

Original Research Article

Decision Making Capacity and Constraints Faced by Rural Women while Seeking Maternal and Child Health Care Services in North Eastern Bangladesh

ABSTRACT

The aim of the study was to determine the association between rural women's decision-making power and the constraints faced by them while seeking Maternal and Child Health care services in north eastern Bangladesh. The study sample consisted of 150 mothers living in north-eastern Bangladesh who had accessed institutional MCH care services during their maternal period. Data were collected through structured questionnaire using simple random sampling technique from January-April, 2018 and analyzed using descriptive statistics, decision making index and constraints facing indexing method through SPSS and Microsoft Excel. The study results showed that, decisions about treatment seeking, consultation with doctor during prenatal and postnatal period, institutional birth preference and use / not use of contraceptives were always taken by the husbands, because the index was closer to the weighted value 200. But while making decisions about purchasing household daily needs, purchasing medicine, taking first child and taking more than two children, both husband and wife participated equally. On the other hand, constraint facing index showed that lack of medicine and vaccination, unhealthy environment and unprofessional behavior of clinic's people with CFI 651, 316 and 304 respectively, were the most commonly faced constraints by the rural women which discouraged them to seek institutional MCH care services. Though rural women were not completely suppressed in north eastern region of Bangladesh, but health care seeking decisions were completely under the supervision of the men of the family. Along with the socio-economic barriers, unprofessionalism, unavailability and mismanagement of the offered services also discouraged them to access institutional MCH care services. Awareness building among the rural people, especially in the recipients of this service along with Government and policy maker's intervention to ensure a better quality of MCH care services can change the scenario of MCH care seeking attitude of rural women in north eastern Bangladesh.

Keywords: Maternal and Child Health (MCH) care services; Decision making capacity; Constraints; North eastern Bangladesh; Rural women; Sylhet region

1. INTRODUCTION

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death [1]. Maternal health is a not only health but also social and development issue since it has tremendous impact on the child health and economy of families and healthcare system [2]. In Bangladesh, nearly one-fourths of total population lives below poverty level and households' out-of-pocket payments share over two-thirds of Total Health Expenditure. Moreover, over 55% of the total female populations are in age group 15-49 years with a total fertility rate of 2.3 and high

21 MMR [3]. However, the country has achieved noteworthy progress in terms of reducing MMR
22 by three-quarters by 2015, as a part of its meeting the Millennium Development Goal [4]. Still
23 the strong patriarchal structure and cultural barriers of society could be attributed for poor
24 health status of women in family and society [5]. It is evident that low utilization of maternal
25 health care services is one of the major contributing factors of the high maternal morbidity
26 and mortality in developing countries [6]. Previously many studies have attempted to explore
27 the barriers to the utilization of MHS, some from demographic, economic [7, 9, 10] and some
28 from sociocultural and behavioral perspectives [7, 8, 11, 12]. Apart from the socioeconomic
29 aspects, there is also a growing number of study emphasizing the role of women's decision-
30 making autonomy on maternal health service utilization and pregnancy outcomes [13, 14]. In
31 the perspective of Bangladesh however, involvement of husbands/partners in decision
32 making is particularly important because most families are male-headed and it is also the
33 male figures who usually play the dominant role in important household decision making
34 such as income expenditure and healthcare-related movement [14]. In South Asian countries
35 including Bangladesh, gender discrimination and inequality remains a widespread
36 phenomenon across various walks of life such as decision-making autonomy, intra-
37 household resource allocation, property rights and access to healthcare [15, 16]. Women
38 autonomy is restricted by social and cultural factors in the rural areas in Bangladesh
39 because of decision taking in context specific dominancy by man. Especially in the north
40 eastern region of Bangladesh, patriarchy is very dominant than other as here the community
41 people are very sensitive about religious norms and cultures. There women have less or no
42 decision making capacity. They cannot take emergency decision or hesitate to take decision
43 related to maternal and child care services, education and other aspects of daily life.
44 Educational backwardness, superstitions and conservative attitude restricts women to
45 receive MCH care from male service providers. Antenatal care appointments among the
46 women of north eastern region of Bangladesh are less (51.8%) than national women
47 (67.3%), which is a huge gap [17]. Within the household structure, the decision to select the
48 birth attendant has been found to rest predominantly with husbands and guardians (in 70%
49 cases). For treatment of female diseases or gynecological problems other than pregnancy, a
50 vast majority of women (65%) usually do not seek any medical care, with husbands bringing
51 medicine in a reported 7.7% of cases [18]. There is a very few studies which describe this
52 exact scenario of decision making incapability of rural women of this region particularly. The
53 major concern of this study was to minimize the knowledge gap and attract policy maker's
54 attention to improve the situation of north eastern women while seeking MCH care services.
55 Women's autonomy is a multidimensional concept which conveys a set of discrete
56 components or phenomena essential for ensuring that women can exercise their rights with
57 full potential and participate in decision making, whether it is about household decisions or
58 healthcare seeking. Therefore, this study was conducted to determine the association
59 between women's decision-making power and the constraints faced by them while seeking
60 MCH services in north eastern Bangladesh.

