Journal of Exclusion Studies
Vol. 4 No. 1, February 2014, 1-11
DOI: 10.5958/2231-4555.2014.00211.3

Research Article

Influence of the Socio-cultural Factors in Health-Seeking Behaviour of Women during Pregnancy in Rural Bangladesh

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ABSTRACT

There are several social, religious and economic barriers that prevent pregnant women from seeking services from health facilities. The conventional economic views promotes that the government health facilities located in rural areas provide free antenatal care (ANC), delivery and postnatal care (PNC) services, yet the cost related to medicines, transportation and surgical operations in the case of complications discourages poor women to seek services from these facilities. This economic view may explain part of the puzzle yet social stigma generated through patriarchal structure deserves some credit. For instance, a prevalent perception among male is that pregnancy is a natural process for women and it will pass normally and thus no extra care and support is needed in this phase of life. Men (and sometimes along with women) promote superstitions like not taking much food during pregnancy arguing that extra feeding shall increase the growth of the fetus and will affect normal delivery. The disarray in health seeking behaviour is strongly associated with inferior status of girls and women in Bangladesh. This is mainly due to entrenched dysfunctional gender relations brought about by dated social and cultural practices and is reinforced by literalist interpretations of religious tomes. Overriding all of these, the poor rural woman is treated as if her body and her future are not hers to own and manage. Naturally, this has a trickle down effect on any health-seeking behaviour of women. Based on empirical evidences this paper aims to explore the health situation of rural pregnant women and their health support seeking behaviour

Keywords: Health, Seeking, Behaviour, Women, Pregnancy and Bangladesh

INTRODUCTION

The use of health services is related to availability, quality and cost of services, as well as social structures, religious faith, health beliefs and personal characteristics of the users. According to the World Health Organisation, more than half a million women succumb to death each year from complications of pregnancy or childbirth. The situation of pregnancy- and childbirth-related morbidity and mortality is worse in Bangladesh because of low utilisation of maternal health services (Nuruzzaman 2009). The reduction in levels of maternal mortality and the improvement of maternal health have been central policy goals since the inception of the Fourth Population and Health Programme in Bangladesh in 1992. Efforts to address these issues have recently gained considerable momentum with the formulation of the National Strategy for Maternal Health (Ministry of Health and Family Welfare 2001). This strategy is predicated on the 'Three Delays Causal Framework' that affects safe motherhood service utilisation and outcomes: delays in making the decision to seek care, delays in reaching a medical facility and delays in receiving adequate treatment or management at the facility and emphasises the provision of emergency obstetric care to resolve this endemic problem. Although the maternal mortality ratio in Bangladesh has declined from more than 600 in 1980 to 322 in 2004, it is still one of the highest in the world. Pregnancy- and delivery-related deaths account for 20 per cent of deaths in women of reproductive age. The unavailability of trained service providers, low utilisation of services by pregnant women, along with infrastructure difficulties, together contribute to the high rate of maternal deaths in Bangladesh. Moreover, the utilisation of maternity care provided by trained professionals during and after delivery is alarmingly low in Bangladesh. Although there have been some improvements in recent years, about half of the pregnant women still do not seek any antenatal care (ANC). Similarly, women's awareness of potentially life-threatening conditions during pregnancy, delivery and after delivery is comparatively lower in Bangladesh than that in many other countries. Every day on an average, thirty-two mothers die during delivery. About 70 per cent of pregnant women do not have access to emergency pregnancy support and 78 per cent of the mothers' mortality is caused by this reason (Ministry of Health and Family Welfare 2009). There exists an urban–rural discrepancy in maternal mortality and the statistics is skewed in relatively 'socially conservative' districts. For instance, maternal mortality is higher in Sylhet than in any other areas in Bangladesh (Prothom Alo 19 December 2009). The Bangladesh Demographic and Health Survey 2007 reveals that at the national level, 85 per cent delivery takes place at home and only 18 per cent women receive support from health workers. This survey mentioned that this number is 5 per cent lower in the Sylhet division. Only 10 per cent of pregnant women in the Sylhet division give birth in different government and private health centres. Similarly,

