal and postnatal care, family planning services, and immunization programs and to implement these services a network of community clinics, union health and family welfare centers, and district hospitals have been established (USAID, 2021). Then, to improve nutrition among women and children initiatives like the National Nutrition Services Program are taken that offers pregnant and nursing women and young children under the age of two nutrition instruction, micronutrient supplementation, and food supplementation (USAID, 2021). Through awareness campaigns, health education, and screening programs, the government and non-governmental organizations are attempting to avoid and manage non-communicable diseases like diabetes and hypertension (WHO, 2017). Also, by establishing emergency obstetric care centers and training programs for healthcare professionals, the government and NGOs are trying to increase access to emergency obstetric and neonatal care. (UNFPA, 2021).

2.2 Maternal health care:

To understand women’s perspective on autonomy during pregnancy, it is crucial to shade light on the general state of maternal health care and the challenges women face while seeking maternal health care services in Bangladesh. This will highlight what women in general go through during their maternal health care on a whole and also focus on their condition during prenatal health care as this thesis emphasizes on autonomy while seeking prenatal or antenatal health care services.

Bangladesh has recently achieved notable improvements in a number of health outcomes, but maternal mortality has not changed as significantly (Methun et al., 2022). Despite a significant (59%) drop in maternal fatalities in South Asia since 2000, just this region was responsible for 19% of all maternal deaths worldwide. Bangladesh's maternal health situation continues to be of great concern. In 2020, the maternal mortality ratio (MMR), which was higher than that of other south Asian nations, was projected to be 163 per 100,000 live births (Methun et al., 2022). Later these data were updated as according to Bangladesh Bureau of Statistics (BBS) (2007), in 2007, the MMR has been 348 per 100,000 live births which reduced to 144 per 100,000 live births by 2015 and later in 2020, the rate dropped down to 123 deaths per 100,000 live births (world Bank, 2023).

One of the key determinants influencing maternal mortality is the utilization of maternal healthcare (Akter et al., 2023; Anwar et al., 2015; Kamal et al., 2016; Methun et al., 2022). Well, according to national health policy and World Health Organization (WHO) recommendations, Maternal, Neonatal, and Child Health (MNCH) are the basis of high-quality healthcare services and it guarantees high-quality prenatal or antenatal, birth, and postnatal care services (Huq et al.,

2023; Methun et al., 2022). According to Methun et al., (2022), as a part of the indications for sufficient maternal care, the World Health Organization (WHO) has suggested four antenatal visits for pregnant women, one of which should occur in the first trimester. Here, antenatal care or ANC is a crucial primary program created to safeguard and promote healthy mothers and healthy newborns through the early diagnosis of illness in pregnant women and the provision of the necessary treatment. ANC is an effective way to give guidance, education, reassurance, and support to improve maternal, perinatal, and neonatal outcomes (Khatun & Khatun, 2018). According to the World Health Organization (2011), Bangladesh has the second-highest rates of maternal mortality and morbidity after sub-Saharan Africa with poor prenatal and postpartum care, nutritional inadequacies, a high prevalence of using untrained delivery attendants, and nutritional deficiencies (Walton & Schbley, 2013). Also, the Bangladesh Demographic and Health Survey (BDHS) indicates, in Bangladesh, less than 50 per cent women attended antenatal care among who were expected to have gone to at least four antenatal care (ANC) appointments in 2017–18 (Huq et al., 2023). Therefore, due to lack of appropriate antenatal care, women are facing challenges during pregnancy which is affecting women's maternal health care on the whole (Khatun & Khatun, 2018).

According to empirical studies, the availability, quality, and cost of services, as well as social structure, health attitudes, and individual characteristics of the users are the factors that influence the utilization of health care services (Chakraborty et al., 2003). As Walton & Schbley (2013) states, if socioeconomic, cultural, and religious restrictions are not taken into account, Bangladeshi women may have never faced high risk maternal health care for issues. Education also has a deeper connection with utilization maternal health care. For example, communities with higher education and literacy rate used skilled birth attendants while with lower literacy rate

did not (Akter et al., 2023; Walton & Schbley, 2013). Furthermore, in Bangladesh, maternal health ideas, attitudes, and perceptions are heavily influenced by Hindu and Islamic cultures. Maternal health care information must therefore be presented in a culturally and linguistically relevant manner for patients, particularly female patients. Hindus and Muslims place high expectations on how women should behave outside the home, which may limit a woman's capacity to access prenatal and postpartum care (Walton & Schbley, 2013). Moreover, according to a study, pregnant mother’s awareness increased significantly with education but not necessarily with monthly family income and in order to reduce pregnancy issues at all stages, women's perceptions of their care should be sought out and taken into account (Khatun & Khatun, 2018).

2.3 Maternal Autonomy:

Earlier in this dissertation, it have been mentioned that in Bangladesh, the utilization of maternal health care is significantly influenced by women autonomy. Therefore, to have a deeper understanding of this thesis and its objectives, digging into the situation of maternal autonomy in Bangladesh is essential. Therefore, here, maternal autonomy of women living in Bangladesh is going to be highlighted.

Although reducing MMR by two-thirds over a 25-year period is a noteworthy achievement, this drop is also partly due to Bangladesh's declining Total Fertility Rate (TFR). Comparing Bangladesh to other developed and developing nations, the MMR is still quite high (Methun et al., 2023; Haider et al., 2017). As new SDG target have set by the UN, Bangladesh will need to take comprehensive approaches to meet that target by 2030 and for that factors that influences utilization of maternal health care services needs to be highlighted. It is well-established that

women's autonomy has a significant role in the use of maternal healthcare services in developing nations like Bangladesh (Abedin & Arunachalam, 2020; Haider et al., 2017; Haque et al., 2012).

Despite the fact that the term "women's autonomy" is frequently used in the literature, no universally accepted definition exists. Women's autonomy is a vast, multifaceted notion that includes control over resources and beliefs. It calls for self-assurance to get beyond obstacles in the way of interaction between women and other stakeholders. Women's autonomy is sometimes assessed by integrating several aspects of independence, such as her capacity for making decisions, control over her income, and freedom of movement (Abedin & Arunachalam, 2020; Haider et al., 2017). Women’s decision-making power in the household is one of the sociocultural risk factors for low utilization of maternal health care. A woman is considered to be able to maintain and improve her health through personal autonomy and by seeking the required health-related resources (Rahman, 2011). In a patriarchal society like Bangladesh, women are always considered as subordinate to men and the ability to use her own judgment is severely constrained. Women are considered as mother or wives in a family where men are the sole providers which eventually affect women’s maternal health care (Haque et al., 2012). Also, in many families, young pregnant women’s (15-24 years) decision making authority is vested on the older women of the family for example, mother-in-law and most of the time they do not consider antennal care (ANC) as essential. Teenage mothers are more likely to have less education, be less independent, and lack knowledge of the warning signals of pregnancy difficulties (Abedin & Arunachalam, 2020). Moreover, these families see young women’s movement during pregnancy as shameful (Haque et al., 2012). However, according to the study of Abedin & Arunachalam (2020), decision making autonomy can be divided into three types; 1) no autonomy (respondent has no control over their lives; husband or other family members make

all of the decisions), 2) partial autonomy (respondent can make decisions jointly with husband or other family members), and 3) high autonomy (respondent can make the decision on their own). According to Abedin & Arunachalam (2022), women's higher levels of employment and education are still essential for enhancing perinatal survival as educated women are more likely to be in charge of their own lives and make wiser decisions regarding their reproductive health.

The high frequency of the gender gap in Bangladesh may have an impact on the likelihood that women will access maternity care services. Therefore, in recent times, gender inequality is emphasized in terms of maternal health care as gender equality helps women achieve control over their assets and autonomy in decision making in households and this autonomy of women in the household ensures their equal rights. In Bangladesh, women's autonomy in intrahousehold decision-making reduces the danger of intimate partner violence (IPV). Women’s autonomy and attitude towards IPV are related to required ANC services and sufficient ANC visits (Ahmed et al., 2021). Increased autonomy is favorably correlated with service utilization of maternal health care whereas the acceptance of Intimate partner violence against women (IPVAW) is adversely correlated (Sripad et al., 2019). Around 10 per cent women in Bangladesh believe that a husband is justified to beat his wife at least once for many reasons. Also, women’s acceptance of subordinate position in the household keeps them from making health care seeking decision independently. Intimate partner, mother in law plays a vital role restricting women’s autonomy in health care seeking as they give importance to religion and cultural boundaries (Sripad et al., 2019). Emotional support plays a significant role in gender dynamics during pregnancy as well for instance, spousal sternness forces the woman to balance the needs of the household with her need for medical attention, causing some women to overwork in order to support their families

and maintain a peaceful and supportive home environment while preparing for childbirth (Sripad et al., 2019).

