# Maternal Health Care Seeking Behaviour of Women from Lower and Upper Socio-Economic Groups of Dhaka, Bangladesh – Fear or Fashion?

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# Declaration

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signed Sanzida Akhter Date 23.02.2015

# Dedication

*I dedicate this thesis to my father ABM Khairuzzaman, mother Feroza Akhter Banu, my husband Abdul Wohab and my lovely children Wadi Wohab and Arisha Wohab who have been the key driving forces that enabled me achieve my dream.*

# Abstract

This study examines the differences between mothers from upper and lower socio-economic groups of households of Dhaka, Bangladesh in terms of their perception, experience and practice of maternal health care seeking behaviour for childbirth and the post-partum period, and explains the factors responsible for these differences. Using a 'social constructionist' approach, this study applies a research method based on in depth interviews among the two groups of women who gave birth in the five years preceding the survey, conducted for this study during July-December 2012. The findings show that mothers from lower socio-economic households express a sense of fear and distrust at receiving health care services for childbirth and the post-partum period from public or private modern maternal health care facilities, even though low cost or free maternity care is available at some health facilities in close proximity to their residence. Conversely, mothers from upper socio-economic groups show an overt sense of trust and dependence on modern maternal health care facilities, particularly the private clinics. The findings further suggest that socio-economic status of the mothers and their households, i.e., income, neighbourhood, social network, migration status (particularly for the mothers of lower socio-economic group of households), employment and empowerment status of the mothers are associated with the health care seeking behaviour of the mothers of both the groups. Each group holds a particular and often paradoxical pattern of perception, experience and cultural attributes that shape their health care seeking behaviour for their childbirth. However, the mothers

and their families in both the groups share some common factors in their perceptions and experiences that are deemed crucial in deciding the type, place, and timing of maternal health care received during childbirth and in the post-partum period. These common factors comprise apprehension regarding childbirth, social and authoritative distance between the health care providers and the care receiving mothers, views towards pregnancy and childbirth, choice and control of the childbirth procedure. These factors work in opposing directions in shaping each group's approach to maternal health care and can turn the modern maternal health care into a matter of fear for the mothers of lower socio-economic households and a matter of fashion, rather than necessity for the mothers of upper socio-economic households.

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# Preface

It was during my one month stay in hospital just before my second child was born, that I decided to pursue my higher degree research to understand maternal health care seeking behaviour of mothers in Dhaka. I am the mother of two children, to whom I gave birth prematurely at eight months of pregnancy. I had hypertension, which led to preeclampsia. My life was at high risk during both of my children's births. I was under constant close supervision of a gynaecologist. For the birth of my second child, my hypertension was worse than it was before the birth of my first child. Therefore, I was admitted to a hospital in the seventh month of my pregnancy for close monitoring by the doctor. In the eighth month I gave birth to my child through caesarean section. My hypertensive condition continued after the baby was born and I continued to stay in the hospital for 10 more days after my delivery. I am still enduring the legacy of some complications that happened during my second childbirth and I need regular check-up by a doctor.

My health condition has had a serious impact on my family. My elder child, who was only 2 years old at the time of the birth of my second child, had to stay without me for more than a month. My husband, my elderly mother and my mother-in-law looked after my son at home and looked after my household during my stay in the hospital. The cost of my treatment put a huge financial burden on us and an intense mental stress on my whole family. I was the first person in my family, who went through such an experience of childbirth complication. So, everyone was extremely

anxious about what was going on. My and my husband's families feared losing me during and after my childbirth.

However, my whole experience of childbirth evoked my reflections about the intensity of suffering a mother can have during childbirth, which is considered the prime job of women in our society. I considered myself very fortunate as I could access the best treatment available in Dhaka. I received the social and family support that I needed to comfort myself as well as to run my household. Meeting other mothers, who were also admitted to the same hospital, gave me the impression that people consider the whole event of childbirth and related health care from various perspectives. For some mothers childbirth in hospital is the last resort, for others a hospital is the first thing to consider regarding childbirth. At the same time, another insight was growing inside me thinking of those mothers who cannot access or afford treatment for maternal illnesses, cannot realize the intensity of life threatening problems that turn their childbirth event into a nightmare. During my lonely, physically uncomfortable nights in my hospital bed, my thoughts wandered to those mothers who are deprived of the right of receiving appropriate and timely maternal health care.

From my Masters study in International Development and my research project on Millennium Development Goal Five, I was aware of widespread maternal death and morbidities in Bangladesh. My subsequent experience of complication and illness during and after my own delivery made me think deeply about the problem

and motivated me to learn more about the issue. With that motivation, one year after my second child was born; I started walking along my dream path of a PhD. I am so happy that I have completed a major part of that journey with the writing of this thesis.

# Acronyms

| | |
|---|---|
| ANC: | Ante-Natal Care |
| BBS: | Bangladesh Bureau of Statistics |
| BDHS: | Bangladesh Demographic and Health Survey |
| BDT: | Bangladeshi Taka |
| BHC: | BRAC Health Centre |
| BMMS: | Bangladesh Maternal Mortality and Health Care Survey |
| CBN: | Cost-of-Basic Needs |
| CEDAW: | Convention on the Elimination of All Forms of Discrimination against Women |
| CS: | Caesarean Section |
| CSR: | Caesarean Section Rate |
| CUS: | Centre for Urban Studies |
| DCC: | Dhaka City Corporation |
| DCI: | Direct Calorie Intake |
| DFID: | Department for International Development |
| EmOC: | Emergency Obstetric Care |
| FES: | Focused Ethnographic Study |
| FIGO: | The International Federation of Gynaecology and Obstetrics |
| GOB: | Government of Bangladesh |
| HBM: | Health Belief Model |
| ICD: | International Classification of Diseases |
| ICPD: | International Conference on Population and Development |
| IPPF: | International Planned Parenthood Federation |
| KAP: | Knowledge, Attitude and Practice |
| *MANOSHI:* | *Ma, Nobojatok and Shishu* (acronym for mother, neonate and child in Bangla) |
| MDG: | Millennium Development Goals |
| MMR: | Maternal Mortality Ratio |
| MOHFW: | Ministry of Health and Family Welfare |
| NIPORT: | National Institute of Population, Research and Training |
| OT: | Operation Theatre (Operating Room) |
| PHC: | Primary Health Care |
| PHCC: | Primary Health Care Centre |

| | |
|---|---|
| PNC: | Post Natal Care |
| PND: | Post Natal Depression |
| SBREC: | Social and Behavioural Research Ethics Committee |
| SPSS: | Statistical Package for the Social Sciences |
| TBA: | Traditional Birth Attendant |
| TT: | Tetanus Toxoid |
| UAP: | Unqualified Allopathic Practitioner |
| UNFPA: | United Nations Population Fund |
| UNDP: | United Nations Development Program |
| UN: | United Nations |
| UNICEF: | United Nations Children's Fund |
| UPHCP: | Urban Primary Health Care Project |
| USAID: | United States Agency for International Development |
| USD: | United States Dollar |
| VVF: | Vesicovaginal Fistula |
| WHO: | World Health Organization |

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# Chapter One

# Introduction

## 1.1: Background of the problem

Improved maternal health is a longed for goal in developing countries. In order to achieve this goal, over the last four decades, a number of initiatives have been taken globally and locally with a particular target to reduce both maternal mortality and maternal morbidity. International bodies such as the World Health Organization (WHO), the United Nations Population Fund (UNFPA), and the United Nations Development Programs (UNDP), feminist scholars (Sen and Östlin, 2008; Sen, Ostlin and George 2007), and women activists have put their efforts into bringing women's health issues to the forefront of global affairs. This is evident in the Safe Motherhood Initiatives (safemotherhood 2010), International Conference on Population and Development (ICPD) 1994 (Roseman and Reichenbach 2010), UN Millennium Development Goals (MDG) (UN 2011, p. 29), the Beijing Platform for Action (Declaration B 1995), and the Convention of Elimination of all Forms of Discrimination against Women (CEDAW).[1] As a developing country, Bangladesh, which is a signatory to all of these initiatives, has made remarkable progress in recent years in reducing its maternal mortality ratio (MMR). For example, Bangladesh Maternal Mortality and Health Care Survey (BMMS), 2010 shows that the MMR in Bangladesh has been reduced from 322 per 100,000 live

[1] Article 12.2 of the CEDAW states "Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation" (UN women 2000).

births in 2001 to 194 per 100,000 live births in 2010, implying a 5.6% decline per year over the period 2001-2010 (NIPORT et al. 2012, p. xx).

However, a reduction in the maternal mortality ratio does not necessarily tell the whole story of maternal health in Bangladesh. Rather, maternal mortality is often regarded as the "tip of the ice berg" (Christian 2002, S59; Firoz et al. 2013, p. 794; Hounton et al. 2008, p. 315; Koblinsky 1995, p. S21; Filippi 2006, p. 1,536). For every woman who dies of pregnancy-related causes, 20 or 30 others experience acute or chronic morbidity, often with permanent sequelae that can affect women's physical, mental or sexual health, productive and reproductive capability (Firoz et al. 2013, p. 794). According to Filippi et al. (2006, p. 1,536) "maternal health is more than survival". Without addressing maternal morbidity, achievements towards improved health status of mothers will remain unaccomplished. Lewis (2003, p. 28) claims that "MMRs cannot be used to determine the estimates of pregnancy related complications which the women have survived but have resulted in long-term severe disabilities". To improve maternal health, a deeper understanding of how maternal morbidity happens, and how treatment is sought is needed rather than only estimating the maternal mortality ratio.

Maternal morbidity (also known as "non-fatal maternal childbirth injury") is defined as "any illness or injury caused by, aggravated by, or associated with pregnancy or childbirth. It is a part of reproductive morbidity, which includes maternal (or obstetric) morbidity, gynaecologic morbidity, and contraceptive morbidity" (Reed, Koblinsky and Mosley 2000, p. 3). However, unlike maternal mortality, no timeframe for maternal morbidity can be set, as it can occur and

continue throughout a woman's lifespan (Bhatia and Cleland 1996, p. 1,508). Moreover, there are different types of maternal morbidity induced by pregnancy, ranging from the acute and short-term to the chronic and long-term (Ashford 2002, p. 1; Liskin 1992, p. 79). Depending on the timing of its occurrence, a woman can suffer from maternal morbidity in the ante-natal, intra-natal or the post-partum period. Whatever the type, the duration and causes of maternal morbidity are, if left untreated, it can become a major source of physical, emotional, and social suffering (e.g. social isolation or stigmatisation) for the woman throughout her life. The list of morbidities from maternal complications provides a range of conditions from fever to psychosis which require diverse care responses. The Tenth Revision of the International Classification of Diseases (ICD-10, Version 2015) of the World Health Organization includes a wide range of illnesses in the category of maternal morbidity, e.g., maternal infectious and parasitic diseases complicating pregnancy, childbirth, and the puerperium (as mentioned in section 094-098 of ICD-10), including tuberculosis, syphilis, gonorrhoea, other sexually transmitted infections, viral hepatitis, anaemia, diabetes, malnutrition, postnatal depression etc. For those women who have had a near-miss[2] in childbirth, recovery from organ failure, uterine rupture, fistulae, and other severe complications can be long and painful, and can leave long-lasting after-effects. Some of these problems are temporary but others become chronic (McCarthy and Maine 1992, p. 23). These include urinary incontinence, uterine prolapse, pain following poor repair of episiotomy and perineal tears, nutritional deficiencies, depression and puerperal psychosis, and

2 When a woman survives a life-threatening complication during child delivery, the outcome of this survival is called a near-miss.

mastitis. The severity and consequences of maternal complications often vary according to the treatment facilities available nearby and the access of mothers to those facilities. Table 1.1 presents the type, aetiology and consequences of maternal morbidities that are caused by pregnancy complication and/or by lack of post-partum care[3] and that are common in developing countries like Bangladesh.

[3] Post-partum care could be broken into as immediate (within 24 hours of birth) through 42 days, and extended (up to one year).

**Table 1.1: Complications and consequences during childbirth and post-partum period**

| Complications | Incidents as % of live birth | Maternal disability that may result | Physical consequences | Social and economic consequences |
|---|---|---|---|---|
| Severe bleeding (haemorrhage) | 11 | Severe anaemia | Pituitary gland failure, Fatigue, Infertility | Dramatic reduction of the productive and quality of life |
| Infection during or after labour (sepsis) | disease pain 10 | Pelvic inflammatory disease, Damage to reproductive organs | Infertility, Chronic pelvic pain | Emotional pain caused by infertility, Loss of productivity, Abandonment or abuse by husband |
| Obstructed or prolonged labour | 6 | Incontinence, Fistula, Genital prolapse, Uterine rupture, Nerve damage | Chronic backache urinary problems, Pain during, sexual intercourse, Complications in future pregnancies | Difficulties in doing household chores, Stigma and isolation, Abandonment or abuse by husband, Loss of productivity resulting into economic hardship |
| Pregnancy induced hypertension (Preeclampsia and eclampsia) | 6 | Chronic hypertension<br>Kidney failure<br>Nervous system disorders | Chronic hypertension<br>Kidney failure<br>Nervous system disorders | Uncomfortability resulting in loss of physical and mental strength |

Source: Adapted from Ashford (2002, pp. 2-4)

The sufferings of mothers who develop these morbidities are intense and severe, not only for the mothers themselves, but also for their children, families and overall, for the whole country. Filippi et al. (2006, p. 1,537) broadly categorize the consequences of maternal death and near-miss into economic (lack of capital, no savings, debts and poverty), physical (no living child, damaged pelvic structure, anaemia, impaired functionality, infertility), social (marital disharmony, household dissolution, migration, social isolation, stigmatisation) and psychological consequences (suicide, depression). The wide range of consequences of maternal morbidity indicates how maternal illnesses can put the suffering mothers and their families in a vulnerable situation as a consequence of illnesses which can be prevented or treated. Since most maternal health programs are aimed at reducing the number of maternal deaths, the maternal morbidity aspect of maternal health has often been ignored (Lewis 2003, p. 30; Glazener et al. 1995, p. 282). The treatment seeking behaviour and the suffering experience of women who survive maternal complications have remained largely unaddressed. For example, in many developing countries such as Bangladesh, China, Egypt, Malaysia, Romania, Sri Lanka, and Thailand, MMR has been reduced within a short period of time. However, in none of these countries are there any detailed data or discussion about maternal morbidity, which has remained a widely neglected area in academia and among health workers and activists (Shah and Say, 2007; p. 18).

Women suffering from maternal morbidity are not only not included adequately in discussions in research, policy and programs, they are also left out of routine health care activities, particularly in developing countries. Ashford (2002, p. 1) states that

approximately half of the nearly 120 million women who give birth each year experience some kind of complication during their pregnancy. Of those women suffering from maternal complications, 50% do not receive any treatment; almost all come from developing countries in Asia and Africa (Ashford 2002, p. 2). The same is true for Bangladesh. In spite of a remarkable decline in the MMR in Bangladesh over the last decade, it is reported that as many as 76.6% of mothers still deliver their babies at home, and only 4.4% receive professional health care during delivery (NIPORT et al. 2012, p. 7). Moreover, in contrast to the attention given to ante-natal and delivery care, much less attention is given to post-partum care in the developing world (Fort, Kothari and Abderrahim 2006, p. 18). Again, the same is true for Bangladesh, as evidenced from NIPORT et al. 2012, p. 4, which revealed that while maternal mortality during pregnancy and child delivery declined by 50% between 2001 and 2010, maternal mortality during the post-partum period (i.e., within 42 days after delivery) was reduced by only a third. In Bangladesh, post-partum maternal deaths now account for a higher proportion of maternal deaths, which is 73% in 2010 compared to 67% in 2001 (NIPORT et al. 2012, p. 11).

Since ante-natal care and the attendance of skilled birth attendants during childbirth are considered to be the most effective interventions to reduce maternal mortality during pregnancy and childbirth, not much attention has been paid to the health conditions of the mother after the birth of a child. As a result, many mothers, who experience complications while giving birth and survive, remain untreated sometimes throughout their entire lives. The reasons for this are many, however one of the main reasons is probably the fact that any attention given to pregnant

women by themselves, their family, by the society, and/or by health carers lasts only as long as the time of birth of the child. After their babies are born, the women are generally left without attention, care and the ability to exercise their rights. As Lewis (2003, p. 29) states,

> Some women are denied access to care because of cultural beliefs and practices, seclusion or because responsibility for decision making falls to her husband or other family members. In many cases, the failure of support for pregnant women by families, partners and their government reflects the social value placed on women's lives.

### 1.1.1: The present study

The present study endeavours to bring into focus those factors that influence health seeking behaviour of women during childbirth and post-partum period in a developing country such as Bangladesh. Further, as a pioneering study of its kind, this research will highlight the maternal morbidity and maternal health care seeking behaviour of women by studying small samples of women in the urban lower socio-economic and upper socio-economic households of Dhaka city. To be specific, this study examines the differences between the mothers from lower socio-economic and upper socio-economic households of Dhaka in terms of their perception, experience and practice that shape their decision about the place, timing and type of health care for complications during childbirth and the post-partum period, and analyzes the factors that are deemed responsible for these differences. Although it has been mentioned before that morbidity can happen at any stage of pregnancy and childbirth, this study particularly focuses on complications and morbidity occurring during childbirth and the post-partum period. The reason for this is that, childbirth and post-partum maternal health care has been far less

focused on in studies of pregnancy (ante-natal) care. Also, Bangladesh has achieved much improvement in terms of ante-natal care coverage of the entire population compared with that of childbirth and post-partum care.

The justification of choosing to conduct this study in the lower socio-economic and upper socio-economic households of Dhaka is founded on discussions given in the following section.

## 1.2: The gap in maternal health care between rich and poor women

Having been considered a megacity[4] since 2001 (Hossain 2008, p. 1), Dhaka has a population of 11,875,000 , with an area of 1,464 square km and a population density of 8,111 per square km. (BBS 2011, p. 18). As the main politico-administrative centre of Bangladesh (Hossain 2007, p. 1), Dhaka has a concentration of domestic and foreign investment and massive rural-urban migration but with dramatically rising poverty and prolific growth of slums and squatters. In Dhaka, in 2009, there were 4,966 slums with a total population of 3,420,521, which is 37.4 % of the city's population (Angeles et al. 2009, p. 40). In the Dhaka City Corporation (DCC) area 60% of households are described as being in the low income category, 37% middle income and only 3% are considered high income households (UN 2010, p 4).

Due to the intensity of poverty which also results in a low level of nutrition and inadequate education, it is very likely that maternal morbidity will be very high in

[4] The term 'megacity' is frequently used as a synonym for words such as super-city, giant city, conurbation, and megalopolis. Megacities are defined as cities that were expected to have at least ten million inhabitants by the year 2000 (World Bank 1993).

Dhaka's slums (Uzma et al. 1999, p. 314). Fronczak et al. (2005, p. 273) listed in their study some of the self-reported post-partum morbidity in the urban slums of Dhaka. These are fistula, uterine prolapse, perineal tears, pelvic infection, fever or foul vaginal discharge, urinary tract infection, vaginal tract infection, secondary postpartum bleeding and leg neuropathy. Regarding health care seeking, Fronczak et al. (2005, p. 275) also reported that in spite of the close proximity of health centres within Dhaka city, 82% of deliveries occurred at home and 76% of them were attended by untrained traditional birth attendants. This health care scenario is no better than that of a rural area of Bangladesh, where 89.9 % of child delivery occurs at home (NIPORT et al. 2012, p. 58).

In contrast to the poorer sections of women, the better-off urban women receive high quality health care from the increasing number of private clinics in Dhaka, which provide maternal health care services at a very high cost. Moreover, an overuse of health services in private health clinics is now creating another concern among the better-off women, among health care providers and researchers. This overuse is related to the noticeable over-treatment, i.e., unnecessary clinical diagnosis and treatment during pregnancy and childbirth. According to existing literature in Bangladesh, one example of this over-treatment of richer mothers during delivery is that of resorting to caesarean sections (or CS)[5] well above the limit of between 5 and 15% prescribed by the World Health Organization (WHO) in terms of emergency obstetric care (EmOC) (Wardlaw and Maine 1999, p 26). For the poorer section of the population, the CS rate remains far below the

[5] Caesarean section is one of the components of Emergency Obstetric Care (EMOC) and often considered as a proxy indicator of women's access to health care for complicated delivery (NIPORT et al. 2009, p. 118).

prescribed limit, indicating their inadequate access to EmOC. Thus, there is a remarkable difference between the poorest and richest classes of women in terms of CS. In 2001 the rate of CS performed among the richest sections of the society was 11% compared with only 0.4% among the poorest wealth quintile (NIPORT et al. 2001, p. 56). Moreover, the prevalence of caesarean section as increased among the richest wealth quintile at a much higher rate (25.7%) than among the poorest wealth quintile, for whom it is only 1.8% (NIPORT et al. 2009, p. 188).

Many studies suggest that for the poor and illiterate women, treatment for maternal complications and maternal morbidity is often an unknown, fearful and difficult matter (Afsana and Rashid 2001; Wall 2012; Grimes et al. 2011). On the other hand, in many instances the urban, well-off women seek obstetric treatment such as CS to avoid labour pains or simply to be seen as modern in their use of healthcare, rather than for medical reasons (NIPORT et al. 2010, p.7). Further, the women in the richest wealth quintile in Bangladesh are three times more likely to seek medical care for complications compared with those in the poorest wealth quintile (NIPORT et al. 2012, p. 93). Thus, in Bangladesh the quantity and quality of maternal health care is highly contextualized in terms of socio-economic status of women in society. It is a right for all women regardless of their socio-economic status to have access to maternal health care according health needs, (AbouZahr 2003, p. 18) but in many cases, many women cannot exercise this right.

The reason that this study seeks to make a comparison between the women of lower socio-economic households and upper socio-economic households of Dhaka is that the socio-economic status of a woman affects her chances of accessing and receiving maternal health care, particularly in developing countries where an equitable health care system is yet to be set up. Socio-economically disadvantaged women have a disproportionate burden of maternal deaths and disabilities (Kunst and Houweling 2000, p. 297). The economic status of the woman, solely or in association with her education and empowerment status, acts as an

Influencing factor in her health care seeking behaviour. In addition, economic status plays a key role in determining how the health service providers respond to the expectations and needs of women seeking maternal health care (De Brouwere and Van Lerberghe 2001, p. 3). Economic status is one of the determinants of health care utilisation (Ahmed, Hossain and Khan 2010, p. 3), but poor economic status, along with low level of education and scientific knowledge often reinforces the cultural beliefs and practices that hinder the seeking of maternal health care.

Most of the studies on inequality in maternal health care have particularly focused on urban-rural differences, presumably because poor people are seen to live in rural areas and have low levels of education, lack of convenient transport and accessible health services nearby. There are only a very limited number of studies (Uzma 1999; Fronczak et al. 2005; Fronczak et al. 2007; Hossain and Hoque 2005; Moran et al. 2009) on maternal morbidity and health care in urban slums, such as those in Dhaka. Further, there are no studies on health care seeking behaviour of mothers of upper socio-economic households in urban areas. Economic inequality in urban areas can be deeper and more severe than that found in rural areas (Zaman and

Akita 2011, p. 21). Moreover, since developing countries are urbanising rapidly, inequalities within urban households and their consequences on maternal health care will become progressively more important (Houweling et al. 2007, p. 750). Keeping all the above points in mind, this study endeavours to understand the factors that influence the maternal health care seeking behaviour of women of lower socio-economic and upper socio-economic households of Dhaka city.

## 1.3: Health care seeking behaviour of mothers for childbirth and post-partum morbidity

Health care seeking behaviour is a complex issue involving a wide range of aspects of human lives. They range from very personal traits to societal and state level policy, which interplays between need and supply of health care. The existing literature endeavours to understand the determinants of health care seeking behaviour of mothers in urban and rural areas of developing countries. Among the well documented factors that are incorporated in the most health care seeking behaviour approaches or models are: demographic, socio-cultural and economic characteristics of people and communities, most particularly income and education (Anwar et al. 2008, p. 256); enabling factors like availability, accessibility and cost of services involved; infrastructure development, transport and communication (Shaikh and Hatcher 2005, pp. 50-51); geographical location of the residence of treatment requiring women (Sharma, Sawangdee and Sirirassamee 2007, p. 687); perception, beliefs and attitudes towards illness and treatment; and nature and extent of illness (Goodburn, Gazi and Chowdhury 1995, p 29).

However, these complexities of maternal health care seeking behaviour have mostly focused on the context of rural areas and poverty. Moreover, the complexities of health care seeking behaviour in an urban context, where low cost maternal health care facilities are located close to most people's residences, have not been adequately addressed either (Afsana and Wahid 2013, p. 2050). As mentioned before, the overuse of modern maternal health care by the richer sections of society, as manifested in the higher rate of caesarean section among them, is becoming a concern in the maternal health research, policy and implications (Ronsmans, Holtz and Stanton 2006; Koblinsky et al. 2006). Therefore, this thesis seeks to explore the perception, experience and practice of the mothers of upper socio-economic households that lead them towards an overuse of modern maternal health care and the concerns related with that.

## 1.4: Research Questions

The present study seeks to identify the differences and similarities in the health care seeking behaviour of the mothers from upper socio-economic and lower socio-economic households of Dhaka in terms of health care for childbirth and post-partum morbidity. In the light of this, and the background discussion presented above, the specific research questions of this thesis are formulated as follows:

1. What are the demographic and socio-economic factors associated with maternal morbidity among mothers in Dhaka?

2. How do the mothers from different socio-economic groups perceive motherhood, childbirth and maternal health care for childbirth and post-partum morbidity?
3. How do the lived experiences of mothers shape their perception and their actual health care seeking behaviour during childbirth and the post-partum period?
4. How does the health care seeking behaviour of mothers influence chronic post-partum morbidity?
5. What are the similarities and differences between the mothers from different socio-economic groups in terms of their health care seeking behaviour for childbirth and post-partum period?

## 1.5: Objectives of the study

To answer to these research questions, this study aims to address the following objectives:

1. To understand the socio-economic situation of mothers in which their maternal health care seeking behaviour for childbirth and post-partum illness is shaped.
2. To analyze the perceptions and experience of mothers childbirth and maternal health care of mothers from lower and upper socio-economic groups, influence each other and lead them towards a particular practice of maternal health care for childbirth and post-partum illness.

3. To understand how the health care seeking behaviour is shaped for chronic post-partum maternal morbidity.

4. To compare and contrast the perception and experience of childbirth, motherhood and maternal health care during childbirth and the post-partum period between the mothers of the lower socio-economic and upper socio-economic households.

## 1.6: Rationale for the study

It has been stated before that there is a lack of information on the perception, experience and care seeking behaviour of women for maternal morbidity. It has also been recognized in different studies that not enough efforts have been made to act upon maternal morbidity in order to free women from the burden of maternal illnesses. Improving maternal health is not only about reducing MMR, it is also about the overall improvement of maternal health before, during and after childbirth.

In spite of having low cost or free maternal health care facilities in close proximity of their residences, the poorer women of Dhaka are lagging far behind the richer women in terms of utilization of maternal health care services, including those for severe obstetric complications. As a result, a high concentration of post-partum maternal morbidity is evident among the urban poor mothers of Bangladesh (Ferdous et al. 2012, p. 155). Maternal morbidities, in most cases are preventable and treatable. Since the entire human rights agenda has human dignity as its core

value (Freedman 2003, p. 53), women with short or long lasting maternal morbidity suffer loss of human dignity in their society (Cook, Dickens and Syed 2004, p. 73). Thus, to improve maternal health, maternal morbidities in developing countries must be reduced. Moreover, as mentioned before, the poor-rich gap in maternal health care utilization is also wide. Aided by the proliferation of privately owned corporate modern maternal health care facilities, the richer section of the society is increasingly leaning towards the medicalized process of childbirth, whereas the mothers from the poorer section of the society are still staying away from such facilities, even for life saving obstetric care.

In order to develop policies, strategies and programs aimed at improving the maternal health of Bangladeshi women, it is very important to understand the underlying causes of why women do not get treated for their maternal health complications, and if they do get treated, what motivates them to do so. This question is especially relevant in the context of urban areas where maternal health facilities are fairly easily accessible in terms of distance and transportation, yet many women do not avail of these facilities. This is the basic rationale for the study. It is expected that the findings of the study will help improve maternal health care seeking behaviour of women and improve maternal health in Bangladesh.

## 1.7: Organization of the thesis

The thesis is divided into nine chapters. The first chapter provides an introduction and background to the problem, the research questions, objectives and the rationale for the study. Chapter Two presents a review of relevant literature based on which a theoretical framework is proposed. The method of data collection and analysis are presented in the Chapter Three. Chapter Four presents the socio-economic and demographic background and the maternal morbidity profiles of the mothers from lower socio-economic and upper socio-economic households of Dhaka selected for interview in this study. Chapter Five details the health care seeking behaviour of the mothers of lower socio-economic households by analysing their perception, experience and practice of maternal health care during childbirth and the post-partum period. Chapter Six focuses on the health care seeking behaviour of mothers who are suffering from obstetric fistula, considered as the worst form of maternal morbidity with long term sequelae. Chapter Seven discusses the health care seeking behaviour of mothers from the upper socio-economic households for their childbirth and post-partum care by analysing their perception, experience and practice of maternal health care during childbirth and the post-partum period. Chapter Eight synthesises the findings of Chapters Five and Seven to compare the perception, experience and practice of health care seeking behaviour of the two groups of mothers. Finally, Chapter Nine presents a summary of the findings of the study, suggestions for further research and recommendations for policy.

# Chapter Two

# Childbirth and maternal morbidity-A review of relevant literature

## 2.1: Introduction

The previous chapter provided a background for the research and explained the concept, prevalence and differentials in maternal morbidity and their causes and consequences in order to provide a clear picture of the problem of understanding the health care seeking behaviour of mothers for childbirth and post-partum morbidity. The maternal health care seeking behaviour for mothers in urban areas has rarely been discussed by scholars in the current literature. Keeping that in mind, this chapter aims to engage in a broad theoretical discussion of the factors influencing the maternal health care seeking behaviour of mothers. The theoretical discussion is based on a review of relevant studies on childbirth and women's health, and how the women, their families and healthcare providers view these events according to their socio-economic position within the society. This chapter also examines these women's utilization of maternal health care services (over-use or under-use). Finally, a conceptual framework on maternal health care seeking behaviour for maternal morbidity during and after childbirth has been developed and discussed to determine a premise on which this thesis is based.

## 2.2: Maternal morbidity and maternal health care: poor-rich differentials

The pattern, duration and treatment of maternal morbidity vary largely according to the socio-economic environment in which a mother lives and the cultural beliefs and practices she holds regarding childbirth and maternal health. For example, poorer mothers are more likely than richer mothers to suffer greatly from the morbidity that occurs due to delayed or no treatment of obstetric complications such as obstetric fistula and uterine prolapse or a lack of post-partum care. The urban, wealthier mothers are more likely to report complications and illnesses during pregnancy and childbirth (Bhatia and Cleland 1994). A large poor-rich gap in receiving maternal health care for maternal morbidity is apparent in different countries (Kunst and Houweling 2000, p. 297).

It is important to study the maternal health care seeking behaviour of women because there is a continuum of adverse pregnancy events. In this context, Geller et al. (2004, p. 940) argue that the probability of a woman progressing along the morbidity-mortality continuum is directly related to the preventability of the event, which in turn depends on their treatment and the level of care sought and/or received. The general assumption is that poorer mothers with low levels of education and information experience more problems during pregnancy and childbirth than do wealthier mothers, as the former do not have adequate access to, or information about available health care. However, Bhatia and Cleland (1994) argue that this general assumption might not be accurate in every respect. Rather,

the authors in their study found that the richer and well educated mothers reported more problems during the ante-natal period, because they are able to have their health monitored regularly through ante-natal care, and take precautions to minimise obstetric risks. In comparison, the poorer mothers may end up with more unpredicted complications leading to post-partum maternal morbidity or maternal death due to their inadequate utilization of ante-natal care and skilled assistance at childbirth.