61 **2. MATERIAL AND METHODS**

62 **2.1 THE STUDY AREA:**

63 Sylhet district was selected purposively. The total area of the district is 3,452.07 sq. km. and
64 almost located in the north- eastern part of Bangladesh [19]. It was found that women of
65 Sylhet region were less aware than national women in receiving MCH care. Comparatively, a
66 higher proportion of national women (30.1%) received postnatal care than and women of
67 Sylhet (25.7%) [17]. Five major upazilas of Sylhet district - Sylhet Sadar, Dakshin Surma,
68 Golapganj, Bishwanath and Fenchuganj Upazila were selected purposively as the study
69 area. Five different villages from the respective upazilas - Shahpur village, Jalalpur village,

70 Fulbari village, Chandripur village and Gilachhara village were purposively chosen to collect
71 data in consideration with the time and budget.

72 **2.2 SAMPLING PROCEDURE AND SAMPLE SIZE**

73 The study is conducted based on primary data which employs both qualitative and
74 quantitative methods. The target population of this study were women with at least one child
75 of their own who had accessed institutional MCH care services at least for once during their
76 maternal period. A multi-stage sampling technique was used. In the first stage, simple
77 random sampling technique was used in selecting five upazilas out of twelve in whole Sylhet
78 district. In the second stage, one village from each upazila, thus five villages were selected
79 randomly. Finally, the third stage involved random selection of 30 MCH care service
80 recipients from each village, giving a total sample size of 150 women. Sample size was
81 purposively selected as 150. The basic inclusion criteria were: 1) Relatively backward
82 women having poor lifestyle, 2) Relatively cooperative to talk about these sensitive issues.
83 Selected sample recipients were interviewed following lottery method of simple random
84 sampling technique. Primary data were collected through individual in-depth interviews and
85 observations through structured questionnaire with total forty eight questions, key informant
86 interview and Focus Group Discussion. Secondary data was also collected from several
87 Bangladesh Bureau of Statistics, scientific articles, governmental reports, newspaper
88 reporting, numerous publications journal, thesis and so on. Data was collected from both
89 primary and secondary sources from January to April, 2018.

90 **2.3 ANALYTICAL TECHNIQUES**

91 Descriptive data on the socio-economic characteristics of rural women were presented as
92 percentage and mean. To evaluate the contribution of women in decision making, following
93 method of decision making index was carried out. A woman participates in a given decision
94 when she alone or jointly with someone else, especially husband, makes the decision. The
95 index was defined as the number of decisions a woman participates in. For each decision,
96 scoring was determined by the following way:

97 **X_i=1**= if the decision was taken by Women alone,

98 **X_i=2**= if the decision was taken by Men in the family,

99 **X_i=3**= if the decision was taken jointly by Men and Women in the family,

100 **X_i=4**= if the decision was taken by the parents-in-laws or other family members.