government statistics indicate that at the national level, 46 per cent of rural women seek health support during pregnancy, whereas it is much lower in rural parts of the Sylhet division. It is customary in Sylhet that people avoid rural health and family-planning workers, union heath and family welfare centres, satellite clinics or any other health facility for seeking support during pregnancy and for safe delivery. There are several social, religious and economic barriers that prevent pregnant women from seeking the services of health facilities. Conventional economic views promote that the government health facilities located in rural areas provide free ANC, delivery and postnatal care services, yet the costs related to medicines, transportation and surgical operations in the case of complications discourage poor women from seeking the services of these facilities. Owing to unconsciousness and due to less or no contact with mainstream services, the situation of indigenous women is even more vulnerable. This economic view may explain part of the puzzle, yet social stigma generated through patriarchal structure deserves some credit. For instance, a prevalent perception among males is that pregnancy is a natural process for women and that it would pass normally and thus no extra care and support is needed during this phase of life. Men (sometimes along with women) promote superstitions like not taking much food during pregnancy arguing that extra feeding would increase the growth of the foetus and would thus affect normal delivery. The disarray in health-seeking behaviour is strongly associated with the inferior status of girls and women in Bangladesh. This is mainly due to entrenched dysfunctional gender relations brought about by dated social and cultural practices and is reinforced by literalist interpretations of religious texts, especially the Quran and other similar texts. Under the umbrella term 'purdah' and the sometimes self-serving interpretation of the Quran by men, certain values and practices of Bangladesh society have been made applicable to the daily living experiences of rural poor women (Reza and Ahmmed 2009). These women have to exist in an environment that is marked by a 'forced poverty of social relationships' (*ibid*.) that requires them to be confined to their living quarters free from exposure to outsiders, mainly males. This is done, so she is taught, in order to preserve their modesty *vis-à-vis* the outside world. Overriding all these, the poor rural woman is treated as if her body and her future are not hers to own and manage. Naturally, this has a trickle-down effect on any health-seeking behaviour of women. As data on this issue are scarce, the researchers found conducting research on the topic important and they conducted a study on the pregnant women of *Dawdik* village of the Sylhet district. This article is the outcome of the research, which systematically explained the health support-seeking behaviour of pregnant women, influence of their male counterparts in shaping their health-seeking behaviour, their health problems during pregnancy and their coping mechanisms. It also analysed the males' perceptions on health issues of pregnant women.

METHODOLOGY

With the objectives of an in-depth exploration on the health-seeking behaviour of pregnant women in rural areas, the research project used a qualitative design. The goal of the qualitative design was to represent the participants' reality as faithfully as possible from their points of view (Morgan and Kunkel 2001). In order to ensure an in-depth exploration on psychological, social, religious, gender and cultural perceptions on maternal health during pregnancy, as well as to explore women's and community peoples' knowledge and the deeper causes of neglecting women's health care, the qualitative design could help the researchers gather information through the use of multiple methods of data collection that included interviews, conversations and observations. As the findings of qualitative research was heavily dependent on reliable data (Patton 1990), the researchers paid special attention in the field work phase and worked as major tools of data collection from the participants. Although the Sylhet district is comparatively an economically solvent area than are the other districts of Bangladesh, many people of this district live in remote villages in acute poverty. Illiteracy and unconsciousness rule many parts of their lives. This study was conducted within four remote villages of the Sylhet district. A list of village names was made based on the recent census report. The list was further narrowed down to four villages using the random sampling technique. The researchers visited these areas and engaged in formal enquiries, informal discussions with pregnant women with the aim of identifying awareness and access of the utilisation of maternal health facilities as sources of cooperation with the research project. The team also investigated males' perception and the community's outlook on these issues. All pregnant women and their respective male family members living in the selected villages were regarded as the population of the study and all of them were interviewed as respondents of the research. Owing to socio-cultural and religious barriers, collecting data from pregnant women was difficult to male researchers. In order to compensate that limitation, the research team included female research associates. Moreover, support was sought from NGO health workers, local traditional birth attendants (TBAs) and older women of the respective families. Recruitment of participants was done based on their personal interests. Before the formal interview, the research team identified the participants and visited them frequently, established a rapport with them and motivated them to speak with the research team. Before appearing before the research team, pregnant women obtained assent from their husbands and/or their mothers-in-law.

OBJECTIVES

- This study was conducted in order to explore the health status of rural pregnant women and their medical support-seeking behaviour in general. However,

the specific objectives are: To know the present health status of rural women during pregnancy.

- To know the availability of health-related services, which are provided in rural areas.
- To know the health-seeking behaviour of pregnant women. To identify the socio-cultural, religious and male influences towards shaping existing health-seeking behaviour.
- Aiming to provide information to the development programme planner for designing and implementing need-based development interventions for pregnant women.

