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Childbirth Choices: A Qualitative Study of Pregnant Women's Perceptions Towards Modes of Delivery in Dhaka City, Bangladesh

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Research Article

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Abstract

Bangladesh has one of the higher caesarean section rates in South Asia. National survey data from the Bangladesh Demographic and Health Survey 2022 indicate that approximately 45 percent of births now occur by caesarean section, with markedly higher rates in private facilities and urban centres. This level remains well above the range of 10 to 15 percent traditionally associated with population health benefit by the World Health Organization. Quantitative literature documents the trend, but qualitative research on how pregnant women themselves understand, negotiate, and arrive at decisions about modes of delivery remains limited. This study examined how twenty pregnant women in Dhaka City made sense of delivery choices within a complex interplay of medical, cultural, economic, and relational factors. The study used reflexive thematic analysis as developed by Braun and Clarke, situated within a constructivist position that treats themes as actively produced through researcher engagement with data rather than as fixed entities awaiting discovery. Participants were recruited through purposive sampling at one public tertiary hospital, one private clinic, and one outpatient antenatal centre in Dhaka. In-depth interviews were conducted in Bangladeshi Bengali. Sample adequacy was judged through the principle of information power rather than data saturation, since saturation language sits uneasily with reflexive thematic analysis. Four themes were developed. The first concerns distributed agency, in which decision making was rarely held by the woman alone and was shaped by mothers in law, husbands, and providers. The second concerns fear as a multi-dimensional driver of preference, in which fear of medical failure and institutional distrust were as influential as fear of pain. The third concerns constrained choice, in which economic position and structural access shaped what counted as a realistic option. The fourth concerns hybrid knowledge systems, in which biomedical information, community narratives, religious framing, and prior birth experience were combined. Together these themes challenge framings that reduce caesarean preference to individual fear or knowledge deficit. Childbirth decision making in Dhaka is embedded in structures of gender, economic inequality, institutional authority, and cultural obligation. Interventions focused only on information provision are unlikely to be sufficient. Maternal health policy must address structural barriers and relational power dynamics that shape what women can choose before and during labour.

1. Introduction

1.1 Background and Rationale

Childbirth is among the most consequential events in a woman life, shaping not only health outcomes but long-term psychological well-being, social standing, and family relationships. In Bangladesh, the landscape of childbirth has changed considerably in recent decades. National survey data indicate that the caesarean section rate rose from under four percent in 2000 to approximately 45 percent by 2022, with rates in private facilities and in urban centres considerably higher than the national figure (NIPORT, 2023; Betran et al., 2021). This places Bangladesh among the higher rate countries in South Asia and well above the range of 10 to 15 percent of all births that the World Health Organization has historically

associated with population level health benefit (WHO, 2021). The rapid rise has attracted policy concern in Bangladesh and internationally.

Much of the existing research on this issue approaches caesarean rates through an epidemiological lens, counting procedures and identifying demographic correlations (Hossain et al., 2023; Kamal, 2013). Fewer studies have explored what childbirth choices mean to women themselves, including how they understand their options, who shapes their decisions, what fears and hopes are attached to different delivery modes, and how economic and relational constraints expand or limit their agency. This study responds to that gap.

Dhaka City provides an important setting for this inquiry. As the capital and most densely populated urban centre of Bangladesh, Dhaka draws pregnant women from across the country, including rural migrants, slum residents, lower middle-class homemakers, and educated working women. Hospitals in Dhaka serve women with very different social and economic positions, often within the same ward. This diversity makes it possible to examine how perceptions of delivery modes are shaped by structural position, not only by individual preference.

1.2 Problem Statement

Despite commitments under Sustainable Development Goal 3 on good health and well-being, Bangladesh continues to face significant maternal health challenges. The maternal mortality ratio remains elevated at approximately 163 per 100,000 live births (Hossain et al., 2023). While facility-based delivery has increased substantially over the past two decades, higher facility rates have not automatically produced safe or empowering birth experiences. Medically unnecessary caesarean section carries risks including surgical complications, longer recovery time, higher costs, and reduced breastfeeding rates (WHO, 2021; Betran et al., 2021). It also has implications for subsequent pregnancies.

Existing qualitative research in Bangladesh is limited. Begum and colleagues (2018) conducted an important study in rural Matlab and found that women had a strong preference for vaginal birth but were willing to defer to healthcare providers on the final decision. Sultana and colleagues (2022) explored caesarean decision making among slum residents in Dhaka and found that women were largely excluded from the decision-making process and that information asymmetry between physicians and patients was widespread. Neither study examines the full range of delivery preferences across socioeconomic groups within the same urban setting, and neither explicitly analyses how structural and relational power shapes the conditions under which preferences are formed. The growing literature on disrespect and abuse in facility-based childbirth (Bohren et al., 2015) and on respectful maternity care more broadly suggests that institutional trust and the quality of provider communication are central to understanding why women make the choices they do, yet these dimensions have not been integrated into Bangladesh specific qualitative work on delivery preference.

1.3 Research Questions

This study was guided by four research questions. First, how do pregnant women in Dhaka City perceive different modes of delivery, including vaginal birth, caesarean section, and traditional birth at home. Second, what factors shape their preferences and decisions. Third, in what ways does decision making authority reside with the woman herself, and in what ways is it distributed among other actors. Fourth, how do structural factors, including economic position and access to healthcare, mediate the ability of women to act on their preferences.

