IMPACT OF WOMEN'S AUTONOMY ON MATERNAL HEALTH CARE UTILIZATION: A CASE STUDY OF REHMAN-POOR UNION DISTRICT ASTORE GILGIT-BALTISTAN

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Abstract

The panacea of a healthy society lies upon access and dispensing sophisticated maternal health care facilities to women. In order to shape this strategy the primary area of focus is ensuring autonomy to women especially in some specific circles of life prominently in getting education, control over mobility, control over household income and control over finance. The importance of women's autonomy and maternal health care can be judged by the fact that prior to the advent of health care facilities the maternal mortality rate was very high among rural societies especially. The following quantitative research is focused on determining the level of women empowerment, its various dimensions in the local context and their direct or indirect impact on the maternal health seeking behavior in the form of maternal health care utilization. This study is conducted keeping in consideration the verity that more than two-thirds of Pakistan's population of which around 50% is women, live in rural and remote areas of the country with minimal access to quality health service. Moreover the conventional hegemonic patriarchy which challenges the women's entity in every development phase is also being analyzed in the form of husband's concern over the wife's job, his willingness to compel women to attain maternal health care. In order to have a true say and explore the ground reality moreover in order to further explore the hidden issues within this trauma the researcher conducted the following research in a far flung area of Gilgit-Baltistan in Astore Rehmanpur union which comprises of 12 villages. While conducting the research the researcher came across multi-variations in women's autonomy within a same territory. Interview schedules were opted as tool for the date collection over the entire research. While a random sample of 211 respondents was taken and analyzed the date through latest software SPSS and techniques of statistics.

LIST OF ABBREVATIONS

ANC	Antenatal care
ICPD	International conference on population development
LHV	Lady health worker
MHC	Maternal health care
MHCU	Maternal health care utilization
POA	Programme of action
SPSS	Statistical package for social sciences
UN	United nations
UNFPA	United Nations Population Fund
UNICEF	United nations international children education fund
WHO	World health organization

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CHAPTER NO. 1

INTRODUCTION

Chapter No. 1

Introduction

Since the inception, it has remained an entrenched as well as functional orthodox over the entire customary societies that women's action of autonomy was questioned time by time through various dimensions, initially by challenging the women's autonomy within all communal circles. Ultimately, this antagonism has restricted the exposure for women in the public world therefore by adversely affecting the primary child rearing avenue of mother, eventually leading to issues of maternal mortality and infant mortality. The blooming modernization trends have not altogether succeeded to alter the perceptions of traditional society regarding women empowerment, rather culture has continued its legacy of imprinting the impact on the categorization of the role and position of women in the Society, a phenomenon that is global (Presser and Sen 2000).

A woman plays a pivotal role in raising children and caring for the home, as well as interacting with the world outside the home (Shaikh, Haran and Hatcher 2008). So in one context the social circle of interaction for women is same as that of men but the itching hurdle in the way of women's life is the dubious cultural restriction over her autonomy.

The same situation falls in the case of maternal health care utilization where women suffering from an illness report less frequently for health care seeking as Compared with men (Ahmed, Adams, Chowdhury and Bhuiya 2000). Over half a million women from developing countries die

each year as a result of complications related to pregnancy and childbirth (Stephenson, Baschieri, Clements, Hennink, and Madise 2006; World Health Organization [WHO] 2005). So the matter of fact is that the society has even not granted enough confidence to women in independently enjoying her mobility in order to seek better health care facilities.

1.1.Women's autonomy and maternal health care utilization in world view

The UN has set the Millennium Development Goal, aimed to reduce the maternal mortality rates by 75% up to 2015. Whereas the World Health Organization (WHO) has estimated that 358,000 maternal deaths occur annually in the world, 99% of them in developing countries with sub-Saharan Africa accounting for 57% of these deaths (WHO 2005), While the major targeted places of action are the sub-Saharan African countries and the Asian countries. In African countries, the issue of low antenatal and delivery care services prevailed over a large span of time, i.e. until 2004. This scarcity of health care services sustained there. So these researchers have manifested that higher the women are autonomous from theeasier she seeks modern contraceptives to lesser the infant mortality by reducing fertility desire, and more she adopts delivery care services and postnatal care.

Greater autonomy increases utilization of antenatal and delivery care services, compared with fertility and family planning (Woldemicael 2010). So here a vital matter of concern arises that what are the main factors which act as a driving force for a woman to get autonomy. Several

researchers agree that the effect of women's autonomy on reproductive health outcomes should be examined using measures that reflect women's extent of freedom of movement and of control over financial resources and their decision-making power for the household needs (Bloom et al. 2001; Dharmalingam and Morgan 1996; Furuta and Salway 2006; Ghuman 2003; Saleem and Bobak 2005). In order to implement and sustain these variables of women's autonomy so that efficient maternal health care can be assured, the vital key necessary for these compartments to reach is education for all women. Only an educated woman can effectively handle the financial resources at the domestic level.

Women's education makes her more autonomous while this autonomy seldom acts as a link between women's educational attainment and her better health seeking behavior.

Another dimension which correlates the women's autonomy and maternal health care seeking behavior is the dispensing of reproductive rights, which are also considered a central agent in women's health movements in the world. Over the international arena, the program of action (POA) unanimously adopted by 184 countries in 1994 in united nation's international conference on population and development (ICPD), Where the POA stipulates a need for two kinds of action. The first is to ensure the provision of good quality reproductive and sexual health services to all in need, regardless of age, income, ethnicity or gender. The second involves the creation of social and economic conditions that will lead women (and men) to utilize these services as an exercise of their reproductive rights.

Thus, the POA recognizes that although necessary, the provision of services by itself is not sufficient (Currie and Wiesenberg 2003).

1.2. Women's autonomy and maternal health care utilization pattern in Asia and South Asia

Further zooming in by making a glance on Asiatic and South Asiatic context where the increasing trend of women's autonomy has triggered the better nurturing health care seeking behavior. Despite this, the risk of mother's deaths is still larger in the number than other advanced countries, i.e. 1 in 61 as compared to developed countries, which are 1 in 28000 (WHO, UNICEF and UNFPA 2004). While Health-seeking behavior is a complex phenomenon, and its appreciation could be very intriguing and Informative for designing a coherent policy (Shaikh 2008a; 2008b). On the other hand, autonomy on primary maternal health care utilization is much interrelated. The male-female disparity in health and well-being has been well documented in developing countries and particularly in the Asiatic context (Gupta 1987; Santow 1995). Prominently, in Asian studies work on various dimensions of women's autonomy and maternal health care seeking has gained new heights.

In Asian setup the lack of consistency among relationships found between reproductive behavior and female education or employment has led many analysts to measure women's autonomy directly, rather than using education or employment as proxies for their decision making power (Balk 1994; Jejheebhoy 1995; Visaria 1993). This is so because in south Asia the adult female literacy rate is less than 50% according to the report

published by the World Bank in 2011. Therefore, many of the women folks in south Asia are devoid of seeking the right maternal health care behavior because education is the primary weapon which dispenses the sense of realization among women to attain the better health consultation, moreover the health-seeking behavior depends largely upon the dynamics of communities that influence the overall well-being of the inhabitants and not merely on the individual's choice or circumstances (Mackian 2001). These anomalous dynamics are the cultural structures and practices which sometimes limit the women not to attain MHCU by even restricting her freedom of mobility. This phenomenon certainly and firmly exists in south asian topography because traditional societies lie still here. In many countries, the female counterparts in the house do the job either due to financial constraints or due to set pattern or either because of the status quo, now this diversification is embedded not only in a single country but in entire South Asia.

The other diversity of this issue is that women's role is marginalized to some specific circles, e.g. in much of the agricultural area of South Asia the women are given autonomy to work openly in the fields with their counterparts, where they have little autonomy to work according to their expertise but suddenly this autonomy is strictly bounded by the men's patriarchal authority. Resultantly, South Asian women are generally less autonomous than men, implying that they do not enjoy much decision-making power of personal, household and societal levels.

1.3. Women's autonomy and maternal health care utilization in Pakistan

Taking into consideration the account of women in Pakistan and their empowerment and health issues. The situation of women and children's health is grim in Pakistan, maternal mortality is estimated at 500/10,000 live births, infant mortality rate at 75/1,000 live births and the total fertility rate in more than four children per woman (Shaikh, Haran and Hatcher 2008). The scarcity of primary care services, antenatal care, and intrapartum care are the major factors leading to high maternal mortality in the country (Bhutta, Ali, Hyder, and Wajid 2004). One of the primary reasons behind this catastrophe is that, Pakistani society is dominated by the traditional mindset of the majority because of the prevalent orthodox societal setup since centuries, and adoption of modern facilities are sometimes not preferred prominently in the Pakistani rural setup. So just because of this reason according to various researches more than 90% delivery operations are performed by non-experts.

On the contrary, there also exists an anomalous scenario that in most of the areas, there is allowed for the women to take maternity health care facilities because the women there have the education, and ultimately they enjoy somewhat autonomy, While just because of this lack of education large numbers of women fail to take appropriate maternal health care facilities, especially at the time of prenatal care. While more than 40% of women are anemic and malnourished, one in every 38 women dies from pregnancy-related causes (Fikree et al. 2004). So in this regard the aspect

of education for women in attaining MHCU is pivotal in nature. According to the researches 70% of Pakistani folk reside in rural areas so their women enjoy autonomy in Agri-related activities so the impact of this bounded autonomy further drives back the women in acquiring their pre-natal and post-natal care, due to the agricultural activities and moreover, animal rearing activities.

In areas of Gilgit Baltistan where the research has been conducted the women is falling in the domain of autonomy in agricultural activities. Moreover, the absence of maternity homes is ahead a very drastic challenge in coping with delivery cases.

1.4. Scope of the study

This study is focused to probe the women's autonomy level and its implication on their maternal health care utilization pattern (the prenatal, delivery and post natal stage) in the locale. While conducting this research, different side by variables were being used to study the level of women's autonomy, among the variables education of the respondent, freedom of movement, control over finance are prominently analyzed as key objectives of the research. Furthermore, all the cultural dimensions affecting the level of women's autonomy, which eventually affects women's mobility level and finally their health seeking behavior is discussed. The study also encompasses the authority of women even in domestic level by discussing women's role in child schooling, women's decision making in household large and small purchases. Furthermore, to

what extent a woman is autonomous in casting her votes by her own will is also discussed.

This study is also focused on to find results that employed women are autonomous or not moreover. What is the view of male counterparts regarding women work or job and besides the control over finance of women in their domestic sphere is discussed. While the prominent emphasis is laid to probe the education level of both women and men in the locale, because education is the primary behavior determining variable. The freedom of movement is being analyzed by these clues that are the women freely move towards their relatives and natal-kins or not.

While MHCU is also an important subject matter of this research, therefore, each respondent is being thoroughly analyzed regarding her behavior towards MHCU. The research analyzed the view of women regarding acquiring maternal health care utilization or keeping Daula. The frequency of prenatal checkups were also probed. While the causes and consequences of not attaining MHC were also discussed. Furthermore, the number of postnatal checkups was also studied.

The entire study is conducted in a far-flung area of district Astore Gilgit-Baltistan where even the basic requirements of life, i.e. electricity, gas, telecommunication is not available. The whole union council was under study, which comprises of 12 villages.