101 The functional specification of decision making capacity was determined by

$$102 \quad DI = \sum W_i X_i / n \quad [20]$$

103 Where, **i** = 1, 2, 3 and 4 = Number of decision criterion and **W** = Weight

104 Each of the decision criterions carried equal weight such as 100 for simpler calculation. Here
105 results were ranged from 100 to 400. Where, 100 meant full participation or freedom of
106 making choice for women. On the other hand, 200 meant no participation or freedom in
107 decision making. Score 300 indicated the combined decision making compatibility of both
108 husband and wife. If the score was 400, it indicated that there was no involvement of them in
109 decision making process. Lastly, a summation of all decision were shown by a simple
110 average where the weights were same. The closer the index score was to the weighted
111 value 300, the greater the indication of gender equity in decision-making.

112 For determining the constraints faced by the rural women, the constraint facing indexing
113 method was used, which was computed using the following formula,

$$114 \quad CFI = (C_h \times 3) + (C_m \times 2) + (C_i \times 1) + (C_n \times 0) \quad [21]$$

115 Where, **CFI** = Constraint Facing Index;

116 **C_h** = Percentage of respondents having severe constraints;

117 **C_m** = Percentage of respondents having significant constraints;

118 **C_i** = Percentage of respondents having insignificant; and

119 **C_n** = Percentage of respondents having constraints not at all.

120 All analyses were carried out using the SPSS (Statistical Package for Social Science) for
121 Windows (Version – 22, SPSS, Inc., Chicago, IL, USA) and Microsoft Excel, 2013.

122 **3. RESULTS AND DISCUSSION**

123 **3.1 BASIC SOCIO-ECONOMIC CHARACTERISTICS OF THE RESPONDENTS**

124 An effort has been made to describe briefly some of the basic socio-economic
125 characteristics of the respondents because these characteristics have a significant influence
126 on overall experiences they have faced while making decisions about seeking MCH care
127 services. The summary statistics of these characteristics are presented in Table 1. It shows
128 that majority (41.99%) of the sampled respondents were in middle-aged (25-34) group with
129 mean age 27.83 years and most of them had a large family size (55.33%).

130 Maximum proportion (44.67%) of the women had only primary level of education with a
131 mean value of 3.97. The major (40.67%) proportion of their husbands also had only primary
132 level of education. Education is an important variable while making decisions about
133 accessing health care facilities. From this table, it is evident that, both the recipients and
134 their husbands had a low level of educational qualification which ensured low level of
135 awareness about health related issues. About half of the total population (43.34%) had an
136 inadequate level of family income with a mean value of 0.76. It was evident from the
137 responses that, the women with lesser number of children had more accessibility to MCH
138 care services. Most of the interviewed women (31.33%) had only one child of their own.

139 Table 1 also shows that, majority (64%) of them said that, their home is very far from the
140 nearest MCH care centers of their respective areas with a mean value of 0.36. 52.67%
141 women of the total population said that, they do not get any family cooperation while
142 accessing MCH care services with a mean value of 0.47. Also unavailable female doctors in
143 MCH care centers was an alarming issue. Due to conservativeness, most of the women
144 hesitated to access the maternal services from a male doctor. Majority (59.33%) of the
145 women with a mean value of 0.41 said that, unavailable female doctor was a factor which
146 affected their accessibility to institutional MCH care services.

147 **Table 1. Distribution of rural women by socio-economic characteristics of the**
148 **respondents**

Variables	Percentage	Mean
Age		
Young (15-24)	40.0	
Middle (25-34)	41.99	27.83
Old (Above 34)	18.01	
Family Size		
Small (2-6)	8.0	