2. Literature Review

2.1 Social and Structural Dimensions of Childbirth Decision Making

A substantial body of literature establishes that childbirth decision making in Bangladesh is not an individual process. Family networks, particularly mothers in law and husbands, play a decisive role in determining where and how women give birth (Sarker et al., 2016; Sultana et al., 2022). Sarker and colleagues (2016) found that preference for home delivery with a Traditional Birth Attendant was strongly mediated by the authority of elder women in the household. Trust in Traditional Birth Attendants was relational and generational, whereas trust in hospital services was fragile and contingent on previous encounters. The same authors reported that many Muslim women in rural Bangladesh avoided district hospitals where most doctors were male, illustrating how gender norms function not only as preferences but as structural barriers to care.

Yaya, Bishwajit, and Ekholuenetale (2017) found that institutional delivery was associated with maternal education, household wealth, and urban residence, confirming that access to different modes of delivery is stratified by socioeconomic position. Coates and colleagues (2020) documented in a systematic scoping review that financial considerations were consistently present in the mode of birth preferences expressed by women across global contexts. In Bangladesh, caesarean section at a private facility can be prohibitive for lower income families, yet many women in slum areas still describe caesarean as aspirational because it is associated with modern healthcare (Kamal, 2013; Begum et al., 2018), revealing a nonlinear relationship between economic position and delivery preference.

2.2 Fear, Knowledge, and Delivery Preference

Fear is among the most widely studied psychological factors in delivery preference research. Haines, Rubertsson, Pallant, and Hildingsson (2012) found in a Swedish cohort study that women with higher childbirth fear were significantly more likely to prefer caesarean section and to report less positive birth experiences. The relationship has been replicated across contexts (Khatony et al., 2019; Alavian et al., 2016; Karaca and Engin, 2019). However, the nature of fear matters. Khatony and colleagues (2019) found that fear of labour pain was distinct from fear of losing control, fear of complications, fear of medical error, and fear of an adverse outcome for the baby. Reducing all fear to fear of pain oversimplifies a multi-dimensional experience.

Regarding knowledge, Begum and colleagues (2018) found that Bangladeshi women who perceived caesarean as easier and less painful than vaginal birth were more likely to prefer it, pointing to a gap between medical and lay understandings of relative risk. The same study documented that antenatal care sessions in rural Bangladesh provided no information on the medical indications for caesarean section, which meant that the knowledge held by women was drawn largely from community sources and personal networks. Sultana and colleagues (2022) corroborated this in urban Dhaka, finding that women in slum settlements had not received detailed information about caesarean during antenatal visits. Yet Benyamini and colleagues (2017) argued that attitude toward the medicalisation of childbirth was a stronger predictor of delivery preference than knowledge level alone, suggesting that cultural orientation toward medicine is an independent variable not reducible to an information deficit.

2.3 Healthcare Providers, Institutional Authority, and Unnecessary Surgery

A central debate in the global literature concerns the role of healthcare providers in driving high caesarean rates. Panda, Begley, and Daly (2020) argued that requests by women themselves are not the primary driver, and that provider attitudes, institutional incentives in private facilities, time pressures, and medico legal fears among clinicians played a greater role. This challenges the assumption that high caesarean rates are primarily a demand side problem solvable through patient education. Bohren and colleagues (2015), in a mixed methods systematic review, identified mistreatment during facility-based childbirth as a global concern with documented effects on the willingness of women to use facilities. Shahraki Sanavi, Rakhshani, Navidian, and Ansari Moghaddam (2012) applied the Theory of Planned Behaviour to elective caesarean intention and found that subjective norms and perceived behavioural control were significant predictors beyond attitude alone, suggesting that the preferences of women reflect not only personal beliefs but the perception of what is socially expected and what is practically within reach.

Enabudoso, Ezeanochie, and Olagbuji (2011) found that women with a history of caesarean held mixed views about repeat caesarean, with some preferring repeat surgery out of fear of labour and others preferring vaginal birth after caesarean due to concerns about surgical risk. The authors emphasised that access to individualised counselling was critical but rarely available in low resource settings. In Bangladesh specifically, a 2023 High Court ruling ordered the Ministry of Health and Family Welfare to implement policies against unnecessary caesarean and to conduct a public awareness campaign, reflecting growing institutional recognition that provider side financial incentives in private clinics contribute to unnecessarily high rates.

2.4 Conceptual Framework

This study draws on two intersecting frameworks. The first is the Theory of Planned Behaviour (Ajzen, 1991), which proposes that behaviour is shaped by attitudes toward the behaviour, subjective norms understood as perceived social expectations, and perceived behavioural control understood as the sense of ability to perform the behaviour. Applied to delivery decision making, the Theory of Planned Behaviour

helps explain why women who prefer vaginal birth may still choose or accept caesarean. If family members expect caesarean, or if a woman feels she has no control over the outcome, her stated attitude may be overridden by normative and control beliefs (Shahraki Sanavi et al., 2012).

The Theory of Planned Behaviour focuses on the individual and does not sufficiently account for structural constraints. The second framework, a feminist political economy perspective on reproductive health (Sen and Grown, 1987; Freedman, 2005), adds this dimension by drawing attention to how gender inequality, poverty, and differential access to healthcare shape the conditions within which women make choices. Freedman (2005) argues that reproductive autonomy cannot be assumed from the existence of formal choice, and that a preference expressed under conditions of constrained agency is not the same as a free choice. Together these frameworks generate four sensitising propositions used in this study. First, delivery preferences are shaped not only by individual attitude but also by perceived social norms within family and community networks. Second, the extent to which a woman can act on her preferences is mediated by perceived behavioural control, which is itself structured by economic position and authority relations. Third, fear is a cluster of distinct concerns, each pointing to different underlying needs. Fourth, women construct their understanding of delivery options from multiple, potentially competing, knowledge sources. These propositions are returned to explicitly in the discussion.