1.5. Significance of the study

In sociological perspective, the society is studied as a vehicle comprising of men and women as its driving wheels. A deficiency in any of the

components can cause disruption in the proper functioning of the entire vehicle. A woman is the sole child rearing entity at home so a healthy mother can only socialize a healthy child and ultimately, a healthy society.

Therefore this study primarily focuses on highlighting the women's empowerment dimensions either at domestic and public level by highlighting the control over finance, household large and small purchases, freedom of movement and empowerment in casting vote. Secondly the maternal health care seeking behavior is remarkable in the case of giving locale because maternal mortality and infant mortality rate in Pakistan is still in high percentage. Therefore a healthy society can't be ensured.

So better health care facilities for a woman before and after a child birth ensures a healthy society. This study also lays emphasis on the education of the women as a determining factor of attaining MHCU.

1.6. Statement of the problem

It is an immortal fact that Pakistani culture is gender stratified where the patriarchal inclinations are dominated. Generally, the role of women in the society is directed by the patriarchy. According to Jejeebhoy and Sathar (2001) culture of this entire region is "characterized by matrilineal descent, patrilocal residence, inheritance and succession practices that exclude women, and hierarchical relations in which the patriarch or his relatives have authority over family members. Moreover, in Pakistan as in other Islamic settings, women occupy a separate and distinctive position that effectively denies them education and autonomy''. The manifest justification of this argument lies in the fact that a large percentage of

Pakistani women resides in rural areas where the prevalence of traditional normative structure exists, which limits the women's freedom of mobility. Ultimately, she never becomes able to seek better maternal health care.

There is another dimension, which is being completely ignored by the local health care regulators and educationalists to mobilize and aware the women about the importance of attaining maternal health care, because in the context of research settings various women are educated, but still they don’t know the importance of attaining MHCU,and instead they are consulting Daula or other means as consultation for MHCU, which are often unhygienic for women. That is why we have not progressed in this domain, i.e. maternal mortality rate, in Pakistan is same as in 2006 to 2010, which are 260 deaths per 100,000 live births. According to the researches, 375,000 women suffer each year from pregnancy-related issues. Still, only 205,000 women receive any form of trained health care in pakistan, approximately five million births take place annually (Fikree 1994). So in this situation of devastation how we can stand ourselves in the line of developed countries.

A prevalent factor known as religious clergy stances, which limit the female health care attainment trend. The clergy entirely opposes the contraceptive usage as well as limits the mobility of women to Daula only. Furthermore, Family planning services to avoid unwanted pregnancies. Whereas in Pakistan, the contraceptive usage percentage is only 12% while according to researches there is estimated need to rise by this percentage from 12% to 25%. Furthermore, community-based maternity

services and appropriate referrals when required to have been recommended as interventions for reducing maternal mortality and morbidity (Fathalla 1988). The, likewise situation prevails in my research locale where the family planning is completely ignored to address, and people with religious views are of the view that using contraceptives is sin. So due to this trend various other social problems arose there one of them is unemployment.

Our formal education set up implanted in Pakistan is not enough dynamic to educate, aware and mobilize women. Therefore, the nongovernmental organizations are playing their role in this issue to aware people regarding importance of MHCU.

1.7. Objectives

1. To study the socioeconomic position of respondents.
2. To study the levels of autonomy of women through various indicators in the locale.
3. Impact of women's autonomy on maternal health care utilization.

CHAPTER NO. 2

REVIEW OF LITERATURE

Chapter No. 2

Review of Literature

In this study, the dimensions of women's autonomy as education, labor-force participation, control over finance and decision making position of women is thoroughly reviewed by comparative study. Moreover, the relation and impact of dimensions of women's autonomy are linked with the maternal health care issues of women in Asian, South Asian and Pakistani context. This study explores all the hidden as well as exposed dimensions of women's position within all spheres of society. Furthermore keeping in view the international scenario the state of local maternal health and women's position issue is being analyzed.

Mason (1984) operationalizes the relation of women's autonomy and maternal health care by presenting the concept of autonomy as "individual's capacity and freedom to act independently of the authority of others, for instance, the ability to leave the house without asking anyone's permission or make personal decisions regarding contraceptive use or obtaining health care. Thus, women's autonomy can be conceptualized as the ability to make and execute independent decisions pertaining to personal matters of importance to their lives or their family, even though men and other people may be opposed to their wishes.

The concept of autonomy for women basically strives to bring the entity of women in the mainstream society by giving them position to carry out their part in the society. Unfortunately, our patriarchal society encompasses the male driven decision making the part of women totally

dysfunctional. Therefore, there is a dire need to empower the women in domestic as well as public domains.

Grabowski and Self (2013) mentioned two primary determining factors of women's autonomy, i.e. educational attainment and labor-force participation. Through education, the women attain awareness and according to the prevailing cultural practices, she makes her way to live a better life. Moreover, education dispenses her an exposure to face and adjust herself with the traditional boundaries of culture. While the other determining factor is the labor-force participation through which primarily women attain freedom of movement, and this freedom of movement makes her way to get autonomy in maternal health care seeking. They further mentioned on the issue that an earning woman who works outside the home becomes a functional member of her family, and therefore, she inducts herself in the decision making of home. She is given a separate priority even in household affairs by the members because she performs an additional duty apart from child-rearing and feeding. Basically, in this case she changes her status in family therefore the behavior and attitude of male counterparts to her even also change.

Borooah (2009) finds the farsighted impact of women's educational attainment on her child health care. He argues that education builds a sense of realization and awareness among the women to adopt primary precautionary measures to ensure best health care, while she also seeks to a better health care seeking behavior just because of this education. In the domain of Pakistan and India's maximum of the infant is exposed to

malnutrition, so he addresses this issue by fulfilling the educational need of women. The traditional areas of Pakistan lack the trend of education but now this trend in making its way among the youth gradually but still the female education trend is still at stake. Dharmalingam and Morgan (1996) put forward that the woman's education which is a sure way to determine the woman's empowerment level in a society has a remarkable role in creating a sense of utility of maternal health care among women. Moreover, education creates better understanding of health seeking behavior and utilizing it. Basically, he lays emphasis on the applicability of education for women irrespective of her status or caste so that she can better manage her maternal duty.

Mason (1997) asserted another applicability of the important dimension of women's autonomy, i.e. education that education enhances economic independence among women ultimately she becomes an active participant among family members and imparts her contribution in the financial budget. Moreover, he proposes that education leads to decision-making autonomy in a woman.

On the other hand, there are also some studies that show no effects or opposite effects, such as relatively little freedom of movement among the better-educated (Balk 1997). Basu (1996) argues that, generally there is meager evidence in support of the idea that a woman's education unambiguously leads to increases in her autonomy and suggests that the education-autonomy relationship is not the primary mode through which schooling leads to fertility change.

Chakrabarti and Chaudhuri (2007) analyzed that “among the maternal attributes; education was found to have the strongest association with use of delivery facilities at time of birth. Education improves utilization by (a) increasing awareness, (b) empowering women to take decisions on her own health risks, (c) increasing her ability to communicate with health personnel in an environment alien to her own world." While, on the contrary, they also propose that “Education could reduce health service utilization by increasing the opportunity cost of time devoted to health care. Most studies show that education has a positive effect, implying that its opportunity cost effect is less than the other positive effects of education."

Basu and Basu (2004) highlight a tentative dimension that although women’s freedom of mobility, especially in the form of labor-force participation has a remarkable impact on women’s empowerment level but on the other hand, there are adverse implications for this sort of mobility. Because in this case where a woman indulges herself in the labor force work, she then becomes somewhat irresponsible regarding her maternal health care while it also imprints a negative impact on her child in the wake of prenatal and postnatal stage. They also proposed that child mortality ratio was higher among the working women as compared to that of the housewives or non-working women.

The ratio of poverty in the Pakistani rural society especially is in hype. Therefore, in much of the area all the family members work to feed so the dimension of maternal health care is usually ignored in this case and

ultimately, which leads to issues of maternal mortality and infant mortality.

Murthi et al. (1995) has found that a working woman having access freedom of movement fail to allocate the time properly for her children, and ultimately ill socialization occurs in such domains. Moreover, less time allocation for child care occurs. So he emphasizes on the balance of child health care and labor-force participation level.

Wado (2013) extracts anomalous dimensions of women's autonomy where he suggests the key changes needed to ensure the freedom of movement for women. Basically, he lays importance on the background dimensions by changing the settings where a woman lives e.g. he suggests the media exposure towards women, so that she and her male counterparts be mobilized and aware about women's role in society and living in urban settings will also increase the freedom of movement for women because urban settings enlarge the canvas of people broader and wider. In a village, the freedom of movement is restricted to relatives, natal kins, agricultural fields and doctor which is prescribed by the patriarchal normative structure. So here in urban settings the women are a functional societal entity by indulging her in all spheres.

In Pakistan, the media network is currently influencing the society with its full zeal due to its widespread demand and availability so media side by also plays a good role in mobilizing the society regarding women's oppressed position and the growing issue of maternal issue.

Chakrabarti (2012) finds that “female exposure to the media also leads to a greater probability that children will receive formal health care. They do not find the same benefits accruing when the father is literate, but the mother is not. Specifically, they find that literate mothers make more effective use of healthcare and educational institutions."

Explaining a new dimension of women’s autonomy Jejeebhoy and Sathar (2001) portray the role of religion and region as a key determinant of women’s autonomy. Basically, he annotates this region of South Asia as gender stratifies where women and men are not equal, men have their own level of autonomy and freedom of mobility moreover control over finance while female have only localized functions to perform, her performance is measured by this patriarchal setup of the society. He characterizes that patriarchal authority in our region of Pakistan excludes women from the mainstream society, to some extent, by setting some specific functions to be performed by her. There also has a remarkable impact of societal prescriptive structure at the level of women’s autonomy. So only a flexible prescriptive structure provides a woman's exposure to the outside world and freedom of movement. Moreover, as the religious practices are concerned in Pakistan's women are more separated and alienated there exist different standards for women to act.

Chakrabarti and Chaudhuri (2007) analyzed that “autonomy of the female is measured in two ways. A “freedom” index measures the ability of the woman to go to the market or visit a friend without seeking permission, whereas a “decision” variable measures the extent to which she can decide

on health care and take decisions with respect to the purchase of jewelry and other household items. The household variables include measures of the husband's education, caste, religion, etc. The village characteristics measure the availability of all-weather roads, electricity, a government health facility, a private health facility, etc. The results indicate that the education of both the wife, and the husband plays an important role in whether prenatal care is utilized."

Jejeebhoy and Sathar (2001) explore that "the index of access to, and control over economic resources covers two aspects of women's use of family and own resources: their freedom to use or manage household resources and the extent to which they have independent control over any resource. The index thus sums responses to seven questions. Four of these relate with accessing to household resources: (1) having a say in how household income is spent; (2) getting cash to spend; (3) being free to purchase small items of jewelry; and (4) being free to purchase gifts. Three relate to aspects of women's expression of independent control over resources: (1) whether any of the family's valuables (land/jewelry/ utensils) belong to the woman (that is, are in the woman's name) and are controlled by her; (2) whether she has or had some say are the major say (assigned a value of 0.5 and 1.0 respectively) in how the valuables from her dowry are used or spent; and (3) whether she expects to support herself in old age through her own savings."