2.4 Unexplored Research:

Numerous research have been conducted focusing on maternal health care, importance and effect of maternal autonomy and maternal health care utilization but there are none that talks about pregnant women's perspective on autonomy during prenatal or antenatal care. Also, it is essential to explore the difference of those perspectives among pregnant women of different background and time frame. From the literature discussed earlier, papers of Chowdhury; Afsana & Rashid; Hossain and Biswas & Kabir and the reports of UNISEF, World Bank, USAID, WHO, UNFPA and CRI provides us a general idea of women's health and health care in Bangladesh. They talk about significant diseases that are directly or indirectly related to pregnancy. Moreover, they discuss the issue of gender disparity that women face in Bangladesh while seeking health care. These papers also shed light on the availability of health care services for women in the Bangladesh offered by governmental and non-governmental organization. Then, the research of Akter et al., Anwar et al., Kamal et al., Methun et al., Khatun and Khatun, Walton & Schbley and others, focus on the maternal health care situation and it utilization in Bangladesh. The importance of maternal health care utilization has been the core focus of these papers. Furthermore, factors related to maternal autonomy are discussed in their Studies. Challenges related to maternal health, cultural and religious boundaries have been explored by these authors as well. Furthermore, reports of WHO, BSS and papers of Haque et al., Rahman, Abedin & Arunachalam and others highlights definition of women's autonomy. Their studies have given an idea about the indicators of autonomy which helps to measure autonomy of women. Intimate

partner violence one of the significant highlights of some of their studies. They have explored autonomy regarding maternal health care and the factors that hinder it. They showed that women are considered as subordinate to men in every aspect of their lives including health care that eventually acts as a barrier to their utilization of health care. The fact that women's autonomy is important in maternal health care utilization in Bangladesh has been highlighted in their literature.

Furthermore, there are several existing literature that explores women's and midwives views on issues of women's health care and maternal health care. Indonesian Authors like Irdayanti & Dwi Izzati Budiono (2021), Gadis Meinar Sari 2021) Faridatul Ummi (2021) and Tanzanian Authores like Rashidi Heri Kiangi (2023) and Lilian T Mselle (2023) and others have worked on midwives and women's perception of health care related issues. However, most of them are focused on women living outside of Bangladesh. These papers have not been discussed in this dissertation but they are related to maternal health care. Yet, none of these paper or any existing study shed light on women's perspectives on autonomy during pregnancy and health care even though autonomy have been indicated as a significant factor that ensures utilization of maternal health care in Bangladesh by all and most of these authors. Also, how women from different background perceive autonomy has not been the focus of existing literature.

As pregnant women's views on autonomy has been a less discussed issue, this dissertation focuses on pregnant women's perspective on autonomy during prenatal or antenatal care, the occupational and generational difference of those perspectives. Moreover, exploring the factors behind changes in the perspectives is one of goals of this study. This dissertation emphasizes on the perspectives of unemployed (homemakers), employment (jobholders) and older women

which later helps to find out how a woman's social and economic background can have an effect of their perspectives on different life events. It also makes it easier to find out what women living in different time frame think about their autonomy during a health care condition. Consequently, this study provides with an idea about the factors that helps to change a woman's perspective on their autonomy.

Chapter 3

Findings

In this chapter, I have organized my findings based on themes that align with my research objectives. I have established six sections to address my three objectives, with sections two, three, and four collectively focusing on the first objective. To explore women's comprehension of bodily ownership, autonomy, freedom, and their stance within the family while accessing pregnancy healthcare services, sections 2, 3 and 5 illustrate how pregnant women perceive their levels of autonomy and their familial standing. To investigate whether varying economic and educational backgrounds, family relationships, and time periods can influence a woman's perspective on autonomy during pregnancy and prenatal healthcare, sections 1 and 4 are integrated with sections 2, 3 and 5 to demonstrate diverse perceptions of autonomy among women. Finally, in the last section, the factors that contribute to shifts in women's viewpoints on prenatal autonomy have been illustrated.

3.1 Socio-economic demography of Respondents:

I conducted research interviews in different hospitals and health care centers inside Dhaka and Bogura. The study engaged a total of 18 respondents, with interviews taking place at three

distinct healthcare facilities situated within the regions of Dhaka and Bogura. During the interviews, I engaged with housewives who were undergoing prenatal care at these healthcare facilities. Additionally, I collected insights from job holder respondents, many of whom were not pregnant at the time of the interviews. They shared their past pregnancy and prenatal care experiences. Furthermore, I sought perspectives from the older generation, who reflected upon their past pregnancy and prenatal care encounters. To gain a comprehensive understanding of the conducted interviews and to identify key factors, perspectives were also sought from a Program Manager and two Gynecologists representing the three healthcare centers and hospitals.

3.1.1 Personal Details of respondents:

Out of the total of 15 participants, 6 of them are unemployed pregnant women who were receiving prenatal health care services at healthcare centers during the interview sessions. Another 6 respondents are employed individuals who were interviewed at their workplaces (Regional Labor office clinic). For the remaining 3 unemployed elder participants, interviews were conducted both at hospitals and within their homes. Their individual details, including names, ages, geographical regions, educational backgrounds, occupations, incomes, and religious affiliations, were collected to examine how unique demographic factors influence their perspectives on autonomy.

The subsequent table presents an organized compilation of the participants' personal information.

Table 2: Personal details of Respondents

No	Name	Age (in years)	Education	Religion	Region	Occupation	Income (Per month in Tk.)
1	Sushmita	22	Class 9 passed	Islam	Mymensingh	Unemployed	-
2	Shiuli	27	Honors pass	Islam	Barishal	Unemployed	-
3	Ritu	24	Class 8 passed	Christian	Bandarban	Unemployed (Former worker)	- (Former wage 8000)
4	Ripa	28	SSC passed	Islam	Dinajpur	Unemployed	-
5	Yasmin	23	SSC passed	Islam	Bhola	Unemployed	-
6	Sanjida	23	Honors 4th year (ongoing)	Islam	Dhunot	Unemployed	-
7	Maksuda	42	Masters Passed	Islam	Bogura	Employed	47000
8	Samia	35	MA passed	Islam	Bogura	Employed	20000
9	Jannatun	42	SSC passed	Islam	Panchagarh	Employed	25000
10	Sabina	32	Masters 1st year (ongoing)	Islam	Joypurhat	Employed	22000
11	Arjina	43	HSC passed	Islam	Magura	Employed	24000
12	Rozina	41	Honors Passed	Islam	Bogura	Employed	40000
13	Aysha	Around 60 (doesn't remember)	No formal education	Islam	Bhola	Informal Job Holder (Former formal Job Holder)	Not fixed (14000- former wage)
14	Hasina	60	10 passed	Islam	Gabtoli	Unemployed	-
15	Beauty	59	10 passed	Islam	khetlal	Unemployed	-

In this chapter and the following one (Chapter 4), unemployed women have also been referred as homemakers, employed women as jobholders, and individuals aged 55 years and above are addressed as older women. Furthermore, in Chapter 4, unemployed pregnant women are categorized as younger mothers (as most of them are younger than 30), the employed group of mothers is referred to as middle-aged mothers (as most of them are older than 30 and younger than 50), and the group of individuals aged 55 years and above is described as older mothers.

3.1.2 Family details:

In addition to the personal particulars of the participants, information regarding their family background has been gathered. This includes details such as family structure, the head of the family, the educational levels of both the husband and the parents, as well as the educational background of the in-laws and the husband's income. The objective is to comprehend how family dynamics influence a pregnant woman's viewpoint on autonomy.

The subsequent table illustrates the family-related information of the participants.