3. Methods

3.1 Research Design and Philosophical Position

This study employed a qualitative research design appropriate for understanding subjective experience, meaning making, and social processes rather than measuring the prevalence or distribution of phenomena (Creswell and Poth, 2017). The study was situated within a constructivist position, which holds that social realities are produced through lived experience, cultural context, and interpersonal interaction (Lincoln and Guba, 1985). Data was analysed using reflexive thematic analysis as developed by Braun and Clarke (2006, 2019, 2021), chosen for its theoretical flexibility, its suitability for exploratory research, and its commitment to transparency about the role of the researcher in producing themes.

3.2 Analytical Procedure

Reflexive thematic analysis treats themes as actively constructed by the researcher through repeated engagement with the data, and as shaped by the theoretical framework, questions, and positionality the researcher brings to that engagement (Braun and Clarke, 2019). The analysis followed the six phases described by Braun and Clarke. The first phase was familiarisation through repeated reading of transcripts and listening to recordings. The second was generation of initial codes across the full dataset, conducted by the first author. The third was the construction of candidate themes. The fourth was reviewing candidate themes against coded data and the full dataset. The fifth was defining and naming themes. The sixth was producing the report using participant extracts. Throughout these phases, the second author engaged with coded extracts, candidate themes, and theme definitions in regular discussion meetings. These discussions were treated as a way of testing the coherence and richness of

the analysis rather than as inter coder reliability checks, since reflexive thematic analysis explicitly rejects the idea that meaning resides in codes that multiple coders should agree upon (Braun and Clarke, 2019, 2021).

Sample size was judged through the concept of information power (Malterud, Siersma, and Guassora, 2016) rather than through data saturation. Information power proposes that the number of participants needed depends on the specificity of the study aim, the use of established theory, the quality of dialogue, the analytical strategy, and the homogeneity of the sample. In this study, the aim was specific, established theory informed the analysis, dialogue quality in the interviews was strong, the analytical strategy was case rich rather than cross sectional, and the sample was internally varied. On these grounds, twenty interviews offered sufficient information power for a study of this scope. The language of saturation, which is commonly attached to coding reliability traditions and to grounded theory, is avoided here because it is conceptually misaligned with reflexive thematic analysis.

3.3 Sampling and Participants

Purposive sampling was used to recruit participants who were currently pregnant, attending antenatal clinics or admitted to hospitals in Dhaka City, and willing to discuss their perceptions regarding mode of delivery. Purposive sampling is appropriate when the aim is to understand a phenomenon in depth rather than to produce a representative sample (Patton, 2002). Participants were recruited from three settings: a public tertiary hospital, a private clinic, and an outpatient antenatal care centre in the Uttara area of Dhaka. This deliberate variation in setting allowed for diversity in socioeconomic background, parity, and gestational stage.

Twenty women participated. Ages ranged from 19 to 34 years, with a median age of 25. One prospective participant aged 17 was approached but excluded from the final sample after consultation, given the additional consent considerations involved in interviewing a minor and the absence of a formal assent and parental consent procedure for this study. Gestational stages ranged from four to eight and a half months. Participants included women in their first, second, third, and fourth pregnancies. All had completed at least primary education, and several had completed secondary or tertiary education. Occupational backgrounds included homemakers, one working professional, and one small business owner. Several had migrated to Dhaka from rural areas, two were resident in informal settlements, and one had family members living abroad. Household economic position was assessed through self-report of housing tenure, household earner occupation, and food security, and is summarised in the table below using broad categories. The table is provided so that readers can locate each quoted participant in their wider context.

ID	Age	Gestation	Parity	Setting	Background	Stated leaning
R1	23	6 months	First	Public tertiary	Lower middle	Vaginal, with reservations
R2	26	7.5 months	First	Private clinic	Middle	Caesarean (planned)
R3	29	5 months	Multipara	Private clinic	Middle	Caesarean (medical)
R4	21	5 months	First	Outpatient	Rural migrant	Home with TBA
R5	24	6 months	Second	Outpatient	Slum resident	Hospital
R6	27	5 months	Second	Public tertiary	Lower middle	Vaginal
R7	30	4 months	First	Private clinic	Higher income	Caesarean (elective)
R8	33	6.5 months	Fourth	Public tertiary	Lower income	Vaginal (uncertain)
R9	31	8 months	Second	Public tertiary	Lower middle	Caesarean (medical)
R10	25	8.5 months	First	Public tertiary	Lower middle	Caesarean (emergency)
R11	34	7 months	First	Private clinic	Higher income	Caesarean (medical)
R12	22	6 months	First	Outpatient	Lower middle	Vaginal
R13	19	7 months	First	Public tertiary	Rural migrant	Undecided
R14	28	5.5 months	Second	Private clinic	Middle	Caesarean (elective)
R15	24	6 months	First	Outpatient	Lower middle	Undecided
R16	26	7 months	Second	Public tertiary	Lower middle	Undecided
R17	20	5 months	First	Outpatient	Rural migrant	Undecided
R18	32	8 months	Third	Private clinic	Higher income	Caesarean (elective)
R19	23	6.5 months	First	Public tertiary	Lower middle	Undecided
R20	21	7 months	First	Outpatient	Lower income	Undecided

3.4 Data Collection

Data was collected through in depth individual interviews. Individual interviews were chosen because they enable detailed exploration of personal experience, allow probing of unexpected responses, and provide a private setting for discussing sensitive topics (Rubin and Rubin, 2012; Seidman, 1998). The semi structured interview guide was developed from the research questions and conceptual framework, piloted with two participants, and refined. The final guide is included in the Appendix. Interviews were conducted in Bangladeshi Bengali by the first author in a private room or curtained bay, with one interview taking place in a quiet outdoor area at the request of the participant. Interviews lasted between 25 and 60 minutes.