Gupta et al. (2003) after analyzing the regional as well as normative structure of the subcontinent proposed that the culture of son preference lie

here in this region very prominently because society is patriarchal and there exists more lust for men so that they can be a part to earn money. Therefore, in this case woman faces much ignorance and violence. In another way, Gupta explores that “son preference leads to discrimination against females in a variety of ways. First, son preference influences fertility practices before conception. The perception of the desired number of sons influences the use of contraception and decisions as to whether to have additional children. Second, during pregnancy son preference can lead to gender bias via sex-selective abortion. This, of course, presumes that the family has access to technology that allows the family to determine the sex of the child before birth.

At birth, son preference can also lead to bias via sex-selective infanticide. Finally, after birth and during early childhood the allocation of resources within the household is biased in favor of sons relative to daughters, leading to higher morbidity and mortality for girls relative to boys”.

Sharan, Ahmed and Strobino (2013) highlighted that health care availability is a determinant of women’s autonomy by mentioning that “whether women’s autonomy has an interactive relationship with health service availability in influencing health behavior or outcome is a question that has implications for policy. If autonomy has a substantive effect on health care availability, it would imply that women with high levels of autonomy are able to seek care, regardless of whether service availability is high or low. In such a situation, more investments will be needed for improving women’s autonomy than for improving access to care, since

autonomy will be able to compensate for deficiencies in service availability. On the other hand, if autonomy has a complementary effect on service availability; it would imply that both autonomy and service availability should be enhanced together to improve health care utilization rates among women."

Gupta (1990) finds that although improved child care through availability of health care facilities has a remarkable impact on women's autonomy but prior to this, there are some determining factors must be mashed along with health care facilities to ensure women's autonomy those prominent features are mother's education social class, and exposure towards the outside world.

Currie and Wiesenberg (2003) explore the importance of autonomy in reproductive behavior and importance of improvement in better health seeking behavior by proposing that "Despite advances in medical knowledge. Commentators agree that the greatest gains in health will come through behavioral change. Women must change their health-seeking behavior; worldwide, health advocates find that even though services may be provided for women, it does not guarantee that women use them. For a woman to be healthy, as well as autonomous, she must be able to control every aspect of her reproductive life."

Anderson and Eswaran (2009) formulated the idea that "Increasing a woman's autonomy has been shown to lead to long-term reductions in fertility, higher child survival rates, and allocations of resources within the household which benefit the children within the household."

According to Basu (1993) women enjoying a higher position in the social settings are more benefited with acquiring maternal health care while oppressed women with lower levels of empowerment and position in a domestic or public sphere are more prone to health care problems. The key reason may be the unavailability of enough resources so that to conduct prenatal and postnatal diagnosis.

Wallston and Wallston (1984) lay importance on the changing behavior of health seeking among women. The case of changing behaviors is essential for rural women where the traditional health care centers are being consulted due to which problems of malnutrition, high infant and maternal mortality exists. So there is a dire need of changing this paradigm shift. This behavioral change may shift by the primary dispensing of reproductive rights and autonomy for women.

Segall and Chappell (2000) identified four key belief dimensions, which have a vital impact upon health seeking behavior, i.e. “beliefs about causality, controllability, susceptibility, and seriousness. Each cluster of beliefs impacts on whether an individual will perceive a health problem, seek treatment of any kind, or engage in behaviors that enhance health and reduce the likelihood of illness."

Fikree, Ali, Durocher and Rahbar (2004) throw light on the issue of gender disparity being prevailed in the societies of our culture where women are alienated much regarding their autonomy and maternal health.

They are of the view that “this gender disparity affects the health of the women by limiting their social mobility as well as access to appropriate

health care. Support from the community is minimal or absent, which can lead to mothers' or child's death or severe morbidity."

Jejeebhoy (1995) develops a link between the usurped women's autonomy and the drastic effects of maternal health by proposing that women having lesser autonomy are ill planned to perform family planning and contraceptive usage. Therefore, they are prone to mortality ratios and ill socialization of their children.

Woldemicael (2010) analyzes that "Women's autonomy increases their adoption of modern contraceptives and reduces fertility desire and child mortality. Although some of these studies have also shown that greater autonomy increases utilization of antenatal and delivery care services, compared with fertility and family planning, much less research is about the use of health services, a proximate determinant of maternal and child mortality."

Khan (1999) has empirically related various hurdles of in attaining maternal health care with that of women's autonomy of freedom by building the arguments that "Poor maternal health is associated with unhealthy living conditions, high fertility rates, inadequate hospitals, and low uptake of maternal health services. How does women's gender position or level of autonomy affect these variables? The low status of women's health problems can lead to poor health among women, as well as poor-quality services. Restricted access and limited uptake of maternal health services can be linked to a number of autonomy-related factors. If geographical distance is a problem which is often the case with maternity

hospitals, then restricted mobility for women can be a barrier to access. This has been found even over short distances where, in order to travel, women must be accompanied, even in an emergency."

Regardless of the ample local and international proceedings to reform the maternal health care services, the maternal mortality and infant mortality rate is still in hype, i.e. every year half a million women from developing countries die because of pregnancy and childbirth problems. In research, it has revealed that most women in these affected areas have a scarcity of maternal health services, or they have no reach to these facilities. Moreover, they have not been given sexual education services so that they get aware of the importance of maternal health care utilization. On making a glance in developing countries the majority of women's deaths are due to complications in pregnancy and childbirth. The ratio is so drastic that every minute more than one woman dies due to these complications, and the tool has risen to 536,000 women's deaths per year (WHO 2008).

Khan, Sajid and Iqbal (2010) portrayed the true picture of maternal health problem regarding women in Pakistani context by conceptualizing that in Pakistani society, the key decision maker is the male counterpart, while here the decision of when and where to take the maternal health service is in his hand so much of the health care issue persists due to this hurdle. Whereas in another dimension, women report the health problems either less or late so health-related issue bloom increasingly.

2.1 Assumptions

Reviewing the ample literature upon the phenomena of women's autonomy and MHCU the researcher has concluded following assumptions extracted from the previous studies:

- Concept of women's autonomy is basically a strive to build the capacity of a woman so that the women can act in a free and independent behavior where she could play her role in the society according to her needs effectively.
- The primary source of creating autonomy among women is education through which she becomes able to study surroundings and differentiate between right and wrong ultimately she can better manipulate her skills in domestic as well as in society.
- An education dispenses the women with exposure to her personality. Moreover, through education attainment she can better manipulate the resources for the MHCU. Ultimately, she can better nourish a child who has ultimately created a healthy society.
- Education also leads to other determinants of women's autonomy such as Freedom of movement, control over finance through job attainment, household decision making.
- Women's freedom of movement ensures the better attainment of ANC services, because she can visit the doctor and health care centers independently. So she can better utilize the maternal health when necessary.

- Control over finance empowers a woman by making her able to attain the best health care service for ANC, therefore, getting rid of the issues of infant and maternal mortality.
- The key hurdle to women's autonomy is the patriarchal as well as cultural restrictions while the prime hurdle to the maternal health-care problem is the unavailability of proper services of health care while in addition to it, the restriction of mobility also adds in.

CHAPTER NO. 3

THEORATICAL FRAMEWORK

Chapter No. 3

Theoretical Framework

3.1 Theories of women's autonomy Classical feminist theories of women's autonomy

Theories of these female thinkers are distinctive because they incorporate the standpoint of gender, focus on the lives and work of women, critically engage the problem of social inequality, and offer solutions to ameliorate social problems.

3.1.1. Charlotte Perkins Gilman (1860-1935)

Gilman proposed the concept of "sexuo-economic arrangement." Where he proposes that gender inequality, violence and division of labor in society is the outcome of economic arrangements. She argues that due to this economic arrangement in society "a master class of men and subordinate class of women" emerged. In other words, the usurped autonomy of women in the society is mainly due to this improper arrangement of economic assets. Gilman talks about the restricted freedom of mobility of the women, where she is being limited to only non-productive household work by completely alienating her role of society. In this regard, the control of finance came over the male part while exploiting women physically and emotionally by making her a home worker. After reporting this account Gilman devises the solution to dispense the key dimensions of women's autonomy, i.e. Freedom of mobility, control over finance and rational dismantling of the household where he emphasizes that make women autonomy in household decision making, including child care and

food purchases. So this theory decisively portrays the account of the present work by initially making a glance on the key dimensions of women's autonomy and then measuring their level of exploitation and then devising the solution. The given study also focuses on the key dimensions of women's autonomy, i.e. control over finance, household autonomy, freedom of movement to which all the dimensions are being portrayed by Gilman efficiently.

3.1.2. Marianne Schnitger Weber (1870-1954)

Marianne Schnitger Weber proposed sociological theory based on the key notion that women's role in the social setup is endorsed and highlighted by dispensing her key autonomy rights, and she is of the view that sociology should be created from the standpoint of women. Initially, Marianne proposed three propositions that there is a dire need of women's autonomy moreover their key productive role should be in reshaping of the culture and there should be a separate and identified standpoint of women who ensure their position. Likewise, in the research the researcher studies the various minor issues restricting women's autonomy to occur e.g. local cultural normative structure, people's religious interpretations Marianne here highlights the role of social institutions in enabling or restricting the women's role in the local social circle. Moreover, she also proposed in her theory that freedom of mobility only for men not for women is imbalancing for the society. At the ending point of theory, Marianne argues that the orthodox patriarchal structure of society should be

dissolved. So Marianne emphasizes on the key female autonomy through dispensing of women's role in social circles, which is the key domain of this study.

3.1.3. Gender stratification theorist's perspective

This perspective lays its emphasis on the gender-based difference relating to power and freedom in society. Gender stratification theory lays a basis that societies where women adhere sufficient position and say they're the women have fewer common maternal health issues, because there the women have their say in their private matters, and the society provides them with enough space for their health-related issues. Gender stratification perspective lays importance on the primary mode of women's autonomy, i.e. women's economic empowerment through control over finance and employment autonomy through freedom of movement. These theorists argue that women's economic freedom is the key dimension of women's autonomy because through this domain, they can attain every freedom aspect in their lives. So that's why the theorists argue that "Women's economic power will determine their access to other kinds of power, for example, control over their sexuality and reproduction. Whereas this conducted study also exhibits the three vital dimensions of women's autonomy as control over finance, freedom of mobility and women's decision-making ability, which was primarily driven by the freedom of control over finance.

3.2 Theories of maternal health care utilization

3.2.1 Mercer's maternal role attainment theory

It is a theory which emphasizes on the formation of strong maternal identity for nontraditional mothers. This theory has a wider scope of pregnancy and postnatal care. Basically, this theory works as a nursing model for the antenatal care and development. This theory is based on the strong mother-child relationship. This theory basically tends a mother to perform her maternal duties as an autonomous mother where the mother bonds with the infant, attain competence in general care taking maneuvers and finally express herself as an empowered and responsible mother. The theory is a compact guideline for a woman to be autonomous mother by setting four stages of acquisition namely anticipatory (social and psychological adaption of the maternal role, an initial practice towards maternal autonomy), formal (stage where a mother attains maternal autonomy by consulting the advises and consultations about antenatal care), informal (in this stage mother performs her maternal duties by devising her own methods of care) and personal (joyous stage for women where she feels in attainment of complete maternal autonomy). This theory is related to the given study in the domain of "maternal autonomy" which is the key women's autonomy dimension whereas given study focuses on the women's autonomy with wider lens (it may either be maternal social economical) and its impact on the maternal health care

utilization patterns. So this theory is a guideline for a mother that how she could perform her maternal health care utilization more efficiently.

3.3 Hypothesis

Alternate hypothesis "H_1"

More the women's autonomy higher will be the maternal health care utilization.