Table 3: Family Details of Respondents

No	Name	Family type	Family Head	Husband's Education	Husband's Income (per Month in tk.)	Parent's Education	In-laws Education
1	Shushmita	Joint Family	Husband	10 Passed	25000	No formal education	No Formal education
2	Shiuli	Joint family	Husband and Brother in-law	Honors passed	Around 30000	Educated	Educated
3	Ritu	Joint Family	Husband	5 passed	15000	No formal education	No formal education
4	Ripa	Nuclear family	Husband	Masters passed	22000	No formal education	Educated
5	Yasmin	Nuclear family	Husband	9 passed	30000	Educated	Educated
6	Sanjida	Joint family	Husband	Masters passed	50000	Educated	No formal education
7	Maksuda	Nuclear family	Herself	Diploma	40000	Educated	Educated
8	Samia	Nuclear family	Husband	MA passed	30000	Educated	Educated
9	Jannatun	Nuclear family	Husband	Honors passed	25000	Educated	No formal educated
10	Sabina	Nuclear family	Husband	Diploma	30000	Educated	Unknown
11	Arjina	Nuclear family	Husband	HSC passed	30000	No formal education	Unknown
12	Rozina	Nuclear family	Husband (prioritized) and her combined	Honors passed	Currently unemployed	Educated	Educated
13	Ayesha	Nuclear family (joint during pregnancy)	Son (husband during pregnancy)	No formal education	20000 (son)	No formal education	No formal education
14	Hasina	Joint family	Husband (husband during pregnancy)	Honors passed	30000 (before retirement)	No formal education	Educated
15	Beauty	Joint family (during pregnancy as well)	Husband during pregnancy	Unknown	40000 (during pregnancy)	Father educated	Father in law Educated

3.2 Pregnant Women’s Perspective on Prenatal Autonomy:

Despite the fact that the term "women's autonomy" is frequently used in the literature, no universally accepted definition exists. Women's autonomy is a vast, multifaceted notion that includes control over resources and beliefs. Women's autonomy is sometimes assessed by integrating several aspects of independence, such as her capacity for making decisions, control over her income, and freedom of movement (Abedin & Arunachalam, 2020). During the interviews, whilst discussing pregnant women’s perspective on autonomy during prenatal health care, or prenatal autonomy, the focus has been placed on three key aspects of autonomy: 1) decision-making process, 2) control over resources or income, and 3) freedom to move independently, either prior to or while seeking prenatal health care.

3.2.1 Decision Making Process during Pregnancy

Pregnant unemployed women (housemakers) tend to rely on their husbands' help or approval, as well as their family's support, when seeking healthcare during pregnancy. Frequently, the final decision or influence over choices lies with their husbands. Nonetheless, a few women seek advice and strive to follow their husbands' wishes but in cases of injustice or poor decisions, these women are willing to resist their husbands, although such instances are rare. As Sushmita mentioned,

“Even if my Husband forbids me to do my check-ups, I would not listen to him. If I have a problem, I have to get it checked. He won’t understand my physical problems.”

On the other hand, some are bound to follow their husband’s decisions. For example, Ritu stated,

"No, I don't take all my health care decisions myself. I have to listen to him ultimately and have to do everything according to his will."

The assistance of their families significantly benefits all women but it's mostly husband or mother-in-law who takes the decisions or leads women to take the decisions. However, a considerable number of pregnant housewives view their husbands' role in decision-making quite positively. This is because their husbands not only support them in receiving healthcare but also encourage them to seek medical services. According to Shiuli,

"These health care matters are not discussed with the family much. I discuss these things with my husband and he sees the pros and cons for me. He is very careful about the regular check-ups".

Furthermore, respondents like Ripa and Yasmin hold the belief that their husbands are better equipped to make healthcare-related decisions. Even if given the opportunity to make their own healthcare choices, they express a preference for relying on their husbands' judgment. However, only one respondent among the homemakers named Sanjida thinks that she is independent enough to take her own decisions and no one forces her to do otherwise.

Regarding employed pregnant women, the majority of them do not seek their husbands' approval before making healthcare decisions. Instead, they rely more on advice from friends and family. They independently take decisions and then sought their husbands' support. As Rozina mentioned,

"I take my health care decisions alone. My husband supports me. I take suggestions from my seniors, colleagues, friends and family before seeking healthcare or check-ups. Both my husband and in-laws motivate me to see doctors and do check-ups."

Moreover, according to all the employed respondents, they are never forced to take any decision against their will. However, few of these women take decision combinedly with their husband and there is flexibility in decision making for them.

In terms of the older women, the decision making process did not only get influenced by the husband but also by their family and neighbors. Mostly, family members and neighbors set the rules while taking decisions and women followed them. Some of the families set rules that impacted negatively and some impacted positively. For example, according to Hasina,

"None of the women in my neighborhood took any advice from doctors neither did I. They taught me to be quiet whenever I faced any difficulty."

On the other hand, another older respondent named Beauty mentioned,

"My family or in-laws never forced me to do anything. They wanted me to have proper check-ups and treatments. They had few children in the family so they were very happy that I was pregnant."

Therefore, two pregnant women during the same time period went through different decision making process. The gender of the doctors does not affect the decision-making process of each participant before receiving prenatal healthcare.

3.2.2 Control over Resources during Pregnancy

Resource control varies among three participant groups: unemployed, employed, and the older generation. Here, resources is referred to husband's and family's income in terms of unemployed and the own income of working women. Unemployed pregnant women lack any source of income, including informal means of earning. They depend solely on their husbands' income, which ultimately is not under their own control. As a result, their husbands bear the costs of their regular check-ups and all aspects related to prenatal healthcare. Each of the six homemaker respondents relies on their husbands for financial support for their treatments and tests, which ultimately influences their decision-making process, as they do not receive any financial assistance from their parents. These women do not work outside the home, as their husbands do not support their employment. Additionally, even if they were to work, they would not be empowered to make their own healthcare-related decisions. As Shusmita said,

"My husband is a guardian to me, even if I work in the future, everything would be done by my husband. Now that I do not work and he pays for my treatment, I never feel like he ignores me."

She added,

"I wanted to work but my husband said it is better not to."

Several women who were previously employed had to quit their jobs due to pregnancy, and their husbands did not support them working during this period. These women used to have control over their own resources, but now they are unable to do so. As a result, they must conform to their husband's wishes, as without the husband's financial support, they would be unable to

access any prenatal healthcare. Ritu is among the respondents who believe that she had a better life when she used to earn her own money. According to her,

"I used to work in a parlor and I earned around 8 thousand a month. I quit my job after my first child. Now my husband pays for my treatment. When I was working I could do everything by myself, now that I am not working I have to live the way my husband says."

On the other hand, some of the homemakers do not desire control over resources, and they do not perceive any lack of access to healthcare because their husbands cover the expenses. Instead, they believe that their husbands take good care of them.

Regarding the jobholder women, the situation is markedly different, as all of them have their own earnings, which they can use independently. Crucially, some of these women earn more than their husbands, and they not only have control over their own resources but also over their husbands' income. Maksuda explicitly stated,

"I earn more than my husband therefore I paid for my own prenatal health care. My husband gives his salary to me as I manage both of our financial issues."

A significant number of employed respondents do not personally cover the costs of their prenatal healthcare. Despite having their own income, their husbands assume the responsibility for their healthcare expenses and essential needs during pregnancy. Although they possess complete control over their resources, they opt not to allocate those funds to their healthcare requirements. Moreover, they never experience a sense of insufficiency in their needs or perceive themselves as less independent simply because their husbands are covering their expenses.

Regarding the older women, none of them were employed during their pregnancies, leading to a lack of control over any resources. Their husbands managed the financial aspects of their treatments. Although one respondent became employed well after her pregnancy, she had control over her resources, but this income did not significantly enhance her autonomy during the pregnancy.

3.2.3 Freedom of Movement during Pregnancy

The freedom of movement for pregnant unemployed women is closely tied to their control over resources. Since their husbands cover the costs of prenatal healthcare, they must seek both financial support and permission before attending healthcare centers. If their husbands do not provide the necessary funds, they face challenges in accessing transportation and receiving treatment. They recognize the significance of prenatal check-ups, but due to limited resources, they find it difficult to go out for the required healthcare. As Ripa mentioned,

"If my husband does not let me come or give me money, I would not come. It is important to get prenatal treatment but how can I come if he does not pay."

Furthermore, many respondents hold a strong belief that their husbands would never prohibit them from going for check-ups, but if such a situation were to arise, these women would not proceed without obtaining their husband's permission. Here, Yasmin said,

"My husband would never forbid me to come here. He knows very well that I am a diabetic patient and I have high blood pressure and there is no such good clinic where we live."

However, a subset of these women simply informs their husbands before going for check-ups and does not wait for explicit permission, but they never go alone.

Regarding the employed women, they already possess freedom of movement since they continue to attend the office during pregnancy. Some took maternity leave after the delivery for their first child, granting them this freedom to go for check-ups without the need to seek permission from their husbands. None of them seek permission as their husbands already support them to go out for check-ups. However, in terms of older women, they did not have freedom of movement at all. Only one of them went for check-ups but never went alone. For most of them going outside for check-ups was forbidden and they did not even feel the need for going out even for refreshment. As Hasina stated,

"No one forbid me to go out for refreshment but I never went outside during my pregnancy, not even for a walk. I stayed at home because I did not feel like going outside."

Hence, for certain women, the need for freedom of movement isn't a requirement, as they take pleasure in being at home. For many, the desire for freedom of movement exists, yet it remains unfulfilled due to their husbands' wishes, while some women inherently possess this freedom without needing to seek it.