Variations in maternal morbidity have also been studied in association with other socio-economic and demographic factors, namely education, women's autonomy, age and birth interval. Razzaque et al. (2005, p. S49) showed a higher prevalence of maternal morbidity such as pre-eclampsia and high blood pressure among women with a short interval between pregnancies (for example, less than 24 months). However, similar levels of morbidity have also been found among mothers with very long birth intervals, for example, over five years (Eastman 1984; Conde-Augdelo 2000).

According to the 2010 Bangladesh Maternal Mortality and Health Care Survey (NIPORT et al. 2012, p. 51), 31.2% of the women from the poorest wealth quintile receive ante-natal care from a medically trained provider,[6] compared with 81.9% of women from the richest wealth quintile. In that survey, the complications that were

[6] Medically trained provider includes qualified doctor, nurse, midwife, paramedic, family welfare assistance, Community Skilled Birth attendant (NIPORT et al., 2012, p. 51).

typically reported by the mothers were symptoms of pre-eclampsia, excessive bleeding, high fever with smelly discharge, convulsion/fits, obstructed/prolonged labour, and retained placenta (NIPORT et al. 2012). A distinct variation is apparent between the mothers of the poorer and richer wealth quintiles in terms of their experience of complications and treatment sought. In this regard, Table 2.1 presents a comparative picture of seeking treatment of for obstetric complication according to the wealth and education level of the mothers. It indicates that the richer and educated mothers seek treatment for complication at a much higher rate that their poorer and less educated counterparts.

**Table 2.1: Percentage of mothers with complications and seeking treatment for complications according to economic and educational background**

| **Mothers** | **Poorest wealth quintile** | **Richest wealth quintile** | **No education** | **Secondary school +** |
|---|---|---|---|---|
| Number of mothers who had complications[7] | 1,953 | 1,778 | 2,041 | 932 |
| Percentage of mothers who sought treatment[8] for complications | 60.5 | 76.5 | 59.2 | 81.9 |

Source: NIPORT et al. 2012, p. 85

Thus, it is apparent that those who are being monitored regularly during pregnancy will be able to readily identify any risk of maternal morbidity and take necessary precautions to treat or mitigate those risks. However, as mentioned before, the

[7] The complications that have been reported by the mothers participating in the BMMS survey are symptoms of preeclampsia, excessive bleeding, high fever with smelly discharge, convulsion/fits, obstructed/prolonged labour, retained placenta (NIPORT et al. 2012, p. 84).

[8] Includes those who brought medicine to treat the complication.(NIPORT et al. 2012, p. 85).

poorer mothers tend to suffer undiagnosed from long term maternal morbidity such as obstetric fistula, uterine prolapse and anaemia. These conditions are more likely to have occurred because of a combination of a lack of skilled birth and timely emergency obstetric care (EmOC).

Houweling et al. (2007, p. 746) showed that wealth and maternal health care are linked in the wealth hierarchy across many developing countries, with each progressively poorer group receiving progressively less care. Professional delivery care among the poor is below 30%, but it is 80% or more on average for the richest wealth quintiles. Similarly large gaps have been observed in Zambia, where 90% of the richest women receive medical assistance at birth, but only 20% of the poorest women receive such care (Kunst and Houweling 2000, p. 296). In Peru, this gap is six-fold between the richest and the poorest wealth quintiles (Filippi et al. 2006, p. 1,535).

The uptake of maternal health care varies even within the same socio-economic group. For example, in places where maternal health care is freely available in health facilities nearby, the poor mothers are more inclined to receive health care for children, family planning and also for ante-natal check-ups, than mothers who have farther to travel to receive care. However, where childbirth is concerned, poorer mothers are largely found to be hesitant about receiving delivery care from health facilities. One reason for this could be the cultural connotation of childbirth, which is discussed in detail the latter part of this chapter. Kunst and Houweling

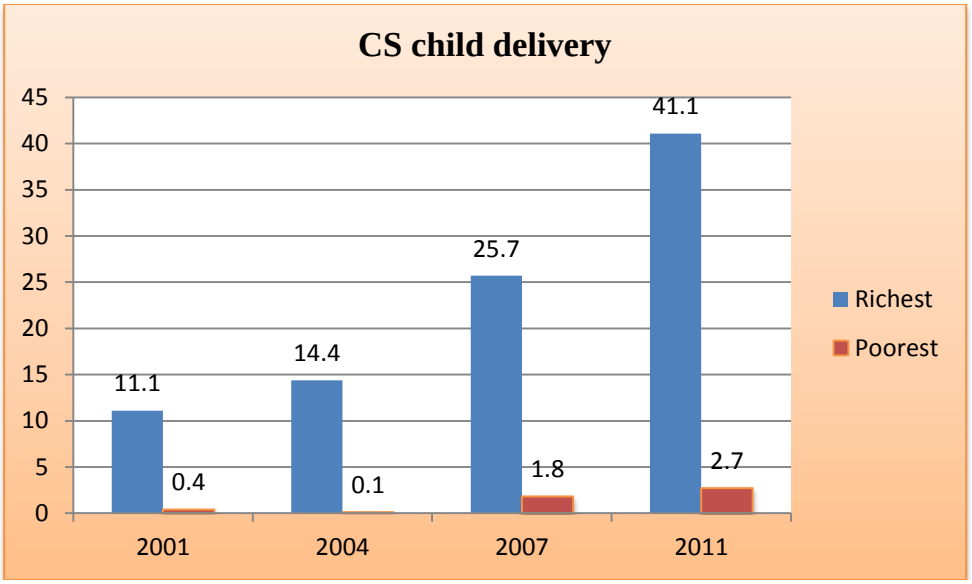
(2000, p. 296) maintained that cultural dynamics, along with economic factors, may be more important determinants of the uptake of maternal health care than any other form of care.

A large inequality in maternal health care between the rich and the poor in Bangladesh has been reported in a number of studies. Matthews et al. (2010, p. 2) have shown that urban inequality in the use of health care services has increased in Bangladesh since 1993. While by 2007, rural people started to benefit from increased access to health services, there has been hardly any progress in minimizing the poor-rich gap in cities with many slum settlements. However, it is pleasing to see that the percentage of births attended by skilled birth attendants, which is considered as the "gold standard for diagnosis of maternal morbidity" (Koblinsky et al. 2012, p. 126), has been increasing in Bangladesh (NIPORT et al. 2013, p. 132).

Along with the increasing rate of skilled birth attendants, inequality in the rate of caesarean section (CS) for childbirth is also greatly increasing in Bangladesh. Anwar et al. (2004, p. 131) stated that among all the segments of maternal health care, inequality in CS is particularly high. As said before, the recommended population based rate for CS should lie between 5 to 15% of all births (Wardlaw and Maine 1993, p. 260; Anwar et al. 2004, p. 131). Anything below 5% indicates that a substantial proportion of women do not have access to potentially life-saving surgical obstetric care. Although the overall CS rate in Bangladesh is 12.2% per

year, the rate vary according to the type of facilities as well as the socio-economic context, a mother belongs to. The Figure 2.1 presents such variation in CS between the richer and the poorer women in Bangladesh.

**Figure 2.1: Poor-rich gap in CS in Bangladesh, 2001-2011**




Source: NIPORT et al. 2003, NIPORT et al. 2005, 2009, 2013

Figure 2.1 shows that in 2011, while the rate of CS delivery for the mothers from the richest wealth quintile is 41.1% that for the mothers from the lowest wealth quintile is still far below the minimum of 5% recommended. Over the years, the rate of use of CS for childbirth has increased, however, at the same time the gap between the rich and the poor in utilizing CS has also increased. As stated by Naznin, Hoque and Abdullah (2014, p. 104), over the last decade, 60% of the population that makes up the lowest three wealth quintiles in Bangladesh had a CS rate which is far below the minimum recommended rate of 5%. If the highest CS rate recommended by the WHO is 15%, then the CS rate of 41% among the mothers belonging to the highest wealth quintiles implies that among 26% of these

mothers, CS has been resorted to for reasons other than emergency obstetric care (EmOC). This raises concerns that CS has been used not as an emergency life-saving measure for mothers and their babies.

Similar significant poor-rich inequalities in skilled birth attendance and CS exist in some other countries as well. In Cambodia and Nepal, a rate of childbirth with skilled attendants of over 80% for the urban rich co-exists with rates of around 20% for women in the poorest wealth quintile (Matthews et al. 2010, p. 2). A significant poor-rich difference in use of maternal health care is even found where health care services are provided free (Anwar et al. 2004, p. 130). The possible reasons for this could be practical, like transportation difficulties, lack of knowledge, reference etc., as well as cultural preference for home based childbirth, and perceived low quality of health facilities that tend to affect poorer sections of the community more than the better-off.

Thus a large inequality in maternal health care is evident in many developing countries of the world. This inequality leads to mothers, who are deprived of appropriate maternal health care during pregnancy, childbirth and the post-partum period, being more at risk of developing conditions that lead to long-term maternal morbidities. Explanations of the poor-rich gap in maternal health care goes beyond the economic ability or inability of the mothers and households. Rather, it requires an understanding of the health care seeking behaviour of mothers in any given socio-economic condition.

## 2.3: Maternal health and health care in urban Bangladesh

As the growth in urban populations surpasses that in rural populations around the world, there would be more births taking place in urban areas than in rural areas (Matthews et al. 2010, p. 1). A substantial portion of the growth in urban areas would be in the urban slums. However, health and social services in urban areas have not kept pace with this urban population growth (Matthews et al. 2010, p.1). In Bangladesh, in the past forty years, the proportion of the urban population has increased from 5% to 28% (Afsana and Wahid 2013, p. 2,049). As evident from literature, urban health care is characterized by:

- Proliferation of private clinics (Matthews et al. 2010, p. 3). In many urban areas, due to an absence of public health services in close proximity, poor urban women are more likely to use private rather than public services. However, quality private clinics being expensive are not readily available to the poor who usually have access only to cheaper, less qualified maternal health care providers (Matthews et al. 2010; Wahed, Moran and Iqbal 2010).

- The urban health care system is usually monetized, as opposed to that of rural services across the world. As Montgomery (2009, p. 8) stated,

> Fee-for-service arrangements are generally characteristics of urban health care, whereas, rural services are often ostensively provided free (or made available for nominal fees) at public health-posts and clinics. In the more monetized urban economy, the urban poor without cash in hand find themselves unable to gain entry to the modern system, of hospitals, clinics and well trained providers.

- The urban health care system is characterized by diversity of health care, ranging from traditional healers including Traditional Birth Attendants (TBA) or sellers of drugs in street market to well-trained surgeons in ultra-modern health facilities. Moreover, in the context of various countries, the range of health care providers varies greatly.

Given these characteristics of urban health care, knowledge of the provision of geographic accessibility of maternal health care might not be sufficient in understanding maternal health care in urban areas. Rather, an appreciation of the urban culture and lifestyle of the poor and the rich urban dwellers in terms of their maternal health care seeking behaviour will provide a better comprehension of the maternal health care circumstances of urban poor and rich women. Khan, Grübner and Krämer (2012, p. 265), argue that the health care system in Bangladesh is generally biased to the rich and the urban elite. Poor people face many more barriers than the rich. Private health care services are escalating in developing countries without proper registration and supervision, and with high concentration of medical experts to render services in those high cost private facilities. On the other hand, the quality of maternal health care in public and low cost health services where poorer mothers tend to go, is being jeopardized due to many reasons, among which are the very low level of allocation of government funding and poor management system (Afsana and Wahid 2013, p. 2049), poor infrastructure and shortage of medical practitioners (Schmidt et al. 2010, p. 99). Besides, there are governance issues in health care delivery which affect the quality and the utilization of health care in Bangladesh (Islam, PhD work in progress).

The literature on maternal morbidity and health care in the urban context in Bangladesh has concentrated on the poorer populations of prominent urban informal settlements in Dhaka (usually known as 'slums'). The accessibility of health care services for slum dwellers in childbirth practices, and the prevalence of post-partum morbidity are the main focus of the studies. One such pioneering study by Uzma et al. (1999) explored the patterns of birth related illness and associated health care seeking behaviour of the mothers, and their beliefs towards their illness and services in the slums of Dhaka. This study revealed the poor living standards of mothers in slums in terms of housing, sanitation and health services, as well as education and awareness, are putting them in the worst maternal health situation. But in spite of several impediments in seeking health care, women in the studied slums were "surprisingly active" (Uzma et al. 1999, p. 319) in seeking health care services from whatever was available.

In a prospective community-based study, Fronczak et al. (2005, p. 272), identified the proportion of women who had delivery related and post-partum morbidities. The authors found that low income urban women in Dhaka are at a high risk of morbidity and mortality associated with childbirth, with an increase in post-partum (75%) morbidity (Fronczak et al. 2005, p. 272). The authors also found a high incidence of home based childbirth even where there was excessive bleeding, a symptom of pre-eclampsia or premature rupture of the membrane, and also in cases where emergency obstetric care was available at close proximity to their residence (Fronczak et al. 2005, p. 277). Fronczak et al.'s findings may prompt other researchers to search for the underlying factors of why women are not seeking

childbirth assistance from skilled health personnel or in health facilities even when they are knowingly suffering life threatening complications. In another study, Fronczak et al. (2007, p. 480) explore the type of delivery care providers, their training and experience and post-partum morbidity in Dhaka slums. The authors found no significant difference in post-partum morbidity by birth location. However, some harmful practices were found to have been practiced widely by home based Traditional Birth Attendants (TBA) that could have led to an increased risk of post-partum morbidity.

Nahar, Banu and Nasreen (2011) measured the women focused development intervention of MANOSHI (acronym for Mother, Neonate and Child in Bangla)[9] on accessing EmOC in urban slums. The authors found the major causes of delays by mothers in making the decision to seek EmOC for obstetric complication was the fear of medical intervention, followed by "inability to judge the graveness of complications" (2011, p. 6). However, they argued, "considering financial assistance provided by MANOSHI, irrespective of type of complications, the time taken for decision-making was significantly reduced" (2011, p. 9). Hossain and Hoque (2005, p. 473) identified the unofficial cost of delivery in public hospitals

[9]*MANOSHI* (acronym for mother, neonate and child in Bangla) has been implemented by an indigenous non- government organization (NGO), BRAC, since 2007 and funded by the Gates Foundation for five years. It aims to reduce the morbidity and mortality of the mothers, newborns, and children in urban slums of Bangladesh through development and delivery of an integrated, community-based package of essential health services. In the short run, the programme seeks to create demand for services in the community through increasing knowledge, building capacity of the service providers (including capacity for home based delivery and neonatal care), and develop effective referral linkages for emergency obstetric care (EmOC)". (Ahmed, Hossain and Khan 2010, p. 664)

and traditional beliefs among the mothers regarding childbirth as the main factors impacting on why women in urban slums are less inclined to give birth in a hospital.

Another important aspect of urban maternal health care, as mentioned earlier particularly for the poorer mothers, is seeking health care from Unqualified Allopathic Practitioners (UAP).[10] Researchers also identified, that in urban Dhaka, UAPs provide health care to a large number of women for childbirth complication (Wahed et al. 2010, P. 4) and perceived post-partum complication (Uzma 1999). These health care providers are easy to access for poor people, as seeing them costs less money than accessing the other health care options, they allow easy access with convenient hours, they respond to house calls and their use is widely accepted within the community (Wahed, Moran and Iqbal 2010, p. 1). Moran et al. (2009) studied the practices of newborn and post-partum care of mothers in urban slums in Dhaka, and found a number of traditional practices that are followed by mothers and their households for the care of newborns and mothers, like cutting and tying the cords, massaging mustard oil into the baby etc. While some of the practices are useful, the authors found that some might need to be changed for improved maternal and neo-natal health. Moran et al. (2009) also highlighted the lower level of social support in urban slums compared to rural areas, where the newborn baby and mother are left alone a few hours after delivery. The authors argued that this could be detrimental to the health of mothers and the baby.

[10] UAPs are generally either untrained or have limited training in safe motherhood along with other disease. They are commonly referred to as rural medical practitioners, medicine sellers, injectionists, injection doctors, medicinemen, quacks, *pallichikitsok* or village doctor (Wahed, Moran and Iqbal 2010, p.4).

Recognizing the dearth of comparative data on development measures between slum and non-slum areas, Khan and Kraemer (2008) undertook a cross-sectional study to identify differences in some public health related variables between slum and non-slum parts of the urban area of Bangladesh, and found that in terms of socio-economic factors like income, Body Mass Index (BMI), exposure to mass media, education and social security, as well as with health related indicators like knowledge of HIV, ante-natal care (ANC) services, child delivery care services, people in slums are in a worse condition than the poor people of non-slum areas.

However, all the studies discussed above focus on the poorer households, and particularly poorer households in the slums of urban Dhaka. The poor-rich gap in the context of Dhaka, and the health care seeking behaviour of the richer women, who are more likely to depend on costly privatized medical professionals for maternal health, have hardly been addressed. No studies have been found which discuss the perspectives and experiences of childbirth and maternal health of mothers from the upper socio-economic households of urban Bangladesh. The following section will discuss the maternal health care seeking behavior, and its different models, frameworks and associated factors as discussed in different literature.

## 2.4: Maternal health care seeking behaviour

Studying health in relation to human behaviour started along with the primary health care (PHC) approach in the late 1970s. From then on, through different

research and training, several approaches to capturing people's health care seeking behaviour have been developed. In general, these approaches acknowledge that understanding human behaviour is a prerequisite to changing health care seeking behaviour and improving health practice (Hausmann-Muela, Ribera and Nyamango 2003). Starting with the most frequently used descriptive type of approach — KAP (knowledge, attitude and practice), during the 1980s, studies in this field have received much attention resulting in updated and explanatory models e.g., Focussed Ethnographic Study (FES), Health Belief Model (HBM), theory of reasoned action and theory of planned behaviour, health care utilization model, and pathway models (Hausmann-Muela, Ribera and Nyamango 2003).

With the objective of understanding health care seeking behaviour of mothers, a number of conceptual frameworks have been developed; however, in most cases those frameworks have focused on maternal mortality. Winikoff (1988) presents one such framework with a holistic concept of maternal health, where maternal death has been shown to be the result of lifelong and intergenerational experiences of poor health and poor health care. Ill health can be extended from mother to child as a result of the complex interplay of socio-economic, cultural and biological factors. A holistic view of maternal mortality is also presented by Nanda, Switlick and Lule (2005), who suggested a pathway to improve maternal health outcomes, dependent upon a complex interaction of factors at different levels, e.g. government policies and actions, health system and other sectors, household and communities. Using this pathway as a guide, Nanda, Switlick and Lule (2005, p.18) collected

"promising approaches"[11] in different countries to reduce maternal mortality under a number of themes: government policies and actions; health systems and health financing; access to health services; capacity building; quality of care; community involvement; monitoring and advancing progress; and partnership and collaboration.

McCarthy and Maine (1992) developed a framework for analysing the determinants of maternal mortality and morbidity. In their view, maternal death and disability (morbidity) is the result of two immediate prior events: pregnancy and development of a complication, or worsening of pre-existing complications, due to pregnancy. These two occurrences are again influenced by some intermediate and distant factors. The intermediate factors are health status, reproductive status, access to health services, health care behaviour, and use of health services. Although this framework seems to particularly address the incidence of pregnancy and pregnancy related complications, it actually embraces numerous broad-ranged socio-cultural factors such as distant factors. This is how this framework encompasses the complexity of maternal mortality and maternal morbidity.

Thaddeus and Maine (1994) provided a very influential framework centring on the importance of timely treatment of obstetric complication, which is considered to be the cause of 75% of maternal deaths[12]. The authors focus on those factors that

[11] Promising approaches refer to "overall programs, specific practices, research practices, research efforts, complex or discrete interventions, innovations or other strategies to improve maternal health outcomes" (Nanda, G, Switlick, K & Lule 2005, p. 2).

[12] The five direct obstetric causes are haemorrhage, obstructed labour, infection, toxemia and unsafe abortion cause 75% maternal death (Freedman and Maine 1993, p. 155).

affect the interval between the onset of obstetric complication and the outcome. They identified three phases of delay occurring at the three stages: delay in making a decision to seek maternal health care (Phase 1 delay); delay in identifying and reaching a health facility (Phase 2 delay); and delay in receiving appropriate and adequate treatment after reaching the medical facility (Phase 3 delay) (p. 1,093). These delays are, in turn, influenced by different factors. Phase 1 delay is affected by the demand side (socio-economic and cultural factors) and supply side (accessibility of facility and quality of care) factors. Phase 2 delay is affected by accessibility of care (e.g. distribution and location of health facility, travel time, availability of transport, cost etc.) and finally Phase 3 delays occur due to poor staff facilities at the health centre, lack of equipment and inadequate management (Thaddeus and Maine 1994, pp. 1,093-1,105). The three-delay model has now taken a central position in maternal mortality reduction strategies in many countries. The inclusion of indicators like travel time to a health centre and the decision to seek maternal health care are routinely included in surveys such as the Bangladesh Demographic and Health Surveys and Bangladesh Maternal Mortality and Health care surveys. In Bangladesh, the Health and Population Sector Program (HPSP) has adopted this three-delay approach (NIPORT et al. 2003, p. 1). Killewo et al. (2006, p. 410), in their study undertaken in Matlab, found the first delay as the most important barrier for accessing care for serious illnesses. Failure to recognize the graveness of illness and lack of money for transport were important reasons for delay in seeking care.

The models have been more readily used, quite effectively, for reduction of maternal death in different countries. The sequlae of maternal morbidity, which

means the women who survived maternal conditions that could result in death and have been left with some complication or illness, are not adequately addressed in these frameworks. Understanding the health care seeking behaviour for maternal morbidity during and after childbirth requires not only understanding of the mother's socio-economic condition in terms of education, income, age etc., but also of the woman's position in her family, society and community in the historical and present context, as well as the gender norm of the health care receivers and providers. It is also important to understand how the view towards childbirth is constructed in a specific context and how this view evolves over time as a result of many intervening factors.

The following sections discuss some of the issues that are deemed essential to understanding maternal health care seeking behaviour.

### 2.4.1: Socio-economic status of women and autonomy

Women's socio-economic status has always been considered as one of the most influential factors in shaping the maternal health care seeking behaviour of mothers. In fact, this behaviour reflects the socio-economic status of women (Obermeyer 1993), for example whether they get to spend money on maternal health or whether they get to make informed decisions (WHO 1998). The most important indicators of the status of women which have the potential to improve health status are education and women's access to income earning (Obermeyer 1993; Chakraborty et al. 2003). Education, either directly or through a multiplicity of mechanisms, like changing marriage patterns, improving access to knowledge about illness and rights of women, operates to improve their health status

(Obermeyer 1993, p. 362). Furuta and Salway (2006, p.7) found women's secondary education was strongly associated with greater use of health care. Previously in Table 2.1, we have seen the positive association of women's education and treatment sought for childbirth complications and post-partum illness. The second prior issue is women's participation in income earning activities, as women who are involved in gainful employment are more likely to use modern health care services to treat complications during pregnancy (Chakraborty et al. 2003, p. 333).

The discussion of women's socio-economic status is often accompanied by women's autonomy in shaping maternal health care seeking behaviour. The dimensions that are commonly used in understanding this are women's freedom of movement, discretion over earned income, decision making related to economic matters, freedom from violence or intimidation by husband, and decision making related to health care (Fotso, Ezeh and Essendi 2009, p. 3; Dharmalingam 1996). Fapohunda and Orobaton (2013, p. 10) define women's autonomy as women's viability, visibility and worth, and is manifested in their ability to participate in decision making, owning property, being able to overcome inequality perpetuating tendencies and maintaining control over their own sexuality. Gabrysh and Campbell (2009, p. 8) included the women's position in the household, financial independence, mobility and decision making power regarding one's own health care as factors with associated women's autonomy. In their study in 31 developing countries of the world, Ahmed et al. (2010) introduced 3Es (economic, educational and environmental status) as components of women's autonomy, and found their

direct linkages to the uptake of the most basic material health services, like ante-natal care and skilled attendance at birth,

The general assumption about women's autonomy and maternal health care is that autonomy of women leads to improved health care seeking behaviour and, subsequently, improved health outcomes for mothers. However, there are a number of studies that contradict this assumption, if not with all dimensions of women's autonomy, then at least with some. For example, the study of Fotso, Ezeh and Essendi (2009, p. 5) in Kenyan informal settlements found "utilisation of maternal health service for child delivery is not enhanced by high levels of women's overall autonomy, freedom of movement or decision making." Similar kinds of conclusions can also be found elsewhere (Riyami et al. 2004; Ghuman 2003), particularly in African and Asian developing countries. However, some other studies (Bloom, Wypij and Gupta et al. 2012) found a positive relationship between women's autonomy and maternal health care seeking in the context where free of charge maternal health facilities are in close proximity to the residence of mothers. Thus, it can be assumed that as in urban areas health facilities are in close proximity, women's autonomy might be important factors to determine women's maternal health care status. Other studies also indicated that in order to reap the benefit of women's autonomy for women's health care, conducive situations like education of the mother, discussions with the husband (Fotso, Ezeh and Essendi, 2009) and economic prosperity (Fapohunda and Orobaton 2013, p.10) need to occur.

A wide range of studies has been undertaken on various dimensions of women's autonomy and maternal health care behaviour, however, mostly in the rural and poorer households. Moreover, in those studies women's autonomy has been considered in creating demand for maternal health care from the mothers and their households' perspectives. Yet to be explored is whether and how women's autonomy impacts the health care experience of mothers while receiving care from health facilities. In addition, whether richer women being a part of rich and educated households can make autonomous decisions regarding their childbirth and related health care has not been fully investigated.

### 2.4.2: Construction of motherhood, illness and maternal health care

As mentioned before, childbirth events are highly embedded in the specific context of a society. The concepts of 'motherhood' and 'maternal illness' are also viewed and explained differently in different societies. Health care related to childbirth and associated morbidity is also shaped by the notion of motherhood and maternal illness embedded in the context of the environment. In every society, the symptoms, pains and weakness considered as 'being sick' are shaped by cultural and moral values, experienced through interaction with members of one's immediate social circle and visits to health care professionals, and influenced by beliefs about health and illness (Lorber and Moore 2002, p. 2). Oakley (1984) described how the concepts of childbirth and motherhood have been viewed and defined differently in different societies, and argued that the "meaning of childbirth is interlocked with a society's attitudes towards women" (p. 10). Stating that motherhood is an 'institution', Oakley further argued that "the institution of

motherhood is the way women become mothers in industrialized society today" (p.11).

Similarly, maternal health care is largely shaped by the notion of how childbirth is considered in relation to women's health. The different concepts of motherhood in ideology and in practice put women in a peculiar position in society, which ultimately affect maternal health. On one hand, mothers are romanticized as life giving, self-sacrificing and forgiving, and as powerful with the spirit of motherhood, while on the other hand, they are powerless, subordinated to the dictates of nature, instinct and social forces beyond their awareness (Ram and Jolly 1998, p.11). Afsana and Rashid (2009, pp. 124-125) argue that the construction of childbirth has created disparities and inequities for women in accessing obstetric care. For example, the authors maintained that the silent endurance of labour pain has been valued in Bangladeshi culture for a long time, and this silence brings a self-pride to mothers (Afsana and Rashid 2009, pp. 124-125). However, the irony is that in rural areas and in the poor households this silence may keep the mothers from divulging any issues, which means they are not privy to health care information that they might need to save their life. In addition to that, existing poverty and lack of scientific knowledge in society provides for misinterpretation of illnesses and misguided blame on the mother herself for maternal morbidity.

Conversly for the urban based richer women, childbirth is commonly construed as an illness episode that is expected to be treated under medical supervision. These

women are more likely to link childbirth with something uncontrollable and unpredictable (Wijma, Wijma and Zar 1998), for which they prefer to follow bio-medical process of childbirth. Bio-medical processes of childbirth emphasize pathology that is diagnosed and treated, as argued by Hunter (2006, p. 120) under the Cartesian Principle in which mind and body are considered separately. This principle also views the body as a machine that is fixed by medical intervention if broken. There is hardly any space for emotive language and contextual information in this principle.

The construction of childbirth in this way, as argued by Fisher, Hauck and Fenwick (2006, p. 66), "provides an intervention point for medical professionals and medical technology that supposedly transforms the uncontrollable natural process of birth into a relatively predictable and controllable technological phenomena". This view is also associated with the behaviour and skills of the professional providers of health facilities who may not be tolerant of the specific cultural beliefs and practices of childbirth. In contrast, richer, often better-educated women and their families may have a more modern world view, greater identification with the modern health care system, greater confidence in dealing with officials, and greater ability and willingness to travel outside the community, all of which may facilitate use of professional maternity care (Houweling et al. 2007, p. 750). On the contrary, as Houweling et al. argue, poor women see childbirth as a 'non-illness' event, and as they associate health facilities with treating illness, they may prefer TBA Birth Attendants or family members for childbirth.

Thus, the concept of childbirth is constructed differently for the poorer and the richer mothers in their respective socio-economic context. The health care associated with childbirth also takes shape along the line of how childbirth is constructed. Understanding health care seeking behaviour in a comparative context (for example, lower and upper socio-economic), requires understanding the different contextualisation of childbirth.

### 2.4.3: Quality concern in health care facilities

Women's socio-economic position, interpretation of childbirth and illness, as well as the condition of the health facilities, all contribute to shaping the maternal health care seeking behaviour for maternal morbidity. In addition to that, services provided in a health care centre are equally as important to the cause as well as the cure for maternal morbidity. The quality of care provided in the health facilities and the experience a mother gets largely influence her subsequent visits to health facilities, regardless of the socio-economic context. Bruce (1990, p. 64) developed a framework of quality in health care, which included six elements: choice of methods; information given to clients; technical competence; interpersonal relations; follow up mechanism and appropriate collection of services. Bruce argued that all six elements of quality of care impact upon the knowledge, satisfaction and health of the care receiver. Although Bruce developed this framework in the context of family planning health care, the elements could be equally applicable to the other segments of health care, particularly related to maternal and reproductive health. In different studies, the quality of maternal health care and women's perception of it also tend to reflect these six elements. Poor

quality hospital service is one of the factors that are strongly related to a poor maternal health outcome (Goodburn, Gazi and Chowdhury 2003, p. 26; Acharya and Cleland 2000, p. 228). There are some other important things that can be raised as quality concerns in health facilities, including social and hierarchical distance, way of communicating between women and health personnel, perception of care providers to women in general and the mother's illness in particular, and the official and unofficial costs involved in health care.

Mothers receiving care perceive quality of health facilities in many different ways, partly influenced by their respective socio-economic position. In studies, women are found to report dissatisfaction with rude, negligent behaviour of staff in health facilities, thus preferring the care of a TBA or relative (Gabrysch and Campbell 2009, p. 9). In some cases, quality is perceived as hygiene with regard to health facilities, availability of drugs and equipment (Achariya and Cleland 2000, p. 225), and to some people, waiting time (Griffiths and Stephenson 2001, p. 349). WHO (2007, p. 28) reported that it would often appear that being poor and a woman can be the reason for receiving poor services in health facilities and poorly explained reasons for procedures, compounded by the view sometimes held by health workers that women are ignorant. Thaddeus and Maine (1994) showed in their three delay framework how perceived quality of care like long waiting time, availability of supplies, consistency with local belief, and maintenance of privacy impact on the decision associated with seeking health care for childbirth and associated complications.