Medium (7-10)	36.67	
Large (≥ 11)	55.33	
Family type categories		
Joint family	92.0	
Nuclear family	8.0	
Recipient's Education		
Illiterate	28.0	
Primary	44.67	
Secondary	20.67	3.97
Higher secondary	5.33	
Graduation	1.33	
Husband's Education		
Illiterate	19.33	
Primary	40.67	
Secondary	26.67	5.74
Higher secondary	9.33	
Graduation	4.0	
Family income		
Adequate	19.33	
Relatively adequate	37.33	0.76
Not Adequate	43.34	
Number of living children		
1	31.33	
2	26.67	
3	25.33	2.33
4	11.33	
5	5.34	
Distance		
Very far	64.0	0.36
Near	36.0	
Family cooperation		
Yes	47.33	0.47
No	52.67	
Availability of female doctor		
Available	40.67	0.41
Not available	59.33	

149 Source: Field Survey, 2018

150 3.2 DECISION MAKING CAPACITY OF RURAL WOMEN WHILE SEEKING 151 MATERNAL AND CHILD HEALTH CARE SERVICES

152 Women's decision-making autonomy is closely linked to maternal and child health outcomes,
153 with empowerment of women and gender equity being recognized as the cornerstones of
154 effective health programs. There is now growing evidence of gender differences in utilization
155 of health care services globally, and these differences can exist at any stage of health care
156 delivery chain from decision making for health care seeking to effect or quality of care being
157 provided. This is the reason because of measuring the decision making capacity of women
158 in health care seeking was necessary to assess the accessibility of MCH care services of
159 rural women which was the main purpose of the research. Women decision making index
160 while seeking MCH care services were analyzed and presented in table 2. Where this table
161 indicated whether the decision made by women, men, both of them or parents-in-law/other
162 family members on the basis of the scores each category was assigned. Here, eight major

163 decisions regarding the household and health care were targeted and indexed on the basis
164 of the responses of interviewed rural women. These eight major decisions were: 1)
165 Treatment seeking for yourself (respondent), 2) Purchasing household daily needs, 3)
166 Purchasing medicine, 4) Consultation with doctor during prenatal and postnatal period, 5)
167 Institutional birth preference, 6) Use / Not use of contraceptives, 7) Taking first child and 8)
168 Taking more than two children.

169 According to the represented results presented in Table 2, decisions about treatment
170 seeking for the recipients were always taken by the husband, because the index value was
171 222.667 which is closer to the value 200, which was the weight assigned to the husband
172 category. Similarly the decisions about consultation with doctor during prenatal and postnatal
173 period, institutional birth preference and use / not use of contraceptives were almost made
174 by men. Because the index value for each decision was respectively 244.667, 238.667 and
175 206.0, which were closer to the value 200, that was the weight assigned to the husband
176 category.

177 On the other hand, while making decisions about purchasing household daily needs,
178 purchasing medicine, taking first child and taking more than two children, both husband and
179 wife participated equally. Because the index value for each stated decisions were
180 respectively 277.333, 260.0, 273.333 and 300.667, which were closer to the value 300,
181 which was the weight assigned to the category where husband and wife took decision
182 together. This was a great sign of initiating women autonomy in some of the household
183 matters. But the fact was also unavoidable that, women personally did not have right to take
184 any decision on herself. For every single aspect, she either had to listen to her husband or to
185 make some decisions with his consent, because he acted as a superior in it. That means, in
186 the case of MCH care seeking, women did not have the capacity to take decision for herself
187 without the consent of husband and for maximum cases, husband individually took the
188 decision which was a negative sign for the rural women of north eastern Bangladesh.

189 A comparative study showed that, the number of husbands controlling and implementing
190 everything in the family in Bogra was three times higher than that in Rajshahi. This indicated
191 that a positive change in the family domain is yet to emerge in Bogra. In slums there were
192 more conservative than those in Rajshahi. On the other hand, half of respondents from
193 Shapahar reported that their husband was the sole person in controlling and implementing
194 everything relating to family matters. The number of women directly involved in controlling
195 and implementing family business in Shapahar, was very insignificant compared to that in
196 either Bogra or Rajshahi. The most interesting finding was that 38% of respondents from
197 Shapahar reported that both husband and wife shared household matters together, whereas
198 this figure was significantly low in Bogra (1.6%) and in Rajshahi (6.6%) [22].