3.3 Self- assurance and Body ownership during Pregnancy:

As discussed earlier, in chapter 2, Women's autonomy is a vast, multifaceted notion that includes control over resources and beliefs. It calls for self-assurance to get beyond obstacles in the way of interaction between women and other stakeholders (Abedin & Arunachalam, 2020; Haider et al., 2017). In simpler terms, "women's autonomy" means women should have the power to decide for themselves in life matters, such as money, choices, and beliefs. They should feel confident and capable of facing challenges when dealing with society's expectations or negotiating with different people. "Self-assurance" here means having confidence in oneself,

believing in one's abilities, and standing up for one's rights and choices, even when faced with obstacles.

Furthermore, the feeling that your body belongs to you is known as the sense of body ownership. This is a key aspect of how we experience our own consciousness, and it helps us tell the difference between ourselves and the outside world. This distinction is really important for how we perceive things, how we act, and how we think (Chancel & Ehrsson, 2020). Having a sense of ownership over one's body is crucial for survival, as it helps protect the body from threats. But beyond influencing how we act, it also impacts how we perceive the world around us (Hoort et al., 2017). Therefore, this dissertation explores how women's views on body ownership relate to their stance within their family and social environment. It is to understand if their perception of body ownership affects how they feel about autonomy during pregnancy. Essentially, the concept of body ownership is being used to see how it impacts their sense of independence and how much self-assured these women are.

3.3.1 Conception of body ownership during Pregnancy:

Many women, especially pregnant homemakers, often do not fully grasp the concept of body ownership. They may consider their body as theirs, but this understanding tends to be confined to managing household tasks. They may think they own their body because they primarily focus on resting rather than engaging in other forms of work when they feel tired. The connection between body ownership and autonomy is not clear to them. They believe it's their body simply because they were born in it. They may not consider factors such as decision-making power, control over resources, or the freedom to move as integral aspects of body ownership. For example, according to Sushmita,

“Yes, I own my body. I rest whenever I don’t feel like working and work when I feel like it.”

Furthermore, in this regard, Shiuli mentioned,

“My body is my own. However, my husband has rights over me. He pays for my prenatal health care but my body is mine no matter who pays for me or makes my healthcare decisions for me.”

Hence, even though their husbands handle healthcare expenses, make healthcare decisions, and they need permission before going out, these women still maintain a sense that their bodies belong to them. Moreover, they think that it’s better for their bodies if their husbands take decisions for them.

Many women believe that body ownership is crucial for a happy and healthy life. However, when it comes to pregnant women, they often feel that their bodies belong more to their child than to themselves. Sanjida conveyed that she prioritizes her child's health over her own body, aiming to consume nutritious foods and offering more prayers for the child's safety. She emphasized doing what's best for the child, even though she previously had a dislike for fish and eggs; she now consumes them with her child's well-being in mind.

Rozina, a working woman, shares the view that a woman's body is primarily owned by the child during pregnancy. After childbirth, they often experience a sense of disorientation, yet it's essential for them to prioritize self-care. Moreover, other working women like Maksuda, Samia and Jinnatun believe that they held ownership of their bodies during pregnancy, taking care of themselves. However, after giving birth, they shifted their focus entirely to their children's well-being. Both of them emphasize the significance of body ownership in promoting women's autonomy.

In the case of older women, they lacked understanding about the concept of body ownership during their time, and they didn't have the opportunity to take proper care of their children during pregnancy due to limited knowledge. Their approach to their own bodies and their children's well-being largely relied on religious beliefs. Ayesha mentioned that during that period, she resided in a village and lacked comprehension of these matters, including body ownership, medical treatments, or doctors. She expressed that they relied on Allah's help during that time.

3.4 Relationship with family members during Pregnancy:

This section examines the family dynamics and support systems during pregnancy and prenatal healthcare. It explores factors such as assistance with household tasks, emotional support, accompanying to healthcare appointments, and the relationship with in-laws.

The homemakers mostly handle household chores, with few receiving assistance from their mother-in-law or husband, and some managing on their own. These women generally enjoy working and serving their families as they find household tasks manageable. Only one of them has a maid to help her. During this period, all family members, including in-laws, show generosity towards these women and are concerned as well. Although emotional support is lacking from most family members, husbands provide necessary support, rarely. Furthermore, healthcare appointment companions vary, with some going with sister-in-law, mother-in-law, or mother, yet husbands predominantly accompany them. Moreover, within the paternal families of these women, there is no noticeable gender discrimination in terms of healthcare utilization.

Regarding jobholder pregnant women, they managed both their jobs and household tasks during pregnancy as all of them took maternity leave after giving birth, and their husbands actively provided assistance. However, other family members, particularly in-laws who lived farther

away, didn't offer substantial help, except for providing mental support. These women received significant support from their mothers during and after pregnancy. Gender does not influence healthcare utilization within the paternal family, but notable differences exist between these women and their sister-in-laws within the in-laws' family. Despite sharing a strong bond with their in-laws, disparities in healthcare utilization are evident. Among three of the older participants, one resided with her paternal family during pregnancy, where no assistance was provided with chores. The other two participants lived with their in-laws. One received both mental and physical support from her in-laws, including her husband. However, the third participant did not receive such support. Only one of them received prenatal healthcare, and her husband or sister-in-laws accompanied her during appointments.

None of the participants experienced any instances of intimate partner violence or domestic violence during their pregnancies.

3.5 Challenges during pregnancy

While assessing their challenges, pressure from family members, religious boundaries, social stigma, stereotypes, taboos and workplace-related issues have been focused on.

As discussed in the previous section, the majority of unemployed pregnant women perform their daily household tasks without much assistance. Occasionally, their mothers might help them if they reside together. However, their families and in-laws never put pressure on them to work. At times, husbands or mother-in-law might assist, but the primary responsibility remains with the housewives. Regarding the older generation, household work pressure was evident for two out of three respondents. In the case of jobholders, the situation remains same as housewives. However, a majority of them need to balance responsibilities both at their workplaces and in their homes.

They did not face many challenges as their bosses and colleagues have been considerate. As Samia mentioned,

"My office used to start at 9. Whenever I felt healthy and alright, I did full time. If I felt bad or something, I used to leave earlier. My colleagues and boss were kind and considerate so I did not face that much of a problem."

Concerning religious boundaries, none of the respondents encountered challenges. They independently adhered to certain religious practices like regular prayers and maintaining a form of "purdah" during prenatal healthcare. Importantly, no external pressure was exerted on them to follow specific religious rules. Regarding social boundaries, a prevalent one has been refraining from going or staying out after evening. However, this rule proved less effective for working women, although they made efforts to maintain it. In cases of older women, neighbors played a vital in setting social boundaries which placed a serious challenge for pregnant women at that time. For instance, according to Hasina, if she felt unwell or experienced labor pain, she could not inform or seek help. This was to avoid embarrassment, as making noise could reveal her pregnancy to men or outsiders. She mentioned,

"This was a rule. My Boroma (a neighbor) said do not tell anyone if it hurts because people will gather. I went into labor pain on Wednesday and the next day when I was working, it felt like something was coming out. The baby came out on its own but I did not have the chance to tell anyone."

Furthermore, almost all participants experienced superstitions during their pregnancies to varying degrees. While family members did not pressure them to adhere, some participants still

followed these practices to avoid any potential risks. On the other hand, many did not believe in these superstitions but complied to prevent any teasing from family members. As Maksuda said,

"I heard some superstitions like going under some shed during azaan, not eating coconut as it will affect child's eyes, not eating duck. Whether it's true or not, when it comes to baby's safety, I avoid these things to avoid risks."

She added,

"I always keep match light box with me to prevent evil eyes."

Additionally, apart from the mentioned, superstitions such as believing that looking at pleasant things enhances a child's beauty, avoiding seeing animals, refraining from watching horror movies, and avoiding activities like fishing were notably prominent among all participants. Even the older respondents heard these but did not believe or maintain these that much. For example, according to Ayesha,

"I did not believe superstitions. I used to eat everything, went fishing and when I was pregnant with my daughter, I even went to the zoo but my daughter does not look bad, does she?"

Hence, regarding each participant, none held a belief in superstitions, yet they adhered to them as a precautionary measure. Importantly, no one compelled them to follow these practices.

3.6 Factors Influencing changes in Perspectives

There have been noticeable changes in perspectives of pregnant women regarding all the points that have been discussed earlier in this chapter. The most significant factor of all has been pointed out by the KII respondents. According to three of them, the most effective factor that

influenced the changes in perspectives on maternal autonomy over time is “Media” or the expansion of social media network. According to Dr. Salma Sultana, a gynecologist,

“Generational gap plays a vital role in these differences. Nowadays, mothers have access to knowledge and information that older generation did not have. Mothers now come to us knowing a lot of things beforehand.”