MAJOR FINDINGS

General Characteristics of the Participants

The research team found 632 married women in the studied villages. Among them, 84 were pregnant. Early marriage was strongly prevalent among the participants. Out of 84 participants, 72 got married in the age of 15–20 years. All four villages were Muslim dominated, and naturally the majority of the participants were of the Muslim faith. Literacy rate was found to be very poor among the pregnant women. More than half of them were illiterate. Almost all of the participants were found to be engaged in household activities, except one who was a primary school teacher. Two-third of the participants reported that the current one was their third or fourth experience of pregnancy. About half of the participants were living in joint families wherein most parts of their lives were guided by their mothers-in-law. Almost all of the husbands of the participants were farmers.

Present Health Status

Healthy pregnancy was barely seen among the participants. Pregnancy-related complications were found to be alarming among two categories of participants—women aged under 18 years and women experiencing third and fourth pregnancies. Birth spacing is a significant indicator for good health of pregnant women, but a majority of the participants having second time or more experiences had maximum 18 months gap between the two pregnancies. Pregnancy under the age of 18 years was not uncommon. We found nine individuals who got married at the age of 14 years and became pregnant at the age of 17 years. Due to not having control over their bodies, pregnancy was imposed upon them by their husband's family members. Despite not having the physical ability, few of their husbands imposed pregnancy upon them without their assent. We asked the participants whether their husbands took their opinion on child birth. We found none who had a role in decision making on having children. One participant mentioned,

> It is in fact not necessary to ask any wife before having a baby in our society. Husbands will take decision or it shall be imposed by mother in-law or other influential family member of husband's family. As the girl come to her husband's house at her immature age, she cannot raise her voice over husband about her personal wellbeing, she has to accept everything. It is said that, pregnancy is normal and common matter among married women. In many cases pregnancy is unplanned and is the result of lack of use of contraception. Sometimes want for boy baby force an women to accept repeated pregnancy in our area.

Among these participants, four were experiencing severe complications. About two-third of the pregnant women from both of those groups were experiencing problems such as oedema, abdominal pain, body ache, headache and back pain. Only one-third of the participants reported that they were not experiencing any major complications.

Birth Plan

As birth is considered a natural process, a majority of the community people view that they should not make any specific plans for the same. Almost all of the villagers mentioned that they do not take any preparation for safe delivery. They do not even know the possible date of delivery correctly. Importance of safe delivery is not known to them. All practices and behaviours related to delivery are based on their traditional beliefs and experiences. Few of the traditional preparations even cause serious harm to both the infant and the mother. At home, the room where the baby is delivered is known as the 'Atur Ghar'. According to the villagers, this place should be closed and secured free as fresh air should not pass into the room as evil spirits may enter the room with air that could harm the infant. The mother and the infant have to spend a few days in captivity. Thus, a separate place is prepared as part of the birth plan. Instead of medical arrangements, many villagers go to traditional healers and collect 'Tabiz' for the safety of the infant and the mother. One of the participants who was the mother-in-law of a pregnant woman viewed,

> We arrange everything at our home. Once pain is started, we call upon a female neighbor who has experience in delivery or we deal the case on our own. I have taken some preparation, I have cleaned the place where baby will be born and will stay for few days along with her mother and I made some blanket for her. We have collected *Tabiz* from the clergyman of nearest mosque. This shall help us as it is formed with God's words. We also have planned to consult a traditional healer who can prescribe some herbal medicine for pain free and risk free delivery. Due to not having personal autonomy to take decisions, most of the women cannot make birth plans personally; they have to rely on their husbands or other family members.

One of our participants who was pregnant said,

> I am sick, but my husband or my mother in-law does not consider it seriously. They view it as usual. As this is my first experience, I have consulted with my mother and my mother requested my husband to take me at my mother's house so that she can support me. My husband agreed and I shall go to mother's house. My baby shall be born there.

We asked her about possible arrangements to be taken by her mother. She said that there was a TBA in their village who supported all villagers and that she would arrange the attendant's support. We found only about 15 per cent of the participants were conscious about the importance of a birth plan and that they regularly consulted medical professionals. All of these women said that they would go to hospitals, health centres or clinics for safe delivery. This group had a good understanding about the importance of safe delivery.