199 Within the household structure, the decision to select the birth attendant has been found to
200 rest predominantly with husbands and guardians (in 70% cases). For treatment of female
201 diseases or gynecological problems other than pregnancy, a vast majority of women (65%)
202 usually did not seek any medical care, with husbands bringing medicine in a reported 7.7%
203 of cases. In this study, the authors group the responses of fear of 'medical intervention', 'evil
204 spirits', 'shame', and 'delivery at home' as all rooted in the specific cultural background of the
205 women – although they comment that the percentages of Muslim and Hindu women refusing
206 referral are similar, which seems to confirm finding that religion played little part in decision-
207 making capacity of women while seeking MCH care services [18].

208 Compared with women who decided on their healthcare alone, those who decided jointly
209 with husband/partner had higher likelihood of using all three types of services (except for
210 antenatal visits among rural women). However, women could decide large household

211 purchases alone had higher likelihood of attending at least four antenatal visits. Similar
 212 association was observed for utilization of postnatal care among women in rural but not
 213 urban areas [4].

214 **Table 2: Decision Making Index of Rural Women in accessing MCH care**

Decisions	Respon dent (1)	Husba nd (2)	Both (3)	Parents-in-law or other family members (4)	Value	Decision Making Index
1. Treatment seeking for yourself	29	80	19	22	222.667	Husband
2. Purchasing household daily needs	1	74	33	42	277.333	Both
3. Purchasing medicine	7	76	37	30	260.0	Both
4. Consultation with doctor during prenatal and postnatal period	22	62	43	23	244.667	Husband
5. Institutional birth preference	21	79	21	29	238.667	Husband
6. Use / Not use of contraceptives	27	89	34	0	206.0	Husband
7. Taking first child	0	69	52	29	273.333	Both
8. Taking more than two children	0	63	23	64	300.667	Both

215 Source: Field Survey, 2018

216 **3.3 CONSTRAINTS FACED BY THE RURAL WOMEN WHILE SEEKING** 217 **MATERNAL AND CHILD HEALTH CARE SERVICES**

218 Table 3 shows the constraints faced by the rural women while seeking MCH care services in
 219 North Eastern Bangladesh. This was estimated by using organized questionnaire. A four-
 220 point rating scale was used for computing the constraint score of a respondent. After
 221 analyzing all the facts while visiting the studied areas and observing the responses of the
 222 recipients of the MCH care services, eleven commonly faced problems were identified which
 223 were the major of all the other constraints. These constraints were: 1) Objection from the
 224 parents-in-law, 2) Lack of cooperation of husband, 3) Had to go far for accessing the service,
 225 4) Nobody to accompany, 5) Did not get good doctor / Family Welfare Visitor, 6) Lack of
 226 female doctors, 7) Lack of medicine and vaccination, 8) The clinic's people were not well
 227 behaved, 9) Lack of proper accommodation facility, 10) Irregular treatment and 11)
 228 Unhealthy environment.

229 Table 3 disclosed that, lack of medicine and vaccination with CFI 651 was ranked as first.
 230 From the study area, it was found that, 70% of the total interviewed population severely
 231 faced the problem of deficiency of medicines and vaccines required by them and their
 232 children. Besides they mentioned that, money was charged to them several times unfairly for
 233 these services. Because of that reason, they decided to spend their hard earned money to
 234 the private MCH care service centers to get better quality services. Only 13% recipients did
 235 not face such kind of problem at all. Unhealthy environment with CFI 316 was the second
 236 most faced constraint. The hygiene status of the MCH care centers holds a great importance

237 in attracting more women to come and receive services. Not only MCH care, but also every
 238 type of health care system require a healthy and hygienic environment. Attitudes and
 239 behaviors of maternal health care providers influence health care seeking and quality of
 240 care. Bad behavior of clinic's people with CFI 304 was ranked as third most faced problem.
 241 In the study, 52% women got an unexpected level of behavior from the service providers.
 242 Irregular treatment with CFI 286 and not getting good doctor or Family Welfare Visitor with
 243 CFI 271 were the fourth and fifth problem respectively. Absenteeism of the doctors and
 244 service personnel was a mentionable reason behind this issue. The sixth problem was lack
 245 of proper accommodation facility with CFI 269 which discouraged rural women to seek MCH
 246 care services. Recently Government is making MCH care centers with better
 247 accommodation capacity. But how much development is reaching to the rural and backward
 248 areas of Bangladesh is the biggest question right now.