Another gynecologist, Dr. Shakhera Akhter, suggests that modern pregnant women are more aware about these check-ups and their autonomy due to the influence of media and the awareness it brings. Furthermore, government and non-government campaigns, fieldwork, and counseling provided by NGOs and clinics contribute to raising awareness of their autonomy. In contrast, in earlier times, women did not have access to such resources. Furthermore, according to the Program Manager of BAPSA, a maternity clinic, Mohammad Zobair, in earlier times, during 1970s, mothers did not have the assistance of professionals. He believes that the advancement of the country's medical industry, coupled with the impact of the internet, significantly contributes to changing women's perspectives on maternal autonomy. According to him,

“Due to internet, information is very available now. Consultancy and appointments are available online from specialist doctors. Also, the structure of our medical industry is very well planned. It helps the mothers more than before.”

When considering the contrast between homemakers and jobholders, education emerges as significant influencing factor. According to Dr. Shakhera Akhter, jobholder mothers who seek her check-ups exhibit greater awareness of their bodies. They take her advice seriously and adhere to it. Conversely, unemployed women may struggle to comprehend medical factors or

terms and display less interest in following recommendations. They often rely more on their husbands. Dr. Shakhera emphasizes the pivotal role of educational background and self-confidence in this dynamic.

Furthermore, I believe that besides education, a woman's personal income, family background, and husband's education hold substantial influence as contributing factors. These elements collectively shape a woman's self-confidence and conception of body ownership. Conversely, the concept of "autonomy" itself can have a negative impact. From my findings, it is evident that many women are unaware of the existence and significance of autonomy during pregnancy, preventing them from attaining it. Over time, this lack of awareness hinders women from altering their outlook on maternal autonomy.

Table 4: Summary of Comparison

	Autonomy	Self-assurance and Body ownership	Relationship with family members	Challenges during pregnancy
Unemployed women	Decision Making process: -No decision making power. - Depends on husband and other family members. -considers husband's as guardians. Control over resources: -No income sourse and no control over husband's' income. Freedom of movement: -takes permission before going for prenatal care. -never goes outside alone.	-Has little to no idea of body ownership. -thinks that ownership of the body comes inherently. The concept is limited to household works. -to them body ownership has nothing to do with autonomy. - Their lack of body ownership results in lack of self-assurance.	-Does household works for the in-laws mostly without any assistance from family members. -gets less priority than sister-in-laws. -gets help from mothers sometimes -tries best to fulfill family members expectations. -No domestic violence during pregnancy. -no gender inequality inside maternal family in terms of health care.	-does all the household works. -no decision making power. -no control over resources. -no freedom of movement -faces social stigmas and boundaries
Employed women	Decision Making: -Has decision making power. -does not depend on husband. Control over resources: -has their own income -has control over their income -sometimes has control over husband's income as well. Freedom of movement: -has freedom of movement -does not take permission before going for prenatal care.	-Understands body ownership -Body is owned by their babies during pregnancy and after pregnancy. -enjoyed body ownership before pregnancy. -knows the importance of body ownership. -self-assured	-gets full support from mother and husband. -gets mental support from in laws. -does not do household works for others. -no domestic violence. -no gender inequality inside maternal family in terms of health care.	-needs to balance between household and office work. -no help from the in-laws -faces social stigma
Older women (Age: 50+)	-No decision making power -No control over resources -No freedom of movement	No sense of body ownership and self-assurance.	-does household works for the family. -gets no help from the family members. -gets no mental support.	-does all household works without assistance. -no decision making power, control over resources and freedom of movement. -no mental support -no prenatal treatment -faces social stigmas and boundaries.

Chapter 4

Discussion and Analysis

In the preceding chapter, the findings of pregnant women's viewpoints on maternal autonomy, particularly during pregnancy, have been presented. The segment also looked into the disparities in these perspectives across mothers with distinct occupations and over varying time periods. Furthermore, a comprehensive exploration of the factors contributing to the evolution of these perspectives among mothers was incorporated, drawing from insights derived from Key Informant Interviews (KIIs). In this chapter, a comparative analysis is presented, aligning the research findings with existing literature on maternal autonomy and maternal healthcare utilization. The study's outcomes are further examined, incorporating insights from interviews and KIIs, while also considering the theoretical framework established in Chapter 1.

In the following discourse, the initial section examines divergent viewpoints among the three mother groups. Subsequently, the second section elucidates the underlying factors that contribute to these disparities, while the concluding section delves into the theoretical framework explaining these phenomena.

4.1 “Autonomy” among pregnant women

As earlier mentioned, in chapter 2, obstacles such as distance, transport costs, cultural norms, and a shortage of female healthcare workers limit Bangladeshi women's healthcare access. Mobility constraints, absence of female medical staff, and the need for male supervision also create barriers (Afsana & Rashid, 2016). Moreover, in Bangladesh, healthcare providers display bias against women, restricting their ability to receive top-notch medical care. This bias

manifests in various ways, encompassing withholding information, neglecting their healthcare requirements, and administering inadequate treatment (Rahman & Haque, 2018). In relation to my participants, the majority did not encounter significant difficulties when seeking antenatal or prenatal care, except for some older participants to a certain extent. Instead, they received support from their families and surroundings. Given that maternal autonomy ensures maternal healthcare utilization, the findings indicate that varying degrees of maternal autonomy were experienced by all employed and unemployed participants, while only one older participant shared this experience. Additionally, according to Khatun & Khatun (2018), antenatal care effectively provides guidance, education, reassurance, and support, leading to improved outcomes for mothers, infants, and neonates. This belief was held by the homemakers and jobholder participants and their families. Therefore, younger respondents (employed and unemployed) possessed autonomy in utilizing maternal healthcare, as they and their families recognized its importance for the well-being of both mother and child.

Through my analysis of the respondents, I have observed that pregnant women tend to perceive their autonomy based on the degree of control they currently possess. They do not seem to desire more autonomy than they already have. Their perspective on autonomy changes depending on their context of living. For example, unemployed pregnant women often lack decision-making power, control over resources, and the freedom to move as they wish. However, they still feel free within the limits set by their husbands, and they are satisfied with this level of autonomy. In contrast, working women experience various forms of autonomy in both their jobs and personal lives without actively seeking it. So, their view of autonomy is quite different from that of homemakers. Lastly, older women did not really understand or experience autonomy during pregnancy as we do today because the concept was not prevalent during their era.

As evident from the varying degrees of autonomy in accessing prenatal healthcare and the perspectives among the respondents, the upcoming section will discuss the diversity of their perceptions concerning autonomy during prenatal care.

4.1.1 Autonomy as Adaptability

Based on my findings, it is evident that the perception of autonomy varies significantly among pregnant homemakers, jobholders, and older women. Unemployed women, in particular, do not fully grasp the idea of autonomy, so they don't feel it's important. In essence, they have assimilated into the patriarchal society's rules, norms, and values to such an extent that the idea of autonomy and freedom seems unnecessary. Instead, they've embraced adaptability as a substitute for autonomy. For these women, adaptation has replaced autonomy, just as Sripad (2019) mentioned, some women to overwork in order to support their families and maintain a peaceful and supportive home environment while preparing for childbirth. It is easier to comply with their husband's decisions than to fight for their own decision-making authority- a choice that brings them contentment.

In chapter 2, several literature have been discussed, among those, according to the study of Abedin & Arunachalam (2020), decision making autonomy can be divided into three types; 1) no autonomy (respondent has no control over their lives; husband or other family members make all of the decisions), 2) partial autonomy (respondent can make decisions jointly with husband or other family members), and 3) high autonomy (respondent can make the decision on their own). According to this division, pregnant housewives, among my respondents, fall under both "no autonomy" and "partial autonomy". Within this group, only one participant, Ritu (24), acknowledges having no autonomy due to limited control over resources. Others, however, do

not believe in having "no autonomy" even when they lack decision-making power. They feel autonomy is not necessary as their husbands know what is best. They willingly give authority their husbands and adapt by following their suggestions. Furthermore, a significant number of these women are categorized as having "partial autonomy" since they believe decisions are made jointly with their husbands and family members. However, other responses, like freedom of movement and control over resources, indicate that husbands' decisions hold the ultimate sway, and they unconsciously adhere to them. For instance, Sushmita (22) expressed that she would not obey her husband if he objected to her attending prenatal checkups. Yet, since her husband covers the expenses, she ultimately has to comply due to her limited control over resources. Hence, decision-making authority, freedom of movement, and control over resources are interrelated when it comes to securing autonomy. As per Haider et al. (2017), evaluating women's autonomy necessitates considering these three facets of independence.