Depending on the view towards childbirth and related socio-economic conditions mothers experience quality in different ways. For example, for the poorer women in a developing country, apart from the distance and cost factor, unofficial user fees (Afsana 2004), disregard by the medical professionals to traditional childbirth practice (Afsana 2005), social distance between the professional and themselves, and complicated institutional procedures are all found to be matters of concern. Afsana (2004, pp. 177-178) showed how cost (both official and unofficial) incurred at every step of facility-based obstetric care makes mothers and households even poorer, resulting in them refusing to access facility based obstetric care. Parkhurst and Rahman (2007, p. 397) in their study on the perception of CS child delivery in Bangladesh, showed that

> Having a CS almost always involved paying to be a 'private' patient in a doctor's private clinic, with high fees charged. Yet nurses and midwives in public hospitals often received tips or small payments from women who delivered in the labour wards. In some cases, pregnant women who attend services could be caught in a struggle between midwives and doctors who may both be looking to supplement their income.

In another article, Afsana and Rashid (2001, p. 83) identified some crucial behavioural traits in their study in BRAC Health Centre (BHC) between the birthing mothers and BHC staff. For example, inadequate cultural understanding and dismissive attitudes of the health care providers towards poor women are common behavioural issues that may discourage mothers to seek care for maternal illness.

It has been mentioned before that the urban richer mother considers childbirth more of a medical event and follows the advice or direction of the medical professional.

The health care service provided to them might be viewed and considered differently than that of poor mothers. This could also be because, due to the monetary affluence, the richer mothers are treated better in the health facilities than the poorer mothers. Houweling et al. (2007, p. 750) state, in this regard, that professional providers in health facilities treat poor women with less consideration than they do the richer, more educated women. This difference in treatment is likely to dissuade one group of mothers (poorer mothers) to seek care from health facilities for childbirth and post-partum issues, whilst persuading other groups (richer women) to access these services.

The social and authoritative distance between the healthcare providers and doctors is another big concern that contributes to shaping health care seeking behaviour. Especially, when it is a matter of childbirth, women need extra support both mentally and physically, not only at home but also when they are in health facilities. At a health facility, there is more likely to be some clash in terms of beliefs, rituals and practices that a mother holds regarding childbirth, with those associated with the medicalized process of childbirth (Afsana 2005), as the bio-medical process of childbirth tends to reject traditional ideas and practices and sets a specific medical standard which holds a dominant position in most societies (Afsana and Rashid 2000, p. 74). Thus, it is obvious that some distance between the health care receiver and providers will exist apparently as well as inherently. While richer and more educated mothers can adapt to this distance faster, for the poorer, less educated mothers it becomes a challenge to adapt. t. Afsana and Rashid (2000, p. 75) stated “the knowledge of bio medicine, however, stands in apposition of cultural authority and plays a dominant role”. This dominant role that “makes the

care receiving mothers feel powerless and disengaged from the birth process, however, is taken for granted" (Afsana and Rashid 2000, p. 75). The authors also claimed that in many cases women were not provided with enough explanation and information about what was being done to their body. All of this results in a wide gap in the relationship between health providers and birthing women. However, as argued by Houweling et al. (2007, p. 750), "poorer women tend to stop using traditional maternity care in contexts where medically trained, accessible, affordable and good-quality professional care becomes available, though they may be slower to adopt such care than rich women".

### 2.4.5: Use and overuse of maternal health care services

So far, we have seen that poorer mothers in some countries, including Bangladesh, are less inclined to seek obstetric care from health facilities for various reasons. This may put them at risk of developing a lifelong illness or condition. In comparison, a large number of rich women across the world welcome surgical interventions in childbirth even if it is not strictly necessary. Many study findings suggest that for the poor, illiterate mothers, treatment for maternal complication and maternal morbidity is often an unknown, fearful and difficult to access world. However, in many instances for the urban well-off women some obstetric treatments, particularly caesarean section (CS), are a matter of responding to the modern delivery practice trend or that of avoiding delivery pain. This section will discuss these two opposite tendencies, among the poorer and richer mothers, particularly in the context of performing CS childbirth.

Anwar et al. found that in Matlab, indicators of CS seemed to be more socio-economic rather than medical, as most CS operations took place in private sector facilities and were used mainly by well-off families (2008, p. 257). On the other hand, the fear of treatment for complication, particularly CS, exists among many rural women. For example, one particular study (Parkhurst and Rahman 2007, p. 396) found that women in rural Bangladesh fear going to facilities because doctors ask for CS when they are not needed. However, this fear is grounded by the cultural perception of childbirth, high cost involved in health facilities and often by some true stories of unnecessary CS performed by the medical practitioners. Moreover, CS is regarded as a reproductive defeat in many societies (Parkhurst and Rahman 2007, p. 393). Due to these various reasons, the poorer mothers tend to not use the maternal health care that may require making the childbirth safe for mothers and baby.

On the other hand, overuse of maternal health care is more common among the urban middle or upper class women in Bangladesh. CS is done for treating some obstetric complication. As richer women do routine ANC check-up, it is more likely that their problems are diagnosed, avoided or treated by doing CS. However, in many cases CS is not related with dealing with complication, rather it is more likely to be related to avoiding labour pain or profit for the provider, sometimes at the cost of further deterioration of women's health. A study by Liu et al. (2007, p. 457) found that the overall incidence of severe maternal morbidity is 27.3 per 1,000 women who had a planned caesarean delivery, compared with 9 per 1,000 women who had a planned vaginal delivery. As argued by Deneux-Tharaux (2006, p. 541) "[I]t seems likely that the range of indications for caesarean delivery has broadened

considerably, and that more caesarean deliveries are performed with few or no medical indications". The author further argued that some professionals have gone so far as to propose elective caesarean delivery as an acceptable first-choice method of delivery for women with a normal pregnancy. Modern women consider elective caesarean section as an opportunity to avoid the natural labour pain. According to NIPORT et al. (2012, p. 7), among women who reported no complications, 9.4% had a CS, presumably for the convenience of the mother or the provider. In both rich and poor countries, caesarean rates are raising exponentially without a concomitant improvement in maternal and foetal health outcomes (Althabe et al, 2006; Wagner, 2001). The higher rate of CS among the upper income households as well as their leaning towards a bio-medical process of childbirth have often been criticized as over dependence on limited medical resources for childbirth (Turner, Agnew and Langan 2006; Rothman 2000; Lupton 2000) and as further enhancing inequality in maternal health care (Christilaw 2006, p. 234). Too much dependence of mothers on medicalized childbirth processes has also been criticized as undermining women's autonomy over childbirth (Oakley 1981; Kent 2000).

An overuse of medical technology by richer mothers, particularly in terms of using CS as the child delivery procedure, and underuse of the same by the poorer mother is evident world-wide (including developing countries). The disparity of access and utilization of maternal health care, which is considered as a basic human right, has led to widespread concern and debate in literature from different perspectives. Particularly, the overuse of medical intervention in childbirth had been contested

by feminist and medical sociologists, writers in regards to women's autonomy (Oakley 1984; Rothman 1982; Davis-Floyd and Cheney 2009).

Regarding overuse of maternal health care, Davis-Floyd and Cheney (2009, pp. 10-11) state that:

> [m]uch of our knowledge of unmedicated birth has been lost. Physicians have been deskilled and often no longer know how to attend normal deliveries patiently. After all, why learn how to attend a vaginal breech birth when a caesarean is so much easier (for the physician), and often more lucrative, to perform? As birth became more medicalized around the world, in most places, midwives lost their prestige as the guardians and guides at normal deliveries, becoming subordinated to physicians and trained out of traditional practices toward more industrial and technocrat approaches to birth.

This statement suggests that the authoritative and hegemonic attitude of medical knowledge is more likely to overshadow other existing and traditional knowledge of childbirth (e.g. knowledge of midwives, traditional guides to normal deliveries) and be a triumph of industrial and technocratic approaches to childbirth. Calling medicalization the "colonisation of birth by medicine", Oakley (1984, p. 15) says, "[i]t is a thread in the fabric of cultural dependence on professional health care". Giving importance to the social aspect of childbirth, Oakley further argues that "birth is a biological episode only to hospital administration and official statistics. The women, who give birth, have a past and a future. So it is in this biographical context that childbirth has a social meaning" (1984, p. 23). Malacrida and Boulton argue that the modern birthing experience is "consumer driven" (2013, pp. 2-3) and state that "the increase in CSRs (Caesarean Section Rates) reflects the escalating medicalization of childbirth and how medical authority over birth takes away women's natural capacity of childbirth". This can be manifested by communication

between the health providers and mothers, information and counselling provided to the care-receiving mothers, and cultural sensitivity of the health providers.

Quite a broad range of studies have discussed the issues that disempower mothers from the birthing process and make them merely a passive receiver of medical technology in childbirth. Kabakian-Khasholian et al. (2000, p. 112) mentioned that health systems often ignore the emotional process women undergo during labour and delivery by totally medicalizing all the features of childbirth, and suggest "to view childbirth with a holistic approach and render the care more suitable to the multidimensional aspects of the childbirth experience". A similar argument is reflected in Oakley's (1984) statement:

> The quality of medical care depends on the extent to which interventions of proven effectiveness are properly applied to those who can benefit from them. It also depends on allowing women choices, in giving them back the power to decide not only whether they have children but when, where and how they may do it. It means counting the costs and appreciating the benefits, it means seeing childbirth as a momentous time in a woman's life, an act of significance in terms of her own particular life and identity.

In spite of all these criticisms, the medical conquest of childbirth seems to be largely welcomed by the richer women (Fox and Worts 1999, p. 328), as it provides them with the opportunity of labour-free, hassle-free birth, and at the same time ensures better health care and health outcomes for mothers and newborns. However, the thing that is not being highlighted in this realm of modern treatment is the fact that the health hazards of a CS can also trigger new health hazards for both mothers and infants (Malacrida and Boulton 2013, p. 43). Another important concern is that in the developing countries where resources (both human and infrastructural) are limited, and where people have to pay from their own pocket for every visit to doctors, overuse of medical maternal health is promoting a capitalistic

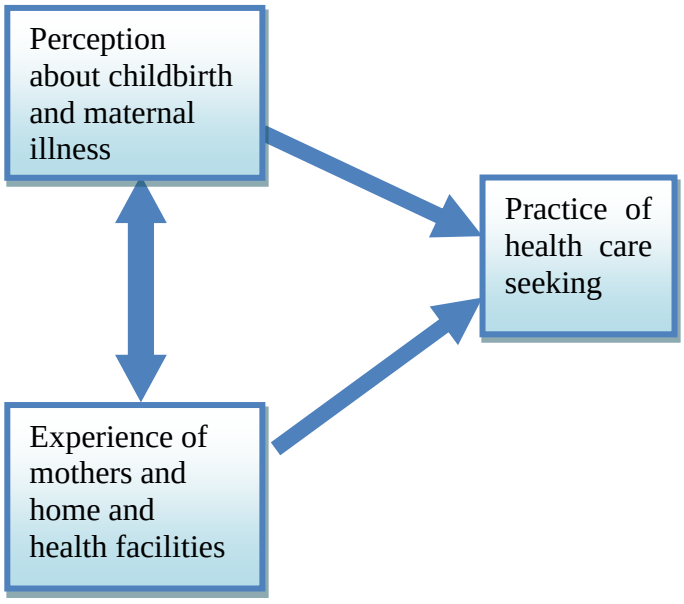
profit oriented approach in maternal health, instead of an essential human right. And herein lies the importance of taking the tendency of CS into serious concern in the discussion of maternal health care and of putting greater emphasis on providing mothers with enough information and counselling regarding elective Caesarean birth. Chapters Seven and Eight will discuss these issues in greater detail.

## 2.5: Health care seeking behaviour: perception, experience and practice

Studies on maternal health care seeking behaviour have usually been focussed on the utilization of health facilities and skilled medical assistance during childbirth. The different approaches, models and frameworks, as discussed previously, looked at the challenges and barriers, as well as facilitators in and outside the home, that determine the maternal health care seeking behaviour. MacKian (2003) produced a review of the research done on health care seeking behaviour. Drawing on evidence of the research from partner DFID countries the author has addressed the question about "what facilitates the use of health services, and what influences people to behave differently in relation to their health". She summarized the large number of studies on the various aspects of this debate into two types, namely (i) studies that emphasise the outcome, or the utilization of health facilities as the end point, and (ii) studies which emphasise the process, illness response or health seeking behaviour. In the context of the present study, the first approach may be seen to focus on the extent of utilization of maternal health care service during delivery and the post-partum period and the barriers to such utilization. The second approach has the underlying assumption that behaviour is best understood in terms of an

individual's perception of their social environment. The present research follows the second approach, i.e., focuses on the process that leads to maternal health care seeking behaviour of mothers from the lower and upper socio-economic households in Dhaka. The process, in this context consists of an individual's particular perception and experience (own and that of family and friends) that leads them towards a particular practice of health care seeking behaviour during childbirth and the post-partum period. Thus, health care seeking behaviour in this study can be seen via three interrelated issues: Perception, Experience (own and that of family and friends) and Practice of healthcare seeking behaviour (PEP), as presented in Figure 2.2.

**Figure 2.2: Interrelationship of Perception, Experience and Practice of healthcare seeking behaviour (PEP) during child birth and the postpartum period**




Source: Drawn by the author based on her literature review

This figure presents the basic premise of the three primary interrelated factors: Perception, Experience and Practice (PEP), used in the current research. This study

will focus on the perception and experience of urban lower income and upper income households in order to see any difference or similarity between these two groups of women that leads them towards a particular practice of maternal health care during and after childbirth.

It has been mentioned previously that various studies have visualized maternal health care seeking behaviour in a holistic manner encompassing all the socio-economic and demographic factors mentioned previously for a population, classified by rural, urban residence and by rich and poor status. However, the present research focuses particularly on Perception, Experience and Practice of health care seeking behaviour as the main issues for consideration. To be specific, the aim of this study is to understand how the perceptions of a mother that leads to, or be modified by her experience at of mothers or their families at home and/or health facilities in turn shape her health care seeking behaviour for childbirth and post-partum period.

The reasons for identifying perception, experience in understand the practice of maternal health care across various socio-economic statuses are threefold. First, as has been mentioned before, the maternal health care context in urban areas is different to that in rural areas in Bangladesh. The day-to-day life experience of mothers both in lower and upper socio-economic households in an urban context is also different from that of mothers in the rural context in terms of work, mobility, housing pattern, availability of health services etc. Thus a specific study is required

to understand mothers' health care seeking in the urban context of Bangladesh. Second, the wide gap between the poor and the rich in maternal health care for childbirth and post-partum care is well-known. The existing data indicate a particular practice of health care by mothers situated in a specific socio-economic situation. The influence of socio-economic condition on the perception and experience of the mothers need to be explored. Third, as discussed previously and as revealed in different data (NIPORT et al. 2013; NIPORT et al. 2012), poorer mothers seem to be more receptive to receiving ante-natal care (ANC) and family planning services than childbirth and post-partum care. The reason for this is related to how 'childbirth' is understood, and the rituals and beliefs related with childbirth that are deeply rooted in culture and society. A deeper understanding of the how each mother and her household perceives motherhood, childbirth is required to understand their health care seeking behaviour related particularly to childbirth and post-partum period.

The theoretical base that serves to understand the assumption behind the framework presented in Figure 2.1 is social constructionism. This research, therefore, has used social constructionism as its theoretical framework. The approach supports giving meaning and privilege to women's experiences of childbirth and allows me to value participants' experiences as an authentic source of knowledge.

## 2.6: Social construction of reality – perception, experience and practice

Developed by Berger and Luckman (1966, p. 27), social constructionism "concerns itself with the social construction of reality". Broadly speaking, this approach holds that reality is not naturally given, rather socially produced. And how it is socially produced is the main focus of social constructionism (Alvesson and Skoldberg 2009, p.23). The social constructionist approach holds the basic assumption that knowledge is subjectively constructed from the "socially embedded reality" and based on the shared signs and symbols that are recognized by members of a particular culture (Grbich 2013, p. 7). Thus, according to social constructionism, knowledge is the outcome of the interactions among individuals engaging in its construction (Bryman 2001). This approach involves examining the way people "interpret and make sense of their experiences in the worlds in which they live and how the contexts of events and situation and the placement of these within social environments have impacted on constructed understandings (Grbich 2013, p. 7).

Therefore, the construction of realities varies as people live in varied social contexts. The relationship in this construction is guided by the social values of people and of those with which they interact (LeCompte and Schensul, 1999). Thus, from this view, the construction of knowledge about childbirth and maternal health care is influenced by the socio-cultural context of the individual and family, interactions between people in the neighbourhood and health care centre. This means that the construction of meaning of childbirth and health care experiences of one person will be different from that of other persons.

Guided by this view, this research looks at how perception and experiences of health care for maternal illnesses are constructed under two opposing socio-economic contexts and how, based on those perceptions and experiences, mothers shape their respective health care seeking behaviour with regard to maternal morbidity. Social constructionism serves this research objective best as its core focus lies in the assumption that reality is varied and subjectively constructed according to context.

Perception plays a major role in influencing women's health care seeking behaviour. While the word 'perception'[13] has originated from the discipline of psychology, there are social and external factors that help a person develop a particular perception regarding a social phenomenon. Perception of a person, regarding health, health status and health care develop according to his/her subjective understanding (Baert and Norre 2009) and vary considerably by aggregate and individual socio-economic and cultural contexts). Perception defines the views towards childbirth, causes of complications during and after childbirth and towards own maternal health, and demand of seeking health care from health facilities and in-house care during and after childbirth. A woman may form a particular perception about maternal health care based on the experience of her own life, of a person or people in her family and community or social network, her level

[13] Perception is man's primary form of cognitive contact with the world around him (Eforn 1969, p. 137) According to him, "the term perception denotes a form of awareness" (Efron 1969, p. 143).

of education and the factual information available to her, and from her existing cultural practice (Killewo 2006, p. 409). Perception can also be shaped by general awareness of the dangers of childbirth and intervention available at health facilities by individual experiences with pregnancy, childbirth and health services, as well as by risk assessment of the pregnancy. Socio-cultural factors primarily influence decision making on whether to seek care, rather than whether women can reach a facility, hence socio-cultural factors influence the practice of maternal health care. One could conceptually distinguish the mother's own motivation to use services from whether she can act on her wishes (Gabrysch and Campbell 2009). The latter is much more related to her socio-economic status, and empowerment status within households and communities.

Perception varies according to the societal and cultural context of the particular country, and that largely influences the rate of institutional health care seeking of the given population across different socio-economic and ethnic groups. For example, Yassin et al. (2003, p. 456) described six categories of ideas that Egyptian mothers held about the causes of diseases during pregnancy and childbirth, namely: attack by an evil eye from a jealous relative; attack by an evil spirit; consumption of inappropriate food; physical activities; punishment of God; and lack of personal hygiene. The authors found a tendency of the Egyptian mothers to attribute certain health problems to certain causation categories and an implicit judgment of the personal responsibility of the disease. These six categories of causation of morbidity during pregnancy and childbirth, and personal responsibility of judgment associated with them, produce a varying pattern of health care seeking of maternal

morbidity in Upper Egypt (Yassin et al. 2003, p. 459), which is not replicated in other countries.

Liamputtong and Naksook (2003, p. 32) presented the perception of Thai-Australian mothers' that their deteriorating health following childbirth might be due to not following the Thai post-childbirth traditions like Yu fai[14] and dietary precautions and rest. Sibley et al. (2009, p. 387) showed how belief in post-partum bleeding as normal and necessary to cleanse the womb led to delays in seeking treatment, resulting in medical complications.

Among the mothers from the richer households, it is a common perception, that health facility based care increases a woman's sense of security and safety, which contributed to their perception of the value of institutional care, and encouraged further utilization of services. Women's perceptions that facility based care provides a safe environment for receiving care evolved from the quality of care they received and their delivery outcomes with previous pregnancies. Many women who experienced complications during previous births or low parity had an increased fear and awareness of the risks involved in failing to seek care, and thus sought care to avoid complications (Lubbock and Stephenson 2008, p. 79).

However, compared with other parts of reproductive health like ANC and family planning, childbirth is more of a cultural and social event and involves perceptions that are deeply rooted in the respective culture of mothers. In Bangladesh society,

[14] Yu fai is a Thai ritual of post childbirth period where a "woman who has just given birth lies on a woodedn bed over a warm fire for 30 days of the confinement period" (Liamputtong and Naksook, 2002, p. 32).

there are many notions regarding childbirth practices. Indigenous knowledge and practices of birth persist for generations, particularly in rural areas (Afsana and Rashid 2000; Blanchet 1984; Rozario 1998). Even the concepts of 'normal' and 'complicated' childbirth are connected in the context of culture and societal practice (Afsana and Rashid 2000, p. 23). The authors (p. 24) also found that what Bangladeshi women perceive as 'normal' versus 'complicated'[15] childbirth is quite similar to the bio-medical definition of childbirth. However, the women's perception of dealing with normal and complicated childbirth differs from how bio-medical childbirth understands them.

This perception originates to a large extent from the life experience of mothers and leads towards a particular childbirth and maternal health care experience and practice. As Lubbock and Stephenson (2008, p. 79) argued, women's understanding about the importance of maternal health care and healthy pregnancy are shaped by previous experiences, including communication within households and communities and also health care experience received at health facilities. Like perception, experience regarding maternal health care also can be shaped by anything at home, within communities, workplace and health facilities that influence the time, place and type of health care during childbirth and the post-partum period. Previously, in the framework provided by Winikoff, (1988), we have seen that experience of discrimination throughout one's life can perpetuate

[15] Signs llike childbirth without any prolonged labour, baby born with impact labour, baby born with intact placenta, birth with unrutptured membrane. On the other hand, 'complicated' childbirth, as experienced by mothers, is considered as those which have prolonged labour pain without further progress (Afsana and Rashid 2000, p. 24).

maternal ill health. Experience at home that might influence maternal health care has also been discussed and presented in Phase 1 delay in Thaddeus and Maine's (1995) three delay model. Afsana (2001, p. 81) also argued that women's own life experiences, their status within society, and hierarchies of power at home determine the maternal health care for mothers. Gupta (1995, p. 488) discussed how women experience lack of interest from other members of their household regarding their health problems, and this creates a situation in which a woman feels that her reproductive health problems must be borne silently as 'women's problems'.

However, experience at home in terms of maternal health care varies according to socio-economic status. Everyday life experience of working mothers often involves performing regular, hard household chores, and earning money through informal low paid manual labour. Looking after families and children hardly leaves the mother with time to visit health facilities for childbirth or post-partum issues, no matter how close or convenient the health facilities are. In comparison, the richer women may have hands-on help for household chores and looking after families. The richer women, who work, usually work in formal occupations and are often entitled to maternity leave. Thus, everyday life experience within households makes a huge difference among mothers in making decisions about time, place and type of maternal health care during childbirth and the post- partum period.

Experiences of care received in health facilities highly influence the subsequent visit to health facilities for mothers, regardless of socio-economic background. As suggested by different studies, in terms of health care experience, mothers

receiving care highlight a number of things like official and unofficial cost (Afsana 2004; Nahar and Costello 1998), level of interaction with the care providers, maintenance of privacy (Kabakian-Khasholian et al. 2000, p. 109-110; Afsana and Rashid 2000), and procedures followed during childbirth and the post-partum period (Kabakian-Khasholian et al. 2000, p. 109-110), as major concerns in deciding to visit health facilities.

The specific perception and experience of childbirth and the maternal health of a mother leads her towards a particular pattern of maternal health care for childbirth and the post-partum period, i.e. whether and where to seek care, and when and what type of health care to seek. We can see a specific practice of health care seeking for childbirth and for post-partum care for a specific group of mothers. As suggested by Kunst and Houweling (2000) poorer mothers prefer home based childbirth and seem to have an aversion to attempting hospital based childbirth, while richer mothers depend on hospital based childbirth (preferably in a private facility) and maternal health care. As a result, the occurrence and pattern of maternal morbidity varies across different socio-economic groups and status in society. The analytical chapters (Chapter Four to Seven) of this thesis are based on the conceptual framework (Figure 2.1) presented in this chapter.

# Chapter Three

# Research Methodology

## 3.1: Introduction

This chapter provides a discussion of the theoretical approach and methods of data collection and analysis adopted in this study. It is aimed at understanding the voices of the mothers from lower and upper socio-economic household regarding their respective perceptions and experiences influencing their health care seeking behaviour for childbirth and post-partum morbidity. The previous two chapters presented the significance of studying maternal health care seeking behaviours of mothers with regard to childbirth and maternal morbidity in the urban context. These chapters also identified the importance of context-based deeper analysis of the socio-economic and cultural factors, women's perceptions and experiences that can play a significant role in shaping their maternal health care seeking behaviour. However, it is also important to reflect on the voices of the mothers on how they perceive maternal health care in a given situation and, based on that, how they construct their health care seeking behaviour. Keeping these in mind, this study adopts a qualitative research approach using 'social constructionism'.

## 3.2: Social constructionism and qualitative research

As discussed in Chapter Two, this research is informed by social constructionism, which examines how reality is socially constructed. Using social constructionism as an epistemological basis allows me to explore the complexities and diversity of

women's perception and experiences of childbirth, maternal illness and health care behaviour in urban Dhaka.

Social constructionism inspires qualitative approaches for studying the research problems. As basic characteristics, this approach values subjectivity, inter-subjectivity and the researcher's reflection on the researched (Grbich 2013, pp. 7-8). Berg (1998, p.7) explains the virtue of qualitative research thus:

> Qualitative research properly seeks answers to questions by examining various social settings and the individuals who inhabit these settings. Qualitative researchers, then, are more interested in how humans arrange themselves and their settings and how inhabitants of these settings make sense of their surroundings though symbols, rituals, social structures, social roles and so forth.

Thus, a qualitative research approach appears to be the appropriate method for collecting information on the perceptions and experience of childbirth and maternal health care among the mothers from lower and upper socio-economic households in Dhaka. As discussed in the previous chapter, this perception develops from a subjective understanding of a phenomenon, which emerges from a person's engagement with their socio-economic and cultural context. To grasp the complexity of context as well as to portray the subjective understanding requires a string grasp of the context. A qualitative research approach provides the tools that can meet that requirement, such as in depth interviews. This research used in depth interview as data collection tool.

The methodological principle which this research draws upon is the experience of individuals as an authentic source of knowledge. The accounts of the experience of research participants are collected through in depth interviews. As Stacey (1994)

suggested, people themselves have the best expertise in understanding and explaining their experience because they are the ones who live in the context, while constructing the experience. Thus, their account not only gives information of the experience but also renders meaning to that information, as they relate their experience with the existing context. Valuing the experience of mothers in such a way can contribute to producing knowledge of childbirth and maternal health care from a different perspective, where the mothers' voices are heard, and their experiences are reflected upon and accounted for.

Guided by the social constructionist approach that socio-economic context shapes women's perception and experience of childbirth and maternal health care, the field work for this research was conducted with women from two socio-economic groups in Dhaka, namely, a group of lower socio-economic households and a group of upper socio-economic households. As mentioned before, the aim of choosing these two different groups is to see how the Perception and Experience and Practice (PEP) of maternal health care is shaped in socio-economic conditions. The following sections describe the selection of study sites, sampling process, and recruitment of the study participants.

## 3.3: Defining lower and upper socio-economic households

This study defines lower socio-economic and upper socio-economic households based on sociological understandings of social stratification. Modern urban based social stratifications are largely defined by 'class' of which income and occupation

are two major components (Giddens and Sutton (2013).[16]. Although the formation of a class requires more than the criteria of 'income' and 'occupation', these two criteria can suffice to broadly define two very diverse socio-economic groups of a metropolitan city, Dhaka.

In this city, cosmopolitan occupational diversity plays a major role in shaping the structure of social stratification (Khan 2012). The city has a complicated occupational structure but Khan suggests that the heads of the Dhaka households can be classified into four broad occupational groups, namely (i) salaried professionals; (ii) large, medium and small businessmen; (iii) workers employed in low or unskilled occupations and (iv) workers with no formal occupation. Khan (2012) further classified them into two broad categories namely, (i) higher status groups comprising the first and second of the above mentioned occupational groups and (ii) lower status groups comprising the third and the fourth of the occupational groups mentioned above. The higher status groups mostly also have higher incomes compared to the lower status groups. This is the basis of my selection of upper socio-economic households to represent the higher status groups comprising highly salaried professionals and the large, medium and small business people. Similarly, the lower socio-economic households have been chosen to represent the lower status groups, comprising workers employed in low or unskilled occupations and

[16] Giddens and Sutton (2013, p. 485) define class as a group of people sharing "common economic resources, which strongly influence their type of lifestyle".

workers with no formal occupation. However, there may be exceptions to this categorization of households in terms of socio-economic groups. Having lived in Dhaka for the last 20 years, I have personally observed that not all professional-salaried people and their families belong to upper income household categories, and at the same time, not all the low skilled and unskilled people necessarily belong to low income household categories. For example, professional-salaried people may include employees at the lowest end of salaries, which would classify them as poor, but because they work in formal employment, receive a regular income; they may be exposed to modern ways of looking at maternal health care.

## 3.4: The study area

Dhaka is the obvious choice of study for a research project on urban women as it is a Bangladesh's pre-eminent city. Within this sprawling metropolis, the poor mainly live in informal settlements (slums) scattered throughout the city. The structure of housing where low income people live is generally of poor quality with very low level basic infrastructure. Human Development Research Centre (2011, p. 4) mentioned that only 25% of the population of Dhaka is served by a sewer network. The sanitary conditions in urban slums are therefore very deplorable, with only 8% to 12% having hygienic latrines. In the late 2000s, sanitation coverage reached only 8.5% of Dhaka slums (MICS 2009, mentioned in Human Development Research Centre 2011, p. 4).

Structural disadvantages along with a low level of education and health services make the poor people of the urban Dhaka more vulnerable than the richer people.

The adverse surroundings of low income settlements, coupled with a high density population, gives rise to a myriad of social, health-related and environmental problems (Siddiqui et al. 2000; Hossain 2008). In contrast, in the areas inhabited and frequented by the rich, there are relatively high standards of living.

The existing health care centres in the city have failed to cope with the rapid growth of the city's population (Siddiqui et al. 2000). Kelly (2012) reported that hospitals are already unable to meet the growing demand of treatment and services. NIPORT et al. (2008, p. 213) in their Bangladesh Urban Health Survey 2006 reported that 48.8% of urban slum area of Bangladesh has no access to health programs or service centres in their surroundings. While there is a recent proliferation of private hospitals and clinics in Dhaka, according to Siddiqui et al. (2000) those health facilities provide services only to the people from upper socio-economic households. For the urban poor, receiving health services from the limited available health resources is challenging due to many seen and unseen barriers, including unofficial user fees, malpractice of power by the authority, and lack of awareness (Begum, Yeasmin and Seem 2010, p. 44).

## 3.5: Study sites: low socio-economic households

In selecting households from the lower socio-economic group for my research, I first chose an informal settlement in the Dhaka City Corporation (DCC) area. A simple definition of a slum is "a heavily populated urban area characterized by substandard housing and squatters" with lower income, inadequate access to safe water, sanitation and other infrastructure, poor structural quality of housing and insecure residential status (UN Habitat 2007, pp. 1-3). The Bangladesh Urban

Health Survey portrayed a picture of slums in Dhaka using different socio-economic, demographic and health indicators, among which the following were important in helping me decide to work in slum communities in Dhaka (NIPORT et al. 2006).