Perception on Health Support during Pregnancy

Owing to massive awareness campaign regarding safe motherhood by a few NGOs, most of the pregnant women are found to be conscious about their health during pregnancy. However, the general perception of the studied villagers was ambiguous. It might be because of partial awareness campaigning targeting only women and adolescent girls. The study team conducted three Focus Group Discussions FGDs with male residents of every village and all most all of them did not know about the importance of regular healthcare during pregnancy. In most cases, the husbands of pregnant women had poor understanding about this topic. Despite having a deep interest to get proper medical services, pregnant women could not afford or arrange it due to the non-cooperation of their husbands. One of the husbands viewed that,

> We do not know about its importance. My mother, wife of my sisters never went hospital during pregnancy for any support. We think it is a natural process and baby shall be born automatically. God has given the baby and he will see her wellbeing.

Superstition is also another significant factor explored by the research team. One of the mothers-in-law of a pregnant woman said,

> No one should go outside in the whole period of pregnancy. Going outside is dangerous. Any evil spirit can attack the pregnant woman. So we do not allow them to go outside. It is the common perceived idea of the community people that pregnancy is a natural process and extra support and treatment is not mandatory at this stage. Most of the villagers believe that it is not essential to go to hospitals during delivery; rather, the support of a TBA is enough for this.

Few of the participants viewed,

> God has a decision what will happen. We are nobody to change the fate. Therefore we should trust upon god.

Religious misinterpretations sometimes restrict women from receiving medical support from male physicians. One of our participants failed to arrange regular check-ups as her husband forbid her to go to the male medical doctor. She described how she was restricted,

> My husband told me that our religion never permits to go to another male who may see or touch any parts of your body. As the physician is a male, I should not go there. He collected some water and oil purified by a local clergy man with holy words (commonly known as *Pani Pora*) and suggested to drink and use regularly. My husband believe that these two items shall ensure my safety and good health, evil spirit shall not touch me and my baby shall be a pious one.

ACCESS IN EXISTING HEALTH SERVICES

Our research sites were located at a distance of about 11 km from the divisional headquarters of Sylhet city where both government and private health services are available. However, one union health centre and an upazila health complex are located at a closer distance to the villages. All these hospitals, health centres and clinics have maternal health support services and many of them provide services free of cost. However, mainly due to lack of consciousness, villagers only visit these hospitals occasionally. 'Pregnancy is a natural process and this time shall pass naturally, why should we go to the hospitals or health support centres? Our mothers and sisters advised us to remember almighty God, he will see our wellbeing'—this was the common perceptions among a large number of participants. However, a small number of participants were conscious about the importance of receiving treatment and advice from the medical practitioners and they regularly visited their care givers. They could arrange it as their husbands cooperated with them. According to the participants, religion was another significant factor that restricted them from going outside for treatment during pregnancy. It was observed that the women of the study area led their lives in a conservative manner. Their male counterparts and family usually do not allow them to go outside for any purpose. Few of our participants noticed that they were allowed to consult a physician if the physician was female. Almost all of the participants informed that they were not allowed to go outside the home alone; their husband or any other male member of the family helped them in outside affairs occasionally if the male member had available time to do that. Traditionally in rural areas, the general well-being of women is widely neglected. It might be because of their inferior status (Ahmmed and Reza 2006). A group of women who had basic education viewed that their status was low inside the family, that their

life was controlled by male members, that they had no freedom and that they could not do anything as per their own desire. They reported that they are totally dependent on their husbands and that is why their well-being depended on their husbands' desires. The study observed that health issues of women are not properly addressed by their counterparts or by other family members. Even in many cases, mothers-in-law and sisters-in-law, who have experienced complications related to pregnancies, avoid the importance of health support to women during pregnancy and always discourage them from going to hospitals and clinics. These realities sometimes restrict women in receiving medical support closer to their community. However, few women were found who had regular contact with health workers of local NGOs. These health workers frequently visited pregnant women's houses as part of their duties. This group of participants also visited satellite clinics and tried to follow the advices of medical professionals. Trained TBAs are another source of support for a few pregnant women. TBAs are trained by NGOs and villagers usually rely on them. Two reasons were identified for such an attitude—(a) TBAs are known to the villagers and the pregnant women have easy access to them as they live inside the village and (b) family members usually support receiving suggestions from TBAs and there is no or minimum cost of services provided by TBAs.