With participant permission, interviews were audio recorded. For one participant who declined recording, detailed contemporaneous notes were taken. All recordings were transcribed verbatim in Bengali by the first author. Translation into English was carried out by the first author for analytical purposes. To strengthen translation rigor, a bilingual colleague with no involvement in the study independently back translated all directly quoted passages used in the findings, and any divergences were discussed and resolved.

3.5 Ethics, Consent, and Safeguarding

Ethical review for this study followed a layered process and the authors wish to be fully transparent about its limitations. At the time the fieldwork was conducted in April 2024, the host institution did not have an active institutional review board with capacity to review qualitative student research. Permission to conduct the research was granted in writing by the Departmental Research Committee of the host institution prior to fieldwork. The authors recognise that departmental level approval is not equivalent to independent ethics review and does not, on its own, satisfy international expectations such as those expressed in the Declaration of Helsinki. This is a substantive limitation of the study and not a procedural detail. In recognition of this gap, the protocol, instruments, and consent procedures were developed in close consultation with two senior researchers in maternal health who had served on ethics committees elsewhere, and the safeguarding plan described below was put in place before any participant was approached. Future work building on this study will be submitted for full external ethics review prior to any further data collection.

Verbal informed consent was obtained from each participant before interview. Written consent was not used because in the clinical settings where interviews took place written forms can heighten anxiety, can create concerns about information being shared with medical staff, and can reflect literacy and power asymmetry counterproductive to open dialogue. The verbal consent process included a clear explanation of the study purpose, the voluntary nature of participation, the right to stop at any time without giving a reason, the right to decline specific questions, confirmation that participation had no effect on medical care, information on data storage and use, and the contact details of the researcher and a senior supervisor. Verbal consent was recorded in researcher field notes for each participant. Each participant was assigned an anonymised code from R1 to R20. No names, hospital names, or ward details are reported. No incentives were offered. Data were stored on an encrypted device and anonymised prior to analysis. The research involved no clinical procedures and no deception.

Several participants disclosed domestic hardship, economic stress, and medically complex situations. All participants were reminded at the outset that the conversation was a research interview, not a medical consultation. Where a participant appeared distressed, the researcher paused, checked their well-being, and offered to stop (Finlay, 2002). Information about available support services, including antenatal counselling at the hospital and the Bangladesh National Helpline for Women, was made available.

3.6 Reflexivity

The first author is a female Bangladeshi postgraduate student from an urban, educated, middle class background with no personal experience of pregnancy or childbirth. The second author is a female Bangladeshi academic with research experience in development studies and gender. These positions shaped data collection and analysis in several ways. Being a young woman enabled some participants to speak with relative ease about gendered concerns. However, the social position of the first author may have led some participants from low income or rural migrant backgrounds to frame their responses in ways they judged acceptable. Open and non-directive questions were used throughout to limit this effect. The authors entered the study with prior assumptions from public health literature that frames high caesarean rates as a problem requiring correction, and made deliberate efforts during analysis to take seriously accounts of caesarean as a desired or lifesaving choice. Reflexive memos were maintained throughout data collection and analysis.

4. Findings

Four themes were developed through reflexive thematic analysis. The themes were not predetermined by the literature review categories in a deductive sense, but they were also not extracted from a theoretically neutral standpoint. Reflexive thematic analysis recognises that the theoretical framing of the researcher shapes what becomes visible as a pattern of meaning. The four themes presented here therefore correspond closely to the four sensitising propositions set out in the conceptual framework. This correspondence is reported transparently rather than concealed under the language of emergence. The themes cut across delivery modes rather than mapping them as discrete categories, and together they identify processes and meanings that are absent from the dominant quantitative literature.

4.1 Distributed Agency: Childbirth Decisions as a Negotiated Process

Across the interviews, it was striking how rarely participants described themselves as the sole or primary decision maker about mode of delivery. Decision making authority was distributed among the pregnant woman, her husband, her mother in law, other family members, and her healthcare provider. This complicates the framing in much of the literature, which treats delivery preference as an individual attitude or choice.

The role of the mother in law was particularly significant, consistent with findings from Sarker and colleagues (2016). What the present data added beyond Sarker and colleagues was a sense of the specific mechanisms through which this authority operated. It was not simple prohibition but the framing of hospital delivery as unnecessary and traditional birth as culturally appropriate. R4, a woman who had migrated to Dhaka for an antenatal check up, planned to return to her village for delivery.

We like to give birth at home and go to the Traditional Birth Attendant. We only go to the hospital when something goes wrong. I think home is a good place to give birth.

R4 was not uninformed about hospital services. She chose not to use them because her community of reference validated the Traditional Birth Attendant as competent and trustworthy. A second statement from the same participant illustrates how family authority can override even her stated wish to attend a facility.

I wanted to give birth at the hospital, but my family did not allow me to.

The Theory of Planned Behaviour helps make sense of this dynamic. The attitude of the participant was favourable toward hospital delivery. Her subjective norm in the form of family expectation, and her perceived behavioural control in the form of her ability to override family authority, both worked against that attitude. This is a finding of practical importance. Interventions targeting individual knowledge or attitude will not change outcomes if the relational authority structures around women are not also addressed.