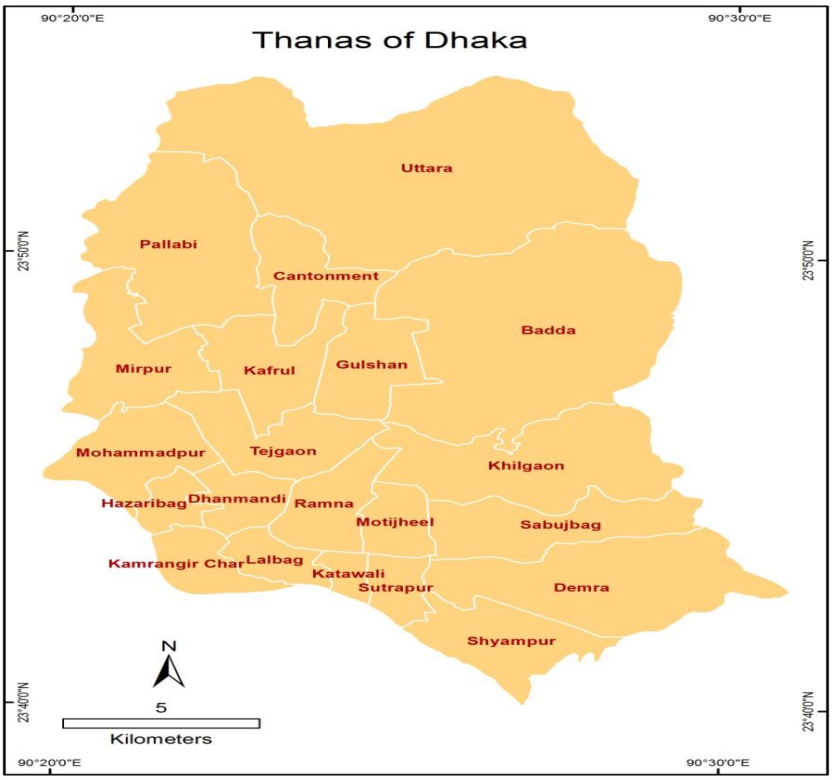
- About 40% of slum households in that survey belonged to the lowest wealth quintile.
- 88% of slum women delivered babies at home, compared with 54% of the non-slum people in the study.
- 18% of the slum women had medically trained assistants during delivery compared with 56% of the non-slum women.
- More women in slums than in non-slums reported two or more complications during delivery, and nine out of ten non-slum women who experienced complications associated with pregnancy sought treatment, compared with about three out of four women in slums.

My initial plan was to collect a list of the slums in DCC from the available information and then choose one or two slums randomly depending on the size. However, as there is no list of slums available, I selected them based on two simple criteria through judgmental sampling:

- Overall low income level and low level of development intervention in this area
- Safe and secure for my research assistant and me.

I divided DCC into major city districts and randomly chose a section named Mohammadpur, as shown in figure 3.1.

**Figure 3.1: Map of Dhaka and its *Thanas*.**




Source: Dhaka, Bangladesh: DMA/Upazilas WGS84 2012

Mohammadpur is a city district (locally called a *thana)* within the metropolitan area of Dhaka with a population of 355,843 as at the 2011 Census (BBS 2012) and an area of 10.62 square kilometres (Banglapedia n.d.). The Mohammadpur city district has a population density of 27,346 per sq. km (Banglapedia n.d.). My research assistant and I took a rickshaw drive to the Mohammadpur area to explore the slums or clusters of lower socio-economic households. We also talked to the local shopkeepers, hawkers, rickshaw pullers and other people to get information on the area, and the location of slums etc. Of the slums we found in the area, we picked Sona Mia *Bosti (Bosti* – the Bangla term for 'slum') in Mohammadpur

'*Beribadh'* (dyke) to conduct field research because, this slum appeared to be small in size and therefore convenient to get to know better. It also had less developmental intervention.

As stated by the key informant, Sheher Banu (see the next paragraph for recruitment of key informant) and other slum dwellers, Sona Mia is the name of the person who is in charge of looking after this cluster of 350 households on a big piece of land owned by 60 absentee landlords. Like most slums in Bangladesh, this slum was first inhabited nearly 25 years ago by people who migrated internally from Barishal.[17]

One of the distinguishing characteristics of the poor is 'substandard housing' (Narayan et al. 2001, p. 51). Like any other household in the informal settlement areas of Bangladesh, the mothers chosen for this study live in huts which offer a very low standard of housing. The most common features of the huts are scarcity of water; unhygienic and insufficient sewerage and water arrangements; lack of electricity; insufficient space within the huts to accommodate the family members; leaky roofs and mouldy walls. Several other studies on urban slums of Dhaka provide similar descriptions of the houses in the slums (Pryer et al. 2002; Hossain 2007; Alamgir Jabbar and Islam 2009).

[17] Another district of Bangladesh.

With an average number of four members in each *Jhupri* (hut),[18] Sona Mia slum has an approximate population of 1,400. The huts are adjacent to each other. There are only 12 tube wells[19] and six toilets to be shared by all slum dwellers, which indicate a serious lack of proper sewage and hygiene. For drinking, bathing and other purposes the residents carry water to their hut from the tube well in buckets. Usually women do this job. The main profession of the male slum dwellers here is rickshaw pulling and/or working as assistants to truck drivers etc. Women usually work as household maids or stay at home to look after young children. Overall, the Sona Mia slum is a typical Dhaka slum, where proper ventilation, drinking water, electricity and sewage facilities are absent, and this absence caused by poverty, leads to further poverty (Alamgir, Jabbar and Islam 2009, p. 75).

Along with the low living standard, Sona Mia slum is characterized by a very low level of development and minimal health facilities. Sona Mia not well attached to metropolitan advantages of life. The mothers interviewed in this slum reported to have known only three sources of maternal health care, namely a maternity centre of Urban Primary Health Care Project (UPHCP, popularly known as Marie Stopes[20]), the BRAC Health Centre (BHC) and the Dhaka Medical College

[18] *Jhupri* is a kind of house made of low cost housing materials like tin, bamboo, straw and polythene and becomes vulnerable during the rainy season (Hossain 2008, p. 18).

[19] A tube well is a well made by driving a tube into the earth that draws water from the underground aquifer (Smith, Lingas and Rahman 2000, p. 1,093). In Bangladesh, tube wells are used as a source of drinking water.

[20] This Urban Primary Health care Project Centre is supported by Marie Stopes International. That is why; people call this centre as Marie Stopes.

Hospital. Maternity centre and BRAC are situated near the slum, while the Dhaka Medical College Hospital is some 12 kilometres away. These mothers received maternal health care services mostly from the Marie Stopes and BRAC centres. Compared to many other slums, where micro-credit[21] and other social development programs contributed better mobility and skills for women (Alamgir, Jabbar and Islam 2009, p. 373), Sona Mia has women who are less mobile and less skilled.

Sona Mia reflects one end of the spectrum of slums in Dhaka in terms of how established they are with infrastructure and services, and what opportunities they offer to their residents to improve their living standards. To better reflect the diversity of slums, I decided to add another better known slum to the study: Karwan Bazar slum, which is located in Tejgaon[22] Thana near one the largest wholesale markets in the central area of Dhaka and the inhabitants seem to be in a slightly better-off economic position.

Karwan Bazar has developed alongside a railway line, close to the bustling business area of Dhaka. The people are living without running water, and work in an unsanitary environment. Similar to Sona Mia, the health and hygiene conditions in the Karwan Bazar settlement, with over 1,000 households, are very poor. However, due to their proximity to the big market, the people living in Karwan

[21] Small amount of collateral free institutional loan, usually provided to the poor group member with a view to develop self- reliance and income generation among them (Rahman 1999, p. 67).

[22] Tejgaon is a *Thana* (city district), located at the centre place of Dhaka.

Bazar have various income earning opportunities. Compared with the slum dwellers of Sona Mia, those of Karwan Bazar are found to be well networked socially, more informed about available health care, more mobile and have better access to social services. However, their hygiene and housing conditions are similar to that of Sona Mia slum dwellers. A major inconvenience of the Karwan Bazar slum is that its location along a busy railway line, with a daily frequency of around 15-20 trains, weakens the structure of the huts and makes them unsafe to live in. Like the mothers of Sona Mia slum, all of the mothers interviewed in Karwan Bazar also live in rented huts, but their rent is higher because of the locational advantage.

## 3.7: Study sites: upper socio-economic households

For upper socio-economic households, I purposely selected an area from one of the affluent residential areas of Dhaka. From the Dhaka City Corporation website, I made a list of the affluent areas of Dhaka city, and from that list, selected Dhanmondi based on the purposive sampling method. Purposive sampling is where the researcher exercises his or her judgment or knowledge of a population and the aims of the research to select a sample (Walter 2010, p. 139; Marshal 1996, p. 523). I chose Dhanmondi, because it is:

- well known as an affluent residential area with a high standard of lifestyle;
- characterized by a growing number of multiple apartment complexes, a concentration of maternal and child health clinics and hospitals, diagnosis centres etc.

- well known to me as a geographic location and in terms of its socio-economic characteristics.

Dhanmondi, is a typical affluent area, with a population of 147,643 (BBS 2012), a literacy rate of 71.7%, a relatively skilled workforce where 41.7% are salaried professional/service holders, and 27.6% run a business (Banglapedia 2012). It is a *thana*[23] consisting of three *Wards*[24] and 20 *Mouzas*[25]. Siddiqui and Ahmed's (2010) study on Dhaka's formation listed Dhanmondi as one of those areas, where upper middle class people live in Dhaka. Rahman (2007, p. 163) described the living areas of upper middle class people of Dhaka as surrounded by all the urban facilities such as garbage disposal, schools, colleges, hospitals, post offices, quality grocery shops. My experience of living for many years in Kanthal Bagan, a neighbouring suburb of Dhanmondi, and roaming the streets and lanes of Dhanmondi by rickshaw and on foot during this field research, confirm the view that it is an area inhabited mostly by the upper socio-economic people of Dhaka. This is further confirmed by the presence of modern designed, multi-storied apartment houses, wide and clean roads, prominent shopping malls, expensive restaurants, health clinics and private hospitals.

[23] Unit of police administration (Ali 2012)

[24] A ward is an operational division of a city, especially an electoral district, for administrative and representative purposes. It is an elective unit of a city corporation, created for the purpose of providing more direct representation, from which a single council member is elected.

[25] Lowest revenue collection unit in Bangladesh (Islam n. d.)

## 3.8: Selection of Health Care providers

An important portion of my research was devoted to understanding the socio-cultural, economic and structural factors within the health facilities that influence the health service providers to render satisfactory health services to women seeking health care with regard to maternal morbidity. To gather relevant data, I interviewed some health care providers from different categories. My basic guide to select health care centres came from the interviews with the respondent mothers. The majority of the respondents in my study sites of Sona Mia and Karwan Bazar slums and of the upper middle class household area of Dhanmondi reported that the health care centre/clinic/hospital they went to for health care during their pregnancy, delivery or post-partum treatment and check-up were the Ad-din hospital, Urban Primary Health Care Project Centre (popularly known as Marie Stopes), the Square Hospital Ltd., and a few other public and private hospitals and clinics. A portion of respondents from the low socio-economic group reported that they just went to a traditional birth attendant (locally known as *Dai*) for the above mentioned purposes. Some respondents reported other health care providers, however the time limitations of my thesis meant that I could only focus on the most frequently mentioned. From my own point of view, I also considered that I covered at least one of each of the different categories of health care providers ranging from TBA to expensive modern private clinic.

Ad-din Women's Medical College Hospital, Dhaka is a private not-for-profit organisation that has been operating in Bangladesh since 1980. This hospital has branches in some other cities of Bangladesh, including Jessore. In Ad din Hospital, where health services are provided for mothers and babies for pregnancy, delivery,

post-partum care, neonatal care, maternal morbidity care and treatment, like fistula surgery and care, treatment for obstetrical prolapse, perennial tears and other related treatments (Ad-din Women's Medical College 2012). Ad-din aims to provide quality preventive and curative care for children and women at low cost. It operates a busy and popular outpatient department for women and children, providing ante-natal and post-partum care, family planning, treatment for sexually transmitted infections, obstetric, gynaecologic, and surgical services for women, and child health services. People from diverse socio-economic backgrounds attend Ad-din for a range of health services.

One of the unique services of Ad-din is a fleet of sixty-six ambulances that facilitate transport for emergencies and women in labour. Another important characteristic of Ad-din is that it is one of the four hospitals which provide fistula care in Bangladesh, supported by USAID. This hospital provides fistula care not only in its Dhaka branch, but also in Jessore. In my study samples of women being treated for fistula at both the Dhaka and Jessore branches of this hospital.

To address the ethical requirement of my research, before I started data collection within Ad-din, I obtained written permission from the Ad-din Foundation to interview patients and health service providers. I interviewed 20 mothers (including 11 Fistula affected mothers) who were receiving maternal health care from Ad-din hospital as well as a health care provider. The maternity centre of Urban Primary Health Care Project (UPHCP) (in Bangla it is called *'Nagar swathe kendo')* is a health care centre, Mohammadpur. This centre is run under the UPHC project of the government through the Dhaka City Corporation and funded by Marie Stopes

International. In order to bring the whole population of Dhaka under this project, including maternal health, Dhaka is divided into different project areas. Mohammadpur Project Area is one of those. In each project area, there is one maternity centre and eight Primary Health Care Centres (PHCC). As described by the Project Manager of the UPHCP Centre, this project aims at providing health services to the poor people of Dhaka, while ensuring a high quality of health service. Their mission is to bring primary health care (including maternal health) within easy reach of the poor inhabitants of the project area. At the onset of the UPHC project, they made a list of the households, which mostly belong to slums, including their socio-economic and health status. Each household was given a red card which is considered an access card for free treatment for all members of the household including child delivery and post-partum care. This UPHC also brings maternal health care, particularly ante-natal care (ANC) and counselling to the doorsteps of slums by setting up satellite clinics in each slum one day a week. I interviewed two people: the Project Manager and a medical doctor serving this centre.

Finally, I also interviewed maternal health care providers and gynaecologists who provide maternal health services in a private modern clinic in Dhaka, where some of the richer mother in this study delivered their children, For the confidentiality purpose, the name of that health care facility is not mentioned.

## 3.9: Recruitment of research participants

It has been noted before that the research participants in this study came from two different socio-economic classes, namely lower socio-economic households and

upper socio-economic households. In addition, the following criteria were developed for the selection and invitation of participants eligible for this study:

- Women who have given birth in the five years preceding the survey and have suffered or are suffering from a condition related to maternal morbidity. In this regard, women's self reported maternal morbidity has been counted. However, women's self-report of maternal morbidities does not necessarily mean she has a medically valid morbidity ( Ferdous et al. 2012) but the self-reported morbidities are important as it is what women feel and base their health care seeking behaviors on.
- Women who have given birth in the last five years without any complications;
- Health service providers, whose services were utilized by the women in the study.

Because the theme of the study is sensitive and not often spoken about, a variety of sampling procedures have been followed to encourage participation. However, due to different kinds of sampling procedure for upper-income and lower-income households, the comparison between these two groups of mothers is not free of bias. For example, sampling procedure (snowball) has led to a sample of women from the upper socio-economic households, who all had C-section, where as random sample of mothers from lower socio-economic households have mothers both with normal childbirth and C-section. Therefore, the comparison between the rich and the poor is not free of bias. Table 3.1 summarizes the sampling procedure that has been followed in recruiting the research participants.

**Table 3.1: Number of participants in this study against each criterion**

| Units of research | Sampling procedure |
|---|---|
| **Study sites** | |
| Sona Mia Slum | Purposive |
| Karwan Bazar Slum | |
| Ad-din Women's and Children's Hospital | |
| Urban Primary Health Care Project Centre | |
| Dhanmondi residential area | |
| **Respondents** | |
| Respondents from Sona Mia Slum (n=14) | Random |
| Respondents from Bazar Slum (n=9) | Random |
| Respondents from Ad din Women's Medical College Hospital (n=20) | Accidental |
| Respondents from Urban Primary HealthCare Project Centre (n=5) | Accidental |
| Respondents from Dhanmondi residential area (n=30) | Random and then Snowball |

### 3.9.1: Recruitment of key informants and research participants: Sona Mia slum

I recruited 14 mothers as research participants from Sona Mia by using the random sampling method with the help of the key informant, who is a well-known resident of Sona Mia. The sampling frame for the random selection of the eligible mothers was prepared with the help of the *dai,* as mentioned below. At the entry point of Sona Mia, I found a little tea stall. A middle aged lady was running the shop, with a 2-year-old boy on her lap. We walked towards her, exchanged greetings and asked her for some time to have a chat. The lady, named Sheher Banu happily welcomed us to sit on the bench in front of her shop. We found her very cordial, helpful and informative about the slum and people living there. She offered tea and biscuits. As she runs a shop she has good communications with the slum dwellers. She accompanied me walking through the slum and having a look at the structure, pattern and life at a glance. While she was accompanying us, another lady from next door to Sheher Banu's house was looking after her shop. I requested Sheher

Banu to help me in my work in the slum as the key informant. She agreed and took us to the hut of a *dai* who helps with most of the deliveries in the slum (I interviewed this *dai* later, as a health care provider). With assistance from the *dai*, I made a list of women living in Sona Mia who had given birth in the five years preceding this research field work. She also reported how many did and did not have complications, and I made the list accordingly. I interviewed 14 women between 1 August 2012 and 16 September 2012 from Sona Mia chosen randomly from the list. Where anyone among those 14 was not available or did not agree to participate, I approached another mother on my list.

### 3.9.2: Recruitment of key informant and research participants: Karwan Bazar Slum

I visited Karwan Bazar slum a decade ago, as an undergraduate student in Sociology, to make a poverty profile of ten households of slum dwellers as a requirement for a course named 'Sociology of Poverty'. Although it was more than a decade ago, and the slum has changed in size and structure, the place felt somewhat familiar to me. I spent the first day walking through the slums with the objective of finding a key informant and to be informally oriented with the slum dwellers, and to get information regarding the socio-economic and structural characteristics of the slum. Unlike Sona Mia, where the dwellers are known to each other, Karwan Bazar is big and sprawling, and not many people know each other. I had some informal chats with both men and women to understand their lifestyle and ask if any of them could be a key informant. However, most of them seemed to be quite busy with their own work or not very interested in helping. Eventually we

met a lady named Najma who works in the nearby Urban Primary Health Care Project Office, who showed interest in working with us as a key informant. She had been living in the slum for more than a decade; held a job, earned money and provided advice and suggestions to the slum dweller women regarding their health problems. With the help of this key informant we walked through the slum and exchanged informal greetings and smiles with the people (particularly women and children) we met on our way. We did this with the objective of making ourselves familiar to them. With the help of the key informant I also made a list of the women who became pregnant or mothers during the five years preceding or during this research field work. I selected 10 mothers at random from the list to interview.

### 3.9.3: Recruitment of research participants: Upper socio-economic households

In regards to approaching women in upper socio-economic households, the first method was to drop off a very brief questionnaire in each letter box or at door step. The questionnaire contained questions concerning whether there were any birth in those households in the last five years. The responses to the questionnaire helped in ascertaining whether any woman in the households could be invited to participate in the survey. The questionnaire was accompanied by an information letter and a letter of request for their availability for the interview and their contact details. I did a letterbox/doorstep drop of 50 households, but the response was rather poor. Only two mothers replied to my request to participate in this interview. Therefore, I adopted the approach of snowball sampling – also known as chain referral sampling –where "the researcher collects information from a small number of the

target population and asks them to use their help to locate other members of the population, who they know and who might match to the sampling criteria" (Lewis-Beck, Bryman and Liao 2003, pp. 1-4). I used the following steps in selecting the upper middle class respondents through snowball sampling:

- I contacted the two respondents who replied to my earlier request to participate in an interview, and set a time to meet with them. All three interviews took place in their respective residences.
- At the end of the interview, I explained my sampling process to them and requested their help in finding other possible respondents from their social network.
- All three respondents agreed and gave me contact details of possible respondents, and allowed me to use their name as a reference. In most cases, the possible respondents they suggested were their friends, neighbours, mothers of children's schoolmates and, in a small number of cases, their relatives.
- I contacted these people and asked them if they are available for interview, and followed up accordingly.

## 3.10: Sources of data

This study used face-to-face in-depth interviews as a primary source of data. The researcher's field notes were also used as a source of data.

### 3.10.1: In-depth interview

An interview is a conversation between people with a major purpose of gathering information (Berg 1998, p. 57; Nachmias and Nachmias 1976, p. 100; Burgess 1984, p. 102). Taylor and Bogdan (1998, p.88) define in-depth interviews as "repeated face-to-face encounters between the researcher and informants directed towards understanding informants' perspectives on their lives, experiences and situations as expressed in their own words". The in-depth interview as a social research model is developed from an interpretivist perspective that sees that social research needs to address the complex ways in which people understand their lives. This process is regarded as a useful way of gaining and recording the experience and perception, in addition to factual information, of the participant individual or group about the phenomenon that is being researched (Saldana 2009, p. 40; Rice and Ezzy 1999; Pope and Mays 2006, p. 15). The experience and perception of mothers regarding their health care for childbirth complications and maternal illnesses may involve issues and aspects of life that are personal and confidential. One-to-one in-depth interviews were justified as the appropriate data collection method for this study for understanding such a complicated and personal issue.

To guide myself through the interview process I used a semi-structured interview schedule. Semi-structured interview schedules mostly comprize open-ended questions that enable the researcher and interviewee to keep the discussion in the area to be explored, keeping the discussion as wide as possible (Pope and Mays 2006, p. 13). Separate interview schedules were prepared for different categories of participants, i.e. respondent mothers and health care providers, to ensure that each

category's respondents' perspectives are properly reflected (see Appendix Two for the interview schedules used in this research).

Pope and Mays (2006, p. 15) suggested preparatory caution to the researcher using interviews, that the researcher needs to consider how s/he is perceived by interviewees and the possible effects of the his/her personal traits such as class, race, sex and social distance during the interview. I had the opportunity to gauge the possible effect of my class and social position on the interviewee, particularly from the lower socio-economic household mothers from Sona Mia. I found that they thought of me as a development worker, who might provide micro credit, medicine or injections. Noticing my files, a large bag full of documents and recording equipment, they asked me whether I was a development worker who would give them some immediate intervention. However, with the help of the key informant, I explained to everyone the purpose of my visit and interview, not only to minimise the impact of my perceived class and social position on the interview but also to ensure that the participant would participate in the interview without any hope of direct benefit from it.

### 3.10.2: Interview process, piloting and ethical issues

Trying out the questionnaire in a similar research setting is regarded as a feature of good research before starting the main data collection interviews (Silverman 2013, p. 207). This process is called piloting, and is applicable in both quantitative and qualitative research. Before I started the main interviewing phase, I took the

interview schedule to a couple of young mothers who live in a poor household on the roadside in Dhaka. I interviewed them guiding myself with the proposed interview schedule. This piloting helped in three different ways to work out which part of the schedule needed to be modified: first, it allowed me to practise my interview and improve my skills before I started my data collection; second, interviewing and listening to the recorded interview allowed me to reflect on the information collected at that pilot phase to check if the interview brought out some deep insight and detailed experience of those mothers regarding their childbirth and maternal health. Finally, I modified my interview schedule based on the outcome of those pilot interviews.

After completing the piloting and associated modifications, I started interviewing at Sona Mia slum. As it was a one-on-one in-depth interview, I explained the ethical issues to each participant separately before I started interviewing. This study followed the procedure of ethics approval guided by the Social and Behavioural Research Ethics Committee (SBREC) of Flinders University (see Appendix One). Ethical issues included that the interview may be recorded, but that the participant's anonymity and confidentiality would be guaranteed and that they would have the right not to answer any question during the interview or could refuse to continue with the interview at any time and in any situation. I also explained the consent form and information sheet, and obtained the interviewees' signature on the consent forms before the interview started. I maintained the confidentiality of research participants by using pseudo name in the thesis.

I tried to restrict the number of interviews to a maximum of two in one day, so as to make time for note-taking and reflection. The timing and place of the interview were always the choice of participants. I undertook the interviews at whatever time and place they suggested. The respondent mothers from Sona Mia, Karwan Bazar and Dhanmondi participated in interviews in their respective homes. The mothers who came to health care centres were interviewed in the respective health care centre. The health care providers participated in interviews in their workplace.

In some cases I did not record the interview as the participants did not want this. In these cases, I took detailed notes at the interview and wrote up the conversation immediately afterwards.

### 3.10.3: Probing and building rapport

During the interviews, I used probing questions (also known as secondary questions) where necessary to further explain the question to the participants. In social research, the use of probing questions is a well-known method for clarifying questions and eliciting more detailed information (Minichiello, Aroni and & Hays 2008, p. 100). As suggested by Oakley (1981), in using an open style of interviewing in childbirth research, I encouraged participants to share their relevant life events and experiences which had influenced their pregnancy and childbirth. When some participants experienced difficulties in being open or in understanding the detail of questions I asked, I provided example of my own birthing and maternal health care experience, some of which has been stated in the preface of this thesis, to help them collect their thoughts on the relevant topic.

Building rapport with the interviewee is a very important aspect in conducting a good interview, in which the researcher will feel that he/she is really getting an insight into someone's life. Rapport is the relationship of trust and ease between the interviewee and interviewer, where the interviewee can answer without any fear or mistrust and also where the interviewer can dig deeply to get a good insight of the phenomenon (Walter 2010, p. 305). Minichiello et al. (2008, p. 83) argued that gaining the trust of another human being is the fundamental requirement of achieving rapport. Especially in research on a sensitive phenomenon like childbirth and maternal morbidity, which involves the sharing of very personal experiences, it is important that the participants feel comfortable sharing their personal history with an outsider. Explaining my position in Australia and in Bangladesh as well as the objective of the interview was the first step of building trust with the interviewee. In the lower socio-economic settings of Karwan Bazar and Sona Mia, I started the discussion informally by sharing my own childbirth experience to put them at ease and make them feel comfortable. Introducing myself as a mother of two and with a history of childbirth complications reduced the distance between me and the participant. Lastly, with the view of building and maintaining rapport, I was careful in asking questions. As suggested by Minichiello et al. (2008, p. 84), I organized my questions to be open-ended with mostly 'how' and 'when' or 'what', and tried to avoid answering with 'why'. However, a cautionary note, I had to keep in my mind was that establishing too personal a rapport may turn the in-depth interview into a conversational partnership (Rubin and Rubin 2004).

### 3.10.4: Field notes

Minichiello et al. (2008, p. 116) suggest that note taking allows the researcher to record the unspoken expression or body language of participants that comes with their speech and analysis. I took notes instantly in the field or immediately after the interview, sometimes while interviewing to take note of the surroundings of where the interview was held, and body language and expression (sadness, frustration, joy etc.). These field notes guided me to better contextualize the information gained from the interview as well as to relate my own reflection on the interview.

## 3.11: Information processing and analysis

For analysis of the collected information, I have used thematic analysis, which involves searching for themes that appear as important in understanding the problem being researched (Fereday and Muir-Cochrane 2006, p. 82). Themes are those parts of data that are deemed important by the researchers for the analysis of the research problem and used to form a comprehensive picture of the problem (Aronson 1994). The process involves the identification of themes through careful reading and re-reading of the data (Rice and Ezzy 1999, p. 258). Among all the other methods used in the qualitative approach to research, I decided to use thematic analysis, because thematic analysis is characterized by flexibility, which suits a constructionist approach well, and can potentially provide a rich and detailed account of data within a complex and diverse context (Braun and Clarke 2006, pp. 77-78). Themes could be of two different types depending on the starting points of analysis. In the first type, which is known as ‘inductive’ or ‘data driven’, themes emerge from the data. Here the research develops themes as directed by the

data instead of fitting the data into a pre-existing framework (Braun and Clarke 2006). For this research I have taken the inductive thematic analysis approach. Although, as presented in Chapter Two, I have presented a framework to present the premise in which the health care seeking behaviour of mothers have been studied; that is Perception, Experience and Practice. The Themes and sub-themes for analysis has been developed considering Perception, Experience and Practice (PEP) as base of themes.

However, thematic analysis, as a distinct method of analysis, has received criticism. Some consider thematic coding merely as a tool that can be used across different 'traditions' of analysis rather than a method of analysis (Boyatzis 1998). Some criticize thematic analysis for its flexibility advantages (Antaki et al. 2003) and absence of clear agreement on the thematic analysis process among researchers (Holloway and Todres 2003).

Nevertheless, I used this method of analysis because it has been widely used in qualitative research across many disciplines (e.g. Banning et al. 2009; Bayes, Fenwick and Hauck 2008; Berman and Wilson 2009; Clarke, Sheppard and Eiser 2008; Souza et al. 2009). Braun and Clarke argued, "through its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account of data" (2006, p. 78). Kaphle (2012, p. 65) also stated that thematic analysis is appropriate, writing "any theoretical framework carried with it a number of assumptions about the nature of

the data in terms of the reality, which can be made transparent through a good thematic analysis".

Chapter Two has already presented a basic conceptual framework of interrelation of perception of childbirth and maternal health care, experiences of mothers in home and health facilities, and practice of maternal health care to be applied to understand the health care seeking behaviour of both lower socio-economic and upper socio-economic household mothers. Based on this basic framework, the thematic analysis has been developed. Accordingly 'Perception', 'Experience' and 'Practice' have been considered as the three main themes of analysis for both upper socio-economic and lower socio-economic households.

Although qualitative research analysis, by its nature, is an "iterative and reflexive" process (Fereday and Muir-Cochrane 2006, p. 82) involving constant moving back and forth between the entire data set. Step-by-step guidance from Braun and Clarke (2007, pp. 87-93) for analysing information as described below has been used in this analysis.[26] It has been mentioned that the participants for this research came from three different sources − mothers from lower socio-economic households, mothers from upper socio-economic households, and health care providers. Assuming that the perception, experience and practice regarding childbirth and maternal morbidity-related health care of these three different categories of

[26] Braun and Clark (2007) have mentioned 6 steps of thematic analysis. However, in this research steps 4 and 5 have been merged together, resulting in 5 steps.

participants may be different, the data were divided into three groups and coding was done accordingly using NVivo 10. NVivo is a software program consisting of a set of tools to assist a researcher in managing data and ideas, querying and visualising data and reporting from the data in qualitative research (Bazeley and Jackson 2013, pp. 2-3). Following is the description of the steps taken to analyze the information.

**Step 1: Familiarity with data set**

Braun and Clarke suggested that the researcher should immerse him/herself in the data in such a way that he/she gets 'familiar' with the depth and breadth of the content (2007, p. 87). I took three major steps to familiarize myself with the data. First, transcribing data from the interviews, although time consuming, helped me familiarize myself with the data set very well. Hearing the voices of the participants while transcribing also helped me identify their unspoken feelings and nonverbal expression. Bazeley and Jackson (2013, p. 73) pointed out that, "[t]ranscription is the way of building intimate knowledge of your data". Second, while transcribing, my goal was to keep the transcription as true to the conversation as possible. I noted the sighs, laughs, and expressions of anger that the participants expressed. And finally, I read and re-read the transcribed data absorbing the data into my consciousness, thoughts and reflections while transcribing. I took memos, noted questions, ideas and possible explanations in the memo function of NVivo that emerged and were prompted by my reading. These memos turned into an important source of information while explaining data in different chapters of my thesis.

**Step 2: Generating initial codes**

I started initial coding of my data using NVivo software, after familiarizing myself with my data sets, forming some ideas and patterns, and identifying some initial parts that might be deemed important. Bazeley (2013, pp. 146-147) emphasized the importance of a theoretical approach in generating ideas of what to code and what not to code. Keeping that in mind while coding, in accordance with the theoretical approach of social constructionism, I coded not only what the participants said and recorded, but also my observation of the context of the mothers interviewed, their non-verbal expression as noted in my field notes. I structured the nodes and codes in a branching tree system with categories, sub-categories and sub-sub-categories. I created three main 'parent nodes' as 'low socio-economic households', 'upper socio-economic households' and 'health care providers'. The coding process involved recognition of (seeing) an important memo and encoding it (seeing it as something) prior to a process of interpretation (Fereday and Muir-Cochrane 2006 p. 83). While coding I followed Braun and Clarke's (2006, p. 89) advice of coding as many themes as possible, and coding extracts of data inclusively, keeping a bit of relevant surrounding data.

**Step 3: Searching for themes**

Themes start to develop from the coded data in this phase. In fact, searching for themes in my research started from the phase of transcribing. I took notes on possible themes while listening to the interviews. At this stage I read the code and data extracts that I put against each code, then sorted the different codes into potential overarching themes, and the relevant coded data extracts within the

identified themes. I used mind maps to organize codes into theme piles as suggested by Braun and Clarke (2006, p. 89). When a few major themes were developed, the major themes were presented as a parent node in NVivo 10, and the sub-themes as child nodes. An example of coding an interview in NVivo under the theme of sharing health concerns with the husband or keeping them to oneself is presented in Box 3.1.