CONCLUSION

In Bangladesh, only 13 per cent of the pregnant women get support from skilled and professional birth attendants. The maternity mortality rate is 320 within 10 million in Bangladesh. Safe maternity can reduce the death of mothers and infants and can also help develop a healthy nation, as well as help in reducing infant mortality rate and in developing mothers' health status that are prime targets of the Millennium Development Goal (MGD) in connection to health. Without changing the behaviour of rural people of Bangladesh, it is difficult to achieve MGD in connection to health. Data show that despite having different health services, a majority of the rural people avoid receiving those services. Even the government's cost-free services fail to attract a large number of people mainly because of their perception regarding health services. Pregnancy is considered a normal process and most of the rural people still rely on traditional healing processes for overcoming critical health situations during pregnancy. Mass media, especially the electronic media can play a vital role in changing people's attitude. In addition, with perception and lack of knowledge about health issues during pregnancy, the research explored a few areas that need to be addressed properly. Government health workers usually avoid visiting houses/villages regularly at research areas. Although NGO's health staffs arrange regular visits, they spend inadequate amount of time in counselling, which is essential to change people's

perception and understanding about health during pregnancy. The research team found no arrangement to organise group/community meetings on health issues with villagers, which could help motivate them for receiving existing medical services closer to their community. Owing to poverty, many people cannot reach medical support centres. Weekly clinics can be arranged at the middle of two villages so that they can receive treatments inside their village. The research explored that due to some complex formalities and due to the non-professional behaviour of the medical staff, few people avoid receiving treatments from government health centres. Thus, government health centres should introduce one-stop and easily accessible health services for the rural poor. Medical professionals should be trained in such a manner so that they can deal with their clients professionally. Simultaneously, union health centres should be upgraded so that all supports regarding pregnancy and delivery are available there and responsibility of the medical staff should be ensured through intensive supervision. As people have good trust on TBAs and as they have easy and quick access to TBAs, the government should initiate massive programmes to train all TBAs in such a way so that they can provide appropriate suggestions and emergency assistance to rural pregnant women. The government can use rural spiritual leaders and community leaders for creating awareness about pregnancy-related health services under the guidance of the local self-government. A special chapter on pregnancy health can be added in the textbooks of lower secondary grades. This can create an understanding about the importance of pregnancy health among children and ultimately can help them in their personal and community life. To reduce maternity mortality rate, the government of Bangladesh has taken some operational steps, such as delivery with the help of skilled birth attendants, providing financial support for bearing the cost of birth delivery and providing nutritious food packages to malnourished pregnant women. These steps should be implemented in such a way so that all people who are in need can take the support of the government.

It is not worthy to mention that it is difficult for the government to take the entire responsibility regarding quality health support for pregnant women in rural areas. Hence, government–NGO cooperation can strengthen the impact of existing services, and this cooperation can create new areas and understanding for better health services of rural pregnant women.

REFERENCES

Ahmed, S.M., Tomson, G., Petzold, M. and Kabir, Z.N. (2005). 'Socioeconomic Status Overrides Age and Gender in Determining Health Seeking Behaviour in Rural Bangladesh', *Bulletin of the World Health Organisation*, 83: 109–117.

Ahmmed, M.F. and Reza, M.H. (2006). 'Violence against Women at Family Level: Some Observations', published in (in Bengali), *Annual Bengali Journal of Bangladesh Public Administration Training Centre*. 9th Year Issue, Kartik, 1411: 83–104.

Nuruzzaman, M.H. (2009). 'Affecting Maternal Health Services Utilization Married Adolescents and their Use of Maternal Health Services in Bangladesh', *Internet Journal of Health*, http://www.britannica.com/bps/additionalcontent/18/36122546, accessed 27 December 2009.

Ministry of Health and Family Welfare (2001). 'National Strategy for Maternal Health', Bangladesh Secretariat, Dhaka.

Ministry of Health and Family Welfare (2009). Progress Report on Maternal and Reproductive Health, Bangladesh Secretariat, Dhaka.

Morgan, L. and Kunkel, S. (2001). *Aging: The Social Context*, Pine Forge Press, Californea, USA.

Prothom Alo (19 December 2009). 'Maternal Health in Sylhet: Vulnerable than other districts' Dhaka, December 19, 2009

Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods (2nd edition).* Sage Publications. California. USA.

Reza, M.H. and Ahmmed, F. (2009). 'Structural Social Work and the Compatibility of NGO Approaches: A Case Analysis of Bangladesh Rural Advancement Committee', *International Journal of Social Welfare*, 18: 173–82.