Among participants with greater economic and educational resources, authority was distributed differently. R7, a working professional in her second trimester, described her husband as deferential to her and to the judgement of her doctor.

My husband decision matters. But I think that if I say I want a caesarean because it is an easier process and less painful, he will respect that. My delivery process depends on the situation anyway.

The phrase about depending on the situation appeared frequently. In several accounts it did not reflect genuine openness to multiple outcomes but rather a deferral, a way of expressing comfort by ceding ultimate authority to the doctor. This is consistent with the finding by Shahraki Sanavi and colleagues (2012) that low perceived behavioural control predicted greater acceptance of medical direction, including caesarean. Importantly, this preference for medical authority was not passive resignation. For several participants it was an active and rational choice, particularly when trust in a specific provider had been established.

R3, who had a history of previous caesarean, subsequent pregnancy loss, hypertension, and diabetes, illustrated a fracture within family authority.

My in laws are quite disappointed about the situation, but they did not try to understand my medical emergency. My husband is very careful and he takes care of me so much.

The medical condition of R3 provided her with legitimate authority to proceed with medically recommended caesarean despite family resistance. Family authority is internally differentiated, and medical risk can function as a resource that some women deploy to reclaim decision making power.

4.2 Fear as a Multi-Dimensional Driver of Delivery Preference

Fear appeared throughout the data as a powerful influence on delivery preference, but the data revealed it was not a single emotion. It encompassed several distinct concerns, including fear of labour pain, fear of physical injury, fear of medical failure, fear of social disapproval, and fear for the survival of the baby. The delivery preference associated with each kind of fear varied. This finding builds on and extends existing literature that has tended to treat fear primarily as fear of pain (Haines et al., 2012; Khatony et al., 2019). The five categories are illustrative groupings developed in the analysis rather than a validated taxonomy, and they overlap in the accounts of individual women.

Fear of labour pain was most associated with preference for caesarean.

I want to do a caesarean because day by day my baby is becoming bigger. I am very afraid of injury. Normal delivery takes a longer time. With a caesarean section I will have anaesthesia so I may not feel anything, and I will not face pain. I think it is a safer birth for me.

R2 links fear of pain directly to a belief about relative safety. Caesarean was safer because it was predictable and managed. This conflation of painless with safe reflects a coherent lay logic, not simply a misconception correctable by information provision. Khatony and colleagues (2019) found a similar conflation in Iran, noting that fear of pain was often inseparable from fear of complications.

Fear of physical injury extended beyond pain to specific obstetric risks. R1 described knowledge of perineal tearing and postpartum haemorrhage.

From what I have heard, tears can happen during birth. What worries me is the pain that might happen and the time it will take to heal later.

Postpartum haemorrhage is something I know about. I am very afraid, especially the thought of losing a lot of blood after giving birth. That is why I am a bit negative about normal delivery, though I do not still support caesarean section.

These accounts show that the fear R1 expressed about vaginal birth was not rooted in ignorance. She was aware of specific risks. Whether her perception of how those risks would unfold in her own care was fully calibrated to clinical evidence cannot be judged from interview data alone. What is clear is that providing her with a leaflet describing the same risks she already knew about would not address her underlying concern, which was about whether the risks would be adequately managed in her care setting.

Fear of medical failure emerged as a distinct form that has been less examined in earlier literature. R9 was admitted with a uterine tumour.

The doctor said it was very risky. My health condition is very vulnerable. Because of this severe condition, the tumour and the uterus might be removed. So, this will be my last pregnancy.

The fear R9 expressed was not of pain or injury in the conventional sense but fear of an irrevocable medical outcome, namely the loss of her uterus and her future fertility. This kind of fear coexisted with full medical engagement, which complicates the framing of fear as a driver of avoidance or irrationality.

R10 was admitted with dengue during late pregnancy and faced an emergency caesarean.

Initially my plan was to do a normal delivery. The doctors said the same, but the plan of the Almighty is the main plan and this may be good for me.

The shift expressed by R10 from preference to acceptance was not driven by information provision but by the medical emergency itself, mediated by trust in her providers. This is consistent with the finding by Coates and colleagues (2020) that mode preferences are not fixed but shift in response to clinical circumstances and provider communication quality.

For R8, fear was entangled with gendered social pressure. Having had three daughters and experienced serious health complications after her third delivery, she found herself in an unplanned fourth pregnancy.

I was not ready for this pregnancy. My family said to abort because it might risk my life. But it is too late now.

The R8 account contains intersecting fears. Fear about her own physical survival sits alongside a social fear connected to gender preference for sons within her family. This intersection between reproductive fear, gender preference, and medical risk is largely absent from the existing quantitative literature on delivery preference.

4.3 Constrained Choice: Economic Position and Structural Access

One of the clearest patterns in the data was the extent to which apparent delivery preference was structured by economic position and access to healthcare rather than reflecting freely held individual attitudes. For women with limited economic resources, the range of realistic options was narrow, and what appeared as preference was often a response to constraint. This deepens the argument by Freedman (2005) about the need to distinguish between preferences expressed under constrained conditions and choices made under conditions of genuine agency.

R5 spoke briefly about her situation before the interview was terminated. The single short passage retained from her account, included in accordance with the limited use protocol described in section 3.6, captures the structural pressure she described.

I am very eager to do my delivery in the hospital with proper care, but my family is not okay with it because of financial problems.