According to Rahman (2011), Women's influence in household decision-making is recognized as a sociocultural factor linked to reduced use of maternal healthcare. Traditionally, a woman's ability to enhance her health depends on personal autonomy and access to essential health resources (Rahman, 2011). However, my findings present a distinct perspective: despite lacking decision-making authority and control over resources, these women receive comprehensive prenatal healthcare as their husbands ensure it. Also, according to Sripad et al., (2019), women’s acceptance of subordinate position in the household keeps them from making health care seeking decision independently and this is evident in terms of my unemployed respondents as they choose to be in the subordinate position. Therefore, their autonomy is unrelated to their utilization or access to healthcare; instead, these women’s tendency to conform to the patriarchal norm of "Husband knows better" grants them access to healthcare.

Moreover, to Walton & Schbley (2013), in Bangladesh, maternal health ideas, attitudes, and perceptions are heavily influenced by Hindu and Islamic cultures. Maternal health care information must therefore be presented in a culturally and linguistically relevant manner for patients, particularly female patients. Hindus and Muslims place high expectations on how women should behave outside the home, which may limit a woman's capacity to access prenatal and postpartum care. However, in terms of my housewife respondents, perceptions of autonomy are more influenced by the patriarchal norms than religious cultures as none of them faced any religious barriers while seeking health care.

4.1.2 Autonomy as a "Preexisting Privilege"

In contrast to pregnant homemakers, employed women maternal autonomy is a preexisting privilege. They do not need to struggle for it as it inherently comes alongside their control over income. With decision-making authority, freedom of movement, and control over income, they experienced "high autonomy," as highlighted by Abedin & Arunachalam (2020), discussed in the previous section.

In a patriarchal society like Bangladesh, women are always considered as subordinate to men and the ability to use her own judgment is severely constrained. Women are considered as mother or wives in a family where men are the sole providers which eventually affect women's maternal health care (Haque et al., 2012). However, within the context of employed women, they also contribute to the household income, altering the dynamic where the husband is the sole provider. Consequently, due to their increased control over financial resources, the notion of being subordinate to their husbands is no longer applicable. Instead, since some of these women earn more than their husbands, they possess greater decision-making power within the

household. Based on the responses of my participants, these women make autonomous decisions, particularly in matters concerning their own health care. While their husbands may occasionally be involved in the decision-making process, the wives predominantly hold priority in determining their own health care choices. According to Akter et al., (2023); Walton & Schbley (2013) and Abedin & Arunachalam (2022), women's higher levels of employment and education are still essential for enhancing perinatal survival as educated women are more likely to be in charge of their own lives and make wiser decisions regarding their reproductive health. The situation observed among my employed participants precisely aligns with these factors. Their employment status and higher educational attainment, in comparison to housewives and the older generation, bestow upon them a unique position. This distinctiveness arises from the established autonomy they have attained earlier in life, characterized by decision-making authority, unrestricted freedom of movement, and control over their own income. As a result, during their pregnancies, these women do not view autonomy as an immediate priority. Nevertheless, they acknowledge its importance and consider it a privileged aspect of their lives.

4.1.3 Absence of autonomy

For older women, understanding the idea of autonomy during pregnancy was challenging, leaving them with no autonomy in this aspect. The outcomes of my investigation align with Abedin & Arunachalam’s (2020) autonomy framework, categorizing these older women as fitting into the "No autonomy" classification. Among these older women, only one had accessed maternal or prenatal health care services, while none possessed decision-making authority, freedom of movement, or control over resources. In this regard, they share commonalities with the housewife participants in terms of lacking an understanding of the importance of freedom and autonomy. As previously mentioned, according to Walton & Schbley (2013), maternal

health notions, attitudes, and perspectives in Bangladesh are notably influenced by Hindu and Islamic cultures. For older women, their understanding of autonomy is shaped by their immediate environment and societal restrictions. This is evident as their decisions are influenced not only by husbands and family members but also by neighbors, underscoring the constraints on their autonomy.

4.1.4 The occupational and generational variations of Autonomy perspectives

In Chapter 3, respondents are categorized into two occupational groups: Employed (referred to as jobholders) and Unemployed (referred to as homemakers). Additionally, they are classified into three age groups: younger (homemakers), middle-aged (jobholders), and older mothers. As discussed earlier in this chapter, each group of pregnant women holds distinct perspectives on autonomy.

Concerning occupational groups, employed women largely view autonomy as an advantage in their prenatal care journey, as they have already experienced a degree of autonomy prior to pregnancy. During prenatal care, they often wield decision-making authority in healthcare matters, occasionally even surpassing that of their husbands. They also maintain control over their income, and in some cases, even over their husbands' income. This group enjoys a level of freedom of movement. In contrast, unemployed pregnant women perceive autonomy as a form of adaptation or adjustment within the confines of their husbands' rules. Many of them consider their husbands as guardians, and autonomy is deemed unnecessary by a substantial portion of this group. While some express dissatisfaction with their subordinate roles, they tend to adapt due to limited decision-making authority, control over resources, and freedom of movement.

These two groups are also grouped as middle-aged and younger mother; therefore it goes same for the generational difference.

Ultimately, older mothers lack a well-defined perspective on autonomy during prenatal care, as they do not comprehend the concept during their own pregnancies. They do not receive prenatal care, and their experience during pregnancy is characterized by a lack of autonomy.

4.2 Impact of Media, Education and employment and Family dynamics on viewpoint of Autonomy

The evolving perceptions of autonomy among pregnant women across various occupations and timeframes are influenced by media, education, and family dynamics. These three factors collectively contribute to shaping distinct perspectives on autonomy among women. This section aims to reveal the impact of these factors on viewpoints through an exploration of literature, insights from Key Informant Interviews (KIIs), and personal observations gathered during the interview process.

4.2.1 Media's Transformative Role

The primary factor driving the changes in perspectives, as highlighted by Key Informant Interview (KII) respondents, is the impact of "Media" and the expansion of social media networks. According to them, due to generational gap, modern mothers possess unprecedented access to information, granting them a wealth of knowledge beforehand which older mothers could not. The heightened awareness observed among modern pregnant women can be attributed to the influence of media. Additionally, government and non-government efforts, complemented by counseling from NGOs and clinics, contribute to this increased awareness—an aspect previously lacking. This aligns with a study by USAID (2021), highlighting that both the

Bangladeshi Government and various NGOs are actively addressing significant health challenges among women. A notable initiative in this regard is the Maternal and Child Health services program, encompassing antenatal and postnatal care, family planning, and immunization. This initiative is supported by a network of community clinics, union health centers, and district hospitals (USAID, 2021). In addition to this point, the Key Informant Interview (KII) respondents emphasized the significant impact of a well-structured medical industry in fostering the advancement of maternal autonomy perspectives.

4.2.2 Role of Education and Employment

Education significantly increases pregnant mothers' awareness. Education is closely linked to maternal health care utilization. Moreover, women's employment and education levels play a vital role in perinatal survival, empowering them to make informed reproductive health decisions (Akter et al., 2023; Abedin & Arunachalam, 2022; Khatun & Khatun, 2018; Walton & Schbley, 2013). Well, education does increase a mother’s awareness which is evident in my respondents if we compare them by the three groups; unemployed, employed and older generation. If we look into the personal demography, it is noticeable that jobholders have higher education than most homemakers and older respondents. Most of the jobholders are masters passed whereas most of the unemployed and older women are high school passed. Also, same goes for the husbands’ education if we take a look into the family demography of them. From the findings, it is evident that jobholder women have more autonomy in terms of health care then housewives and older women. Also, their perspective of autonomy is more well-defined than the other two groups. It is because education and employment gives them more control over their bodies and income and they are more self-assured. As according to Haider (2017), women's autonomy is increased by their participation in social and economic activities. Furthermore, according to KIIs, jobholder

mothers who seek her check-ups exhibit greater awareness of their bodies. They take her advice seriously and adhere to it. Conversely, housewives may struggle to comprehend medical factors or terms and display less interest in following recommendations. They often rely more on their husbands and here, education plays the major role. However, other family members' such as parents or in-laws education do not influence their perspectives.

4.2.3 Influence of family dynamics

The relationship between family size and a woman's relation with her family members plays a pivotal role in shaping women's perceptions of autonomy. This correlation becomes evident in the demographic data, where it is apparent that a significant portion of homamakers and older women resided within joint families during their pregnancies. This living arrangement necessitated a thoughtful consideration of other family members, particularly their mother-in-laws, before making decisions. These women were tasked with managing household responsibilities and preparing meals for the entire family, often with minimal assistance from their spouses or mother-in-laws. Consequently, their perception of autonomy revolved around accommodating the needs of family members, avoiding chaos, and fostering a harmonious atmosphere. This aligns with the findings of Sripad et al. (2019), which indicate that some women engaged in excessive work during pregnancy to provide for their families and cultivate a tranquil and supportive domestic environment in anticipation of childbirth.