Null hypothesis "H_o"

More the women's autonomy lesser will be the maternal health care utilization.

3.4 Independent variables

In the study settings primarily dimension of woman's autonomy is being entrenched while further narrow downing the area of study the concept of "women's autonomy" is being operationalized as the independent variable. Woman's autonomy includes further sub variables, which determine the woman's autonomy levels. Firstly, it is education, which is taken as vital women's empowerment determining factor. Secondly, control over finance is another factor, which determines the women's position in society as well as in the domestic sphere. Moving ahead the household decision making factor is the third woman's level of autonomy determining factor. In this case woman's consent over domestic issues such as child schooling, household large purchases, small purchases, right for a casting vote are being asked.

3.5 Dependent variables

Women's health seeking behavior is taken as subject matter of this study. Concisely, the maternal health care utilization is being taken as the dependent variable. In other words, the impact of women's autonomy on maternal health care utilization pattern is being discussed. In maternal health care utilization pattern the antenatal stage of caring is being encompassed, which involves the prenatal care, care during delivery time and post natal care. To measure the entire process of maternal health care utilization freedom of mobility of women, prenatal and postnatal checkups are being analyzed.

3.6 Propositions

- Women's freedom of mobility paves her way to control over finance, which ultimately leads to household autonomy of the women. In the present context, a woman with freedom of movement try to explore earning sources and ultimately contributes to the household economy which changes her position in the household, so her position in house stands equal to that of the bread earner man, and ultimately, she is also being involved in household decision making because now she has an active part in running household finance.
- Women with greater maternal autonomy seek better health care utilization patterns. Moreover, women who keenly adopt the maternal role prove themselves as better mothers.

- Women involvement in the formation/reshaping of normative behaviors of culture makes her autonomous and ensures her standpoint position in social as well as the domestic sphere.

CHAPTER NO. 4

CONCEPTUALIZATION AND OPERATIONALIZATION

Chapter No. 4

Conceptualization and Operationalization

4.1 Conceptualization

4.1.1 Women's Autonomy

Basu (1992), Dyson and Moore (1983) defined autonomy as "the capacity to manipulate one's personal environment through control over resources and information in order to make decisions about one's own concerns or about close family members".

Women's autonomy can be conceptualized as the "ability to make and execute independent decisions pertaining to personal matters of importance to their lives or their family, even though men and other people may be opposed to their wishes" (Mason 1984).

Jejeebhoy (2001) has conceptualized the concept of autonomy into five major aspects which are key contributors in the determining the autonomy of women i.e. autonomy of knowledge (educated women are more autonomous because they adhere world view), autonomy in decision making (educated women have more hand in household decision making), physical autonomy (educated women have far more freedom of mobility), emotional autonomy, economic and social autonomy.

According to Kishore (2004) the concept of autonomy is the building block of three indices namely customary (making decisions related to procreation and child rearing), non-customary (making decisions outside the traditional areas) and realized (actual autonomy of freedom of freedom).

4.1.2 Maternal health care utilization

According to Britannica Encyclopedia (2009) maternal health care is,

"The care of women, especially of childbearing and childrearing women"

According to WHO (2013),

"Maternal health care utilization 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.

4.2 Operationalization

4.2.1 Women's Autonomy

Women's autonomy in the context of this study asserts the primary dimensions of freedom which cause the women to change her status in the family as well as in society primarily through the education attainment because education provides the women with world view and somehow awareness relating to her social roles more importantly assists her in attaining maternal health care utilization (Jejeebhoy 2001). Secondary dimension taken as the determinant of autonomy is control over resources, as it is an entrenched fact in over society that men adhere the sole resources and under this domain he suppresses women and alienates her role into a narrow dimension therefore when woman attains control over resources she can have her say in the domestic as well as in public matters. In order to get control over resources women should have freedom of mobility in their settings so that through the freedom of movement she can

attain better maternal health facilities moreover she can get an exposure of the outside world.

(Basu 1992, Dyson and Moore 1983)

4.2.2 Maternal health care utilization

The phenomenon of antenatal care encompasses the three vital practices of prenatal care, during delivery time and postnatal care (WHO 2013). The prenatal care is measured by the no. of checkups performed by the women before delivery i.e. when she is pregnant, while who has assisted her during the prenatal checkups while who accompanied her at the time of delivery while where her delivery was performed. Furthermore the postnatal care is being determined by the no of post natal checkups and where the women performed postnatal checkups. While the circumstances under which the women didn't perform theses antenatal checkups were also being analyzed.

CHAPTER NO. 5

RESEARCH METHODOLOGY

Chapter No. 5

Research Methodology

The present research is based on quantitative research design. This research design is being selected because it is most suitable to analyze the issue of women's autonomy and maternal health care utilization in the context of Rehman poor union District Astore Gilgit-Baltistan. The other major reason behind this selection is that it helps to test the hypotheses and gives the better understanding of the cause effect relationship between two variables as mentioned in the previous chapter.

5.1 Universe

The area of study is Rehman Poor Union Council of District Astore Gilgit-Baltistan comprising of 13 villages. While this locale is culturally rich and diverse moreover this terrain exhibits a fine distribution of patriarchal practices where the women's role is marginalized and access to maternal health care utilization is hurdled due to unavailability of proper maternal health care services. Another reason for taking this area as study locale is the distinct variation in woman's autonomy level in the villages within the union. One village exhibits higher women autonomy while the other village locale exhibits marginalized role of women's position. So this diversity is the fascination of current study locale.

5.2 Unit of analysis or target population

Keeping in consideration the limitation of research topic only married women were targeted for study while within the set of married women

only the women who have passed 40 days of their delivery are being interviewed.

5.3 Sampling design

In order to distinctly characterize and sort an appropriate sample which can be a suitable representative of the entire population the researcher has gone through the technique of purposive sampling. Moreover, the LHVs were not having the proper record and there is unavailability of the list of registration of vital events especially of the mother who have produced babies in the last 6 week, so purposive sampling technique was adapted for the collection of the respondent's data.

5.4 Sample size

In order to probe the key issues and various dimensions of women's autonomy in the context of locale only 211 respondents were being interviewed.

5.5 Tools of data collection

To conduct a research in areas of traditional sort normally where the literacy rate among women especially is not up to that level moreover difficulty in understanding English is also another issue for the respondents there, the interview schedule method as a tool for data collection was applied. This method is also applied upon the pretext that while conversations the side by aspects of women maternal and autonomy issues may be high lightened.

5.6 Pre-Testing

In order to take a general view and check out the initial response and environment for further survey researcher has conducted 10 pre-Testing interview schedules. Moreover in the study settings it was necessary for me to take the prior view of people regarding their involvement in information sharing and cooperation. So the pre-testing assisted me in this scenario.

5.7 Data analysis

After thoroughly conducting the survey, data was being converted into inferential form through using advance data screening software and SPSS and then analyzing the data to draw inferences.

5.8 Opportunities and Limitations of the study

This study is much more vital in its unique attribution of versatility on levels of women's autonomy. Due to slightly change of one factor of education the settings of one village are much different to that of another village.

Moreover in this study researcher has got the prospect to explore the agricultural autonomy level moreover autonomy of women in the place where she practices agricultural autonomy and her level of freedom of mobility. As this study is entirely conducted upon married women, so it was difficult for the researcher to take interview therefore LHVs assisted in this problem, because in the prevailing cultural conditions it was unable for a male to visit and take interview from a women relating to her maternal related issues.

5.9 Ethical Concerns

While the study settings were inhibiting the traditional rural setup therefore the researcher had come across many ethical dilemmas. As during day time the women were used to go to fields so researcher has two schedules the interviews in the afternoon or evening time. Moreover first he had to take permission from the husbands and in many cases LHVs assisted the researcher in interviewing. Moreover prior to set interviews the researcher assured the respondent about the pretext of this research and affirmed her about the confidentiality of her name and details. Furthermore there was a part of interviewing questions which were related to pure pregnancy related issues so according to the outlook of respondent i.e. either she is more religious, not eager to tell the researcher directly the answer of this question. The LHV besides researcher used to ask the question and he was set to write down the details. Moreover showing Anonymity to the local culture was considered as an important aspect. So keeping in view the research guideline researcher changed his dressing code and even his language style of an urban based to rural inhabitant.

CHAPTER NO. 6

RESULTS

Chapter No. 6

Results

6.1 Frequency tables

Table 6.1.1 Age of the respondents

Age intervals	Frequency	Percent
20-24	10	4.7
25-29	44	20.9
30-34	46	21.8
35-39	80	37.9
40+	31	14.6
Total	211	100.0

In the above mentioned table regarding the age profile of respondents is jotted down. As the mentioned figure 37.9% respondents with a frequency of 80 are reported to fall within the age group of 35-39 while 21.8% respondents fall within the age group of 30-34%. Moreover 20.9% respondents (44) fall within the age group of 25-29. Only 4.7% (10) respondents exhibit age 20-24. Whereas 14.6% respondents were aged greater than 40 years . So it can be summoned that young population is being targeted as the unit of analysis.

Table 6.1.2 Marital status of the respondent

Marital status	Frequency	Percent
Married	207	98.1
Widow	4	1.9
Total	211	100.0

Out of the noted frequencies regarding marital status of respondents, the married respondents have the largest percentage of 98.1% with a frequency of 207 while only 4 respondents are observed as a widow .So 98 % of the respondents of my research are married while 1.9% is widowed.

Table 6.1.3 Family structures of the respondents

Family structure	Frequency	Percent
Nuclear	122	57.8
Joint	73	34.6
Extended	16	7.6
Total	211	100.0

In the above drawn table nuclear family setup has the highest percentage of 57.8% with a frequency of 122 whereas extended family system has the lowest percentage of 7.6% with a frequency of 16 and frequency of joint family system lies in between as 73.so 34.6% respondents belong to join, 57% adheres nuclear while only 7 % exhibits extended family system.

In the study majority of the respondents have nuclear family setup because in the research of the conducted study, parents tend to live with the eldest

son while rests of the sons are being spread to form their own shelter. So that's why the rate of the nuclear family system persists more.

Table 6.1.4 Respondents' age at marriage

Age categories	Frequency	Percent
15-20	46	21.8
21-26	134	63.5
27-32	31	14.7
Total	211	100.0

The research results show that 63% respondents are being married at age of 21-26 while 21% respondents have age up to 15-20 at the time of their marriage, while only 14% respondents have late marriages at the age of 27-32.

Table 6.1.5 Number of children of the respondent

Categories of no. of children of the respondent	Frequency	Percent
1-5	145	68.7
6+	66	31.2
Total	211	100.0

The finding exhibit that 68% of the respondents have 1-5 children while 30% respondents have 6-11 children. So in this scenario the o of child birth rate is moderate.

Table 6.1.6 Number of male children of the respondent

Categories of male children of the respondent	Frequency	Percent
No male Child	21	10.0
1-5	182	86.3
6-11	8	3.8
Total	211	100.0

The study explores that 86% of the respondents have 1-5 male children whereas only 3% of the respondents have male children ranging from 6-11.

Table 6.1.7 Number of female children of the respondent

Categories of female children of the respondent	Frequency	Percent
No female child	24	11.4
1-5	181	85.8
6+	6	2.9
Total	211	100.0

85% of the respondents have female children with a ratio of 1-5, while only 2% have female children greater than 6. Whereas 11% have no female child.