**Box 3.1: Example of nodes in research**

Coded for:
Culture of silence/sharing with husband

<Internals\\interiews\\women\\sona mia slum\\sona mia bosti shaheeda> - § 4 references coded [100.00% Coverage]

Reference 1 - 100.00% Coverage

If I look at it, I feel scared. (living with fear always). I can see something reddish coming out. If I sit, it comes out. Elder people ask me walk "chipe chupe" (keeping legs as close as possible). I am new and naïve. I don't know these many things.

Reference 2 - 100.00% Coverage

I know it's not my fault. I told him. If I tell him more, he will think that see, I don't have money in my hand, but she keeps telling me about her problem. He might go somewhere else leaving us here, or might go home. How much I can disturb him complaining about my health. He has been disturbed already.

Reference 3 - 100.00% Coverage

We don't have money. If I ask for anything, he cannot buy it. He cannot buy medicine. He get angry if I tell him. "From where can I get all these? Do I give up my life?"

Reference 4 - 100.00% Coverage

no, *Apa*, But, you know, he is a male, he can go anywhere.
<Internals\\interiews\\women\\sona mia slum\\sona mia bosti asma> - § 1 reference coded [2.05% Coverage]

Reference 1 - 2.05% Coverage

Researcher: you said that you have trouble having sexual interaction with your husband. Does your husband get angry for this sometimes?
A: No. he usually does not get angry. But he might in the coming days. Allah knows better if he will get married again. If he says, I will marry again, why I will feed you, you are a misfit. He can say. Don't you understand apa?,*purush jat*, (male).

The next job at this stage is to interlink the major and sub-themes to understand the health care seeking behaviour of mothers in urban Dhaka. I did this by using the 'model' function in NVivo and mind mapping (Bazeley 2014) to try to link the themes and sub-themes. At these stages, I came up with some alternative initial thematic frameworks, which were, at the next step, rethought and modified. The final thematic frameworks have been developed to understand the health care seeking behaviour of the mothers of upper socio-economic and lower socio-economic households.

**Step 4: Defining, reviewing themes and developing final themes**

Braun and Clarke (2006, p. 91) suggested that once the initial thematic exercise is done, a stage of refinement starts. Some themes or sub-themes may be found to be unimportant, some themes might merge into others, or in some cases a new theme may arise. This stage involves another thorough reading of coded data extracts and reflecting on the mind map and initial thematic framework through coded data extracts to check if they have been put in the theme that best represents it, and whether the coded extracts of data in each theme appear to form a coherent pattern. In doing this, I tried to consider the validity and relevance of each theme in understanding the health care seeking behaviour of mothers. Through this final review, some major thematic frameworks were developed, which are presented as summery findings in Chapters Five, Six and Seven. Those frameworks respectively represent the perceptions and experiences of mothers from the lower socio-economic households with regard to childbirth and maternal illness, those of upper socio-economic households, and similarities and differences between the mothers

of the two socio-economic groups in terms of their perception and experience and practice.

**Step 5: Producing a report**

Minichiello et al. (2008, p. 292) ascertained that data analysis and writing up the report is intertwined, and that a researcher must present results in a communicative, clear and concise way. In this research, I started drafting the report early on, during the phase of understanding and establishing linkages among themes, then the final thesis writing started once the thematic framework had been finalized. At this stage, I wrote different chapters using the themes emerged from the previous steps. I provided sufficient evidence of the themes while writing about the linking data. I regularly went back through the entire data set to ensure that significant data had not been missed in producing the thesis. Each extract from the data set was embedded within a story that illustrated the voices that I was trying to uncover in this study. Findings from the analysis of data have been presented in the next five chapters.

Some numerical data also emerged from the interviews with the participant mothers. These data describe the participants' economic and demographic status and needed to be analyzed quantitatively. The basic SPSS program was used to analyze those data by doing some cross tabulation and frequency distribution.

## 3.12: Conclusion

This chapter has explained the approach that has been taken to guide the whole research process of this study. The basic assumption of a social constructionist

approach is that reality is subjectively constructed and varied according to the context, in which a person lives. This study aims to understand how the perception and experience shape women's health care seeking behaviour for childbirth and the post-partum period in urban Dhaka is as a result of the influence of various socio-economic factors. In this endeavour, the social constructionist approach provided this research with a suitable scope to understand the respective context and maternal health care seeking behaviour. This study used a qualitative research approach following an in-depth interview as a data collection tool complemented by field notes. The approach and data collection tool allowed me to draw insightful information from the interview with the mothers and health care providers. In addition, my reflexivity on the interviews with the participating mothers let me strengthen the relationship between myself as a researcher and the research participants, which is an important pre-condition of in-depth qualitative information. The next chapters discuss the findings of this research, as they emerged from the thematic analysis of the information collected.

# Chapter Four

# Socio-economic and demographic background of the mothers and their maternal health care behaviour

## 4.1: Introduction

The main objective of this chapter is to describe the socio-economic, demographic characteristics and maternal health care behaviour of the mothers of lower socio-economic and upper socio-economic households interviewed in this study. Previous studies (Oakley 1984; Rothman 1982; Winikoff 1988) have shown that the experience of motherhood is interwoven with the social, economic, cultural, familial and political contexts, in which the mothers live. In particular, the mothers' maternal health care seeking during childbirth and the post-partum period is highly influenced by their own socio-economic conditions and that of their households (Celik and Hotchkiss 2000; Gabrysch and Campbell 2009; Amin, Shah and Becker 2010; Mpembeni et al. 2007). This chapter describes the socio-economic conditions of the women interviewed and their households, their maternal morbidities and the treatment they have received. How and why these conditions influence women's views and ultimately their decisions concerning medical treatment will be examined in subsequent chapters.

## 4.2: Background characteristics of the mothers from lower socio-economic households

As mentioned in Chapter One, Dhaka, the capital of Bangladesh, is characterized by higher concentrations of poverty compared with other cities in the country due to the predominance of poor migrants (Hossain 2008, p. 16). The overall picture of the lower socio-economic households in this study is similar to that of what Hossain (2008, p. 19) has described in his study on urban slums of Bangladesh.

> The slum population in Dhaka City faces extreme poverty due to its low level of earnings and the majority are living below the poverty line in terms of both calorie intake and cost of basic needs. What is more, the slum dwellers are mostly involved in low paid jobs in informal sectors of the urban economy. To be precise there is a predominance of day labouring and rickshaw pulling among this poor group of city dwellers.

Among the 48 respondents in the lower socio-economic households selected for this research, 23 came from two informal settlements in Dhaka; Sona Mia and Karwan Bazar. Like several other slums Sona Mia and Karwan Bazar are inhabited by people who migrated to Dhaka predominantly from rural areas of Bangladesh due to a combination of push and pull factors. The push factors consist of poverty and related factors and a lack of employment opportunities in the villages, while the pull factors include opportunities for work and better income. However, it was apparent from their living condition that their reasons for migrating to Dhaka for better income and better work opportunities appears not to have been realized as their situation has not improved The income, economic and social status of the mothers from the poorer households, discussed in the following section also depicts this. The 23 mothers from Sona Mia and Karwan Bazar interviewed in this study and their household members still live a precarious life with hunger, poor health

and poor living conditions. The remaining 26 mothers of low socio-economic status came from different low income areas of Dhaka and its surrounding areas, who were interviewed when they came to receive care and treatment in the Ad-din Women's Medical College Hospital or the Urban Primary Health Care Project Centre in Mohammadpur, Dhaka.

### 4.2.1: Income status of the respondents

Pryer (2003 p. 80) in her study of Dhaka slums found that among the women aged 15 years and above who live in slums, 49% were engaged in some income generating work. However, in the present study, a much smaller percentage of women are found to be working for an income. The reason is that most of these women have small children to look after at home, as this study selected only those women in the sample who gave birth or became pregnant at least once during the five years preceding the survey.

The daily income of the mothers of lower income households interviewed in this study and the income of their families (which includes the mothers' income) are shown in Table 4.1 as well as in Figure 4.1. Although the table and the figure show the same data, the figure has been added for a better visual presentation. The table is useful for calculating measures such as the mean income. The cross tabulation of income of mothers and that of respective families as presented in Table 4.1 shows that nearly 69% (33 of 48) of the mothers interviewed had no income, and of those 15 mothers who did have an income, the majority (11) earned only BDT 100 or less

per day. The reason for this, as mentioned above is that most of the women interviewed in this study have to look after small children at home. Thus most of the lower income women interviewed in this study depend on the income of their families (mostly the husbands of these women) which, on average is BDT 305 per day[27]. Figure 4.1 shows how skewed the individual and family income are towards the lower end of the scale. Beeghley (1988, p. 203) stated that in a cash based society people without jobs are more likely to remain poor. The people living in urban slums can only have income earning activities for their livelihood, unlike those living in rural areas where people can engage in farming, firewood wood gathering etc. for their livelihood. Thus, for the urban poor, being without a job means living in poverty. As shown later in this thesis, living in poverty implies poor maternal health outcomes.

**Table 4.1: Distribution of lower socio-economic mothers by their own income and family income/day, Dhaka 2012**

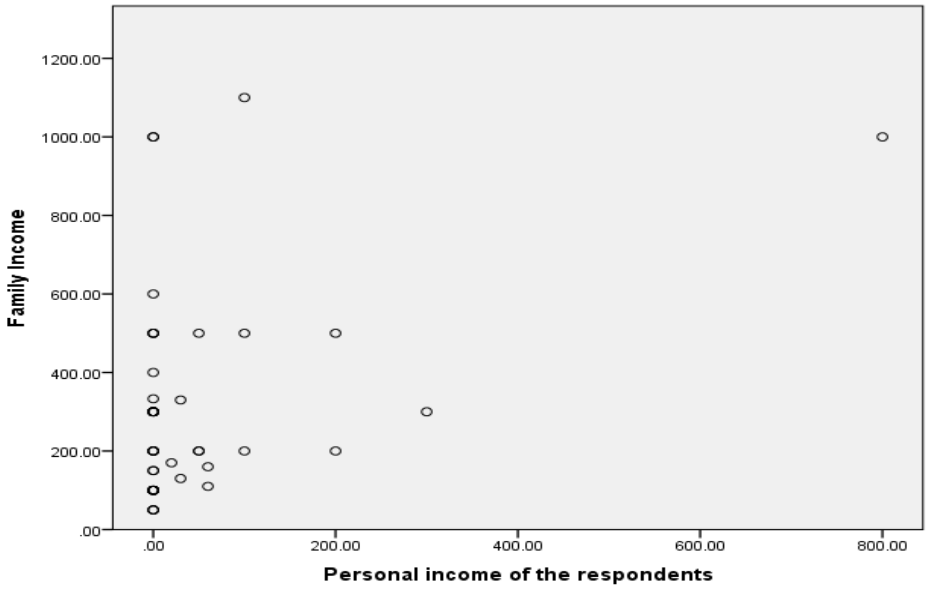
| **Women's individual income (BDT/day)** | **Family income (BDT/day)[28]** | | | | |
|---|---|---|---|---|---|
| | **1-100** | **101-300** | **301-500** | **501+** | **Total** |
| No income | 12 | 13 | 5 | 3 | 33 |
| 1-100 | 0 | 7 | 3 | 1 | 11 |
| 101-300 | 0 | 2 | 1 | 0 | 3 |
| 501+ | 0 | 0 | 0 | 1 | 1 |
| Total | 12 | 22 | 9 | 5 | 48 |
| Mean family income: BDT 305/day (USD 4) for average number of family members 4 | | | | | |

Source: Field work 2012

[27] BDT stands for Bangladeshi Taka. 1 USD equals approximately 75 BDT.

[28] Family income refers to income of all earning members of the family of responded mother including her own income.

**Figure 4.1: Distribution of lower socio-economic mothers by their own income and family income**




Source: Field work 2012

Table 4.1 also shows that most of the families (34) have a daily income of BDT 300 or less (USD 3.90 or less). With an average family size of 4 this put them into the category of 'hard core poor'[29] (Matin and Hulme, 2003, p. 651), because they all fall below the lower poverty line. Most of the families, where mothers are not earning any income are concentrated in the income range of BDT 300 per day or less (Table 4.1 and Figure 4.1). This suggests that if these mothers had an income they could have contributed to improving their family incomes considerably. By having an individual income a woman can have a higher status, which can

[29] "The conceptualization behind the hard core poor is that they experience extreme poverty and that, because of their lack of opportunities for upward mobility, their poverty lasts a long time or throughout their entire life" (Matin and Hulme 2003, p. 651).

positively influence her power to make decisions to seek health care for her maternal conditions.

### 4.2.2: Employment undertaken by the mothers and their households

Work available for the mothers of lower socio-economic households and their husbands consists mostly of informal, casual, low skilled, labour intensive and low paid jobs. However, the types of work available in Sona Mia and Karwan Bazar slums are different from one another. Being located next to the big *Bazar* (market places) of Dhaka, inhabitants of the Karwan Bazar slum have opportunities for a variety of work close by. In particular women and young children from Karwan Bazar slum are able to pick scraps of vegetables and small fish every day from the market shops to supplement their income. Men can earn by selling vegetables, by helping in the shops, or by working as porters. Helena in Karwan Bazar slum describes her family's opportunities for earning some income in the morning, which helps them manage their daily living without having to work all day, as many slum dwellers do. I met her late one morning while she was cooking lunch for her family and she explained to me the advantage of living near the markets to earn a daily living:

| | |
|---|---|
| Researcher: | What do your sons do for earning? |
| Helena: | They do whatever they get. This morning my eldest son earned 150 taka, my 2nd son got some fish. I also earned 100 taka in morning. |
| Researcher: | How? |
| Helena: | I bought some vegetables first and then sold it in the nearby area. I made a profit of 100 taka. My eldest son did *mintigiri* (carrying other people's grocery shopping) in the fish market and earned 150 taka. My 2nd son helped shopkeepers and they gave some fish to him. |

| | |
|---|---|
| Researcher: | That's nice! So this is how you earn your daily living? |
| Helena: | Yes, but sometimes we get nothing. My sons also do not like to work every day. They are young, you know. (Helena aged 40 years, Karwan Bazar slum) |

On the other hand, Sona Mia slum dwellers, because of the unfavourable location of their slum, have less connection with the markets and work opportunities. The geographical distance of the slum from the city centre has a huge impact on the income earning opportunities for the slum dwellers (Baker 2007, p. 13). However, except for a few, those who work (both male and female), are mostly engaged in low paid casual work and their earnings are below the poverty line income (less than US$1 a day). The work and economic status of the husbands and families of the women are not different from those of the women themselves. Studies conducted in Dhaka have found that there were 80 different occupations for males living in urban slums of Dhaka (CUS 1983). Most of the household heads in the slums of Dhaka are engaged in low earning informal services like petty business, e.g. footpath vendor, hawker, day labourer, rickshaw puller, labourer in construction buildings, small job service etc. (Alamgir, Jabbar and Islam 2009, p. 375).

However, the present research did not find such a wide variety of occupations in either Sona Mia or Karwan Bazar slums. Rather, most of the male members of the households interviewed were found to be engaged in informal casual labour work such as pedalling cycle rickshaws (rickshaw puller), assisting truck drivers, selling tea or mineral water bottle, helping in building construction work etc. (see Table

4.2). In most cases, they do not have regular work due to a lack of availability of regular work, which indicates the prevalent underemployment[30] for the poor of Dhaka (Baker 2007, p. 16). Nupur (aged 16 years, mother of one 9 months old child), who has to heavily rely on her own income to run her family, says about her husband,

> He cannot earn much because he does not get work every day. He works in brick breaking *(ita bhanga*). If already enough bricks are broken, he does not get work for the next day. If he goes to work, he can earn 100/150 taka per day. He works on an average only 15 days a month. Moreover, he often falls sick.

The occupation of different earning members in households is considered to be one of the determining factors of a household's economic status. As suggested by Table 4.2 only a few mothers (15 out of a total of 49 respondents) have a regular source of earning money.

[30] Underemployment is those working less than 35 hours per week, as a proportion of the employed labour force.

**Table 4.2: Occupation and income/day (in BDT) of the poor socio-economic households where both the woman and her husband work, Dhaka, 2012**

| | Name | Woman's income | Woman's occupation | Husbands'/ other family members' income[31] | Husbands' occupation | Total family income |
|---|---|---|---|---|---|---|
| Sona Mia | Lailee | 60 | Not specified | 100 | Rickshaw puller | 160 |
| | Johora | 20 | Selling fuel wood | 150 | Rickshaw puller | 170 |
| | Kulsum | 60 | Maid servant | 50 | Brick laborer | 110 |
| | Sheher Banu | Local shop keeper jointly with husband | | | | 200 |
| | Hena | 50 | Pickle seller | 150 | Brick labourer | 200 |
| | Khadeja | 50 | Maid servant | 100 | Rickshaw puller | 150 |
| Karwan Bazar | Jhumur | Grocery shop keeper jointly with husband | | | | 300 |
| | Lolita | 50 | Shop keeper | 450 | Truck helper | 500 |
| | Feroja | 100 | Vegetable seller | 400 | market labourer | 500 |
| | Helena | 100 | Vegetable seller | 100 | Tea seller | 200 |
| | Kamrun nahar | 100 | Vegetable seller | 1,000 | Food carrier | 1,100 |
| | Selina | Help mother run hotel | | | | 1,100 |
| Mothers in health c are facilities | Mina | 200 | Garment worker | 200 | Garment's worker | 400 |
| | Rahima | 30 | Garment worker | 330 | Technician | 360 |
| | Karima | 50 | Day laborer | 150 | Vegetable seller | 200 |

Note: This table refers to only those households where both the woman and her husband work. There are seven women in Sona Mia and four women in Karwan Bazar and all women except three among those who were interviewed in health facilities, who do not work because of various reasons. Work opportunity and reasons for not working are explained in the following section.

Source: Field work, Dhaka, 2012

[31] Family income includes husband's income and wife's income, in cases where wife earns money.

### 4.2.3: Opportunities for work for the mothers

It has previously been stated that the many mothers from lower socio-economic households interviewed in this study are not involved in any income earning activities, mainly because they have young children to look after. The other reasons, as reported by the mothers, are the husbands' objection to their wife's work and the mother's own physical illnesses (particularly those who have any kind of maternal morbid condition such as uterine prolapse, fistula etc.). Many mothers cannot be regular in their work due to their physical illness. It is also to be noted that the mothers (mostly from those interviewed at the health care centres), whose husbands manage income through small businesses, are not working. On the other hand, the mothers from the slums, who need to work, cannot do so because they do not get support with childcare. However, those, who have an extended family around and a good social network, can get this support and go to work. They get support from their parents, particularly from mothers who live nearby. In fact, family networks and social support appeared to provide a major support to the mothers to enable them to engage in money earning activities. As one mother Fatima stated:

> All my family members, my brother and sister-in-law, my parents, my sister, all live nearby. I am the poorest of them all. So everyone helps me. When my husband has no income, my parents buy our everyday grocery. They buy rice, *daal* (lentils) for us. Now I work. I drop my 9-month old daughter at my mother's place in the morning and go to work. I work as a housemaid. Then after finishing my work, I bring my daughter back home. I get 1,800 taka per month. I pay house rent; I have an insurance policy in my daughter's name. I pay for that. I pay for water bill. I spend for family. If my husband gets ill, I pay for his treatment. If my daughter or I am ill, I also spend for our treatment. If I feel like eating something, I buy and eat that. I don't go to others asking for help (Fatima, aged 23 years, mother of one child, from Sona Mia slum).

The above narrative from Fatima, who has been working as a housemaid for the last two months, shows how various kinds of support from the extended family network can help a mother live a better life. In fact, family networks and kinship play an important role in building social capital for the slum dwellers by providing information and adaptation mechanisms (Hossain 2008, p. 20). Other scholars such as Narayan et al. (2000, p. 55) also emphasize the importance of social capital for the poor to meet their everyday needs and to adapt themselves well in the slum community. In the following chapters, we will see how the social network also helps in shaping the health care seeking behaviour of mothers.

Many families in the Sona Mia and Karwan Bazar slums have come to Dhaka recently on their own, leaving their extended family and network back in their villages, and they have not yet been able to build a supporting social or neighbourhood network in their new home. Thus, they neither get any family support to leave their young children with someone to look after them and go for work, nor can they look for suitable work with the help of a network of their own. Saleha, mother of a 9-month old baby, seriously feels the need to work to support her husband, who is often sick. But Saleha can hardly go to work, because she cannot find anyone to look after her child, even though her mother-in-law also lives in the same slum. Her situation is reflected in her conversation with me during the interview:

Saleha: But she (her mother-in-law) sleeps in a different hut. She eats with us, but does not help with any of our work.

Researcher: So, you can leave your daughter with your mother-in-law and go to work or for your treatment?

Saleha: Hmm. But we only feed them. We don't give any money for her daily living cost. She does some work and earns money and lives with her daughter. She only comes to our hut for her food. My sister-in-law does not eat with us. We are poor. We cannot feed ourselves, how could we feed all of them? (Saleha, aged 20 years, Sona Mia slum)

The difference between Fatima and Saleha in this regard is the support they are receiving from their families. The availability of Fatima's mother to look after her child while Fatima is at work gives her not only the opportunity to earn an income (1,800 BDT per month, equivalent to USD 26), but it also gives her self-satisfaction and self-esteem. Her assertion that she can earn and spend as she wishes reflects this. On the other hand, Saleha, having no one to look after her child, is not able to earn and help her husband and herself to alleviate their poverty. The inability of Saleha and her husband to provide full support to her mother-in-law (except for two meals a day) is perhaps the cause of her having a less supportive family network which in turn has led to her continued poverty and even a deteriorating financial situation. Thus Saleha and women like her are caught in a vicious cycle of continuing poverty amid a lack of social and family support, as a support network and kinship in urban informal settlements like the Sona Mia and Karwan Bazar slums play a major role in shaping the socio-economic condition of urban poor mothers.

## 4.3: Demographic characteristics of mothers from low socio-economic households

The basic demographic features of the respondents of the lower socio-economic households in this study are typical of that of Bangladesh in general. Most of the mothers got married and had their first child at a young age.

**Table 4.3: Distribution of the mothers from lower socio-economic households by current and age at first marriage Dhaka, 2012**

| Current age of mothers | Age at first marriage of the mothers (years) | | | | Total |
|---|---|---|---|---|---|
| | Less than 10 | 10-14 | 15-19 | 20-24 | |
| 10-14 | 0 | 1 | 0 | 0 | 1 |
| 15-19 | 0 | 3 | 6 | 0 | 9 |
| 20-24 | 0 | 5 | 12 | 0 | 17 |
| 25-29 | 0 | 2 | 0 | 1 | 3 |
| 30-34 | 2 | 5 | 3 | 0 | 10 |
| 35-39 | 1 | 1 | 0 | 0 | 2 |
| 40+ | 2 | 3 | 1 | 0 | 6 |
| Total | 5 | 20 | 22 | 1 | 48 |
| Current median age: 23.5 years<br>Median age at marriage: 14 years[32]<br>Median age at first childbirth: 16 years | | | | | |

Source: Field work 2012

The current median age of the mothers is 23.5 years. The age range of respondents in this study falls between 15 and 35 years except for five fistula patients, whose age is over 40 years. The cross tabulation presented in Table 4.3 shows that among the mothers interviewed from lower socio-economic households, 17 fall within the age range 20-24 years followed by 30-34 years in which 10 women belong. The highest number of mothers (22) was married at the age of 15-19 years, followed by 20 mothers who were married at the age of 20. In particular, of the mothers currently aged 20-24 years, 12 got married at the age of 15-19 years and five at the

[32] This is the median age at marriage of the married women in this sample.

age of 10-14 years. Although the legal age at marriage for girls in Bangladesh is 18, the median age of marriage of girls in this study is 14 years. Most of them were married soon after they reached puberty, which is the general scenario of marriage age of girls in Bangladesh. The mean age at marriage of girls in Bangladesh is 15 years (NIPORT et al. 2011, p. 87).

As a consequence of early marriage, the mothers give birth at a young age. The median age at first childbirth of the mothers is 16 years, which is far below the median age of first childbirth in Bangladesh overall, which is 18.1 years (NIPORT et al. 2011, p. 70). Early marriage is associated with early age at first childbirth, often before the mothers physical growth and development is complete. Many studies have shown that early childbirth can have adverse health consequences for both the woman and the child (Jensen 2003, p. 10; Field 2008, p.2). Wall (2006, p. 1,206) concisely presents the impact of early marriage and early child bearing on the health of mothers

> The likelihood of obstructed labour is increased in areas where early marriage and childbearing are common, because although growth in height stops or slows with the onset of menarche[33], the capacity of the bony pelvis normally continues to expand after the epiphysis[34] growth plates of the long bones have fused. These problems are worsened if girls have been undernourished throughout childhood and adolescence. Thus, although girls are capable of becoming pregnant at a relatively early age, their pelvis do not develop their full capacity to accommodate childbearing until much later, and many will have their lives destroyed by obstetric injury before they have even crossed the threshold into true adulthood.

[33] First menstrual cycle

[34] Rounded end of a long bone, at its joint with adjacent bone(s)

In Bangladesh, early age at marriage and early age at first childbirth are recognized as major factors in maternal death and maternal morbidity. Available data show that one of the reasons for the high level maternal mortality ratio (MMR) in Bangladesh is the large proportion of adolescent mothers. The MMR among adolescent mothers is 30-50% higher than the overall MMR in Bangladesh (GOB and UN 2005).

To sum up, the socio-economic and demographic background of mothers of lower socio-economic households interviewed in this study is typical of urban poor households of Bangladesh. The income of these mothers and their families is generated from informal, casual, low skilled jobs and ranges between BDT 100 and 300 per day, which is below the poverty line. The work opportunities of these mothers are also limited due to the unavailability of regular work and lack of family support in looking after the children of the mothers who do find work. Their situation is made worse when they suffer from illness. These limitations contribute to their poverty. Their living conditions are very poor, particularly in terms of access to, and affordability of utilities, sewage disposal and overall hygiene. Further, being adjacent to a railway line, the living condition of the mothers in Karwan Bazar is even worse and unsafe. In terms of demographic characteristics; the average current age of mothers of lower socio-economic households is 26 years.

On the other hand, the mothers who were interviewed at the health facilities namely Ad-din and maternity centre of UPHCP, Dhaka have a regular family income

which helps them to plan well for facility based health care during pregnancy, delivery and the post-delivery period.

## 4.4: Maternal health care behaviour of mothers

Many mothers of lower socio-economic households were found to have received inadequate health care during their pregnancy, childbirth and post-partum period. Lack of child delivery care and post-delivery care, coupled with poor nutritional status and early child bearing have left many of them with maternal illnesses such as fistula, uterine prolapse, urinary incontinence, chronic backache etc. This section focuses particularly on:

1. Health care status of the mothers of the lower socio-economic households in terms of their ante natal, delivery and post-partum care.
2. The type and duration of delivery complication and post-partum delivery morbidity of the mothers, and
3. The reasons, as understood by the mothers, and the consequences of maternal morbidity.

### 4.4.1: Maternal health care status of mothers from of socio-economic households

The type, number and quality of maternal health care received by the mothers of lower socio-economic households during pregnancy, delivery and the post-partum period determines their short term and long term morbidity status (McCarthy and Maine, 1992, p. 33). According to the Safe Motherhood Initiative, the provision of ante-natal care, access to emergency obstetric care (EmOC), ensuring skilled birth attendants and education and mobilization of the community are significant components to ensure healthy pregnancy outcomes for mother (McCarthy and

Maine 1992, p. 30). In this section, ante-natal care, delivery care and post-partum care of the mothers from the lower socio-economic group of households is presented.

**Table 4.4: Health care status of the mothers of lower socio-economic households, Dhaka 2012**

| Place of residence and the numbers of mothers interviewed | ANC (Yes/No) | | Place of delivery | | Type of delivery | | Morbidity* |
|---|---|---|---|---|---|---|---|
| | Yes | No | Home | Hospital | CS | Normal | |
| Sona Mia slum (14) | 10 | 4 | 12 | 2 | 1 | 13 | Delivery complication 4) |
| | | | | | | | Post-partum morbidity (8) |
| | | | | | | | No morbidity (4) |
| Karwan Bazar slum (10) | | | | | | | Delivery complication (4) |
| | | | | | | | Post-partum morbidity (6) |
| | 4 | 6 | 7 | 3 | 1 | 9 | No morbidity (7) |
| Interviewed at health care centres (13) | | | | | | | Delivery complication (8) |
| | 13 | 0 | 0 | 13 | 6 | 7 | Post-partum morbidity (2) |
| Mothers affected by obstetric fistula (11) | 0 | 11 | 5 | 6 | 2 | 9 | Delivery complication (11) |
| | | | | | | | Post-partum morbidity (11) |

*The numbers presented in this column are not mutually exclusive, as some mothers had morbid conditions during child delivery as well as after childbirth.

Source: Field work, 2012

Among the total 48 mothers from lower socio-economic group of households, 17 reported not to have had any morbidity or illness (Table 4.4). These 17 comprise six mothers from Sona Mia slum, four from Karwan Bazar and seven interviewed at health care centres. The seven mothers, who came to the health centres in spite of having had no existing morbidity, chose to come to the health facilities for child delivery. The remaining 31 mothers suffered various complications, either at childbirth or during the postpartum period. Many of them had more than one type of complication. Each of these mothers narrated her unique experience with regards to her complication, illness, duration of illness and treatment of illness. The

morbidities or illnesses reported by them consist of uterine prolapse (locally known as '*Poddo ',* which is resemblance of the lotus flower), chronic back pain, urinary incontinence, anaemia and fistula. These conditions are the outcomes of complications such as prolonged labour, frequent pregnancies, early age pregnancy, inadequate and delayed obstetric care and carrying heavy weights during pregnancy. All of these may be linked to whether the women are receiving proper, timely and adequate health care during their pregnancy and delivery. Table 4.4 also gives the number of mothers according to whether they had ante-natal care (ANC), care during delivery and post-delivery care. The information presented in this section focuses generally on the most recent pregnancy of those mothers who became pregnant in the five years preceding this survey.

Compared with other components (delivery care and post-partum care), ante-natal care (ANC) was more prevalent among the mothers (Table 4.4). However, in most cases, the mothers reported at interviews that their ANC visits were limited only to receiving tetanus toxoid (TT) injections and for a few mothers, to receive iron-vitamin tablets. The other elements of ante-natal care such as measuring blood pressure, urine tests, measuring weight, or blood tests (NIPORT 2012, p. 55) were done for a very few mothers interviewed. The reason for this could be what is mentioned in the report on the Bangladesh Maternal Mortality and Health Care Survey by NIPORT et.al. (2012, p. 53), namely that women with a lower educational attainment are less likely to be advised to get their weight monitored during pregnancy or have their blood pressure, urine and blood tested. Perhaps the

health care providers were apathetic towards these lowly educated women who felt that they could not demand such tests.

In other words, the mothers living in the poor socio-economic households received mostly those services which came to their door step. In Sona Mia slum, health workers from the nearby UPHCP came twice a week to provide injections and vitamin-iron tablets to pregnant women. A very similar experience is shared by the mothers living in Karwan Bazar slum, where they received ante-natal care from the nearby '*Surjer Hasi'* (literally meaning Smiles of the Sun) clinic. However, while in many cases they were advised to go for an ultra sound or blood test, they could not afford to do so due to various reasons stated by the mothers. In the words of Rehana:

> *Apa* I won't tell a lie. I did not go anywhere. People suggested me to go for a check-up, especially for injections. But I did not go. I am scared of injections. People said, if you do not go for injections, you might have trouble afterwards. But I did not care, because I do not trust them. I was confused whether they are telling me the truth or a lie (Rehana, aged 16, mother of one child, Sona Mia slum).