249 Table 3 also shows that the lack of female doctors with CFI 252 was the seventh constraint
 250 faced by north eastern Bangladeshi women. Due to the conservativeness and religious
 251 boundaries, most of the women of that region felt discomfort while talking about maternal
 252 issues to a male doctor and preferred female doctors to resolve their problems. During some
 253 previous years, the appointment of female doctors in this service has increased a lot. Still for
 254 some reasons, women of rural areas feel some deficiency of female doctors in their nearest
 255 MCH care centers. From service providers, it was heard that, many female doctors were
 256 unwilling to work in such remote and backward places. Most of them were urban facing.

257 Objection from the parents-in-law was also a hidden but serious constraint ranked eighth
 258 with CFI 224. In almost every family, the recipient lived with their parents-in-law. Most of
 259 them were surrounded by superstitions and conservativeness, illiterate and not aware about
 260 the benefits of provided services in Maternal and Child Health care centers. As a result, they
 261 believed more in traditional birth attendants rather than skilled doctors in MCH care centers.
 262 In most of the families, the parents-in-law held a strong position of themselves. Due to lack
 263 of decision making capacity, most of the women had to depend on the decisions of their
 264 husbands or parents-in-laws. Distance from the MCH care center was also mentioned as a
 265 problem by the recipients. Women had to go far to access the service was ranked as ninth
 266 constraint with index value 215. Recipients had nobody to accompany them while going to
 267 healthcare centers to access MCH care services and thus ranked it as tenth constraint with
 268 CFI 206. Lack of cooperation of husband with CFI 174 was ranked as the last constraint.
 269 Thought lack of decision making capacity, most of the women had the support of their
 270 husbands while accessing institutional MCH care which was a positive sign. Increased
 271 awareness was the only affecting factor behind it. It was found that, rural women of north
 272 eastern region of Bangladesh were already suffering from lack of decision making capacity
 273 because of the socio-economic barriers. Along with those problems, the MCH care sectors
 274 were also unable to provide their services to the recipients at a satisfactory level which
 275 discouraged them to seek institutional MCH care services.

276 **Table 3: Ranking of the constraints faced by rural women using Constraint Facing**
 277 **Index**

Constraints	Sever e (*3)	Signific ant (*2)	Insignifi cant (*1)	Not at all (*0)	Tota l CFI	Value	Rank
1. Objection from the parents-in-law	63	3	29	55	150	224	8
2. Lack of cooperation of husband	31	21	39	59	150	174	11
3. Had to go far for accessing the service	56	8	31	55	150	215	9

4. Nobody to accompany	43	21	35	51	150	206	10
5. Did not get good doctor / Family Welfare Visitor	64	31	17	38	150	271	5
6. Lack of female doctors	62	17	32	39	150	252	7
7. Lack of medicine and vaccination	205	10	16	19	150	651	1
8. The clinic's people were not well behaved	77	23	27	23	150	304	3
9. Lack of proper accommodation facility	56	35	31	28	150	269	6
10. Irregular treatment	72	22	26	30	150	286	4
11. Unhealthy environment	72	41	18	19	150	316	2

278 Source: Field Survey, 2018

279 Availability of drugs, medical supplies and family planning commodities is almost a
280 constant problem in many public health facilities throughout the length and breadth of
281 Bangladesh. While part of the problem lies with lack of effective supply chain
282 management, lack of funds (or timely release of available funds) to pay for supplies
283 is also a serious problem. Shortage of logistics in most public health care centers,
284 especially at the Upazila Health Complexes and district hospitals is a common
285 phenomenon. Often essential drugs and family planning commodities meant for free
286 distribution to patients and users are pilfered and sold to the private sector vendors [23]. For
287 births occurred between 1992-96, 75% of mothers received at least one Tetanus Toxoid (TT)
288 injection during pregnancy [24], while by 1995-99, the proportion had increased to 81% [25].
289 At health facilities, communication tended to be more two-way if a woman had a familial
290 relationship or friendship with the health worker [26].