Conversely, women employed outside the home typically inhabit nuclear families, often with the presence of their mothers to lend a hand with household chores. Despite the need to balance professional and domestic responsibilities, they enjoy greater latitude in making decisions according to their convenience. Furthermore, the distance from other family members alleviate

any pressure to maintain strong bonds, affording these women heightened autonomy within their households. Because family members expect less, there's not as much pressure to work too hard. In light of these circumstances, it becomes evident that the size of the family and the dynamics of relationships with family members engender divergent perspectives on autonomy among mothers.

4.3 Influence of Body ownership and Self-assurance

As discussed earlier, the feeling that your body belongs to you is known as the sense of body ownership. This is a key aspect of how we experience our own consciousness, and it helps us tell the difference between ourselves and the outside world. This distinction is really important for how we perceive things, how we act, and how we think (Chancel & Ehrsson, 2020). In this section, I will present my own perspective, independent of the literature discussed in Chapter 2. Based on my analysis, I have observed that body ownership acts as a silent and indirect but significant factor shifting women's perception of autonomy during pregnancy. Furthermore, I believe that the concept of body ownership provides self-assurance in a woman, thereby enhances her sense of autonomy. In Chapter 3, it was noted that unemployed women may not fully grasp the concept of body ownership. They tend to believe that their bodies are inherently their own, even though their husbands have authority over them. This lack of understanding can lead to a lack of self-assurance and confidence, making them more dependent on their husbands and having less autonomy. In contrast, working women have a better understanding of body ownership. They have had some control over their bodies at some point during their pregnancy, either before or after giving birth. This sense of body ownership and understanding its importance has given them self-assurance and confidence, making them more independent and

allowing them to enjoy greater autonomy. Lastly, older women did not have a sense of body ownership, which resulted in a lack of self-assurance. Consequently, they never experienced autonomy during their pregnancies.

4.4 Interplay of Structure and Agency in Shaping Perspectives

From the discussion of the last section, it is evident that, the autonomy and perception of a pregnant woman's autonomy is influenced by their control over resources, rules of the patriarchal society and family dynamics. By examining this scenario through the lens of "structuration" theory, according to Giddens (1971), an individual's autonomy is influenced by the structure and the structure is influenced, maintained and adopted by the practice of individual's agency. He basically argues that even though actions of people are influenced by the society as their knowledge about it is restricted, they are the elements of the society that influence social structure and social changes (Lamsal, 2012). Therefore, a pregnant women's autonomy and their perception of autonomy is shaped by the influence of the structure of the society and that structure is influenced by that pregnant woman's practice of agency or autonomy.

As previously discussed in chapter 1, in the "Structuration" theory, according to Giddens, structure and agency cannot be separated and to connect these two together he came up with the term "Duality of Structure" (Lamsal, 2012; Fuentes & Lataza, 2008; Horne & Jary, 2004). Here, by structure Giddens means the virtual existence of two elements; "rules" and "resources" that is used or altered in a people's daily life (Dixon, 2011). However, in Giddens's theory, "structure" and "system" are used interchangeably. Here, system refers to the patterns of social relationship in society. Here, when we try to establish a synthesis between the previous discussions and the

concepts presented earlier, an observation emerges that across the spectrum of three distinct groups of pregnant women, each one of their autonomy has been influenced by both structure and system.

To begin, structure such as rules and resources, significantly influence autonomy and how it is perceived. For instance, as discussed, pregnant housewives conform to patriarchal society's rules to gain autonomy, shaping their view that husbands know best, creating a feeling of peace by seeking autonomy through obedience. Moreover, regarding resources, the level of control over income significantly distinguishes the three groups of women. Unemployed and older women, due to limited control, exhibit less independence and a distinct perception of autonomy compared to employed individuals who possess control over resources and consequently enjoy greater independence. Additionally, the patterns of social relationships, or the system, impact pregnant women's autonomy and how they perceive it. Analyzing the family dynamics of the participants, it reveals that their relationships with family members affect their autonomy and how they view it. For instance, as we have discussed, the distinction between living in a joint family versus a nuclear family leads to varying autonomy levels among the three groups of mothers. Those in nuclear families often experience greater autonomy due to better familial bonds and less expectations. Hence, the duality of structure clarifies the diversity of viewpoints among various pregnant mothers.

Furthermore, To Giddens, resource provides human with power that helps human to achieve the ability bring change in their life and social circumstances (Fuentes & Lataza, 2008). Therefore, rules are a composite of meanings and norms, and resources refer to power (Stones, 2020). This

delineates precisely why employed pregnant women acquire decision-making authority through their resource control, a capacity that housewives and older women lack.

Moreover, According to structuration theory, human agency, which is the ability to act, is always influenced by power dynamics. This theory suggests that agency is the key element in bringing about any kind of change in society (Lamsal, 2012). Power dynamics within the family of these three groups of pregnant shows that, resources provide jobholders' human agency which is why in their families husband is not the sole family head, the wives are head as well, unlike the housewives and older women in their time periods. This demonstrates that agency plays a pivotal role in driving social change and influencing structures as well.

According to Giddens, Globalization has profoundly impacted various aspects of our lives, from economic and political ties to social and cultural frameworks. It has transformed the way we interact, gain knowledge, and conduct business. People now unconsciously navigate virtual spaces through constant connectivity to communication sources, blending with physical space and time. This aspect of "structuration" theory justifies that the influence of media is the leading factor in changing the perspectives of autonomy among pregnant women as they can access any information now that pregnant women of older generation could not.

Therefore, the intricate interplay of structure, system, agency, and external factors like globalization paints a complex portrait of pregnant women's autonomy. Furthermore, pregnant women's perspective on autonomy is shaped by the structures and those structures influence their agency and social change as it ensures control over resources.

Chapter 5

Conclusion

Bangladesh leads South Asian countries in gender equality due to increased women's participation in various aspects. However, as significant challenges remain, particularly in areas like healthcare, political representation, jobs, and education. While Bangladesh has reduced maternal mortality, it remains higher than in many other developing countries. This is mainly due to limited utilization of maternal healthcare, influenced by women's autonomy. Therefore this dissertation examines pregnant women's perspective on autonomy during prenatal care among three distinct groups of mothers because over half of the women in Bangladesh face high-risk pregnancy issues that are associated with their autonomy. Also, a significant number of women continue to encounter societal limitations that restrict their mobility and decision-making power for themselves and their children. Considering these combined factors, this dissertation has examined autonomy perspectives among diverse groups of pregnant mothers, analyzed variations in these perspectives, and identified influencing factors driving such shifts.

Although maternal health care utilization depends heavily on women's autonomy throughout pregnancy, there is hardly any literature that focuses on women's perspectives on maternal autonomy or autonomy during pregnancy. In my literature review, I have focused on the general state of women's health care in Bangladesh where studies have concentrated on health and medical issues that are either directly or indirectly related to maternal health care to show how

women in Bangladesh primarily experience problems with maternal health care. As a comparison to the prenatal care environment and the difficulties pregnant women encounter during maternal and prenatal care, my literature then provided an overview of maternal health care. The overview of maternal autonomy in Bangladesh is highlighted in the final section of the literature review, which was added to compare it with other pregnant women's perceptions of autonomy during prenatal care.

Both similarities and differences between my study's findings and those in the literature were found. As the existing literature suggests and reflected in my results, it is evident that women's autonomy is demonstrated by their capacity to make decisions, their ability to move freely, and their control over the resources they possess. When these aforementioned indicators are present, women experience autonomy and are able to effectively access healthcare. Nevertheless, the findings of this research diverged from existing literature. Specifically, the contrast emerged in the context that pregnant homemakers still experience a certain degree of freedom even in the absence of these indicators. However, this freedom is limited to the extent that their husbands permit. Consequently, this situation leads to a subconscious variation in the perception of autonomy among these pregnant women. Furthermore, as indicated by existing literature and confirmed by my findings, education significantly shapes the shifts in viewpoints among pregnant women. While previous studies suggested that religious norms hinder healthcare autonomy for pregnant women, my research demonstrates that, for the majority of contemporary women (both homemakers and jobholders), religion poses no substantial obstacle.

The perception of autonomy has evolved over time, yet my study reveals that the shift is primarily due to some flexibility within patriarchal norms, which have become more

accommodating toward women. The perception of autonomy among homemakers has changed because of the changing attitudes of both men and even women like mother-in-laws, who have become more open and flexible toward wives. Women have only adopted with the changes of patriarchal society and the adaptation of women to these changing norms stems from a lack of confidence in making independent choices, leading them to heavily rely on their husbands. This reliance forms an unseen but significant barrier to women's maternal autonomy. To overcome this, fostering self-assurance and a sense of bodily ownership becomes crucial. Notably, employed women enjoy “high autonomy’ as they are tied to their self-assuredness and sense of ownership. This explains why their perception of autonomy differs markedly from homemakers and older women.