On the other hand, in addition to receiving a tetanus toxoid injection during her pregnancy, Taslima from Sona Mia slum managed to go for an ultrasound test in the fifth month of her pregnancy with help of neighbours. Although both Rehana and Taslima are poor, and without any income or a job, the difference between their situation is that Taslima has been living in Dhaka for quite a few years and has built up a neighbourhood network that she can rely on. On the other hand, Rehana migrated to Dhaka only six months ago and has not yet been able to develop a trust

worthy neighbourhood network. The mothers, whom I interviewed at health facilities, took ante-natal care (ANC) seriously and follow the advice of their health providers.

Compared with ANC, the quantity and quality of childbirth care obtained by the mothers of the lower income households is low. Among 23 mothers from the two slums only five had their children delivered at health care centres (Table 4.4). Of the 23 women interviewed at the Ad-din Hospital and the maternity centre, 12 women had their delivery at a hospital. However, hospital based delivery in all these cases does not mean that they all chose to have a hospital based childbirth had a normal delivery. Rather, these women who went to the hospital for their delivery were taken there in the last stages of prolonged labour or obstructed labour which eventually resulted in conditions like obstetric fistula or uterine prolapse. It is seen in the Three Delay Model of Thaddeus and Maine (1994) discussed in Chapter Two, how delays in transferring women with obstetric complications to hospitals cause maternal death or morbidity.

The importance of post-partum care in preventing maternal morbidity and maternal mortality is indisputable as post-partum complication mostly occurs during the 24 hours following a delivery (NIPORT et al. 2013, p. 132). However, similar to the low prevalence of post-partum care in Bangladesh as a whole, where only 27 % of mothers are reported to have received post-partum care for themselves (NIPORT et al. 2013, p. 133), the mothers of lower income households in this study also have a

very poor response to post-partum care (PNC). None of the mothers, who had a home based childbirth, went to receive PNC anywhere. Those, who did have a PNC reported at the interview that they actually had hospital based childbirth and went for a routine PNC visit. The lack of PNC visits is more likely to increase the chance of post-partum maternal morbidity. The following section elaborates on the causes of and suffering from the maternal morbidity as reported by the mothers from the lower income households.

### 4.4.2: The causes of morbidity and suffering of affected mothers of lower socio-economic households

Uterine prolapse, obstetric fistula, urinary incontinence, perennial tears and chronic backache were found to be the major morbidity incidents among the mothers from the lower socio-economic households. The average duration of suffering varies between two and seven years (Table 4.5). The duration of suffering is the period that a woman has been suffering from a condition since its onset. All the mothers interviewed who were suffering from fistula had sought treatment for their illness. It is important to note however, that not every mother suffering from fistula is receiving treatment. Rather it means that in this research, I interviewed only those mothers who were suffering from fistula and were receiving treatment at the health facilities. Before coming to the health centre, they remained untreated for a long time since developing obstetric fistula. Some of the respondents reported as having more than one morbidity. In particular those having prolapsed uterus also had urinary incontinence, chronic backache etc. As Bonetti, Erpelding and Pathak (2004, p. 167) discussed, maternal morbidities like uterine prolapse can cause

other conditions like lower back pain and put mothers in a very uncomfortable situation to do their daily work.

**Table 4.5: Types and duration of morbidity among the mothers of lower socio-economic households, Dhaka, 2012**

| Type of morbidity/ complication | Number of respondents* | Average duration of suffering in years | Treatment sought | |
|---|---|---|---|---|
| | | | Yes | No |
| Fistula | 10 | 7 | 10 | 0 |
| Uterine prolapse | 10 | 4 | 3 | 7 |
| Urinary incontinence | 3 | 2 | 0 | 3 |
| Perennial tears | 9 | 2 | 0 | 9 |
| Anaemia/weakness | 15 | 4 | 3 | 12 |
| Chronic back pain | 9 | 4 | 2 | 7 |

Source: Field work 2012
*Some respondents reported multiple complications

Among all morbidity conditions suffered by women, fistula is the worst in terms of duration and the nature of suffering (Ahmed and Holtz 2007, p. S10; Bangser 2006, p. 535; Muleta 2006, p. 963; UNFPA 2003, p. 13; Roush et al. 2012, p. 787). The sensitivities surrounding the treatment of fistula as well as the costs involved make the sufferer endure the pain and suffering for very long periods. As shown in Table 4.5, the duration of suffering from fistula is also found to be longer than that for other maternal illnesses. The reason for this long duration for fistula could be many, and would include lack of information on and access to, fistula treatment, and insufficient financial ability to treat fistula. Keeping the severity of this condition in mind, Chapter Six will particularly focus on suffering and seeking remedies for fistula by the mothers who have this chronic condition.

The reasons for maternal morbidity conditions for mothers from the lower socio-economic households are mostly related to their poverty. Early age at marriage, frequent child bearing with high parity, heavy work in household chores during and after delivery, mishandling of vaginal delivery by TBA, under-nutrition, anaemia and socio-economic factors that inhibit timely or any healthcare seeking are considered to be the main reasons for morbidities such as uterine prolapse, urinary incontinence and/or chronic backache. Previous studies conducted elsewhere (Walker et al. 2011, p. 129; Bonetti, Erpelding and Pathak. 2004, 169) have come up with similar findings. Overall, the failure to receive timely and skilled delivery care and post-partum care as well as lack of support with household work after childbirth are other factors which exacerbate these mothers' susceptibility to post-partum morbid conditions.

The post-partum morbidity conditions have serious consequences for these women's lives and their suffering is intense. Their daily life, their work and their relationships with their husbands are badly affected (Bonetti, Erpelding and Pathak 2004, p.167). For example, women with uterine prolapse suffer from abdominal pain, chronic backache, painful intercourse, white watery discharge, a burning during urination and difficulty in lifting, sitting and standing (Bodner-Adler, Shrivastava and Bodner 2007, p. 1,345). Mothers of lower socio-economic households who suffer from maternal morbidity reported various kinds of physical and emotional pain and suffering, as shown in Table 4.6.

**Table 4.6: Pain and suffering due to maternal morbidity among mothers of lower - socio-economic households, Dhaka, 2012**

| | |
|---|---|
| Physical pain | • Difficulties in doing regular work at home and outside<br>• Continuous physical discomfort<br>• Pain and burning |
| Mental and social stress/fear | • Fear of being abandoned by the husband<br>• Mental stress due to not being able to work |
| Economic vulnerability | • Loss of money in treating the illness<br>• Loosing honour in society<br>• Stigmatized by the neighbourhood<br>• Loss or discontinuity of earning due to loss of physical capability to work |

Source: Field work 2012

Any illness causes pain and suffering to the person having that illness, but the duration and intensity of suffering varies according to the particular type of condition or illness. Further, the pain and suffering may not only be physical, but may also cause mental stress and render a person socio-economically vulnerable as well. For example, morbidity such as urinary incontinence and perennial tears cause burning sensation during urination and intercourse.

As stated by Laili from Sona Mia slum, who is aged 25 years and mother of two children:

> I can't go out in the sun. *Amar matha ghuray* (I feel dizzy). Moreover, when I urinate, it burns. Sometimes I stay well, but most of the time it burns so much that I can't even urinate properly and later my clothes gets dirty. My *Tolpet* (lower abdomen) becomes sore a lot. It's been three to four years since I have this problem (Laili, aged 23 years, mother of two children).

Uterine prolapse (locally known as *poddo*), if it happens at an advanced stage, creates problems for women doing households chores. Many mothers from lower socio-economic households interviewed in this study work as housemaids to earn

their living. This work requires them to sit down in a squatting position for long hours to mop floors, wash clothes and cut up vegetables etc. Squatting makes their prolapse worse. Moreover, women suffering from this illness cannot do their work efficiently. Nupur (aged 22 years) from Sona Mia slum, who has uterine prolapse, described her condition as follows:

> Now my only problem is that '*poddo'* comes out and hurts me when I sexually interact with my husband and do my household chores.

This physical suffering from a maternal morbidity has important social dimensions, including social suffering, and being abandoned or exploited by husbands. Particularly, mothers suffering from fistula, in many cases, have been abandoned by their husbands, secluded and stigmatized. As found in this study, mothers suffering from maternal morbidity, such as uterine prolapse, anaemia and backache always fear being abandoned by their husband or fear being labelled as 'unproductive' by the society. Rehana, Hasna, Banu and Rumu from Sona Mia slum and Lolita from Karwan Bazar slum expressed their concern that their husbands will abandon them if they are not capable enough to satisfy the needs of household work and those of sexual and reproductive life. Stanton and Brandes (2012, p. 122) summarize the social consequence of maternal morbidity, particularly in the case of mothers suffering from uterine prolapse in Bangladesh, as follows:

> [W]omen with conditions of chronic maternal morbidities, such as uterine prolapse, sometimes experience *khota* (insult) whereby they are ridiculed by neighbours and in-laws for jeopardizing the marriage through not meeting the sexual needs of the husband or not carrying out household responsibilities.

Stanton and Brandes (2012) also showed in their research that the economic consequences of maternal morbidity are intense at the beginning of the onset of a complication, i.e. the first six weeks after birth and then the consequences tend to diminish. This might be due to fact that the poor family has to take out a loan to treat the maternal complication as soon as it is detected. In this current study, it was found that Rumu and Reshma both had to take out a large loan from their neighbours to go to a hospital and receive treatment for obstetric complications. Rumu got these conditions three years ago and although she has now recovered she is still carrying the debt and working hard to repay the same. Reshma, who had been suffering from post-delivery complications and anaemia for the six months preceding the field work, is still carrying the debt which she incurred during her treatment but she cannot yet return to work to repay her debt. So, in some cases the economic consequences of a maternal illness last longer than other consequences. The long term economic consequence of maternal morbidity was also evident particularly for those women who used to work regularly to earn money as garment workers or housemaids. Conditions like uterine prolapse, urinary incontinence, and backache gives them intense physical suffering and makes them unable to work.

The intensity of suffering eventually makes the women very keen to treat their illness. Ironically however, they have a dearth of information about the availability of, and opportunities for appropriate treatment. In addition, they experience economic, social, familial and structural barriers to receiving treatment. As a result,

their suffering gets more serious and lasts longer. This ironic situation is discussed in more detail in the next two chapters.

## 4.5: Background characteristics of mothers from upper socio-economic households

The socio-economic and demographic characteristics of the mothers of upper socio-economic households are in many ways different from those of the mothers of lower socio-economic households. Unlike the mothers of lower socio-economic households, all the mothers of the upper socio-economic households gave birth in private clinics or hospitals and received modern treatment from highly qualified medical professionals. They rarely have any post-partum morbidity, except for a few incidences of post-partum depression and backache.

### 4.5.1: Occupation and socio-economic of the mothers and their households

As mentioned in Chapter Three, this research considered households of the highly salaried professionals and businessmen in Dhaka as upper socio-economic households. Rahman (2007) suggested that upper socio-economic households are those households which have a monthly income of more than 30,000 BDT (USD 390) from a formal source of earning and where the household head has a tertiary education. According to the income of the husbands alone, a household from this upper income category has an income of at least BDT 30,000 per month. While the husbands earned an income of not less than BDT 30,000 per month, there were 18

mothers who had no income and eight mothers who earned BDT 30,000 or less (Table 4.7). Thus, there were 26 mothers who earned BDT 30,000 or less.

**Table 4.7: Income status of the women and their husbands from the upper income households, Dhaka, 2012**

| Income range (BDT per month) | Number of mothers | Number of husband |
|---|---|---|
| 0 | 18 | 0 |
| 1-30,000 | 8 | 0 |
| 30,001-60,000 | 3 | 10 |
| 60,001-90,000 | 0 | 9 |
| 90,000-12,0000 | 1 | 3 |
| 12,0000+ | 0 | 8 |
| Total | 30 | 30 |
| • Mean income of mothers: 15,966.67 (USD 228)<br>• Mean income of husbands: 160166.67 (USD 2,288)<br>• Mean family income of BDT 195,600 (USD 2,794) | | |

Source: Field work 2012

For these 26 mothers, the higher incomes of their husband have positioned them into the higher socio-economic group. These mothers are able to lead affluent lives and employ at least one maid to do the household work and look after the children while the mother is at work. Most of them have motor vehicles for transport and are members of various social groups to engage with their peers. A few well known private hospitals and clinics are, in most cases, within a stone's throw from these mothers' residences. The income and educational attainment of the mothers from upper socio-economic households reflects their affluence and high educational status. The mean family income of BDT 195, 6000 BDT (USD 2,794) is much higher than per capita income (USD 1010 in 2013 according to Worldbank n. d.) in Bangladesh (worldbank.org). Their family income is many times higher than that of the lower socio-economic households

All the mothers of the upper socio-economic households had at least some level of tertiary education. This high level of education is very likely to influence the healthcare seeking behaviour of these mothers, as previous studies have shown that there is a significant positive relationship between the education of women and their health care seeking behaviour (Kamal 2009).

In terms of occupation, not every mother reported that they were working at the time of the survey. Some of the interviewees were employed before their childbirth but left their jobs to look after their children. Fatima, (aged 32 years, who is the mother of a 6 year old boy and had a miscarrige a few months before I interviewed her) stated that she and her family had employed three people as household help and one driver in their house of five family members (Fatima, her husband, her son and her parents-in-law). She left her job to look after her child when he was born. According to her statment:

> I used to stay in my flat alone. My parents-in-law were out of the country then. My husband told me: 'why do you need to work hard at office the whole day? You go out in the morning and come home at night. It affects your health. I better give you that money'. Can anyone be happy with that decision? But you know it is the woman who has to do all the compromize and sacrifice. Otherwise, *songsar* (the family) cannot survive.

With two exceptions, the working mothers interviewed in Dhanmondi, did not consider their income as necessary for their survival. Rather, their earning was seen to be a complementary income for the family and a way of maintaining their status and self-respect within the family. The income earned by their husbands or the total

income of their families including sources like business or house rental was sufficient to put them into the category of high socio-economic households.

### 4.5.2: Demographic background of mothers from upper socio-economic households

In terms of demographic characteristics, the mean age of the mothers from the upper socio-economic households is 35.5 years, which is 10 years higher than that of the mothers of lower socio-economic households. This difference in current age of mothers between the two groups of households could be due to the selection criteria of mothers for interview in this research. I interviewed those women who became pregnant and gave birth at least once in the five years preceding the survey. The women from the upper socio-economic households have higher educational attainment. A woman with a higher educational level tends to marry later and starts having children later than women with lower or no educational attainment (Islam and Begum 1992).

**Table 4.8: Distribution of mothers from upper socio-economic by demographic characteristics, Dhaka, 2012**

| Age range | Number of mothers | | |
|---|---|---|---|
| | Current age of mothers | Age at marriage | Age at first childbirth |
| 20-24 | 0 | 9 | 7 |
| 25-29 | 3 | 18 | 16 |
| 30-34 | 10 | 2 | 4 |
| 35-39 | 12 | 1 | 3 |
| 40+ | 5 | 0 | 0 |
| Median age: 35.5 years<br>Median age at first marriage: 26 years<br>Median age at first childbirth: 28 years | | | |

Source: Field work 2012

Table 4.8 shows the median age at marriage (26 years) and that of first childbirth (28.9 years) is much higher than the national median age at marriage (15.5 years) and also higher than the median age at marriage of women from the highest wealth quintile of the country, which is 17.4 years (NIPORT 2013, p. 53). Most of the mothers in both the lower socio-economic and upper socio-economic households had one or two children. There could be two reasons behind this; first, the current age pattern of the mothers of lower socio-economic households indicates that most of them are in early reproductive ages, therefore, at the time of the interview they had only one or two children and it is likely that they will have more children as they advance in their reproductive ages. Second, this could also be at least partly due to the success of the family planning program in Bangladesh. The use of contraception and family planning has been more accepted and used by large sections of the population of Bangladesh, irrespective of their socio-economic class (NIPORT et al. 2013, pp. 84-85).

### 4.5.2: Maternal health care status of mothers from upper socio-economic households

Mothers from upper socio-economic households follow a high standard of maternal health care during pregnancy, childbirth and the post-natal period. With their reliance on medical professionals the mothers from upper socio-economic households receive care from well-known private clinics or hospitals in the area surrounding Dhanmondi. Unlike the mothers from lower socio-economic households, the mothers from upper socio-economic households are very reluctant to receive maternal health care from public hospitals or traditional healers. But they

are also opposed to not having any maternal health care; therefore they choose the expensive private clinics or hospitals, which they can afford because of their high income.

> At my first pregnancy I saw my doctor for the first time at one and a half months of pregnancy. I tested for my pregnancy at home with stripe and found that I was pregnant. I went to my doctor the very next day. I could not wait to see the doctor. Both my husband and I decided to go to the doctor first to get some advice. Because this was the first issue and we were totally inexperienced. We did not have any elder person around also. Moreover, as it is Dhaka, I thought I better go to a doctor first. From then on, I used to go to the doctor every month. The first time when I went to see my doctor, he asked me to do some tests, one ultra-sonography to see if the baby is growing alright, breathing alright etc., some blood tests and urine test. He asked me to take the report to him after two weeks. So I went to see him with the reports during the 8$^{th}$ week of my pregnancy. Then doctor checked and found that everything was alright. He then gave me some vitamins, folic acid tablets etc. and asked me to see him once in a month. (Eshrat, aged 38, mother of one child, Dhanmondi)

The above statement from Eshrat gives a clear picture of how some mothers rely on medical professionals from the very onset of their pregnancy. This is quite the opposite of that from the lower socio-economic mothers who did not want to see a doctor for pregnancy and childbirth, the upper socio-economic household mothers want to see a doctor from the beginning to learn about their pregnancy and get expert advice. In the case of Eshrat, she saw her doctor once every month. This heath care seeking behaviour is typical of all the upper socio-economic household mothers. Thus, on average, these mothers visit clinics for ante-natal care (ANC) an average of seven times, which is much higher than the recommended number of four ANC visits (WHO 2006, p. 1).

All of the mothers I interviewed from the upper socio-economic households had a Caesarean Section (CS) for child delivery, although not all of them did so as a medical response to emergency obstetric care (EmOC) to manage obstetric complications. While some mothers had complications which led them to a CS, others chose to have a CS for various reasons which are discussed later. However, their choice was influenced by other mothers who had chosen this for themselves, albeit for different reasons related with their own perception and experience and their socio-economic condition. Table 4.9 illustrates for every mother the reasons why they chose a Caesarean. These reasons indicate that their choice was obviously not determined only by medical factors, but that there were some psycho-social issues as well, such as fear of natural birth, the perceived superiority of medical intervention in childbirth and pregnancy over natural birth methods, and the prevailing social trend. A detailed discussion of this is given in Chapter Seven.

**Table 4.9: Reason for CS done among the mothers of upper socio-economic households, Dhaka, 2012**

| Mother's name | Reason for choosing a CS | |
|---|---|---|
| Hasna | Did not want to take the hassle of labour pain | No medical reason (n=10), which is 33.3% of total mothers of upper middle class households. |
| Yasmin | | |
| Shameema | | |
| Piya | Could not gather courage for labour pain | |
| Konica | | |
| Rokeya Rahman | | |
| Beli | Was not very sure about how normal delivery will be. | |
| Dolly | | |
| Anisa | Everyone did CS in family | |
| Neena | Did not want to continue any more with pregnancy | |
| Chameli | High blood pressure | Medical reason (n=13), which is 43.33% of total mothers of upper middle class households. |
| Morium | | |
| Opola | | |
| Rejina | Diabetic | |
| Fatima | | |
| Urmee | | |
| Usha | | |
| Shelly | | |
| Ishtiya | Water broke | |
| Trina | | |
| Topoti | | |
| Jerin | | |
| Nargis | No labour pain after due date was over | |
| Lubna | Don't know why doctor did asked for CS | Don't know the reason (n=7), which is 23.33% of total mothers of upper middle class households. |
| Saleha | | |
| Shabnam | | |
| Tahmina | | |
| Lucy | | |
| Rina | | |
| Mukti | | |

Source: Field work, Dhaka, 2012

### 4.5.3: Maternal morbidity status of mothers of upper socio-economic households

The nature, type and pattern of treating post-partum complications is quite different among the mothers of the upper socio-economic households compared with lower socio-economic households. All interviewed mothers from the upper socio-economic households could access emergency obstetric care (EmOC), when needed, and had in fact chosen CS for their delivery. As all the mothers from upper socio-economic households stayed under the supervision of their doctor almost a week after child delivery, they were able to avoid any immediate post-partum maternal morbidity, such as excessive bleeding, infection after a CS, or were treated for any condition they had developed after their CS. However, three of the 30 mothers were reported to have post-partum depression for a year on average.

The notable difference between the mothers from lower socio-economic and upper socio-economic households is that maternal morbidity which the mothers of lower socio-economic households suffer from, mostly originates from lack of properly managing obstetric complications during child delivery or due to a failure to receive emergency obstetric care (EmOC). Their maternal morbidity also occurs from their stressful physical activity in the house and outside after childbirth. That is why the conditions such as obstetric fistula, uterine prolapse, urinary incontinence and backache are more common among the mothers from the lower socio-economic households (see Chapter One for aetiology for different maternal morbidities). On the other hand, the mothers from upper socio-economic

households experienced complications mainly during child delivery but they were treated in time.

## 4.6: Conclusion

In this chapter the socio-economic and demographic characteristics and maternal morbidity status of the mothers of both socio-economic groups of households has been presented. The main objective of producing this chapter is to portray a background profile of the mothers, based on which health care seeking behaviour of mothers for maternal morbidity could be understood in the subsequent chapters. From the above discussion, we see a contrasting picture of socio-economic and maternal health status of mothers from the lower socio-economic and upper socio-economic households. Residence, income and employment status, pattern of current age, age at marriage and first childbirth, and the type of maternal health care which the mothers received during pregnancy and childbirth, present contrasting pictures between the two groups of mothers. One group of mothers belongs in an advantaged class in terms of income, employment, residence etc., while the other group of mothers is in some cases living below the poverty line and their poor maternal health conditions have put them into further precarious socio-economic situations due to their inability to work and earn an income.

The mothers from the lower socio-economic group of households for this study come from a typical poverty situation of very low income, low education, poor housing, poor hygiene and poor health status. According to the World Health Organization, this kind of "[p]overty is associated with the undermining of a range

of key human attributes, including health" (WHO n.d.). They are poor in terms of continuous deprivation of what they need. Deepa Narayan (2000, p. 56) explains this poverty as "a combination of issues where people might suffer from shifting combinations of problems over time". The women in the lower socio-economic households studied for this research are poor not only because they come from poor households, but also because they are deprived of many things and services that they are entitled to access and receive legally and socially. They experience poor maternal health because they enter into motherhood with poor nutrition and poor health status; they do not receive proper medical care during their maternal morbidity and complications because they are not informed and educated enough about this. Winikoff (1988) similarly addressed how ill health is perpetuated from mothers to children. A girl child growing up in a resource constrained environment with a reduced share of food, health, education and other household and social resources turned into a bride as soon as (or even before) she reaches puberty has to give birth to a child at early age without 'reliable' and 'adequate' care during pregnancy and childbirth (Winikoff 1988, pp. 197-198), as discussed in Chapter Two, Thus, their poverty experience has multifaceted dimensions that need to be addressed comprehensively to understand their health care seeking behaviour.

That is why, in this study, poverty of the participant mothers and their households should be seen not only from the perspective of lack of money, but it should also be seen from the perspective of numerous non-monetary factors, for example, factors underlying the social, structural and cultural setting, influence the health care seeking behaviour of mothers for their child delivery and post-partum care in poor

socio-economic settings. In fact, as Ruth (2004, p. 16) argued the capability of someone to do something is only partly explained by money or in others words what money buys is merely a "means" to the way "of achieving the functioning". Sen (1979, p. 271) argued that the functioning of achieving something largely depends on the social arrangement (Sen 2008, 273) in which s/he lives plus her/his personal characteristics.

As stated before, in the urban context, where health care facilities are mostly in close proximity of the mothers, the reason for their inadequate health care for childbirth and post-partum care may lie in the socio-cultural atmosphere of the urban slum the mothers live in e.g., social network, availability of information, support network from family and neighbourhood etc. as well as the 'personal characteristics' of mothers like education, age and self-esteem. Together, the social arrangements and personal characteristics may hinder mothers from being 'capable' enough to achieve the optimum 'functioning' by using their limited resources and money. And this leads to morbidity conditions during and after delivery. Many women end up having short term and/or long term maternal morbidity or illnesses. The socio-economic status of the respondents often comes forward as the main determinants for a mother whether to seek or not to seek health care for maternal morbidity.

On the other hand, the affluent socio-economic condition of the upper socio-economic household mothers had led them to follow a certain 'modern and urbanized trend' of pregnancy and childbirth which, in many cases, results in an

overuse of maternal health care for the given maternal health condition of these mothers. This is indicated by more frequent ANC visits and performing CS for childbirth by the mothers of upper socio-economic households than the number recommended by the World Health Organization. While the financial capability of mothers from the upper socio-economic households enables them to choose modern, high cost-dependent private clinic based maternal health care, the choice of a CS without any medical ground or undergoing CS without knowing why it was done (see Table 4.9) may pose a further question about the benefit of depending on the private maternal health care system in Bangladesh. In the following four chapters we will explore and discuss all these issues.

# Chapter Five

# Health care seeking behaviour among women of lower socio-economic households: Does only money matter?

Often, health services of a reasonable quality exist, but few use them. Just as important are the physical and financial accessibility of services, knowledge of what providers offer, education about how to best utilize self and practitioner-provided services and cultural norms of treatment. (Ensor and Cooper 2004, p. 69)

## 5.1: Introduction

The main objective of this chapter is to examine whether it is poverty that affects the health care seeking behaviour of the mothers of lower socio-economic households for maternal morbidity during and after delivery, or if there are other factors, either by themselves or in conjunction with poverty that influence the health care seeking behaviour of these mothers. In particular, this chapter pays specific attention to whether, why and how the socio-economic status of women impacts upon their perception, experience and practice of health care for their maternal morbidity during delivery complications and post-partum illnesses. In Chapter Two it was identified that there is a broad scheme of free and low cost health care services in Dhaka in close proximity to the residences of the low income households of the women interviewed in this study. However, of all the respondents from the two slums, only five reported having had a delivery in a health facility but 25 mothers reported they were suffering from illnesses caused by pregnancy or delivery complications and have not had any proper treatment for

their illness. Moreover, as mentioned previously, the poorer households face both financial and non-financial barriers in accessing maternal health care services (Ahmed and Khan 2011, p.1; Chakraborty 2003, p. 328; Parkhurst, Rahman, Ssengooba 2006, 439; Nahar and Costello 1998, p. 417).

In the light of the information given above and based on the basic conceptual framework presented in Chapter Two, the discussion presented in this chapter will be explained under the three main themes of perception, experience and practice:

1. Perception of childbirth and maternal illness;

2. Experience of mothers at home and in health facilities; and

3. Practice of maternal health care seeking for childbirth and post-partum complications.

This chapter will also draw a comparison between the perception, experience and practice of women of lower income households living in slums and the women who came to receive treatment for maternal morbidity and child delivery at health facilities in Dhaka. This comparison will focus on how and why, despite having similar economic status, some women decided to seek health care for their conditions while some others did not.

## 5.2: Perception regarding childbirth and maternal conditions

As discussed in Chapter Two, the perception that a person has about her health, health status and health care develops from her subjective awareness of the same as well as the socio-economic and cultural context in which she lives. In the following

sections, the perception that the mothers of the lower socio-economic group of households hold regarding childbirth, maternal morbidity and related health care seeking are presented under a number of subthemes, which emerged from the interviews with the mothers. The sub-themes are: apprehension about modern health facilities for child delivery, culture of silence, perceived hidden cost and mistrust, and viewing childbirth as only women's matter.

### 5.2.1: Apprehension about modern health facilities for child delivery

Most of the mothers interviewed in Sona Mia and Karwan Bazar slums had apprehensions about hospital delivery. They have such apprehensions because many of them had a negative perception about modern health care facilities. The mothers from lower socio-economic households interviewed were found to have several forms of fear, as will be discussed in the following pages.

## Fear of caesarean delivery

While emergency obstetric care facilities have been expanded to bring them in close proximity to rural and urban dwellers in Bangladesh (NIPORT et. al. 2012, p.3), mothers of lower socio-economic households still fear caesarean operations. Their avoidance of maternal health facilities for child delivery is generally attributed to their assumption that hospital delivery means caesarean section (CS). Many of the mothers interviewed have received access cards from the nearby health facilities during their ante-natal care (ANC).[35] They were told by the ANC

[35] This has been reported to me by the participating mothers as well as by the health care providers, I interviewed in maternity centre of UPHCP.

providers several times that delivering babies at hospitals would help avoid complication. However, only a very few mothers followed this advice. Many mothers experienced long duration obstructed labour and developed illnesses after childbirth, but were not inclined to go to health facilities for child delivery. The reason why they are afraid of CS may be explained by the statements of some of the women interviewed in this study.

Fatima from Sona Mia slum, who is a working mother, has a strong family and social network in her neighbourhood and can make decisions for her own health care. She lost her first child due to obstetric complication occurred at home. Yet for her second child she still refused to go to a hospital as a precaution. She said, "sister, my heart shrinks with fear when I think of going to a hospital for delivering baby" *(Apa amar koliza voye shukaye jay, haspatal e giya baccha howar kotha sunley).* Fatima's statement indicates how fearful she is in about going to the health facilities to deliver a baby. Her feelings about hospital based childbirth contradict with the findings of Lubbock and Stephenson (2008) discussed in Chapter Two, that an incidence of complication in childbirth makes a mother more inclined to seeking care for the subsequent childbirth. However, in spite of having her first child dead due to obstetric complication, Fatima did not show any inclination to deliver her child in health facilities. She explained why in the following statement:

> At the 8th month of my job (Fatima used to work in a garment factory but now she works as a housemaid), a Marie Stopes worker came to our area. She asked me to go to their hospital on *Noorjahan* Road, Panir *Tanki* area. They said they would give me a red card[36]. They said it is better to have delivery in the hospital, so that if anything happens, they will be able to take care. But I could not go there out of fear. Because, even if it could be a normal delivery, they (doctors) would intentionally go for a caesarean section. We have to work for a living for our whole life, *Apa* (i.e. sister). If we have a baby by caesarean section, we will not be able to work. We will not be able to carry water, wash clothes etc. My abdomen will get pressure and the sutures will be loosened. For this fear, I do not want to go to hospital for delivery, *Apa*. Moreover, if we have one baby by caesarean, for the next baby I will also have to go for a caesarean. It will just be waste of money unnecessarily. (Fatima, aged 23 years, mother of one child, Sona Mia)

This part of Fatima's story expresses the nature of apprehension she holds regarding hospital based delivery; such as, mistrust of hospitals, perceived adverse physical impact of CS and high cost involved in CS. Her apprehension is largely justified by the context she lives in. Given the fact that she is not able to spare a day without working for her living, she cannot afford to go to a hospital for childbirth. However, the fear of Fatima that in health care facilities CS is done without a medical reason may have arisen from the information she received from a neighbour or it might be that she was not given adequate explanation about CS during her ANC visit.

Such apprehensions related to hospital delivery have also been noted in previous studies conducted in rural areas of Bangladesh (Head, Yount and Sibley 2011, p.1,165; Parkhurst and Rahman 2007, p. 395). Parkhurst and Rahman (2007, p. 396) describe how the women distrust a doctor's recommendation to have a

[36] A red card is given to the poor pregnant mothers living near the Urban Primary Health Care Project Centre for free child delivery at that facility.

delivery by CS, and how this further dissuades women from choosing a facility based delivery. However, the irony is that a prolonged obstructed labour and unskilled management of child delivery, which some women ultimately experience in trying to avoid a CS, often result in short and long term maternal morbidity such as uterine prolapse, perennial tear and urinary incontinence and prevent the women from working with full productivity. Some of the women interviewed at the Sona Mia and Karwan Bazar slums and the Ad-din Hospital stated that their suffering and loss of physical capacity to work were caused by their maternal conditions arising out of the long duration of obstructed labour, heavy bleeding during delivery and lack of adequate post-partum care.