Table 6.1.8 Social class of the respondent

Social class of the respondent	Frequency	Percent
Upper class (rich)	16	7.6
Middle class	183	86.7
Lower class	12	5.7
Total	211	100.0

The respondents are being categorized into distinct upper, middle and lower class. These classes are being generated on the basis of wealth and land ownernership. After having a through investigation the results have manifested that 86% respondents having the highest frequency of 183 belong to middle class, while 7.6% respondents having frequencies of 16 respondents exhibit upper classes. Only 5.7% (12) respondents were of a lower class. So 86% of the respondents are of the middle class and 7% are of high and 5% are of low class.

Table 6.1.9 Education of the respondent

Categories of education of the respondent	Frequency	Percent
5-9	118	55.9
10	39	18.5
12	21	10.0
14	13	6.2
16	20	9.5
Total	211	100.0

55% of the respondents have an education level of below materials while 18% are matriculated. Moreover 10% respondents are higher secondary passed. While 6% and 9% are graduate and master's degree holders respectively.

Table 6.1.10 Education of the husband of the respondent

Categories of the husband's education of respondent	Frequency	Percent
5-9	26	12.3
10	50	23.7
12	65	30.8
14	50	23.7
16	20	9.5
Total	211	100.0

The above table of husband's education of the respondents exhibit that 30% of the husbands of respondents are higher secondary passed. While 23% are matriculated, moreover 23% husbands have done graduation. Only 12% respondent's husbands are under matriculation. The main reason this low percentage of husband's education is the scarcity of educational environment in the area moreover the men are being considered as the sole leader of the house at the ahead time. So he was targeted to earn and feed his family. Education up to lower levels is customary while after Matric the respondents either join armed forces or migrate to urban cities like Karachi, Faisalabad so that to earn money.

Table 6.1.11 Type of education preferred for women in the locale

Categories	Frequency	Percent
Religious education	15	7.1
Education up to secondary level	138	65.4
Education up to higher secondary level	27	12.8
Education up to graduation level	16	7.6
Religious education and education up to secondary level	15	7.1
Total	211	100.0

65.4% respondents with a frequency of 138 were of the view that education up to secondary level for women should be allowed. While 12.8% (27) women were holding the stance that education up to higher secondary level should be allowed 7.6% women with frequency of 16 have said that for women's education up to graduation level should be necessary. Only 7.1% (15) women were of this view that only religious education should be given to women. On the other way frequency of another 15 (7.1%) women were of this view that both religious and education up to secondary level should be allowed to women in the locale.

Table 6.1.12 Employment Status of respondent

Respondent employed	Frequency	Percent
Yes	15	7.1
No	196	92.9
Total	211	100.0

Respondents with a frequency of 196 were not employed while only 15 respondents were employed. So the employment percentage of women is 7% while unemployment level prevails in 92%.

Table 6.1.13 Profession of the employed respondent

Profession of the employed respondent	Frequency	Percent
Government servant	13	6.2
Private employee	2	.9
Unemployed	196	92.89
Total	211	100.0

Although the employment percentages of respondents were low so out of them only. 9% (2) respondents were private while 6.2% (13) were government servants. The main reason behind the low percentage of private employment rate is the scarcity of private firms working in the area.

Table 6.1.14 Monthly income of the respondent

Monthly income categories	Frequency	Percent	Valid %	Cumulative %
1000-4999	1	.5	6.7	6.7
5000-9999	11	5.2	73.3	80.0
10,000-1,999	3	1.4	20.0	100.0
Total Employed	15	7.1	100.0	
Unemployed	196	92.9		
Total	211	100.0		

The reported findings exhibit that there is the least amount of respondents who are employed i.e. the frequency of employed respondents is 15. Out of the total employed respondents 5.2% respondents have monthly income less than ten thousand while only 1.4% respondents have more than ten thousand and less than twenty thousand monthly income.

Table 6.1.15 Husband view about respondent's job

Husband's view	Frequency	Percent
Appreciable	15	7.1
Unemployed	196	92.9
Total	211	100.0

Out of the observed (15) employed respondents 7.1% (15) are of the view that their husbands appreciate them in doing the job.

Table 6.1.16 Extent of religiosity of the family of respondent

Extent of being religious	Frequency	Percent
Very religious	38	18.0
Moderately religious	173	82.0
Total	211	100.0

Highest Frequency of 173 respondents with percentage of 82% belongs to moderately religious families while frequencies of 38 respondents belong to very religious families with a mere percentage of 18%.

Table 6.1.17 Respondent can use her earning independently

Respondent's view	Frequency	Percent
Yes	10	4.7
No	5	2.4
Unemployed	196	92.9
Total	211	100.0

Out of the 15 employed respondents 4.7% (10) have reported that they use their earning independently while frequency of only 2.4% (5) respondents have said their earning is managed by their husband or family elder.

Table 6.1.18 Authority running household affairs

Household affairs runner category	Frequency	Percent
Husband/Respondent	146	69.2
The family elder/Father in law	66	31.2
Total	211	100.0

69.2% respondents reported that their household affairs are being managed solely by their themselves and husband. 31.2% respondents with a frequency of 66 reported that their household managers are their father in law as their family elders.

Table 6.1.19 Household asset's owner

Assests owner categories	Frequency	Percent
Husband	139	65.9
You	5	2.4
The family elder	3	1.4
Father in law/Mother in law	64	30.4
Total	211	100.0

65.9% respondents having Frequency of 139 told that their husband is the owner of their household assets. 30.4% (64) respondents have said that their father in law and mother in law is their owners of household assets. While 2.4% (5) respondents were of the view that she himself is the owner moreover 3 (1.4%) respondents reported that their family elder owns their household assets.

Table 6.1.20 Manager of the household budget

Solely manager	Frequency	Percent
Husband	139	65.9
Respondent	13	6.2
Father in law	58	27.5
Husband and respondent (wife)	1	.5
Total	211	100.0

65.9% respondent having Frequency of 139 have reported that their husbands manage their household budget while 6.2% (13) respondents themselves manage their domestic budget. Whereas 27.5% respondents carrying frequency of 58 have shown that their father in laws regulates their home budget .Only one respondent said that they both husband and wife regulate their household budget mutually.

Table. 6.1.21 Consulted in household decisions

Respondent's view	Frequency	Percent
Yes	138	65.4
No	73	34.6
Total	211	100.0

65% respondents with a frequency of 138 replied that they are being consulted in their household decision making process. While 73 respondents with percentage of 34% were not being consulted in household decisions.

Table 6.1.22 Household decisions in which respondent is consulted

Categories of decisions	Frequency	Percent
Children schooling	30	14.2
Household large purchases	48	22.7
Household small purchases	36	17.1
Marriage related matters	28	13.2
Agriculture related matters	66	31.2
Total	211	100.0

Out of the entire conducted research 13.2% respondents with a frequency of 28 said that they are being consulted in marriage related matters in house. While 17.1% respondents having a frequency of 36 were of the view that they are being consulted in household small purchases. 31.2% (66) respondents expressed the view that they are being consulted in matters of agriculture at home. 22.7% respondents carrying Frequency of 48 expressed the view that they take part in decisions relating household large purchases. 14.2% respondents taking Frequency of 30 had reported that they are being involved in decisions relating children schooling.

Table 6.1.23 Work family allows respondent to do outside the home

Job Categories	Frequency	Percent
Agriculture based work	186	88.2
Office work	11	5.2
Family business	14	6.6
Total	211	100.0

88.2% respondents with highest frequency of 186 told that their family allows them to work in agriculture fields outside home while only 5.2% (11) respondents reported that their family allows them even to work at the office, while only 6.6% (14) respondents said that their family permits them to be part of their family business outside the home.

Table 6.1.24 Consultation with Respondent on selection of spouse

Respondent's view	Frequency	Percent
Yes	173	82.0
No	38	18.0
Total	211	100.0

82% respondents with highest frequency of 173 have reported that they were being consulted by their elders in the selection of their spouse. While only 18% (38) respondents said that they were not consulted by their elders in selecting her spouse.

Table 6.1.25 Freedom to freely visit relatives

Respondent's view	Frequency	Percent
Yes	211	100.0

All the respondents with 100% view that they visit their relatives freely.

Table 6.1.26 Freedom of freely visit to natal kins

The respondent can freely visit her natal kins	Frequency	Percent
Yes	207	98.1
No	4	1.9
Total	211	100.0

The reported results depict that 98% respondents have nodded that they can freely visit natal kins while only 1% respondents with a frequency of 4 have replied that they can't visit towards their natal kins without the prior the permission of family head or husband

Table 6.1.27 Sole decision maker of casting vote

Who decides to cast vote	Frequency	Percent
Myself	38	18.0
Husband	119	56.4
Nambardaar village	6	2.8
Father in law	44	20.9
Father	3	1.4
Respondent and husband	1	.5
Total	211	100.0

56.4% respondents with highest frequency of 119 cast their vote under their husband's decision while 44 respondents with percentage of 20% used to cast their vote by the decision of their father in laws. Whereas 18% respondents with a frequency of 38 cast their vote independently .3 respondents reported they cast their vote by the consent of their father. While only one respondent used to cast her vote by mutual consensus between her and her husband.

Table 6.1.28 Freedom to independently visit doctor for checkup

Respondent freely visit doctor in need of a checkup	Frequency	Percent
Yes	190	90.0
No	21	10.0
Total	211	100.0

90% respondents can independently visit doctor in need of a checkup while only 10% respondents can't freely move towards the doctor with prior permission and accompany of men.

Table 6.1.29 Prenatal checkups received by the respondent

Prenatal checkups	Frequency	Percent
0	56	26.5
1-3	98	46.4
4	16	7.6
4+	41	19.4
Total	211	100.0

According to the given table 46% respondents have prenatal checkups below 4 which is a standard set by the WHO. While 19% of the respondents have more than 4 prenatal checkups, whereas only 7% respondents have performed 4 prenatal checkups. 26% respondents have not performed the prenatal checkup because of either unavailability/lack of access of proper facilities.

Table 6.1.30 Respondent visited for prenatal checkups

Where the respondent performed prenatal checkup	Frequency	Percent
TBA/dai/Daula	2	.9
Lhw/Lhv	67	31.8
Doctor	74	35.1
Lhw/lhv and doctor	12	5.7
Not performed prenatal checkup	56	26.5
Total	211	100.0

35.1% respondents with highest frequency of 74 have received prenatal checkups from a doctor. While31.8% (67) respondents have received their prenatal checkups from LHW/LHVs. 5.7% (12) respondents have performed prenatal checkups from both LHW and the doctor. Only .9% (2) respondents have consulted Daula for prenatal checkups .While 26.5% (56) respondents didn't perform even prenatal checkup.

Table 6.1.31 Reasons for not receiving the prenatal checkup

Reason for not receiving prenatal checkup	Frequency	Percent
Not necessary	44	20.8
Costly	4	1.9
Family resistance	1	.5
Lack of knowledge	3	1.4
Not necessary and due to lack of knowledge	6	2.8
Not performed checkup	153	72.0
Total	211	100.0

Out of the total reported 58 respondents who didn't receive a prenatal checkup 20.8% (44) of them didn't take prenatal checkup because they didn't consider it necessary to receive checkup. While 2.8% (6) respondents didn't receive a checkup because they have a lack of knowledge about the necessity of prenatal checkups and feeling not necessary to perform checkup. 1.9% (4) respondents didn't perform checkup because it was costly for them to afford. 3 respondents had a lack of knowledge. Only 1 respondent faced family resistance to conduct checkup.