Even within these few words, the pattern is visible. The preference of R5 was clearly stated and was systematically overridden by economic reality and family authority. The termination of the interview was itself an instance of constrained agency, since the fear of disapproval she expressed meant that even participation in a research interview required concealment. The authors wish to flag that the analytical weight placed on this short passage is deliberately modest, in keeping with the limitations of consent in her case.

The contrast with R11, from a higher income background, is instructive. R11 had sought fertility treatment abroad, held detailed knowledge of the comparative risks of caesarean and vaginal birth, and offered a systemic critique of high caesarean rates in Bangladesh.

Normal delivery is always good for the health of a mother, unless there is a complication. But in a country like ours, there is a much higher tendency toward caesarean section. Hospitals have a high rate, and there is a tendency to do it unnecessarily. My family members are against caesarean section. They want normal delivery, but they are not considering my health condition. There is a life risk to me, the doctor said.

The agency of R11 was constrained not by poverty but by family authority operating in the opposite direction from the situation of R5. Her family was aligned against caesarean while her doctor recommended it. This cross case comparison reveals that constrained agency is not exclusive to lower income women, although the nature and severity of constraints differ substantially.

More economically comfortable participants described the predictability and scheduling of elective caesarean as a positive attribute, allowing better planning for childcare, the work schedule of the husband, and recovery management. This preference was not irrational. It reflected a rational response to the demands of managing complex households with limited domestic support. Coates and colleagues (2020) documented convenience and control as consistent global themes in caesarean preferences, and the data from this study support that finding while also showing that the capacity to exercise this preference depended on economic means.

4.4 Hybrid Knowledge Systems in Constructing Delivery Understanding

Participants did not draw on a single source of knowledge when constructing their understanding of delivery options. Instead, they engaged simultaneously with biomedical information from healthcare providers, experiential knowledge from women in their networks, community narratives, personal experience from previous births, and religious framing of outcomes as ultimately in the hands of Allah. This challenges the linear, deficit-based model of health knowledge implicit in much public health literature.

Religious framing appeared frequently across socioeconomic groups and was not a marker of low education or knowledge deficit. Rather, it functioned as an interpretive framework helping women manage uncertainty about outcomes. The use by R10 of religious framing to accept a shift from her preferred delivery mode was not fatalism or disengagement. She was fully engaged in medical care and had updated her birth plan in response to her changing condition. Religious framing served as a resource for managing distress, not as an obstacle to medical engagement. This pattern was consistent across the accounts in which religious language appeared.

R3, who had high blood pressure, diabetes, and a complex medical history, pointed to a systemic gap.

I did not receive any counselling session regarding the matter. In our country this type of thing is not common. Everyone is assumed to have information about it, but in the real scenario that is not true.

The hospitals in our country should have a separate counselling centre because every pregnancy journey is different.

R3 was not asking for more information in the generic sense of public health campaigns. She was asking for individualised clinical dialogue that acknowledged the specific complexity of her pregnancy. This is consistent with the emphasis by Coates and colleagues (2020) on individualised, respectful care, and with the finding by Enabudoso and colleagues (2011) that women with complex medical histories particularly need access to counselling to support informed decision making.

Community knowledge carried significant weight even when participants had access to biomedical information. R6, who had a prior successful vaginal delivery, drew together multiple knowledge streams.

This is my second delivery. I had my first normally, so now I would like the second to also be normal. I am aware of both normal and caesarean section. Having a normal delivery is a blessing.

The preference of R6 for vaginal birth was not derived from any single source. It was a synthesis of personal experience, community knowledge, and biomedical familiarity. This is consistent with the finding by Benyamini and colleagues (2017) that attitude toward medicalisation was an independent predictor of delivery preference. Her orientation toward her body as capable and natural shaped how she weighted information from all sources.

R11 offered perhaps the most sophisticated engagement with hybrid knowledge, holding simultaneously a systemic critique of unnecessary caesarean rates, a personal medical recommendation for caesarean, and family authority aligned with her systemic scepticism but not with her personal medical needs. Her navigation of these contradictions illustrates the active and sophisticated nature of knowledge construction in childbirth decision making, which is poorly captured by models that treat knowledge as a stock to be increased through information campaigns.

5. Discussion

5.1 Returning to the Conceptual Propositions

The four sensitising propositions developed in section 2.4 can be revisited in light of the findings. The first proposition held that delivery preferences are shaped not only by individual attitude but also by perceived social norms within family and community networks. This proposition is supported by the data on distributed agency in section 4.1, where the role of mothers in law, husbands, and providers in shaping outcomes was visible across cases. The second proposition held that the extent to which a woman can act on her preferences is mediated by perceived behavioural control, which is structured by economic position and authority relations. This proposition is supported by the contrast between R5 and R11 in section 4.3, where constraint operated very differently across class positions but was present in both. The third proposition held that fear is a cluster of distinct concerns, each pointing to different underlying needs. This proposition is supported by the disaggregation of fear in section 4.2, which surfaced at least five overlapping kinds of fear, each with different practical implications. The fourth proposition held that women construct their understanding of delivery options from multiple, potentially competing, knowledge sources. This proposition is supported by the hybrid knowledge findings in section 4.4. Taken together, the propositions and the findings reinforce the value of combining the Theory of Planned Behaviour with a feminist political economy lens. The Theory of Planned Behaviour helps make sense of how subjective norms and perceived control mediate stated attitudes. The feminist political economy lens helps make sense of why those norms and that perceived control are distributed in the way they are.