291 As reported in a study, 90% of patients who had visited qualified private and unqualified
292 practitioners were satisfied with their behaviors and attitudes towards them. Only 66% were
293 satisfied with government service providers. It was also found that government officials
294 behaved roughly with patients who came from poor socio-economic background. Overall
295 quality of EmOC (Emergency obstetric care) in all public health centers except the medical
296 college hospital was poor. The worst quality was found at upazila level [22]. The
297 Bangladeshi Ministry of Health has stated that the quality of maternal health services
298 provided by government institutions is below expectations. It suffers critically from a large
299 number of problems, such as shortage of medical equipment, dearth of
300 doctors/nurses/technicians, unhygienic physical environment, scarcity of power and water,
301 pilferage of drugs and medicines and irregularities in the management system [27].

302 In a study, it was found that many mothers during their pregnancy took precautionary
303 measures against evil spirits. Younger mothers seemed less likely to believe these
304 explanations, at times ignoring their elder's advice about correct behavior, which could lead
305 to restrictions placed on women's movements by relatives [28]. Women were saying that
306 there was nobody to look after other children if the mother left the household. 18 of the 52
307 women agreed that transportation problems affected their decision [29]. Lack of female
308 doctors lower the pregnancy support. Female workers from NGO providing delivery services
309 were found to still choose to deliver their own children at home, most of them mentioning
310 factors such as family pressure, sudden onset of labor, distance from the clinic, and
311 transport as the reasons for giving birth at home [30].

312 **4. CONCLUSION AND RECOMMENDATIONS**

313 Women are still rundown of their own freedom to get decision making for herself or children
314 when desired healthcare required. Reaching gender equality is a slow process, since it
315 challenges people to change many cultural practices and thoughts and it takes far more than
316 changes in law or stated policy to change practices in the home, community and in the
317 decision-making environment. In this study, several decisions were analyzed and a
318 concluding remark could be drawn as, in north eastern region of Bangladesh, women were
319 not completely suppressed. They were given a certain level of power to express their
320 thoughts and opinions in household matters. But the health care seeking decisions for rural
321 women were completely under the supervision of men of the family. It was also evident that,
322 along with the socio-economic barriers, several constraints and mismanagement of the
323 offered services also discouraged rural women of north eastern Bangladesh to access
324 institutional MCH care services. Among them the deficiency of medicines and vaccines was
325 the main problem faced by them. Besides unhealthy environment and unprofessional
326 behavior of the service providers were also the major constraint according to them. In this
327 regard, the respondents put forward a number of suggestions to overcome the aforesaid
328 constraints which will improve their access capacity of MCH care services, health condition
329 of their children along with themselves and in turn help to improve the livelihood standard.
330 Proper support and initiative from the government and other cooperative bodies can ensure
331 proper development. As a key indicator of gender equality, women's decision-making power
332 measures the level of women's involvement in decision-making regarding consumption and
333 expenditures, reproductive choices, and other decisions. South Asian women are greatly
334 excluded from making decisions and have limited access to and control over resources.
335 Women's lack of decision making ability can be attributed to poor utilization of MCH care
336 services. Identification of the determinants of poor participation of women in decision making
337 for health care can help countries develop programs and policies to improve gender
338 inequalities in health care especially maternal health care seeking.

339 **5. LIMITATIONS**

340 Our study has several limitations. During the study, data were collected via personal
341 statements. Due to regional differences, the results cannot be generalized to the whole
342 country. Finally, the research design of the study limits conclusions about causality for some
343 findings.

344 **COMPETING INTERESTS**

345 Authors have declared that no competing interests exist.

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