The respondents who came to Ad-din Hospital and maternity care UPHCP Centre to deliver their babies appeared to have no restrictive perceptions regarding facility based hospital delivery. Although, most of them preferred to have a normal delivery, they were ready to accept a CS delivery if needed. Nevertheless, the fear of CS was also discernable among them. For example, during the delivery of her second child, Minara was suffering from obstructed labour. After half a day of suffering at home she came to the maternity care and delivered through CS. She regretted this, believing that if she had stayed at home a little longer and waited, she might have had a normal delivery and might not have been worried about any post-partum health conditions due to the CS.

> Hmm. if a baby delivers normally, that's very good. I don't need to stay in hospital for these many days. I would have been able to eat whatever I want, I would have moved wherever I want. But now, I have to wait here for five days. I am feeling

> very uncomfortable in my body, can't move properly, can't lie down properly, can't sit properly, I have to take lots of medicine, due to which the baby is not getting enough milk. The head of the baby was stuck. Then what to do? Life is more important. Then my husband gave consent. I am a CS patient. I won't be able to do any heavy work in the near future. Who will do my work after I go home, you tell me Apa? (Minara aged 20 years, mother of one child, Maternity Centre of UPHCP)

Minara's statement illustrates the dilemma that she was going through. In order to save the life of her baby, she had to undergo a CS procedure, but she could not give up thinking about being uncomfortable and having difficulties in working after going home from hospital. The reason for this worry could be explained by the unavailability of social and family support network.

Yet, having low income does not necessarily mean that these women would not go to a hospital for delivery. Sopna, Rabeya, and Amena of Karwan Bazar slum, who have a strong and extended family and social network in their surroundings, decided to go to a hospital for delivery without any delay. However, all of them called the *dai* first, but because the *dai* was not available at the time, they moved to a hospital and prevented serious complications. Amena went to the nearby 'S*urjer Hasi'* health centre by herself soon after her labour pains started. However, when she was advised by the *'Surjer Hasi'* clinic to go to Dhaka Medical College Hospital to deliver her baby, her mother stopped her from going there; instead she got a pain inducing medicine from a nearby Unqualified Allopathic Practitioner (UAP)[37] at a local pharmacy and the baby was delivered normally at the clinic. Amena's childbirth experience again confirms that, when giving birth women want

[37] See Chapter Two for more information about UAP.

to be in an environment they are familiar with and where they feel comfortable. The *Surjer Hasi* clinic is located near Karwan Bazar slum where Amena lives and she was familiar with its environment and service providers. However, when they advised her go to a bigger health centre (Dhaka Medical College), Amena's mother refused to go because delivering a child at the medical college would involve more cost, there would be a larger social distance between the doctor and her daughter and themselves, and they would have no control over the birthing event.

The inclination of the respondents from Karwan Bazar slum to go to a hospital (if needed and if a good *dai* is not available) could be explained by two things: first, the location and structure of the slum itself. Recalling the information of the studied slums presented in Chapter Three, Karwan Bazar slum is one of the prominent slums of Dhaka, located next to a big popular market place and it provides numerous working opportunities, mobility and exposure to the market, for both male and female slum dwellers. Compared with Sona Mia slum, Karwan Bazar is more populous, more exposed to markets, and better networked. Thus, the women living in this slum could be found to be more receptive to modern information than the women living in Sona Mia slum. These factors had predisposed the women of Karwan Bazar to go to the health facilities if the *dai*s were not available. Second, the positive perception of accepting the alternatives to home birth is backed up by the extended social network of the dwellers of Karwan Bazar. A detailed discussion on the social and family network in these two slums is presented in next section on the experience of health care.

## Fear of losing honour

Apprehensions about facility based maternal health service can also come from the fear of losing honour that a woman has or is expected to have as a woman. The statement of Sheher Banu reflects that. She stated:

> *Apa* (sister), we will die, but we will not go to hospital for delivery. There, I heard, male doctors do this (CS). I know, female doctors deliver the baby but male doctors remain with them. Is it not a matter of shame, *Apa*? If any trouble happens, can a female doctor handle that? She will call a senior male doctor. People say that if we go to hospital for delivery they will do something that we will never be able to have any more babies. You know, the Government asks us to have fewer children, that's why they do something during CS. We heard about this from people around us." (Sheher Banu aged 35 years, mother of four children, Sona Mia Slum)

Sheher Banu portrays the cultural orientation of shame[38] and honour that a woman holds in Bangladesh. The women of her neighbourhood resist going to a hospital for child delivery as it is like bringing a very personal, natural event into the public sphere and it risks breaking the expected norm of society of not being physically examined by a male doctor. The urge to keep the norm may make the mothers reluctant to go to a hospital for childbirth.

Apart from this social norm, the quote of Sheher Banu raises other issues that might help in understanding the health care seeking behaviour of mothers of lower socio-

[38] By the word 'shame', I mean what is called in Bangla '*Abru'/sharam. Abru* or *sharam* includes covering one's body in front of others. It is a norm, in which the majority of the people of Bangladesh (and of some other South Asian Countries like India, Pakistan), believe *Abru* or *Sharam* is something that cannot be compromised under any circumstance. In Bangladesh women's behaviour and status is largely governed by the *abru/ sharam* she maintains according to the societal expectation (Krishnaraj and Chanana 1989)

economic household. First, the perceived fear of being sterilized through tubectomy by the health care providers while having medical intervention during childbirth. Sheher Banu could not identify any specific source of such information, but it could well have been due to her misunderstanding of the information given by family planning workers or healthcare providers. No study has been found to support this perception. However, further examination is needed explore this perception. Second, Sheher Banu expresses doubt that a woman can manage an obstetric complication, which reflects wider social attitudes about women's capability of working in highly skilled professions. Being a part of a society which has seen women's roles largely confined to the domestic sphere, Sheher Banu has not yet experienced or observed that women are as capable as men to do medical work in hospital.

The importance of maintaining this 'honour' perspective in relation to childbirth is also echoed in the statement of a traditional birth attendant Saleha (aged 40 years) from Sona Mia slum. While assisting a mother in delivering her baby, she gives high importance to ensure that none of the mother's body parts is exposed to anyone including the birth attendant.

> *Apa*, I have been doing this (working as birth assistant) for the last 20 years. I myself don't know which way the baby comes out. I mean I have never seen. I always cover the mother's body with a big *chador* (wrap) and try to feel the baby using my hand. But in hospital, everyone sees, doctors, nurses, and other hospital people. You cannot keep your *somman* (honour) if you deliver at hospital.

The high importance that the *dai* puts on maintaining a woman's honour or modesty while delivering her child could be one of the reasons that the *dai*s are so much preferred by the mothers as birth attendants. A previous study (Rozario 1995, p. s146) also highlights the importance of maintaining this modesty or honour during childbirth in Bangladesh (particularly in rural areas) and the preference of a *dai* as a birth attendant to ensure that a birthing mother's modesty or honour is protected.

Ross et al. (1998, p.103) describe how cultural proscriptions of physical examination by male doctors and restrictions of women's movement beyond the boundary of their residence define the health care seeking behaviour of women for reproductive health problems. Similarly, Blanchet (1984) argues that "shame, an important component of *purdah*, as it is understood by Bengali village women often explains why birth specialists or even relatives are excluded from attending the delivery of a child". Parkhurst and Rahman (2007) observed the same perception regarding the fear of being physically examined by a male doctor in rural areas of Bangladesh. Where the sense of shame and honour is so internalized, it is to be expected that mothers fear social consequences of breaking that norm. Thus Sheher Banu and other women's preference for enduring prolonged labour, contracting maternal illnesses and succumbing to complications of pregnancy rather than going to a hospital and being examined by a male doctor is not unusual.

My prior assumption was that this kind of shame and honour related to delivering a child in a health facility was not present in an urban setting. The urban slum dwellers might have already overcome the traditionally held cultural views about facility based deliveries by being involved in money earning activities in the public sphere and by living in a crowded place, rather than in a defined home boundary. In India, as claimed by Basu (2005 p. 314) both villagers and urban slum dwellers are "convinced about the virtue of modern behaviour" in birth control and in family planning and others. However, in this study, the urban mothers living in slums have not been yet much convinced about the modern health care, particularly maternal health care. It appears that migration to a metropolitan city like Dhaka, breaking the concept of the home boundary or even working outside the home may not be sufficient to change the women's perceptions related to shame and honour regarding child delivery at a health facility. Sometimes, for the sake of keeping that sense of honour, mothers keep silent or talk less about their maternal health problems. In some cases, that may lead to further deterioration of their health.

### 5.2.2: 'Culture of Silence'

'Culture of silence' has been a widely used expression in the reproductive health literature (Garg, Sharma and Sahay 2001; Gupta 2000; Osakue and Martin-Hilber 1998), ever since it was first coined by Dixon-Mueller and Wasserheit (1991). The propensity to keep silent about one's own illnesses, particularly those related to reproductive organs, comes from the prevailing perception of 'purity' and 'honour' of women's bodies in a society (Afsana and Rashid 2001; Dixon-Mueller and

Wasserheit 1991). This culture is further reinforced by the inferior position of women within their family and society in terms of income, education, social security, access to information and service etc. (Dixon-Mueller and Wasserheit 1991, p. 12). The interviews with the women of Sona Mia and Karwan Bazar slums depict how their culture of silence is putting them in an adverse situation in terms of their maternal morbidity and its treatment. In this study, the culture of silence is reflected in spousal communication as well as the mothers' sense of 'shyness' and 'pride'.

**Culture of Silence: Spousal communication**

Silence between husbands and wives especially regarding the condition of women's sexual or maternal health is considered as lack of spousal communication. Several studies have focused on the spousal communication and joint decision making process regarding family planning and reproductive health and found that spousal communication plays an important role (Furuta and Salway 2006; Santhya and Dasvarma 2002). However, among mothers of the lower socio-economic group in Dhaka, spousal communication about reproductive or maternal health has been found to be rare. Rehana, who recently migrated to Dhaka, gave birth to a baby three months ago. She has been suffering from uterine prolapse, backache and anaemia and has been facing physical difficulties in doing regular household chores. She stated

> When I look at it, I feel scared. I can see something reddish coming out. If I sit, it comes out. Elderly women ask me to walk "*chipe chupe*" (keeping legs as close as possible while walking). I am new and naïve. I don't know these many things. I know it's not my fault. I told him (husband). If I tell him more, he will think that "see, I don't have money in my hand, but she keeps telling me about her problem".

> He might go somewhere else leaving us here, or might go home to the village. How much I can disturb him complaining about my health? He has been disturbed already. Now we don't have money. If I ask for anything, he cannot buy. He cannot buy medicine. He gets angry if I tell him. You know, he is a male (*purush jat*), he can go anywhere. I think a lot that if I cannot work properly, will he keep me (as his wife)? I feel pain in carrying water, sitting a lot time while cooking. My leg hurts a lot. Will he tolerate all this, if I cannot get well? (Rehana, aged 20 years, mother of one child, Sona Mia slum),

Some important issues can be pulled out from Rehana's story. She is fearful of losing her husband, if she annoys him by repeatedly telling him about her health problem and being unable to do her households chores properly**.** Taslima, Nupur, Johora or Rehana, all four respondents from Sona Mia slum were found to have held this fear of losing their husbands, which made them remain silent about their conditions. Even if she informed her husband about her existing illness, the information did not turn into a clear and effective discussion between the spouses, which Santhya and Dasvarma (2002, p. 228) refer to as "clarity of communication" between spouses that could result in a pathway to treatment. This silence is considered as culturally normative expectation from womanhood, which women also internalize for ages (Head,Yount and Sibley 2012, p1,166) This normative expectation of keeping silent about maternal illness, coupled with the fear of social consequences, often takes priority over health consequences. As Dixon-Mueller and Wasserheit (1991, p. 13) stated " [f]or many women, the perceived risk of being beaten, divorced or abandoned, or of losing a source of emotional or financial support, far exceeds the perceived health risk of acquiring an STD".

The worry of losing a husband put Rehana into a paradoxical situation. She was very keen to treat her morbidity and return to her normal life so that she does not

need to annoy her husband anymore and he will not think of abandoning her. During the interview her repeated and eager question to me about a way out to treating her condition revealed her keenness to get better. The fear of abandonment outweighs any sense of valuing her own health and wellbeing; if she decides to get treated, it will be to avoid abandonment, rather than for the sake of her health.

In addition, the above-mentioned communication issues may lead to a lack of understanding between spouses, as happened with Lolita of Karwan Bazar slum:

| | |
|---|---|
| Lolita: | I took medicine from Nayon Doctor (local pharmacy doctor named as Nayon). After I took that medicine the scar in the torn area dried and got better. But I cannot do *mila misha* (sexual intercourse) with him. That place still burns. My husband gets angry with me for this. He often beats me for this, when I cannot have sex with him. |
| Researcher: | What do you say then? |
| Lolita: | What can I say? |
| Researcher: | Has he suggested you to see doctor? |
| Lolita: | Nah. He gave me money and said "bring medicine and take". He beats me and tells me that I have *bhab* (relationship affair) with somebody else, that's why I don't feel like meeting (having sexual intercourse with) him. (Lolita, aged 22 years) |

Apart from the usual lack of spousal communication regarding maternal morbidity, Lolita's conversation with me presents another dimension on how a lack of honest communication between spouses gives rise to misunderstanding. Her husband's assumption that her reluctance to have sexual intercourse is due to an extra-marital affair not only discourages her from seeking help for her illness but also worsens her physical and mental condition due to frequent beatings by her husband. In both these cases, honest spousal communication could help break the silence and find a pathway to treatment, as suggested by Santhya and Dasvarma (2002, pp. 223-224).

**Culture of silence: shyness and pride**

Women may also chose to stay silent regarding their health condition due to the shyness (another attribute that Bangladesh society wants women to have) and sense of pride in having a home based childbirth. For example, Nupur holds onto a culturally built-in shyness within herself which prevents her from going to see a doctor to seek treatment for her urinary incontinence. This is in spite of the fact that her husband is eager to take her to a doctor for treatment and compared with other dwellers in that slum he is quite capable of bearing the cost of the treatment.

According to Nupur:

> I told my husband (about the condition that she cannot hold urine and urinary tract burns tract when she urinates). He said that he would bring the medicine. He asked me to go (with him to see doctor). But can a woman tell this to a male doctor? It's embarrassing. I cannot. Then my husband said: "OK, I will tell the doctor and bring medicine". I said OK you go; I will not go with you. I feel shy. I will rather see the doctor when I go to my father's house (*baper bari*). There are many people, my cousins, *Aunty (khala)* and many. I will take any of them with me to the nearby clinic (*barir kachher* clinic) and go to see doctor easily. There is a *daktar Apa* (lady doctor) there. (Nupur, aged 18 years, mother of a nine month old boy)

Nupur feels shy about talking to a male doctor about her condition which has affected her private body parts, but this shyness makes her more vulnerable to the condition. Nupur believes that in her own family where she grew up, she would find the appropriate support to go to see a doctor. She knows that a lady health worker is available in her maternal village. A similar feeling is expressed in the statement of Taslima (aged 15 years, mother of one child) of Sona Mia slum. Taslima does not share her problem of uterine prolapse even with her husband. She believes that she will be more comfortable sharing her problems with her relations

on her maternal side. She was waiting to treat her problem with mother's (or other maternal female relative's) support during the *Eid* holidays when she would go to her parental home.

This view of Nupur and Taslima could be related to the migration impact, as discussed in previously. Both of them had just moved to Dhaka recently. Being recent migrants, they are not familiar with the urban health care environment. Neither have they yet been able to come out of the traditional view of shyness associated with maternal health care.

The feelings of shame and shyness which are manifested in 'silence' about one's own illness and sufferings among the mothers have been deeply rooted in the societal expectation from the mothers regarding their reproductive role that women should reproduce easily and without complaints (Parkhurst and Rahman 2007, p. 393;, Afsana and Rashid 2000, 2001, 2009; Head et al. 2012, p. 1,166). While rapid urbanisation has brought women into the labour force and introduced them to the modern world, their traditional ideas of motherhood and birth practices remain the same. That is why, in spite of having modern maternal health facilities nearby, seeking clinical care for child delivery or related health conditions is sometimes not welcome by the mothers and families.

Moreover, some mothers who did not need any facility based maternal health care for delivery or post-delivery complications are proud that they did not seek such facility based care. Some women defend this sense of pride even if it might create suffering from complication during and after childbirth. The comments made by Taslima's mother- in-law reflected this pride regarding child delivery and maternal health. During the interview, Taslima's mother-in-law repeatedly stated "by the grace of Allah, all the daughters and daughters-in-law in our family deliver children at home". In answer to the probing question, if Taslima had seen any doctor after her delivery, her mother-in-law replied with great emphasis "no no no... no doctor *'foctor'* has ever come to our house". While Taslima's mother-in-law expresses her satisfaction of having healthy daughters and daughters in law in her family and a history of smooth pregnancy and child delivery, she also is proud that no institutional or professional maternal care has been necessary. Now that Taslima has uterine prolapse, she is not able to speak up about her health problems due to the fear of upsetting the pride that her mother-in-law and her family hold.

### 5.2.3: "These are women's matters, how can a man handle this?"

Many women interviewed have no extended family network around them. They have only their spouses to support them. At the same time, they believe that pregnancy and childbirth and related matters are women's issues, which a husband cannot handle. The general perception is that a woman needs the company of another woman during delivery and in the post delivery period. The husband is not expected to play any role in such matters, nor can he help with delivering a baby or

provide comfort to his wife, or take her to a health facility if she is suffering from female specific conditions. Therefore, by not having any other female family member or friend around for support, a woman who is giving birth or suffering from maternal morbidity puts herself in a highly vulnerable situation. Due to this prevailing practice of not involving the husband in women's health care, Rumu in Sona Mia slum suffered from labour for a whole night and half a day before she received help. She described her situation as follows:

> He is *purush manush (*man). How will he understand? After coming from work in the morning, my husband saw that I was suffering from pain. He asked me, "Why are you sitting like this"? I said, I think I am having pain. He then went to another hut and slept. (Rumu, aged 18 years, mother of one child)

Rumu's mother-in-law also lived with them. So the indifference of Rumu's husband can be explained by his expectation that his mother would look after his wife. Similarly, Nupur also from Sona Mia slum could not go to a health facility for treating her serious obstructed labour due to the absence of any female relative or female neighbour who could accompany her. Although her husband was there, both Nupur and her husband believed that Nupur must be accompanied by a female during childbirth. In her situation, the decision to seek health care for obstructed labour had already been taken by herself and her husband, however, the lack of any female who could accompany her to health facilities led to delay in reaching the health facility (Phase Two delay described by Thaddeus and Maine 1994). Thaddeus and Maine listed the causes of Phase Two delay as distance, transport, roads and cost, but the challenges that Nupur experienced in Phase Two delay are

more of a cultural nature. This indicates that the Three Delay Model needs to incorporate such cultural factor in Phase Two delay.

The indifference of husband is explained by the women themselves as normative behaviour, because the husband is a man and therefore not capable of understanding any matter relating to a woman's health such as pregnancy and childbirth. The ignorance of husbands, which is perceived to be normative behaviour, in fact yields a paradox that has been prevailing in society for ages. The husband impregnates his wife by being physically intimate with her but he is not expected to have knowledge about pregnancy and be involved with the wife's health and treatment relating to her pregnancy and childbirth. Neither the mother nor the family could consider this lack of the husband in maternal health care as a concern that needed to be addressed. The health care provider, interviewed from maternity centre of UPHCP confirmed the need for involving husband in the maternal health care and childbirth. She stated:

> In many cases it is a matter of concern that husbands are less likely to be involved in the pregnancy and childbirth journey of the mothers, who visit here for health care. If we advise mothers something from here, like any advice for diagnosis or maintaining nutrition or follow up visits, they may not share that with their husband. But for my executing that advice, her husband's support may be needed. So, if husband gets actively involved in the whole process, I think, we will get better result.

Active involvement of spouses is also important from the health care providers' perspective. While men are considered as the main decision makers of the family, their ignorance and considering childbirth as only a women's issue create barriers

to addressing maternal morbidity. It puts the woman in an situation because, first cultural norms imply that she is not expected to take her own decision about seeking health care at a health facility, and second, she cannot rely on her husband to take her to health facility if no female is available to render this assistance.

### 5.2.4: Perceived hidden costs and mistrust

The attraction of 'free' or 'low cost' maternal health care turns into a nightmare for the care receiver when they realize that they have to pay money to receive any service from free health facilities. As Nahar and Costello rightly (1999, p. 419) state, "the economic burden of apparently free hospital maternity care is significant and likely to deter utilization by a majority of mothers". This cost is often termed a 'user fee' 'hidden cost', 'informal fee', or 'out of pocket payment' (Sharma, Sawangdee, and Sirirassamee 2005, p. 3; Kruk, et.al. 2008, 1,442). Previous studies have also found that the hidden costs put a damper on women from going to health facilities for child delivery or treatment of morbidities. While the health worker and service providers assure them that the treatment provided to them is free or at very low cost, the women themselves perceive it to be expensive as there could be associated services that are not free and in fact, cost a large amount of money. They fear that their inability to pay the perceived hidden costs will put them into a more vulnerable situation in which they will have no control. Almost all of the respondents agreed that it does not matter whether the service is free, if someone is not able to pay, she will not receive good services from the hospital. The following

statement from Lailee (aged 24 years, mother of two children) in Sona Mia slum, who is suffering from urinary incontinence, expresses her anger and frustration:

| | |
|---|---|
| Lailee: | (angrily) you say it's free. But I asked people, who went there for treatment, they said, you have to spend money for everything. They say free free, but nothing is free. Even you need money to fill in a form. They write slip (prescription), but we have to buy medicine from outside, which is costly, the doctor only sees patients for free. So, what is free? That's why I cannot go. I don't believe that it's free, because, I took my sister to DMC (Dhaka Medical College) once. They used to say, everything is free. But they did not give us any medicine for free. Those who used to do the dressing of wounds, we had to pay for every time they came to do the dressing. We had to buy every injection from outside. We did not get anything for free. The only benefit we had is, we had doctor whenever needed, but they told us which medicine to buy. That's all. |
| Researcher: | Didn't anybody tell you that you are not supposed to pay them this money? They are receiving this money from you illegally. |
| Lailee: | Yes. But if you pay them, they will do the work nicely; otherwise, they just do it carelessly. I stayed there for three months with my sister. From that, I have lost trust from medical (system). So, I stayed there and I experienced it myself. Everybody said, here treatment is free. What treatment are you giving free? I agree that the surgery has been done free. But, all the other costs related to surgery, medicine, and blood transfusion for everything I had to pay. My husband had argument with two nurses. They did not give injection on time. Those who can afford to pay ten or twenty taka, they get better and prior treatment. |

Her inability to bear this unofficial but perceived compulsory user cost in a free maternal health care centre made Lailee angry and distrustful towards health service providers. This eventually has made her less inclined to go to health facilities to have her urinary incontinence treated.

The need to pay money for receiving good services, even if that payment is not officially required, is also reflected in the statement of Jhumur (aged 28 years,

mother of one child) from Karwan Bazar slum. Jhumur had a life-threatening complication during her delivery and ended up staying in Ad-din Women's and Children's hospital for six weeks for recovery and had to spend a large sum of money. She stated:

> If you have money, everything is alright. Everything costs money. They are good. Suppose if we go to Dhaka Medical, no one cares. But here they care. But as I had money, I did not realise anything bad. If I did not have money, I would have found out whether they are good or bad.

Many gaps in service provision can be minimized by spending money, albeit unofficially. Such perceived and/or real costs of services, which are supposed to be free of charge, make bio-medical treatments for maternal morbidity and delivery complications socially and economically distant from the poorer people of Bangladesh (Afsana and Rashid 2001, p. 131).

To conclude, the perceptions among women in the lower socio-economic group of households regarding health care seeking for delivery complications and maternal morbidity has been discussed in four sub-themes. First, their perception about the hospital as a place of institutional interference in a social and personal event like childbirth makes women reluctant to consider giving birth in a hospital. Second, women fear losing their honour by letting a (male) doctor assist them in childbirth. Third, the culture of staying silent about maternal illness prevents women from communicating with their husbands about their maternal illness. And fourth, they fear that they may be unable to pay the hidden costs of their treatment, even though they know the treatment is officially free of charge. The female-centric approach of

seeing childbirth that is internalized by the mothers as well as by the members of community also appears to play an important role in shaping maternal health care seeking behaviour.

I will now turn to the discussion of Theme Two: experience of health care and support received at home and in health care facilities. Here I attempt to show how the experiences of childbirth and post-partum health condition shape lower socio-economic mothers' perception and their health care practice.

## 5.3: Experience of health care and support received at home and health care facilities

Parkhurst and Rahman (2007) analyze how the experience of maternal health and health care can guarantee a fear of health services, particularly of caesarean sections among Bangladeshi women. This present research also found that one of the main reasons why women develop these perceptions in relation to their health care seeking behaviour for maternal morbidity is the experience which they or their family and friends had. The experiences of members of their extended kinship group and their neighbours, the intensity and severity of illness, the status of the women within their households, their financial capability and their responsibility for household chores also help shape their overall perception and maternal health care practice. The following section will discuss the experiences of mothers from the lower socio-economic households under four sub-themes; severity of the health

problems, status of mothers within households, social and neighbourhood network and relations between health care providers and receivers.

### 5.3.1: Severity of the health problem

The severity of problems has been considered as one of the determinants of maternal health care seeking behaviour, especially in determing the Phase 2 delay identified by Thaddeus and Maine (1994, p. 1,101). The present study explores what kind of physical, mental and social suffering a woman goes through because of maternal illness during delivery or in the post-partum period, and how such illnesses influence their health care seeking behaviour. The mothers suffering from fistula for years were extremely eager to find and seek treatment, as physical discomfort, social and mental suffering of continuous leakage of urine is totally unbearable. However, the mothers who had recently experienced uterine prolapse, perennial tears or urinary incontinence were found to be reluctant to currently seek treatment yet irrespective of their background condition, presumably because, their situation was not perceived as worst as getting attention for treatment by themselves or by their families.

Mina (aged 40 years, mother of four children) came to Ad-din hospital to seek treatment after 11 years of suffering from uterine prolapse. She stated that she came to seek treatment because now the condition had been too bad:

| | |
|---|---|
| Researcher: | It seems like you have suffered a lot for such a long time? |
| Mina: need | *Apa*, I could not do. You see, my husband wasted money. Don't I money for such treatment? |
| Researcher: | What made you come here now? |
| Mina: | Apa, if more time passes like this, I will lose all energy. I will be *'nishokti' (*without strength). The *sada sirup* things (white discharge) keeps coming out always and this is making me weak. I will get weaker. That's why I came here for treatment. |
| Researcher: | How did you manage money now? |
| Mina: | I borrowed from people. |
| Researcher: | You have not done this for the last 11 years. Why did you come now for treatment? |
| Mina: | Because, I am losing my strength. I am getting weaker. Children are growing up. Daughter-in-law will come; son-in law will come. What will they say if I am this much sick? |

Her conversation reveals that initially lack of money has been the main barrier for her to seek treatment. Now that she is getting weaker (*nishokti*) and becoming less active in fulfilling the increasing demands of regular household chores, she needs to find a treatment for her illness. Lack of money is still a barrier for Mina and she has to take on a financial burden at a late age of her life by borrowing money from her relatives.

A similar story can be found in the statement of Afroza (aged 40 years, mother of five children) who came to Ad-din hospital for treatment of a very serious case of uterine prolapse. She explained how her health was never a matter of importance in her family, even after she informed her husband about her problem. The neglect of her health made her suffer from much discomfort and fatigue due to the uterine prolapse which she has had for the last six years.

| | |
|---|---|
| Afroza *:* | In our village there are lots of hard work. I had six normal child deliveries. After the birth of the fourth child, this happened. I had to work hard after she was born. I had to cook food for 10-15 kilo rice, had to carry 20 jars of water. I brought up younger sister in law and also many other jobs. Can't tell you how many. |
| Researcher: | Did not you have any one to help you? |
| Afroza*:* | Nah. You know I am *bou* (daughter in law) of the house. If mother in law does not permit, can a *bou* keep a maid servant? Don't you understand? My mother-in-law was a bit naughty. I used to feel problem, when I worked. For example, when I lifted up any heavy thing, I felt pressure at the lower part of my body, I could feel that. I asked my husband many many times about my health problems. But he did not care much *(beshi yah koirto na)*. Now, when things got worse, bleeding started, he sent me here and arranged treatment. Before that, I told him many many times about these problems. My husband did not do anything, no care. I often tell him, if I realized at the beginning, I would divorce you. I could not leave my *songsar* to love to my son. |
| Researcher: | Why did you feel that after so many years of family life? |
| Afroza: | He did not care for me at all. If he did treat me earlier, I would not have this much of suffering. Now, suffering is too much. I asked him several times. But whenever we discussed the problem with health care, he brought us other problem to take priority and avoided mine. |

Afroza maintained that she has always been highly respected by family members and relatives for her contribution for bringing up six children and making them highly educated and making the family status high, yet her health status has been ignored by her husband and mother-in-law. Her health condition only came into focus when she was bleeding heavily and suffering from severe pain. Thus among the various competing priorities, particularly in a resource constrained household, the mother's health gets less attention unless it is life threatening.

Table 5.1 presents the type and duration of child delivery complication and post-partum problems that have been reported by the participating mothers from the

lower socio-economic households. The table shows that among the 19 mothers who have reported they had some kind of maternal illness or childbirth complication, only five sought treatment. Among those five mothers, the two mothers suffering from uterine prolapse for years, have now been receiving surgical treatment from Ad-din Hospital. The mothers, who did not seek treatment, seemed to have waited for their illness to get worse and for their economic condition to get better.

**Table 5.1: Duration of suffering from maternal morbidity and initiation of treatment by the mothers**

| **Places** | **Name** | **Morbidity /complication** | **Months of suffering** | **Time** ( after the onset of illness) **when first treatment sought** |
|---|---|---|---|---|
| Sona Mia Slum | Rehana | uterine prolapse and anaemia | 1.5 | No treatment yet |
| | Taslima | uterine prolapse | 9 | No treatment yet |
| | Nupur | uterine prolapse | 9 | No treatment yet |
| | Fatima | Post-partum complications | 0.5 | 0.5 |
| | Johora | Anaemia | 6 | 3 months |
| | Hasna | Urinary incontinence | 2.5 | No treatment yet |
| | Lailee | Perennial tears and burning | 4 | No treatment yet |
| | Lolita | Urinary incontinence | 7 | No treatment yet |
| | Rumu | Perennial Tears | 5 | No treatment yet |
| | Reshma | Post-partum complications | 2.5 | 2.5 months |
| Karwan Bazar slum | Jhumur | uterine prolapse | 24 | No treatment yet |
| | Helena | headache, weakness | 48 | No treatment yet |
| | Najma | Prolonged labour | 4 days | Attended by TBA |
| | Kakoli | Prolonged labour | 4 days | Attended by TBA |
| | Amena | Perennial tears, incontinence | 5 | No treatment yet |
| | Sheuli | Prolonged labour | 3 | |
| Ad din | Shefali | uterine prolapse | 36 | 0.5 months |
| | Afroza | uterine prolapse | 72 | 0.5 months |

This table excludes the information of mothers, suffering from obstetric fistula, as their information has been presented in Chapter Six

Source: Field work 2012

### 5.3.2: Status of the mothers within their households

As stated in Chapter Two, women's socio-economic status within the households holds an important place regarding maternal health care seeking behaviour. It has also been mentioned in Chapter Two that the most important indicators of the status of women in terms of improving health status and bringing them access to health care is education and women's access to income earning (Obermeyer 1993; Chakraborty et al. 2003). While education helps change perception regarding childbirth and maternal health care, access to and control of income makes them empowered to make decisions and access health care. Furuta and Salway (2006) have shown how a woman's household position influences her seeking skilled maternal health care in Nepal. They found that a woman's position within the household in terms of her employment and control over her own earning have a significant association with obtaining maternal health care. As mentioned in Chapter Four, all mothers from the lower socio-economic households in this study have below primary level (Year 5) education. Some of them earn money although at very low wages and in most cases, their income only supplements their husbands' income. In most cases they could not gather money for taking care of their own health, as their entire income is spent in supporting their households. In spite of that, a regular income, even if low, gave some of the mothers an economic safety net to save themselves and their families from extreme poverty. It also helped them have a say about health care and be prepared for any obstetric emergency. In the previous chapter we have seen how Fatima expressed her sense

of self-esteem and pride in being able to provide support for her family and in not needing to ask for financial help from others. This is because, she earns works and earns money, although little in amount, regular in nature of income. At the same time she explains that her husband also gives value to her as she proves herself very supportive and spends money on the welfare of the family.