5.2 Beyond Individual Knowledge and Fear

The dominant framework in the existing public health literature constructs high caesarean rates in Bangladesh as a problem of individual level knowledge deficits and misplaced fear. The implication is that if women had better knowledge and if their fear of vaginal delivery could be alleviated, they would make more medically appropriate choices (Begum et al., 2018; Sultana et al., 2022). The findings of this study challenge this framework in three ways.

First, many women held detailed knowledge of the risks associated with both vaginal delivery and caesarean section. R1 was aware of postpartum haemorrhage. R11 articulated a systemic critique of unnecessary caesarean. R3 understood her medical situation with considerable precision. The problem these women faced was not knowledge deficit but structural constraint and relational power imbalance. Providing more information to women in the position of R5, who wanted hospital care but could not afford it and was subject to the authority of her husband and family, would not address the barriers she faced.

Second, fear was not a simple variable pointing uniformly toward caesarean preference. Fear of vaginal delivery co-existed with caesarean preference in some accounts, but fear of medical failure and fear of irreversible consequences were present in women who were actively engaging with medical recommendations. These forms of fear did not produce avoidance or irrational choice. They produced a form of anxious compliance that calls for attentive clinical communication, not corrective information.

Third, the findings confirm and extend the argument by Panda, Begley, and Daly (2020) that requests by women themselves are not the primary driver of high caesarean rates. Across the accounts gathered here, there was limited evidence of women demanding caesarean without medical indication. Where elective caesarean without clear indication was present, it was concentrated among economically comfortable women who valued scheduling and predictability for reasons of household management, consistent with the global review by Coates and colleagues (2020).

5.3 Distributed Agency and the Limits of Autonomy Based Frameworks

A striking finding was how rarely delivery decision making was located within the individual woman alone. Husbands, mothers in law, healthcare providers, and economic necessity all shaped outcomes in ways that the woman could not unilaterally override. This supports the argument by Freedman (2005) that reproductive autonomy cannot be assumed from the existence of formal choice. A woman who nominally chooses a mode of delivery under conditions of domestic authority, economic constraint, and limited structural access is not exercising the kind of autonomous agency that the concept of informed consent presupposes.

This has important implications for respectful maternity care in Bangladesh. Global standards, including the recommendations by the World Health Organization (2016) on antenatal care, emphasise the right of women to make informed and autonomous decisions. In settings where decision making is structurally distributed as it is in Dhaka, realising these standards requires more than providing information to the individual woman. It may require engaging family members in shared discussions, creating institutional spaces in which women can express preferences confidentially, and addressing the economic barriers that prevent some women from accessing their preferred care. The literature on disrespect and abuse in facility-based childbirth (Bohren et al., 2015) further suggests that institutional trust is a precondition for genuine autonomy, and that this trust is built through provider behaviour and institutional culture, not through information leaflets alone.

The internal differentiation within family authority is also an important finding. The husband of R3 supported her medically recommended caesarean against the resistance of her mother-in-law. The family of R11 was aligned with vaginal delivery against medical advice. The pressure on R8 included considerations of son preference. These accounts show that family authority is internally contested and variable. Interventions that treat the family as a uniform obstacle will miss this complexity.

5.4 Hybrid Knowledge and the Inadequacy of Information Deficit Models

The finding that women drew on hybrid knowledge systems has implications for how information interventions in maternal health are designed. The standard model of health education assumes the target of intervention is a knowledge gap. The woman does not know the facts, so if she is told the facts, her behaviour will change. The data in this study do not support this model. Women are active and

intelligent processors of multiple knowledge streams. Biomedical knowledge may be outweighed in specific contexts by relational trust in community networks, by economic constraints, by religious interpretive frameworks, or by the accumulated authority of senior family members.

The call by R3 for individual counselling services is, from this perspective, more than a practical suggestion. It is a request for a form of knowledge exchange that moves beyond information transmission to genuine dialogue in which her specific situation, fears, family dynamics, and medical history can all be considered. This is the kind of intervention that the evidence base supports (Coates et al., 2020; Enabudoso et al., 2011) but that is largely absent from the Bangladeshi healthcare system as described by participants.

5.5 Towards a Relational and Structural Model

Taken together, these findings suggest the need for a relational and structural model of childbirth decision making that moves beyond the individual centred frameworks dominant in the existing literature. Such a model would hold that delivery preferences and outcomes are jointly produced by individual psychological factors such as attitudes, fears, and knowledge; by relational authority structures involving family, providers, and community; by structural position involving economic resources, access to healthcare, and gender inequality; and by institutional features of the healthcare system, including the availability of counselling, provider communication practices, and financial incentives for caesarean in private facilities.

No single intervention targeting only one dimension is likely to produce sustained change in delivery outcomes. The 2023 High Court ruling mandating policies against unnecessary caesarean is a step toward addressing the institutional and policy dimension. But without parallel attention to structural inequalities that prevent some women from accessing their preferred care, and to the relational authority structures that override the preferences of women at the family level, the impact of such policy is likely to be limited.