Thus, this dissertation addresses the research problem by examining pregnant women's perspective on autonomy during prenatal care, highlighting variations in these perspectives among homemakers, jobholders, and older women. Additionally, it investigates the factors contributing to these shifts in perspectives. Finally, this thesis has tried to establish a connection between its findings and the analysis of how a pregnant woman's autonomy and its perceived form can be shaped by societal rules, family dynamics, and control over resources. This examination is guided by the theoretical framework of Anthony Giddens's "structuration" theory, which demonstrates how alterations in the structure and systems can empower agency and autonomy in a pregnant woman's experience. Moreover, that agency has the potential to reciprocally impact the existing structure and systems within the pregnant woman's context of living.

5.1 Summary of Findings and Analysis

The data gathered for this study distinctly illustrates that a majority of pregnant women, irrespective of their occupational history and age, lack a comprehensive understanding of the essential autonomy required during prenatal care. Autonomy remains an ambiguous concept for them, varying from individual to individual. While some recognize its significance, others do not. Among some women, the lack of awareness about the importance of autonomy leads to a lack of desire for it. Some refrain from desiring it due to their existing possession of autonomy, while for others, autonomy holds little to no meaning.

Moreover, this dissertation has identified variations in the perception of autonomy among three distinct groups of pregnant women. Pregnant homemakers view autonomy through the lens of adaptability. According to this perspective, autonomy is thought to come from accepting, adapting and following the rules set by men, especially husbands. They believe that obeying their husbands, who they consider to know better, leads to better health during pregnancy. They are satisfied with the degree of freedom they have. In contrast, jobholders perceive autonomy as an inherent advantage. Due to their financial independence, they already possess autonomy as an integral part of their lives, even before pregnancy. They do not need to struggle for it, take it from their spouse, or acquire it separately. Additionally, older women had no comprehension of autonomy during their pregnancies. The idea of autonomy was entirely foreign to them. They simply followed the instructions of their husbands, older family members, and neighbors throughout their pregnancies. The lack of autonomy prevented them from grasping its significance. Despite sharing some similarities with contemporary homemakers, the differing mindset of their husbands set them apart.

Furthermore, this dissertation delved into the factors that contributed to the changing perspectives among these three groups of mothers. Elements such as media exposure, education, and family dynamics exerted influence on these shifts. For instance, modern media has empowered contemporary pregnant women with access to information unavailable to older generations, enhancing their awareness of autonomy. Education has provided self-assurance and comprehension of medical matters, allowing women to make informed decisions independently (without their husband), thereby enhancing their autonomy. Additionally, family relationships play a role; understanding family members provide the freedom and autonomy for women to make their healthcare decisions.

5.2 Recommendations

The following recommendations are put forth after conducting a thorough examination of the research data:

- **Educational Programs:** Develop and implement educational programs targeting pregnant women, to raise awareness about women's rights and autonomy during pregnancy. These programs should provide information on reproductive health, pregnancy-related decisions, and the importance of decision-making autonomy. These programs should be incorporated as standard practice within hospitals, where pregnant women come for prenatal care. In instances of time constraints, consider providing leaflets or guidebooks to pregnant families as part of this standard approach.

- **Engagement of Men:** Involve men in discussions and awareness campaigns on the importance of supporting their partners' autonomy during pregnancy. Encourage open communication between couples about pregnancy-related decisions.
- **Support for Working Women:** Recognize and support the autonomy of working women by implementing policies and programs that accommodate their work schedules and help them ensure maternity leave benefits.
- **Networking:** Create support networks or community groups where pregnant women, especially older women, can share experiences and knowledge. This can help bridge the gap in understanding autonomy during pregnancy and promote a sense of empowerment.
- **Healthcare Provider Training:** Provide training to healthcare providers to ensure that they involve pregnant women in discussions about their care and treatment options, empowering women to make their own decisions and know what is best for them.

5.3 Limitations

The limitations of this dissertation are:

- The limited availability of secondary data on how women perceive maternal autonomy has made my research challenging. Most available data focus on maternal healthcare utilization and related factors, rather than the specific topic of maternal autonomy during pregnancy. As a result, I had a vague understanding of women's views on this subject before beginning and during my fieldwork. Furthermore, due to this limitation, I was unable to establish a solid background supported by existing literature for this dissertation.

- The most significant challenge I faced was the need to change my research topic when I was already halfway through my paper. I had to completely rewrite everything, including my research objectives and questionnaire, just before beginning my fieldwork on the initial topic. Additionally, it proved challenging to reach out to participants from the previous topic since many of their accurate contact details were missing in the hospital records. As a result, I decided to shift my research focus and commence my fieldwork anew at a later stage.
- Another substantial challenge arose when I encountered technical difficulties with my laptop, leading to the deletion of a significant portion of my files, even after changing my research topic. Consequently, I had to rewrite those sections of my dissertation. Having to rework the entire document twice became an exceptionally time-consuming process which was mentally and physically draining. I also believe that during the second rewriting process, I may have unintentionally omitted several crucial points.
- Another problem I faced during my fieldwork was trying to arrange interviews with doctors. As Doctors are constantly busy, getting them to spare time for me instead of seeing patients was quite challenging. There were times when I had scheduled appointments, but I had to go to the hospital only to find out that a doctor had to handle an emergency surgery, causing our meetings to be canceled. This happened twice. On the third day, I had to wait in the hospital waiting room for 4 hours before finally getting a chance to talk to one of the doctors. However, even then, she could not give me much time due to her busy schedule.

- Due to the topic change and rewriting challenges, I had limited time to conduct proper research and write the paper. I could not conduct as many interviews as I wanted, and I had to leave out important aspects from the paper as a result.

5.4 Further research:

In the course of conducting this dissertation, my primary focus has been on exploring women's perspectives on autonomy during prenatal healthcare. However, as the research progressed, numerous new insights emerged that I was unable to fully delve into due to time constraints. After analyzing the results, it became evident that husbands play a pivotal role in influencing women's perspectives on autonomy in this context. I have noted this down in the paper but could not discuss it thoroughly. Additionally, in terms of the findings, it became apparent that social constraints pose more substantial barriers than religious constraints when pregnant women seek autonomy, although the limited number of respondents in my study prevents me from definitively establishing this point. Furthermore, I also discovered that women from different socioeconomic classes perceive autonomy differently, which represents a significant and noteworthy insight.

Therefore, further research could delve into the influence of husbands on pregnant women's perception of autonomy, the comparison between social and religious constraints in seeking autonomy during pregnancy, and the variations in autonomy perceptions among women from diverse socioeconomic classes.

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Appendix 1

Questionnaire

Part A: Socio-demographic profile:

1. Name:
2. Age:
3. Religion:
4. Regional Address: (District)
5. Educational background:
6. Occupation:
7. Monthly earning:

Part B: Family details:

1. Family type:
2. Family size:
3. Who is the head of the family?
4. How much the head of the family earns monthly?
5. Parents' educational background:
6. In Laws educational background:
7. Husband's educational background:
8. Details of the family members they (respondent) live with:

Part C:

1. What is your overall experience of prenatal care?

2. How are you treated by your maternal family and In-laws during your pregnancy and prenatal care?
3. Who took care of you and assist you during the health condition?
4. How did you get mental and physical support from the families?

5. What was the decision making process during your prenatal care? How do you feel about it?
6. How the financial issues during prenatal care are managed? How do you feel about it? Who pays for the health care services?
7. How often do you go for prenatal care?
8. Did you need permission before going for check-ups? Did anybody accompany you? How do you feel about it?
9. Comparison between you and male members of your family in terms of health care conditions.
10. Have you ever faced domestic violence? If yes, by whom and how?
11. What is body ownership to you? How important it is to you?
12. Is there any cultural or religious barrier you faced during prenatal care and pregnancy?
13. What challenges did you face during your health care?
14. Explain the taboos that you had to deal with during this time and your attitude towards it.

Appendix 2

Questionnaire (KIIs)

- How important do you think autonomy is for utilization of maternal health care?
- Is there any clinical history regarding this issue? (for Doctors only)
- Do you see any differences between employed and unemployed pregnant patients? (for doctors only)
- Pregnant patients are accompanied by whom, usually? What's' their attitude towards the patient? (for doctors only)

- What factors do you think contribute to the changes in autonomy perspectives among various groups of pregnant women?
- Are there any support system for pregnant that can be utilized to strengthen women's idea of autonomy during pregnancy and prenatal care?

Appendix 3

Photos from Fieldwork

Medical department of Regional labor office

One of the unemployed respondents and her family

Outside of doctor's chamber

One of the employed respondents

Outside of BAPSA Manager's room

Regional Labor office