Table 6.1.32 Views of respondent about keeping Daula/Dai

Respondent's view	Frequency	Percent
It is good to keep Daula/Dai	11	5.2
It is not good to keep Daula/Dai	15	7.1
Don't know	185	87.7
Total	211	100.0

The cannotation of Daula expresses the old women of the village who bears expertise in the births complications of women and who better manages how to feed and infant. Under this conceptualization the finded statistics show that 5.2% (11) respondents nodded it as well to keep Daula. Only 7.1% (15) respondents were of the view that keeping Daula is not good.

Table 6.1.33 Respondent Gained services of Daula/Dai/Maid

Respondent's view	Frequency	Percent
Yes	9	4.3
No	202	95.7
Total	211	100.0

95% respondents with a frequency of 202 have not received services of Daula while only 4.3% (9) respondents have gained Daula services. Although there prevails much credibility of traditional mode of treatment and health care but now there is scarcity of Dai or Daula. About a decade

ago there were prominently Dai dispensing maternal health care consultations but now hardly 1 older woman with experience of maternal issues is present which hardly presents services during a birth time for the baby.

Table 6.1.34 Childbirths occurred at home

Childbirths occurred at home	Frequency	Percent
0	29	13.7
1-5	119	56.4
6-10	59	28.0
11-15	4	1.9
Total	211	100.0

The study exhibits that 56% of respondents have 1-5 child births occurred at home while 28% have 6-10 childbirths occurred at home, whereas 13% have no childbirth occurred in the home.

Table 6.1.35 Childbirth occurred in clinical

No. of Childbirths	Frequency	Percent
0	208	98.6
1-5	3	1.4
Total	211	100.0

98.6% respondents have child births occurred not in clinic while only 1.4% (3) respondents have 1 childbirth occurred in clinic. In the research locale there is scarcity of clinics while only 3 functional dispensaries were

present whom function is only to do the preliminary checkup of fever, nausea, vaccination etc.

Table 6.1.36 Childbirths occurred in hospital

No. of Childbirths	Frequency	Percent
0	136	64.5
1-5	74	35.1
6-10	1	.5
Total	211	100.0

64% of the respondents have no Childbirth occurred in hospital, while 35% of the respondents have 1-5 childbirths occurred in hospital.

Table 6.1.37 Assistant of respondent during delivery

Assistant during delivery	Frequency	Percent
Doctor	26	12.3
Mother	26	12.3
Mother in law	99	46.9
Sister in law	28	13.2
Sisters	25	11.8
Lhv	5	2.3
Grandmother	2	1
Total	211	100.0

46% of respondents with a frequency of 98 reported that they were being assisted by their mother in laws during delivery. 12.3% (26) respondents were being assisted by a doctor during delivery time. 11.8% respondent

with Frequency of 25 have sister accompanying her at the time of delivery. 12.3% (26) respondents were assisted by their mothers during delivery. Surprisingly only 2.3% (5) respondents took the services of LHV for the delivery process.

Table 6.1.38 Postnatal checkups received by the respondent

Categories of postnatal checkups	Frequency	Percent
0	74	35.1
1-3	98	46.4
4	6	2.8
4+	33	15.6
Total	211	100.0

As per the medically determined time period of postnatal checkups it is 6 weeks. But the study settings have numerous environmental, social and cultural hurdles which restrict the women to complete her postpartum checkups limit. The reported results therefore exhibit that out of the entire sample of 211respondents only 35.1% (74) respondents didn't perform postnatal checkups. While 46% respondents have received 1-3 postnatal checkups, moreover 15% of the respondents have received more than 4 postnatal checkups. 2% respondnets have performed 4 times postnatal checkup which is a standard set by the WHO.

Table 6.1.39 Reasons for not receiving the postnatal checkup

Reason of not receiving postnatal checkup	Frequency	Percent
Not necessary	53	25.1
Costly	6	3.4
Not accessible	2	1
Dissatisfaction of treatment	1	.5
Family resistance	3	1.5
Lack of knowledge	9	4.2
Not performed checkup	137	64.9
Total	211	100.0

25.1% of the respondent reported that they didn't feel necessary to receive postnatal checkup. One of the main reasons behind this is the diet and the involvement of local female elders that restricts to go to the doctor for postnatal checkup. They tend to rely on the traditional mode of treatment. 3.4% of the respondents found it costly to receive postnatal checkups therefore they avoided it. In fact the poverty ration also prevails there. About 1.5% of the respondents have argued that family resistance has restricted us to go and receive postnatal treatment. While only 4.2% respondents were of the view that due to lack of knowledge we didn't go for postnatal checkup.

6.2 Cross-Tabulation and Hypothesis testing

Alternate Hypothesis: H_1 = More the women's autonomy higher will be the maternal health care utilization

Null hypothesis: H_0 = lesser the women's autonomy lesser will be the maternal health care utilization

Level of significance: α 0.05

Statistical tests:- Chi square tests

Results: According to chi square tests, result of the level of significance 0.05 there is a relationship between women's autonomy and maternal health care utilization.

Table. 6.2.1 Education and maternal health care utilization cross tabulation and hypothesis testing through chi-square testing

		Where did the respondent visit for prenatal checkups				
		TBA/Dai/ Daula	Lhv/ Lhw	Doctor	Lhv and doctor	Total
Education of the respondent	5-9	1	35	45	3	84
	10	0	13	16	5	34
	12	0	11	5	1	17
	14	0	4	5	2	11
	16	1	4	3	1	9
Total		2	67	74	12	155

The given reveals the relation of education with gaining of MHCU services. One of the important dimensions in this study is that the entire respondents are with the education level of under matriculation have accessed the MHCU more than the highly educated respondents. In resemblance to these results another study conducted in Pakistan which

asserts that education has no prior association with utilization of ANC services in Pakistan (Nisar and White 2003). Now discussing the results, only scarce respondents are above matriculation, while many of them are LHVs themselves. According to the table only one respondent with education under matriculation has consulted day while 35 have consulted Lhv, 45 have visited doctors and 3 have consulted both doctor and Lhv for their prenatal checkup. As far as the case of respondents with education up to matriculation level, no respondent has consulted Dai, 13 have accessed Lhv, 16 respondents have referred to Doctor while 5 respondents have consulted both doctor and Lhv. Furthermore respondents of education up to masters have entirely consulted Lhv and a doctor. An explorative study being conducted in Indian Punjab asserts that education paves a way to boost women's self-confidence escalates their acquaintance to information and alters the way others respond to them (Gupta 1990).

Chi-Square Test Statistics

	Education of the respondent	Where did the respondent visit for prenatal checkups
chi-square[a,b]	178.929	105.981
Df	4	3
Asymp. Sigh.	.000	.000

A 0 cells (. 0%) have expected frequencies less than 5. The minimum expected cell frequency is 42.2.

B 0 cells (. 0%) have expected frequencies less than 5. The minimum expected cell frequency is 38.8.

The relationship between education of the respondent and no. of prenatal checkups received by the respondent is significant. Pearson Chi-square for the independent variable education and dependent variable no of post-natal checkups are 178.929 and 105.981while DF is 4 and 3 respectively, p value is 0.000 for both which is less than 0.05. Therefore the alternate

hypothesis is accepted and the null hypothesis is rejected. In the case of this testing the nonparametric chi-square test is being employed because the data was not showing normal distribution or bell shape structure rather it was positively skewed in the histogram so because of this reason the non-parametric test was employed.

Table 6.2.2 Education of the respondent and Assistant during delivery cross tabulation

		Who assisted during delivery												
		0	Doctor	Mother	Mother in law	Sister in law	Sisters	Lhv	Auntie	Grandmother	Mother in law and Lhv	Sister and sister in laws	Sister in laws and Lhv	Total
Edu of the respondent	5-9	0	17	14	53	11	15	1	1	1	0	4	1	118
	10	0	5	5	15	5	6	1	1	0	0	0	1	39
	12	0	1	1	10	6	2	1	0	0	0	0	0	21
	14	1	2	3	5	0	1	0	0	0	1	0	0	13
	16	0	1	1	15	1	1	0	0	0	0	1	0	20
Total		1	26	24	98	23	25	3	2	1	1	5	2	211

The table portrays the correlation of the education level of the respondents and who assisted during delivery. The table manifests the one common thing among all the respondents of educational groups that the respondents were maximally assisted during delivery by their mother in laws because they were the accompanying ones with the respondent, while the percentage of consulting with doctors is less than this and the third number comes off the Lhv. The highest percentage of mother in laws during delivery is upon the pretext that they are locally known as skilled safe delivery attendants. As it is fact that the ANC is a vital determinant of safe delivery (Bloom et al. 1999).

So on the basis of this Allendrof (2010) suggested that "the skilled birth attendants can provide some care in the home while they also help to ensure safe deliveries by recognizing danger signs and ultimately referring women to health facilities when complications arise during home deliveries".

Chi-Square Test Statistics

	Education of the respondent	Who assisted during delivery
chi-square[a,b]	178.929	474.592
Df	4	11
Asymp. Sigh.	.000	.000

a 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 42.2.
b 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 17.6.

The relationship between education of the respondent and who assisted during delivery is significant. Pearson Chi-square for the independent

variable education and dependent variable who assisted during delivery is 178.929 and 474.592 while d_f is 4 and 11 respectively, p value is 0.000 for both which is less than 0.05. Therefore the alternate hypothesis is accepted and the null hypothesis is rejected. Moreover the nonparametric chi-square test is being employed here because the data was not showing normal distribution or bell shape structure rather it was positively skewed in the histogram so because of this the non-parametric test was employed.

Table 6.2.3 Education of the respondent and postnatal checkups received by the respondent cross tabulation

		No of postnatal checkups received by the respondent				Total
		0	1-3	4	4+	0
Education of the respondent	5-9	44	56	2	16	118
	10	6	26	1	6	39
	12	7	9	1	4	21
	14	1	6	1	5	13
	16	16	1	1	2	20
Total		74	98	6	33	211

The above table depicts that respondents with an education level of under matriculation have received postnatal checkups maximally than the matriculated individuals and higher education level respondents. The reason behind this anomalous finding is this that the higher educated respondents are much aware and they are hygienically very critical in maintaining the maternal health care facilities. While many of them are Lhv themselves, many are doctors so they need not to go to the doctor for their antenatal care because the maternal education has made them much

capable to cope with the maternal issues sophisticatedly. Maternal education alters the women acuities regarding disease causation and cure and ultimately influence antenatal care (Caldwell, Reddy and Caldwell 1983). The maternal education regarding the ANC during pregnancy has a positive influence on postnatal health care services utilization (Chakraborty et al. 2002).

Chi-Square Test Statistics

	Education of the respondent	Postnatal checkups received by the respondent
chi-square[a,b]	178.929	96.204
Df	4	3
asymp. sig.	.000	.000

a 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 42.2.
b 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 52.8.

The relationship between education of the respondent and no of post natal checkups received by respondent is significant. Pearson Chi-square for the independent variable education and dependent variable who assisted during delivery is 178.929 and 96.204 while d_f is 4 and 3 respectively, p value is 0.000 for both which is less than 0.05. Therefore the alternate hypothesis is accepted and the null hypothesis is rejected.