5.6 Limitations

This study has several limitations and these should be read alongside the ethics discussion in section 3.5. The sample was recruited from hospital and clinic settings in one area of Dhaka, which means that women who gave birth at home without ever attending an antenatal clinic are not represented. The findings are not generalisable to the rural Bangladeshi population. The single interview design did not allow tracking of how perceptions changed over the course of pregnancy or after delivery. The positionality of the first author as a young, educated Bangladeshi woman may have influenced what participants were willing to disclose. The R5 interview was terminated under distress, and the limited use of her account, while ethically considered, leaves part of the analytical picture incomplete. Translation was carried out by the first author with back translation of quoted passages by an independent bilingual colleague, which strengthens but does not eliminate the risk of translation effects on subtle interpretive moves. Coding was led by the first author with discussion and review by the second author, which is consistent with reflexive thematic analysis but means that no formal inter coder reliability statistics are

reported. Most importantly, ethical review was at departmental rather than independent institutional review board level, which the authors recognise as a substantive limitation. Despite these limitations, the study makes a meaningful contribution by providing analytically grounded qualitative evidence about delivery decision making processes in Dhaka, adding theoretical depth to a literature dominated by quantitative survey data.

6. Conclusion

This study explored how pregnant women in Dhaka City perceived, understood, and made decisions about modes of delivery. Using reflexive thematic analysis with twenty participants, four themes were developed. They show that delivery decision making in Dhaka is a distributed and socially negotiated process shaped by relational authority structures, by multiple intersecting forms of fear, by economic constraints on realistic choice, and by hybrid knowledge systems.

The study found that the apparent preferences of women frequently reflected constrained agency rather than free individual choice. Women from lower income households faced barriers of cost, family authority, and physical access. Women from higher income backgrounds faced different constraints, including family authority and the demands of managing complex households. Across all socioeconomic groups, decision making authority was distributed rather than individually held. Fear was pervasive but not homogeneous, and several distinct kinds of fear pointed toward different clinical and policy responses. Knowledge was hybrid and active rather than deficient and passive.

For clinical practice, healthcare providers should recognise that a stated preference for caesarean does not necessarily reflect a free choice. Respectful maternity care requires creating conditions in which women can express genuine concerns and receive individualised responses. Individual counselling services within antenatal care would be a practical step. For policy, interventions must address provider side incentives in private facilities, structural economic barriers, and family network communication, rather than focusing only on the individual knowledge and attitudes of women.

Future research should examine how delivery preferences change over the course of pregnancy and after birth, using longitudinal qualitative designs. It should investigate the specific mechanisms through which provider side incentives affect caesarean recommendations in Dhaka. It should test the impact of individual antenatal counselling on the ability of women to exercise informed choice in public hospital settings serving lower income populations. Future work building on this study will be submitted for full external ethics review prior to any further data collection, in order to address one of the main limitations of the present study.

This study contributes a relational and structural reframing of delivery preference. Autonomous informed choice must be understood against the conditions of gendered power, economic inequality, and institutional authority within which it is exercised. Improving maternal health outcomes in Dhaka will require not only better information but greater structural equity, more responsive healthcare institutions, and genuine engagement with the social and relational complexity of the lives of women.

Declarations

Author Contributions

Author 1: Data curation, Formal analysis, Investigation (fieldwork and data collection), Writing and original draft. Author 2: Conceptualization, Methodology, Supervision, Writing, review and editing. Both authors have read and approved the final version of the manuscript and agree to be accountable for all aspects of the work, including its accuracy and integrity.

Competing Interest declaration

The authors declare no competing interests.

Generative AI Disclosure

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Ethics Statement

This study was conducted in accordance with the Declaration of Helsinki. Formal ethical approval through an institutional review board was not obtained prior to data collection, as the concerned institution did not have a formal research ethics committee or established institutional review board process in place at the time the study was conducted in April 2024. However, approval and permission to conduct the research were granted by the institute's Departmental Research Committee, prior to the commencement of fieldwork. This is consistent with the broader context of many universities in low and middle-income countries where formal ethics infrastructure remains in development. In the absence of institutional ethical clearance, the authors adhered rigorously to established principles of research ethics throughout the study. All participants provided informed verbal consent prior to participation, were fully informed of the study's purpose and their right to withdraw at any time without consequence and were assured of confidentiality and anonymization. No incentives were offered. Data were stored securely and anonymized prior to analysis. The research involved no clinical procedures, no deception, and no foreseeable risk of harm to participants.

Consent to Publish declaration

Not applicable.

Data Availability Declaration

Qualitative study conducted in this study is not publicly available. The data consist of verbatim interview transcripts from in-depth interviews with pregnant women on sensitive reproductive health topics. Participants provided informed verbal consent for research participation but did not consent to public data deposit. Full public release of the transcripts would risk re-identification of participants given the specificity of some clinical and personal disclosures. The datasets are available from the corresponding author on reasonable request, subject to confirmation that the intended use is consistent with participant confidentiality.

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Appendix: Semi Structured Interview Guide

The following questions formed the basis for in-depth interviews. The guide was semi structured. Questions were used as prompts and the order was adapted based on the flow of each conversation. Follow up probes were used as appropriate.

Demographic information was recorded at the start of each interview, including age, gestational stage, number of previous pregnancies and deliveries, educational background, occupation, and place of origin and current residence.

1. Can you tell me about how your pregnancy has been going so far?
2. Have you begun to think about how you would like to give birth? What are your thoughts at the moment?
3. What do you understand about vaginal delivery? What do you know about it from your own life or from others?
4. What do you understand about caesarean section? What have you heard about it?
5. Are there people in your family or community who have influenced how you think about this? Can you tell me more about that?
6. Have you spoken with any doctors or healthcare workers about delivery? What was that conversation like?

7. Do you have any worries or fears about giving birth? Can you describe them?
8. Do you feel that the decision about how to give birth is yours to make? Who else is involved in that decision?
9. Are there any practical concerns, such as cost or location, that affect what options are available to you?
10. Is there anything else about this that you would like to share?