Table 6.2.4 Household decision making and maternal health care utilization cross tabulation and chi-square testing

		Where did the respondent visit for prenatal checkups				
		TBA/dai/ Daula	Lhw/L hv	Doctor	Lhv and doctor	Total
Consulted in household decisions	Yes	1	48	37	11	97
	No	1	19	37	1	58
Total		2	67	74	12	155

The given table inferences that respondents who have their say in household decisions have frequently visited Lhv and doctors, while the respondents devoid of being positioned of household decision making are less capable to visit to get the maternal health care services. A study conducted in south India proposes that women's reproductive health seeking behavior has a positive association with that decision making power (Bhatia and Cleland 1995b).

Chi-Square Test Statistics

	Consulted in household decisions	Place where respondent visit for prenatal checkups
chi-square[a,b]	20.024	105.981
Df	1	3
Asymp. Sigh.	.000	.000

a 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 105.5.
b 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 38.8

The relationship between consults in household decisions and where respondent visited for prenatal checkups did is significant. Pearson Chi-square for the independent variable consulted in household decisions and dependent variable where respondent did visited for prenatal checkups is 20.024 and 105.981 while d_f is 1 and 3 respectively, p value is 0.000 for both which is less than 0.05. Therefore the alternate hypothesis is accepted and the null hypothesis is rejected.

Table 6.2.5 Consultation in Household decisions and Assistant during delivery cross tabulation

		Who assisted during delivery												
		0	Doctor	mother	mother in law	sister in law	Sister	Lhv	Auntie	Grandmother	Mother in law and sisters	Sister in law and sisters	Sister in law and Lhv	Total
Consulted In Household Decisions	Yes	1	11	15	70	15	18	2	1	1	1	1	2	138
	No	0	15	9	28	8	7	1	1	0	0	4	0	73
Total		1	26	24	98	23	25	3	2	1	1	5	2	211

The tabulated inferences suggest that respondents being consulted in household decisions are being assisted by their mother in laws (70) and secondly by doctors (11) maximally. While on the contrary this percentage is very low in the case of respondent not being consulted in household decisions. So this inference suggests that women's who have a say in the household attain better health care facilities. According to an exploratory study being conducted in New Delhi, it was proposed that women having

more position in a domestic sphere use better antenatal and skilled delivery care services (Basu 1992).

Chi-Square Test Statistics

	Consulted in household decisions	Who assisted during delivery
chi-square[a,b]	20.024	474.592
d_f	1	11
Asymp. Sigh.	.000	.000

a 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 105.5.
b 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 17.6.

The relationship between consultation in household decisions and who assisted during delivery is significant. Pearson Chi-square for the independent variable consulted in household decisions and dependent variable who assisted during delivery is 20.024 and 474.592, while d_f is 1 and 11 respectively, p value is 0.000 for both which is less than 0.05. Therefore the alternate hypothesis is accepted and the null hypothesis is rejected.

Table 6.2.6 Consulted in household decisions and Postnatal checkups received by the respondent cross tabulation

		No. of postnatal checkups received by the respondent				
		0	1-3	4	4+	Total
Consulted in household decisions	Yes	47	65	3	23	138
	No	27	33	3	10	73
Total		74	98	6	33	211

The respondents having say in household decisions have performed 1-3 times postnatal checkup with frequency of 65. While 26 respondents have received postnatal checkup 4 and more than 4 times. So it can be concluded from these statistics that women who are more autonomous in domestic sphere in the wake of decision making are more accessible to antenatal care. As we assume the household decision making as a core determinant of women's autonomy so on basis of this proposition many studies conducted in South Asia and elsewhere manifests that women's position in positively associated with women and the child's health status (Murthi, Guio and Dreze 1995).

Chi-Square Test Statistics

	Consulted in household decisions	Postnatal checkups received by the respondent
chi-square[a,b]	20.024	96.204
d_f	1	3
Asymp. Sigh.	.000	.000

a 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 105.5.

b 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 52.8.

The relationship between consulted in household decisions and no of post natal checkups received by the respondent is significant. Pearson Chi-square for the independent variable consulted in household decisions and dependent variable no of post natal checkups received by respondent is 20.024 and 96.204. While d_f is 1 and 3 respectively, p value is 0.000 for both which is less than 0.05. Therefore the alternate hypothesis is accepted and the null hypothesis is rejected.

Table 6.2.7 Control over household budget and maternal health care utilization cross tabulation and chi-square testing

		Where did the respondent visit for prenatal checkups				
		TBA/Dai/ Daula	Lhw/ Lhv	Doctor	Lhv and doctor	Total
Who manages Household Budget	Husband	1	44	44	8	97
	You	1	4	4	1	10
	Father in law	0	19	26	2	47
	Husband and respondent	0	0	0	1	1
Total		2	67	74	12	155

The table is focused to explore the dimension of women's autonomy i.e. control over autonomy and its impact on ANC utilization. The results

suggest that respondents who manages the household budget visited towards doctors and Lhv for a prenatal checkup with a frequency of 8 while respondents whose household budget is managed by their husbands are more accessed to visit the doctor and Lhv for prenatal checkup. As the study is primarily conducted in a far flung rural areas so managing of budget is much prevalent there with males not with females this trend of budget managing by women is practiced much in cities therefore the impact of culture and rural settings restrict the women from this trend. But despite this the women there are evolving this trend and making their way to the autonomy. As it is being suggested that autonomy is the control over resources in order to make decisions about one's own needs (needs in the case of this study is ANC) and about family members (Basu 1992, Dyson and Moore 1983).

Chi-Square Test Statistics

	Manager of household budget	Place where respondent visited for prenatal checkups
chi-square[a,b]	222.270	105.981
Df	3	3
Asymp. sig.	.000	.000

a 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 52.8.
b 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 38.8.

The relationship between who manages the household budget and where did respondents visit for prenatal checkups is significant. Pearson Chi-square for the independent variable who manages the household budget

and dependent variable where did respondents visit for prenatal checkups is 222.270 and 105.981 respectively. While d_f is 3, and p value is 0.000 for both which is less than 0.05. Therefore the alternate hypothesis is accepted and the null hypothesis is rejected.

Table 6.2.8 Independence over earning and Respondent visited for prenatal checkups cross tabulation

Can you use your earning independently		Where did the respondent visit for prenatal checkups			
		Lhw/Lhv	Doctor	Doctor and Lhv	Total
Can you use your earning independently	Yes	3	4	1	8
	No	2	2	1	5
Total		5	6	2	13

The statistics are confined only to the employed respondents of the study. The results show that 8 respondents who can use their earning independently have consulted doctors and Lhv for prenatal checkup. While five respondents who are unable to use their earning independently have consulted doctors and Lhv. Bloom, Wypji and Gupta (2001) suggested that control over finance an important determinant of women's autonomy which ultimately leads to ANC.

Chi-Square Test Statistics

	Independence of earning	Respondent visit for prenatal checkups
chi-square[a,b]	1.667	105.981
D_f	1	3
Asymp. Sigh.	.197	.000

a 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 7.5.
b 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 38.8.

The relationship between can respond using his earning independently and where did respondents visit for prenatal checkups is significant. Pearson Chi-square for the independent variable can respond using his earning independent and dependent variable where did respondents visit for prenatal checkups is 1.667 and 105.981, While d_f is 1 and 3 respectively, and p value is 0.000 for both which is less than 0.05. Therefore the alternate hypothesis is accepted and the null hypothesis is rejected.

Table 6.2.9 Freedom of movement towards relatives and Place where respondent visited for prenatal checkups Cross-tabulation

		Where did the respondent visit for prenatal checkups				
		TBA/Dai/ Daula	Lhw/ Lhv	Doctor	Doctor and Lhv	Total
Freedom to visit relatives	Yes	2	67	74	12	155
Total		2	67	74	12	155

The tabulated statistical data exhibits that all the respondents of the study are autonomous much in freely visiting towards their relatives and natal kins. While the results show that 74 respondents visited doctors, 67 visited Lhv and 2 visited days while 12 respondents combine visits doctor and Lhv. So freedom of the moment is a sure way to get the maternal health care. “Freedom of movement has been found to be an important dimension of women’s autonomy and its associations with maternal health care utilization suggests that even in traditional societies where women have limited autonomy, certain freedoms such as those pertaining to women’s mobility can have an important bearing upon their health behavior” (Bloom et al. 2001).

Chi-Test statistics

	Respondent visit for prenatal checkups
chi-square[a]	105.981
Df	3
Asymp. Sigh.	.000

a 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 38.8.

The relationship between can the respondent freely visit to his relatives and where respondent visited for prenatal checkups is significant. The chi square value is 105.981, d_f is 3 and p value is .000 which is less than 0.05, therefore the alternate hypothesis is rejected and the null hypothesis is rejected.

Table 6.2.10 Independence of visiting to doctor in need of checkup and place of visit for prenatal checkups Cross tabulation

		Where did the respondent visit for prenatal checkups				
		TBA/dai/ Daula	Lhw/ Lhv	Doctor	Doctor and Lhv	Total
Can you independently visit doctor in need of a checkup	Yes	2	61	69	12	144
	No	0	6	5	0	11
Total		2	67	74	12	155

The above given table shows the relation between can the respondent visit independently towards doctor for a check up and where did he visited for prenatal checkups. According to the result 69 respondent visit doctor who can freely visit there, while 61 respondents also visit Lhv who can freely visit a doctor. While 5 respondent who doesn't own the freedom of visiting to doctor freely can even visit a doctor while 6 respondents who are also not subjected to visit freely the doctor can even go to Lhv for prenatal checkup. These results show a remarkable level of autonomy among the women of the study settings that they are much more independent in the case of visiting doctor in need of a checkup. This freedom of movement has a remarkable impact on the health seeking behavior of women. As Bhatia and Cleland (1995) suggested that reproductive health-seeking behavior of women is absolutely linked with their freedom of movement.

Chi-Square Test Statistics

	Independently visit doctor in need of a checkup	Where did the respondent visit for prenatal checkups
chi-square[a,b]	135.360	105.981
Df	1	3
Asymp. Sigh.	.000	.000

a 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 105.5.
b 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 38.8.

The relationship between can respondent independently visit doctor in need of checkup and where did respondents visit for prenatal checkups is significant. Pearson Chi-square for the independent variable can respond independently visit the doctor and dependent variable where did respondents visit for prenatal checkups is 135.360 and 105.981, While d_f is 1 and 3 respectively, and p value is 0.000 for both which is less than 0.05. Therefore the alternate hypothesis is accepted and the null hypothesis is rejected.

CHAPTER NO. 7

DISCUSSION AND CONCLUSION

Chapter No. 7

Discussion and Conclusion

7.1 Discussion and Conclusion

The research is primarily targeted upon the married women who have passed 40 days of their pregnancy time, so 98% respondents are reported being married while only 2% are currently widowed. While the factor of age at marriages was also considered so 48% of women had married at the age of 25 and above. So many researchers argue that women having marriage at bigger ages are more autonomous and independent. Jejeebhoy and Sathar (2001) explored that Women who get married at delay are observed as more independent and autonomous than those who are being married in smaller ages. Furthermore in order to measure the dimensions of women's autonomy and their prior impact on MHCU. Initially the respondent was being asked about their family structure in the response of which 57% respondents appeared to bear nuclear family setup while the rest of 43% respondents constitute joint and extended family setup. The family structure was measured because past asserts that women's family structure has an obvious impact on ANC and women's family structure firmly determines her autonomy level. Matsumura and Gubhaju (2001) examined that woman bearing the nuclear family structure are less likely to employ ANC as compared to that woman which constitute extended/joint families. Moreover the studies of Obermeyer and Potter (1991) Matsumura and Gubhaju (2001) Miles, Doan and Brewster (1998) also employ the same relation as mentioned in the above study.

The sampled population has revealed the literacy rate as 100%. This dazzling figure of female literacy rate mostly prevails in the entire store district where women are being given education to some extent no matter the level of education i.e. religious or formal, that is why the literacy level of District Astore is 90% while that of Hunza is 100% in entire Gilgit-Baltistan.

Due to the increasing trend of women's education there existed a remarkable impact on the maternal health care utilization patterns among patterns i.e. the percentage of women receiving ANC has elevated to 74% (in prenatal checkups) and 65% (in postnatal checkups) as revealed in the study. So it is overwhelmingly revealed that education attainment has a positive impact on maternal health care. While the education provided to the womenfolk in the context of Rehman poor union collectively exhibits both the religious as well as no-religious formal education to women. In the local settings the education is necessarily provided to women as well as men irrespective of the financial endurance. The basic reason behind this fact is the availability of education in the door setup i.e. various community education centers have been developed by not only government but by some private organizations free of cost. So this trend of educating women basically empowers her in the getting and understanding the importance of acquiring maternal health care facilities and enhancing her freedom of mobility. This phenomenon coincides with the preliminary researches. Ware (1984) asserts that education for women leads or reflects to her higher standard of living as well as her access and control over

finance and other resources. Moreover women schooling elevates her acquaintance with contemporary health care facilities by making her able to correspond with modern health care providers and, by prioritizing the maternal health care as vital in her choices as vital and primary (Schultz 1984). According to Khan, Soomro and Soomro (1994) education is a "crucial social development variable" which broadens the mind of a woman in understanding the effectiveness of acquiring the maternal health care. So under these conditions education has a positive impact upon maternal health care utilization. Barrera (1990) has conducted a study in the Philippines and concluded the result that educated mothers are used to avail more public health care facilities than that of the uneducated women. Women with better education were more likely to receive the recommended number of ANC visits (Nielsen et al. 2001 and Erci 2003).

While above all researches are based on the Asian and South Asian perspective, now looking the applicability of this perspective in Pakistan. Mumtaz and Salway (2005) projected that "Women's education emerged as a key factor in a qualitative study leading to an appreciation of the importance of ANC."

Another vital dimension involved in the women's position is the control over finance. Initially the phenomena of control over finance is linked to that employed women who earn money and they have control or not in their earnings. So in this stud context the control over finance is described only in the domain of employed women. According to my research only 7% women were employed in the entire region. Out of them only 4%

women have control over their income. This low percentage of the employment ratio among women is due to cultural constraints and lack of appropriate opportunities for women's employment. Only a limited amount of women have employment and surprisingly the women with 7% employment ratio are all employed in the health department, but once again unfortunately the people of the native area discredit the job of women in the health department, even some of the people attribute the income of women as illicit and illegal. So culture plays an important role in minimizing the women's financial autonomy.

Ultimately this control over the resource level also affects the maternal health care practice of women. Adamu and Salihu (2002) had conducted a research in Nigeria they proposed that limiting financial means to women restricts her in attaining maternal health care services. While women having more stable socioeconomic status receive better health care Magadi et al. (2000).

While a research on the Pakistani context by Nisar and White (2003) also revealed that women having high income status and control over it enjoy sophisticated maternal health care facilities.

Moreover 74% respondents have household decision making autonomy (collectively household decision making and decision making in choosing a spouse). This decision making autonomy leads them towards gaining freedom of mobility and ultimately the antenatal care. This study clearly manifests that a higher percentage of respondents with 74% having

decision making autonomy exhibits more than 70% level of the ANC, reported in the study.

When the women were asked questions regarding their freedom of mobility there occurred amazing results which are collectively termed in the percentage as 96% (211 women can freely visit their kins, 207 women can freely visit their natal kins, 190 women can visit doctor independently for a checkup) i.e. out of the entire sampled population such a large level of women exhibits their freedom of mobility. Here the affiliation of women with their kins also determines her autonomy. As Bloom, Wypij and Gupta (2001) asserted that women having close ties with her kins are more autonomous in various socio-demographic dimensions. Moreover they also examined that women with freedom of movement can better seek ANC. Allendorf (2010) proposed that women with close bond relations with their kins and family better utilizes maternal health care. Assembling the entire debate at the end it comes in the forefront that there are varying stages as well as dimensions of women's autonomy which are interlinked in varying domains while they are necessarily linked to maternal health care utilization. It is due to the fact that besides women's other key responsibilities, this key responsibility of women is also maternal health care and the women's position in the household, her decision making ability, her educational level as well her control over finance decisively affects her role.

Various studies conducted in the world specifically in Asia and South Asia reveal the positive relation of these dimensions of women's autonomy with

that of maternal health seeking behavior. Bhatia and Cleland (1995) conducted a study in India propose that women's reproductive health care seeking behavior is positively linked to the education, freedom of movement and decision making of women. There exist no of contemporary researches which have bifurcated the autonomy into various dimensions as "women's physical freedom of movement, their participation in decision making, their access to resources, and their ability to visit their natal kin in the Asian context" (Balk 1994; Cleland et al. 1996; Morgan and Niraula 1995).

7.2 Suggestions

While encompassing this area of study for research the researcher strived to inbound all the possible magnitudes of this study, but due to already involve ample aspects of the study ceased me to take in remaining other aspects of the women's autonomy and MHCU. Ultimately they're entrenched some outstanding facets which affect the women's autonomy as well as MHCU. In this portion of the study the researcher is focused to highlight the supplementary areas which were being devoid of focusing. So it will prove a guideline for further research in the area in this domain. Initially the culture has a remarkable impact on determining the women's position in society so researcher strongly suggests studying the normative structure of the area and applying its impacts on women's position and MHCU practices. While conducting research the researcher came through many incidents where he concluded that studying the normative structure and applying its impacts on the women's empowerment level has a dire

need. Secondly a key objective must be set in studying the women's position and ANC that the role of health care providers in creating freedom of reproduction among women, because the role of health care providers in such areas with rural setup is much neglected. They have neither proper record nor check and balance so those to sustain the maternal health care utilization efficiently.

As people there have primarily cattle rearing and agriculture as a profession where the women enjoys much freedom of mobility just because of freedom of agriculture and seldom this freedom of agriculture leads them to attain a position In household decision making so the arena of "agricultural autonomy" must be thoroughly studied. Moreover this agricultural autonomy side by creating women's health issues, and on the other hand a cruelty factor upon women i.e. the men circle do not assist them in the agricultural activities rather all work is done by women. Only a minor percentage of participation is ensured by men especially during threshing. Moreover the ratio of maternal mortality should especially be studied in the area because the terrain is rugged and in winter when the temperature fall below freezing point the communication channels are blocked and at that moment the facility of maternity homes is not available due to which every year 50-70 women die each year due to pregnancy complications reported by a local dispenser to me. No matter a woman is much autonomous but until the role of health care providers is not being studied the problem may persist there.

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ANNEXTURE-I

QUESTIONNAIRE

The Impact of Women's Autonomy on Maternal Health Care Utilization in

Rehmanpoor-union, Astor

(Interview Schedule)

I am a student of Department of Sociology, Quaid-i-Azam University, Islamabad, doing research on "The Impact of Women's Autonomy on Maternal Health Care Utilization in Rehmanpoor union, Astor". Kindly spare few minutes of your precious time for an interview to help me out in my research work. All your personal information will be used for research purpose only. Thanks (Zia-ur-Rehman)

A. Socio-Demographic Profile

1. Name of the Respondent ……

2. Age …… Years

3. Marital Status:
i. Married ii. Separated iii. Divorce

4. Family Structure:
i. Nuclear ii. Joint iii. Extended

5. What was your age at marriage?
…… Years

6. Number of Children you have:
i. Male -------- ii. Female --------- iii. Total ------

7. From which class of society do you belong? ……..
i. Upper class (rich) ii. Middle class iii. Lower class (poor)

8. Your Educational Level:
…… Years

9. What is the education of your husband?
……. Years

10. Which type/level of education is preferred for women in your area? …….

i. Religious education
ii. Informal education up to secondary level
iii. Informal education up to higher secondary level

iv. Informal education up to graduation level or higher.

11. Are you employed?
i. Yes ii. No

12. What is your profession?
i. Government servant
ii. Self employed
iii. Private employee
iv. Any other specify ……..…….

13. What is your monthly income?
(Rs.)…….

14. What is your husband's view about your job?
i. Appreciable ii. Not in favor of my job

B.WOMEN'S AUTONOMY

15. Do you think that your family is?
i. Very religious ii. Moderately religious iii. Not religious

16. Can you use your earning independently?
i. Yes ii. No

17. Who runs your household affairs?
i. Husband ii. You iii. Family elder iv. Any other (specify) ----------

18. Who owns the household assets?
i. Husband ii. You iii. Family elder iv. Any other (specify) ----------

19. Who manages budget in your house?
i. Husband ii. You iii. Family elder iv. Any other (specify) ----------

20. Are you been consulted in house hold decisions?
i. Yes ii. No

21. If yes then specify the type of decisions in which you are involved?
i. Children schooling
ii. Household large purchases
iii. Household large purchases
iv. Marriage related matters
v. Household small purchases
vi. Any other specify……

22. Normally which type of work your family allows you to do outside home?

i. Agriculture based work
ii. Office work
iii. Family business
iv. Any other specify……

23. Were you consulted by your parents in the selection of your spouse?

i. Yes ii. No

24. Can you visit doctor in the need of treatment independently?

i. Yes ii. No

25. Can you freely visit your relatives?

i. Yes ii. No

26. Can you freely visit your natal kins?

i. Yes ii. No

27. Who decides to caste vote to specific candidate?

i. Myself
ii. Husband
iii. Family member
iv. Nambardar of the village
v. Any other specify…….

C.MATERNAL HEALTH CARE UTILIZATION

28. Please mention the frequency of receiving pre-natal check-ups? ***(If 0 visit, then go to Q. 30)***

0	1	2	3	4	5 +

29. Where did you visit for pre-natal check-up?

i. TBA/*Dai/Duala*
ii. LHV/ LHW
iii. Doctor
iv. Others (Pls. specify) _____

30. What were the main reasons of not receiving pre-natal check-up?

i. Not necessary
ii. Costly
iii. Not accessible
iv. Dissatisfaction of treatment

v. Family resistance
vi. Lack of knowledge
vii. Others (Pls. specify)_____

31. What is your view about keeping "*DUALA*"?

i. It's good to keep *Duala*
ii. It's not good to keep *Duala*
iii. Don't know

32. Had you gained services of any "DUALA"?

i. Yes ii. No

33. Where did your child birth occur?

i. Home
ii. Clinic
iii. Hospital
iv. Any other (Specify) _____

34. Who assisted you during delivery?

i. TBA/*Dai*/*Duala*
ii. Midwife
iii. Doctor
iv. Others (Specify) _____

35. Please mention the frequency of receiving postnatal checkups?

0	1	2	3	4	5	Other (specify)_____

(If 0 then go to Q.36)

36. What were the main reasons for not receiving a postnatal check-up?

i. Not necessary
ii. Costly
iii. Not accessible
iv. Dissatisfaction of treatment
v. Family resistance
vi. Lack of knowledge
vii. Others (Pls. Specify) _____