Control over income has also helped the mothers to make financial plans for pregnancy and delivery. Robena (aged 22 years), interviewed at Ad-din Hospital, who works in a garment factory she contributed to the family of her in-laws, from the money she saved, an amount equivalent to her income when she would not be able to work during her delivery and the post-partum period. Robena was able to do this, as she earns and spends her own money; she also spends money for paying house rent, one of the largest costs in urban Dhaka regardless of economic class. It was evident from the interviews that the mothers who are working have more control of decision making on household issues as well as on their own health. This finding is consistent with other studies conducted in urban and rural areas of other countries (Furuta and Salway 2006; Chakraborty et.al. 2003; Obermeyer 1993).

Johora's experience also revealed how in spite of the reluctance of her husband to buy medicine for her anaemia, she manages to buy these from her income of only 20 BDT (30 cents) a day:

> It costs me 200 taka[39] per bottle. There is another better one, which is 230 taka per bottle. But I go for the cheaper one. I save from the money that I earn from selling

[39] The currency of Bangladesh (BDT) is locally known as 'taka'.

> fuelwood. If I ask for money from my husband, he would not give any. He says, I will not give you, bring money from your parents. He says things which are nonsense. But, how come my parents should give me money? They are poor. He (her husband) does not want to bear my cost (for her treatment). He says, I have money, let it be there. You cannot consume this. Allah knows why he does that with me. I think, he does not love me much (*amar upor vokti kom*). Johora (aged 25 years, mother of two children, Sona Mia slum)

Johora's husband puts a low priority on her health, although he earns a sufficient amount of money. However, according to Johora she keeps herself going only with the medicine she can buy from her small earnings. Johora, through her story portrays a picture of a total lack of spousal support to deal with her maternal health problem. The low income of Johora may reveal that the other side of the economic empowerment of women is that earning mothers are expected to pay for their own health care.

It can be concluded from the above discussion that access to income even if that income is small, provides women from the low income households with some sort of control regarding decision making on maternal health care. The mothers who earn money themselves, were found to have bought medicine or gone to the doctor to treat their problems and could afford to buy good food on their own to keep them in good health, sometimes even without the support from their spouse.

Although income may be one of the determinants of health, it is recognised that the ability to earn an income may not be enough by itself to ensure a healthy maternal life, which requires access to material assets and intellectual resources. Intellectual

resources imply "knowledge, information and ideas" (Batliwala 1994, p. 129). We have seen previously, that some women in the lower income households have some concerns about maternal health care during childbirth and post-partum period, which discourages them from seeking such care, even when there is a need for emergency care for complications. Their concerns appear to originate from a lack of knowledge and information as well as from their traditional cultural orientation to childbirth.

### 5.3.3: Social and neighbourhood network

In the urban slums of Dhaka, the strength of social and neighbourhood networks as well as the family network plays a very important role in shaping the health care seeking behaviour of mothers. If they have difficulties in accessing service and information about maternal health care and its availability, then the social and community networks in the slums provide the requisite support and strength and care for the women who go through delivery complications or post-partum maternal illnesses. Those who did not have such social and family support, found it much more difficult to have proper maternal health care.

While Rehana of Sona Mia slum was very eager to treat her health conditions she could not borrow any money from anywhere to bear the costs of her treatment. One reason is that she and her husband had only recently migrated to Sona Mia slum and had not yet made connections within their neighbourhood. To quote:

> My husband told me, he told me in a reasonable way, please go and see if your can borrow some money from somebody. Then we can see a doctor. But I could not get money from anybody. In this as yet a strange place, who will give money to us? That's why I could not go for treatment. I am staying like this. (Rehana, (aged 20 years, mother of one child)

On the other hand, Jhumur (aged 28 years, mother of one child) of Karwan Bazar slum was able to pay for her blood transfusion, child delivery by caesarean section and the management of eclampsia in the Ad din Hospital mainly by borrowing money from her neighbourhood. Jhumur was born, brought up and married in the same slum, a fact which gave Jhumur and her husband a great advantage in terms of social and community networks. Afroja, who was suffering from fistula, also received similar support to manage the transport cost to health facilities for her treatment.

Social and family support is very important also in determining the place and type of health care to be received by the mothers. Jui, who came to the maternity centre of UPHCP to deliver her baby and decided herself to have a caesarean delivery, describes the extent of support she received and will continue to receive after her delivery:

> After I got pregnant, my mother-in-law did not allow me to do any household work. I wanted to do household work. But she said, "no, you are younger (*tomar boyos olpo*). If you have any trouble, that will be very bad. Better you don't need to work; you need to stay healthy and well. If you get sick, the baby will be sick too". We are only four in our family. There are not lots of jobs to do. After I finished my bath, my husband used to wash my clothes. In order to reduce my pain and suffering during my pregnancy, my in-laws brought me to my parents' house two months before my delivery". (Jui aged 17 years, mother of one child, Maternity Centre of UPHCP)

While most of the mothers from lower socio-economic households avoid facility based hospital deliveries due to a fear of losing their ability to work and of losing family support, Jui decided to have a hospital based caesarean delivery with the support of her family network. Jui's story shows that the decision to have a CS largely depends on the support received from the family and extended families. She must have had the assurance that she would be looked after during the post-partum period. Jui's experience of receiving care from her in-laws and husband during her pregnancy gave her the confidence that she would be well looked after if needed. Fatima, from Sona Mia slum was able to overcome her post-partum illness because of the support she received from her maternal family. She maintains:

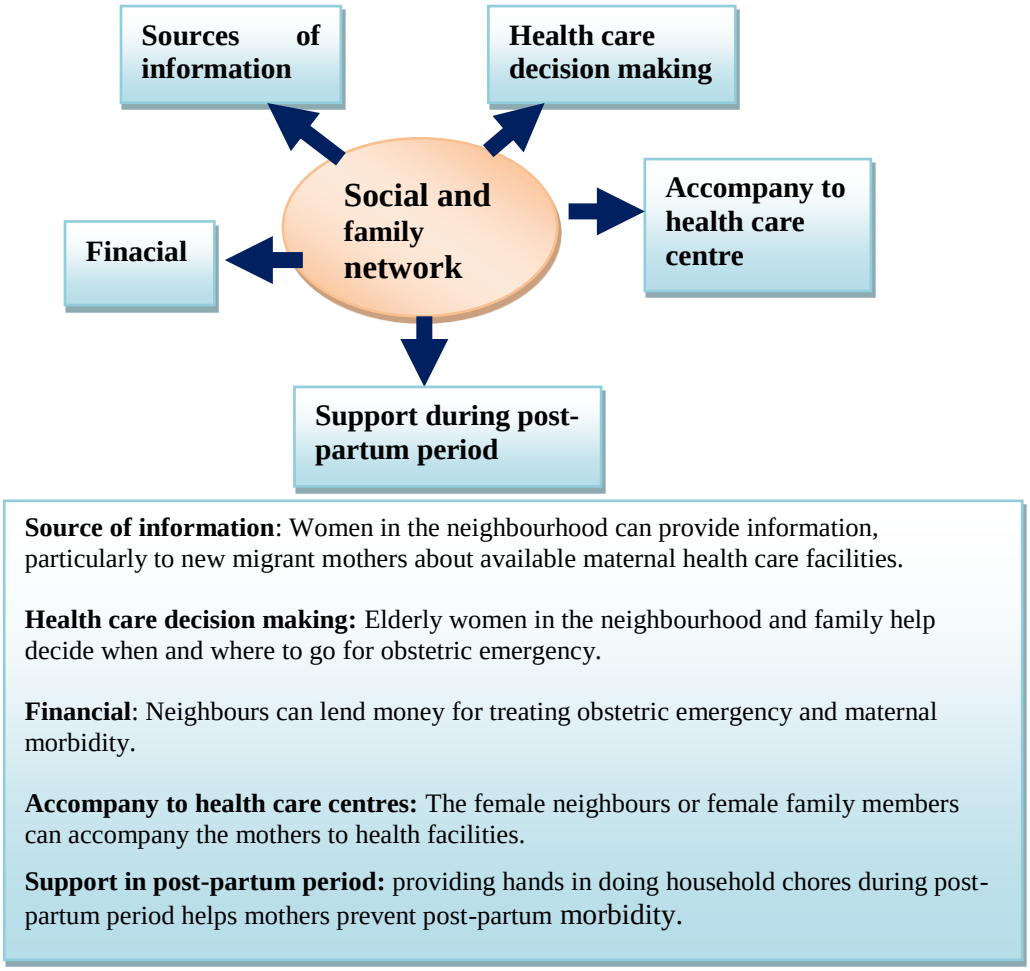
> Na *Apa*, not only money. If my parents were not here, I could not even come back to life/survive. Those who do not have parents are very helpless. Among my family members, my condition (financial) is the worst. So, everyone helped me. When, my husband does not work, my parents buy food and grocery for us. My mother was with me. I did not fear anything at all. My mother stayed with me for the whole month. My mother helped me with household work for a month. She did all the heavy work. She did not let any harm come to me. She did not let me come out of the room for a month.

The availability of a social and family network is also found to be important in deciding the place of delivery and treatment of maternal morbidity. Lutfunnessa (aged 22 years, mother of one child) lost her first child due to convulsions, which started a week before the due date of delivery. The child died before she arrived in the clinic near her home. She chose Ad-din hospital for the delivery of her second child, as two of her brothers' wives had their babies delivered there. They had a good experience with this hospital, which influenced Lutfunnessa's choice. Therefore, social and family network can be influential in shaping health care

seeking behaviour of mothers for childbirth and post-partum period at home and in health facilities. The positive experience of Lutfunnessa's sisters in law also influenced her decision to have her baby delivered at Ad-din hospital.

Figure 5.1 illustrates how social and family networks provide help with maternal health care in various important ways. These are based on the findings of the thematic analysis of interviews with the mothers from the lower socio-economic households. Social and family support in and around these households helps the women in accessing maternal health care but also provides them with physical, financial and moral support during and after delivery. And thus many of the participating mothers were able to manage childbirth complication well and recover quickly from post-partum morbidity.

Figure 5.1: Supports that social and neighbourhood network provide.




Source: Drawn by the author based on thematic analysis of data collected during field work, Dhaka, 2012

The length of residence in the urban location is a crucial factor in building a network. Those, who migrated recently (such as Rahima and Rumu), left their extended family members in their villages. Thus, the absence of family members, inadequate social acquaintances within the neighbourhood and financial insecurity have made it difficult for them to obtain the kinds of support shown in Figure 5.1.

On the other hand, those who had migrated to Dhaka long ago or were born and brought up in Dhaka were already accustomed with the available maternal health care services and their benefits and challenges. Moreover, by living for a long time in the neighbourhood, they have already built a social and family network that has highly influenced their maternal health care seeking behaviour.

### 5.3.4: Experience at the hospital: relations between care providers and receivers

In the previous section, the apprehensions of mothers regarding facility based treatment have been discussed. While the roots of many of these apprehensions can be traced to the experiences of their relatives, neighbours and friends, some of the respondents narrated the particular difficulties they experienced themselves at the health facilities. The way a health care provider communicates with a health care receiver is a very important factor in the hospital experience of a mother and an important determinant of whether the mother will seek service from the hospital in future. This factor is referred to as the interpersonal relationship. Bruce (1990, p. 74) identified 'interpersonal relationship' as one of the fundamental elements of quality of care and defined it as "affective content of the client/provider transaction". Marjia from Karwan Bazar slum described her ante-natal care experience in which the interpersonal communication and the behaviour of the doctor prevented her from going back there to seek further ANC further. She explains:

> For my second son, I went to Maternity Centre (of UPHCP) only twice. I had my check-up and took vitamins. I did not go there anymore. The doctor, whom I used to see there, was transferred to some other place. And I did not like the doctor who

> replaced my previous doctor. *Tar kotha amar pocchondo hoyna* (I do not like the way she talks). That's why I did not go. The previous doctor used to speak nicely, she used to show us different pictures and books, and she tried to make us understand many different things. But the new doctor is not like her. *Se khali phan phan kore* (She is rude). She does not care much about the patients, she wants to do everything fast. She does not try to speak to us and make us understand things. That's why we don't go. (Marjia, aged 24 years)

The above quote from Marjia is a clear indication of what a woman expects to receive from her health care provider. She wants to be treated nicely and respectfully by the doctor. She wants to get the things and information explained to her clearly and in an easily understandable way. But when she found that her expectation was not fulfilled, she rejected the thought of going to health facilities, because unlike the mothers from the upper socio-economic households (as presented in Chapter Seven), she did not consider it essential to go and see a doctor regularly during pregnancy, childbirth or in the post-partum period. This is that kind of situation about which Bruce (1990, pp. 74-75) rightly explained that 'interpersonal relations' go beyond providing accurate information and the degree at which it is comprehended by service receivers. Rather, the desired outcome of interpersonal relations between the health care providers and receivers may be "that the client reports a belief in the competence of the provider, trust of a personal nature and a willingness to make contact again themselves or even refer others".

To sum up, a few aspects of the lived experience of mothers from the lower socio-economic households, individually and/or in conjunction with prevailing perception (as discussed in Theme One) affect their health care seeking behaviour during and

after childbirth. These aspects are intensity of suffering from childbirth complications or post-partum illnesses, economic and empowerment status of the women within the households, experience of service received from the health facilities and availability of family and social network.

On the other hand, the most important issue that was found to be influential in health care seeking behaviour of the mothers are presence and absence of social and family network. The general tendency of the mothers was to rely on the suggestions, guidance and advice of family members, especially older neighbours, mothers-in-law, mothers or traditional birth attendants in the neighbourhood, rather than on the advice they received from health care providers during their ANC visits. Those women, who are recent migrant to Dhaka and have not yet developed any supportive social network, are found to suffer more with maternal morbidity. Conversely, the mothers who migrated to Dhaka long ago or were born in Dhaka and have supportive social and extended family networks were found to have been more capable of managing delivery complications and treating maternal morbidity. Although none of the mothers or their families were economically well-off, even a low but regular income of the mothers changed their empowerment position within the households and made them active in taking part in the health care decision making process. Nevertheless, in the final count, whether and how to seek health care for maternal morbidity largely depends on the suffering and intensity of the problems. Until the conditions become life threatening and seriously hamper the

daily household activities performed by the suffering mothers, initiatives to treat the problems are neither taken by the mother, nor by her family.

## 5.4: Health care seeking for maternal morbidity: Practice of avoidance

The perception and experience of the mothers of lower socio-economic households regarding health care seeking for childbirth and post-partum maternal morbidity suggest patterns of health care behaviour which can be described as a practice of avoidance of the facility based maternal health care. The perception of the mothers regarding childbirth and related maternal health care as presented in the above discussion suggests that they have a deeply rooted fear of medical intervention in childbirth for many different perceived and practical reasons including cost, unfamiliarity with the institutional process, inadequate supportive social- and family network within their neighbourhood, concept of honour and '*sharam',* existing culture of silence and inadequate spousal communication regarding concern of health issues raised around childbirth etc. As a consequence, even though the low cost health care facilities are within their reach geographically, the mothers and their families were found to be reluctant to go and give birth to their babies in health facilities.

The discussion presented in Chapter Four suggests that the mothers from lower socio-economic households live in a very non-conducive socio-economic, cultural and demographic environment that discourages them from seeking maternal health

care for childbirth and their post childbirth health condition. The very low income of the individuals and families, occupational irregularity and uncertainty, low level of education and young age at marriage have usually been considered as barriers against seeking maternal health care. The financial, physical and social limitations of the mothers of lower income households and those of their family members prevents them from seeking maternal health care at health facilities. They do not make any effort to overcome these barriers because they do not regard childbirth as a special event worth having special care. This is presumably because they have a sense of awareness that perceiving childbirth as a 'special care worthy event' or seeking health care for that from modern health facilities does not go with the perception and experience that have been discussed above. Therefore, most of the mothers from the lower income households tend to remain unenthusiastic about facility based maternal health care.

> Those are not for poor people like us. Even if I agree that they give free service, we cannot manage to go there. We have to arrange our daily meal (*tin bela khawa),* we have to look after children, give service to husband *(shami r seba jotno*). When can I go there (in health facilities), stand on the line and so. Rather, whatever is stored for us, will happen. What's the benefit of thinking too much. (Laili, aged 24 years, Sona Mia slum)

Laili's statement indicates that her reluctance to go to a hospital is borne out of her lived experience of life of poverty, continuous hard work to earn a living and maintaining her family and lack of information about health care services. The overarching factors were her socio-cultural perception towards childbirth.

In another statement, a Traditional Birth Attendant Bibi Saleha conveys the reluctant attitude that the mothers have about going to a hospital for childbirth.

> *Apa,* the mothers, who have money, think that they will not be able to bear the labour pain. Then, when it's delivery time, they go straight to a hospital. But, those, who really have trouble with their delivery like no labour pain, or whose babies are stuck inside, are really the ones who need to go to a hospital. But they do not go. The hospital may be close by, but the women do not want to go. They fear (*tara voy pai)* about what will happen in the hospital.

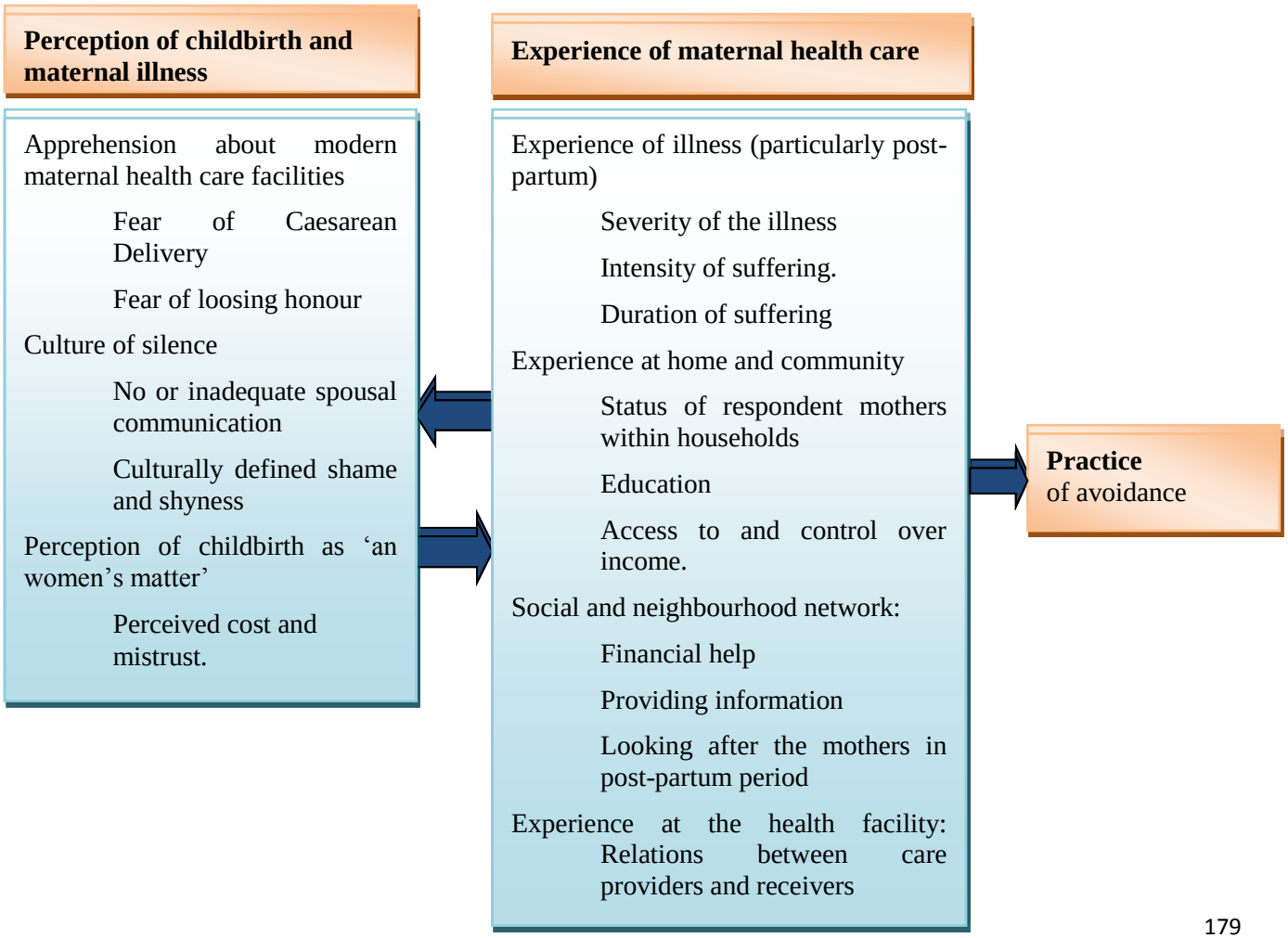
The statement of Bibi Saleha indicates that the fear of the unknown which the mothers have about hospitals is the main reason that they are reluctant to a hospital for childbirth or post-partum check-up. Only those who were suffering from fistula or who were at the worst stage of suffering with uterine prolapse were proactive in seeking and receiving proper treatment, even by borrowing money from others and travelling long distances to reach the hospitals. The lack inclination of the mothers to deliver their baby at a facility based health care centre does not necessarily indicate that they are opposed to facility based modern maternal health care, but disinclination may be explained by the apprehensions they have developed through their life experience and their cultural orientation towards pregnancy and childbirth.

## 5.5: Conclusion: Does only money matter?

To sum up, the perception, experience and practice of maternal health care seeking of mothers in this group for their childbirth and post-partum health leads to some important findings. Mothers from the lower income households were found to have been more inclined to give birth at home and be assisted by TBA or their

neighbours and relatives. Unlike, rural Bangladesh, Dhaka is well connected with transport and roads. Moreover, the city is well supplied with low cost or free government and non-government health facilities to ensure their access to mothers from lower socio-economic households. The households studied in both slums are situated within the reach of health facilities where maternal health care including childbirth services are provided. The mothers also had access cards where they could obtain free health care. However, although some mothers reported that they had received ANC from the nearby clinic (for example UPHC and *Surjer Hasi* clinic), they were not convinced by their ANC visit to deliver their babies and/or to receive post-partum care at health facilities. Rather, they appeared to have a sense of avoidance about receiving such care at a health facility. As discussed in this chapter, this avoidance is attributed to some factors associated with the prevailing perception among the mothers and families regarding childbirth as well as their experience regarding the same. Figure 5.2 summarizes these perceptions and experiences, which were developed through the major sub-themes while analysing the information. This figure indicates that perception and experience, while also influencing each other, ultimately shape the health care seeking behaviour of the mothers.

**Figure 5.2: Summary findings of health care seeking behaviour of mothers of lower income households, Dhaka, 2012.**



In terms of perception of childbirth and maternal health care, the mothers of lower income households have major concerns regarding institutionalised childbirth. These concerns appear to have arisen from two causes. The first cause is the lived experience of mothers, which is characterized by poverty, lower levels of education and lower status of mothers within households. Institutional childbirth portrays a picture of doctors and nurses using unfamiliar medical terminology, unnecessary administration of medical intervention (like CS), administrative procedure in the health facilities which might involve both unofficial and official cost and social distance between the service providers and service receiver (Afsana 2005). Being poor and lowly educated and having inadequate information about institutionalized childbirth, the mothers perceive seeking maternal health care from hospital as a distant matter, even if the hospital is not far away and is not difficult to reach in terms of transportation.

The second cause is the mothers carry a view that childbirth is an event that should happen in a private and homely atmosphere and should not take place in the presence of outsider male including a male doctor may risk the societal normative expectation of '*sharam'* and 'honour'. Their perception of maternal health is that illnesses or discomforts during pregnancy, childbirth and the post-partum period must be endured for as long as possible, even until the time when there are risks of death. The view that pregnancy and childbirth has nothing to do with illness provides the mothers with a culture of 'silence' and 'endurance' regarding maternal morbidity even at the expense of hampering their productive, reproductive and

sexual life. The mothers also were found to be hesitant in discussing their maternal health with their husbands as they feared jeopardizing their marital relationship.

It could be assumed that urbanisation in Dhaka even in low income urbanised settings would loosen these culturally attributed values. The structure of the slums included in this study and their surroundings, as well as the nature of household/outside work which the mothers do (Chapter Four) show that they are not practising the norms of seclusion or restricted boundary of housing as people in rural Bangladesh usually maintain. Rather, the mothers were found to be fairly mobile, exposed to markets and modern health information. However, this exposure to modern ways of living still could not get these women out of their traditional shyness or modesty which prevented them from seeking treatment for maternal conditions at a health facility. Rather, in spite of being able to receive regular ante-natal care and advice from health care facilities, their health care behaviour appears to be largely defined by the advice/suggestion/guidance from family members and elderly neighbours.

The particular experience that can be related to health care seeking behaviour for childbirth complication and post-partum illness was manifested in the status of mothers in the households which involves access to and control over individual and family income, health care experience in the health facilities and availability of supportive family and social networks in the neighbourhood. The mothers who

were found to have been less fearful about institutionalized childbirth and treating maternal illness were found to have had better access to and control of income, even though that income was merely subsistent and supplementary. Those mothers were also found to have been supported by the family and social networks in the neighbourhood.

Figure 5.2 presents the connection between perception and experience. Although there are many different factors at play in shaping the health care seeking behaviour for mothers, from the above discussion presented in this chapter, we can assume some particular connections between some perceptions and experiences. First, experience of severe illness may lead the mothers to ignore their apprehensions about hospital based maternal health care and seek professional care. Second, their social network may help the mothers to be better informed about the available health care service, as well as giving the mothers opportunities to share the illness experience. This is how mothers can get rid of their apprehension and seeks care. Third, the mother's socio-economic status within their households, particularly their access to income, may minimise the spousal communication gap.

During the interviews, women were found to be very positive about accepting family planning and using contraceptives, receiving ante-natal care etc.

But whenever they had concerns about maternal health care for childbirth and illnesses related to private parts of their body the mothers were found to have been

bound by numerous practical and perceptional matters as discussed above. That is why, the low cost and geographic proximity of the maternal health care facilities and availability of access cards could not necessarily persuade them to use health facility based childbirth. Financial affordability of facility based maternal health care could have been a limitation, but of course, not the only one.

While safe motherhood initiative recognises that every pregnancy and childbirth has risks of developing complications (Maine and Rosenfield 1999, p. 481), the mothers from the lower income households did not appear to share the same notion in their experience and perception regarding childbirth. What Obermeyer (1993) mentioned in the context of childbirth in Morocco and Tunisia, appears to be relevant for the mothers of lower income households in this study. The author (1993, p. 362) stated

> [p]regnancy and birth are not defined as health issues, but are understood as natural reproductive events. Consequently, they are not seen as requiring routine medical care. Though often mentioned, the processes linking ideas about risk with patterns of health-care use are poorly understood. Yet these connections may be as important to behaviour as other normative structures that define the value of women in a society.

Financial barriers, lack of education and information and inadequate access to health services are considered as the usual barriers for mothers to receive health services for maternal health. Keeping that in mind, Bangladesh has expanded its maternal health service by setting up low cost government and non-government hospitals of different levels all over the country, so that women can reach them

conveniently and at free or low cost. Consequently the country has achieved a remarkable reduction in maternal mortality ratio, reduction of fertility and expansion of the coverage of ante-natal care. It has been stated in different studies (Callister and Khalaf 2009; Rozario 1998) that childbirth is generally considered less of a health-related event for the mother. Rather it is regarded more of a social and family event, that needs more than the low cost and physical proximity of maternal health care facilities in order to ensure improved maternal health. One of the issues that need to be considered by going beyond cost and distance is the giving of information that would help mothers to break their perceived fear of institutionalized maternal health care for childbirth. A culturally sensitive level of interpersonal relations among the service providers and service receiving mothers and family, which Bruce (1990) has considered as one of the fundamental elements of quality of care, would help overcome those fears. While this chapter has focused on health care seeking behaviour of mothers for childbirth and post-partum illnesses, the next chapter will discuss how mothers seek treatment for chronic maternal morbidity, caused by obstetric complications.

# Chapter Six

# Obstetric fistula: The sufferings of affected mothers and their search for a remedy

[W]e have all had our hearts wrenched by photographs of starving children. But how many people have imagined what it means to be in labour for five days, in pain, exhausted, know that your baby is already dead and you will die soon because the hospital where a caesarean section could be done is out of reach, either physically, financially, or socially? (Maine D. 2000, p. 175)

## 6.1: Introduction

In the previous chapter we have seen that most of the mothers did not seek any health facility based care. Rather they preferred home based normal childbirth and post-partum care because of many socio-economic, cultural factors, health service related experience and overall view towards childbirth. This chapter focuses on obstetric fistula, a particular form of maternal morbidity, which emerges from untreated prolonged obstructed labour, mostly while giving birth at home and has the most adverse impact on a woman's life. The information presented in this chapter is based on interviews of 11 mothers who were visiting the Fistula Ward of Ad-din Women's and Children's Hospital (seven in Dhaka and four in Jessore) for treating their fistula.

On the very first day of my visit to the Fistula Ward of Ad-din Hospital, I was overwhelmed to see the women who came to the hospital in search of treatment for obstetric fistula. As soon as I entered the Fistula Ward after the purpose of my visit was explained to the patients, the mothers who came to receive treatment for fistula

started calling me "*O Apa, amar kacey asen. Amar kotha age shonen"* (O sister come to me first. Listen to my story first!). Their eagerness in sharing their stories with me, a person unknown to them and who did not belong to their socio-economic class, indicated that hardly any of them had had a chance to share the experience of their sufferings with anyone. The story of 11 mothers I interviewed at the Fistula Ward provided me with a picture of some of the worst devastation, destitution, stigma, humiliation and disempowerment of women I have ever seen. I felt urged to highlight their stories, their experiences and their challenges in treating fistula with more weight and distinctive attention. That is why, the case of fistula warrants discussion in a chapter of its own.

As discussed in previous chapters, childbirth is not viewed as a medical event by the mothers from lower socio-economic groups; hence they were reluctant to receive care from health facilities which, according to these mothers, treat illness. However, a condition such as fistula, which these mothers had, is considered as a medical event by the afflicted mothers even though it developed from a perceived non-medical event such as childbirth, resulting in their sufferings mentioned above. This made these mothers so keen to seek treatment and share their stories. With the objective of understanding health care seeking behaviour of women with severe maternal morbidity, this chapter discusses the socio-economic and structural context of the development of obstetric fistula among the mothers interviewed, and about their experiences and challenges in suffering from this condition. Then it discusses how the obstetric fistula affected women managed to get treated for this disease, the challenges they faced and how they overcame them, and opportunities

associated with their journey to treating fistula. At the end, it has been argued that in a context of devastating multidimensional sufferings caused by fistula, and very limited access to information, institutional support and treatment facilities, only a wider empathetic social network can help the mothers seek treatment. This chapter is based on the interviews with 11 fistula affected mothers in the Ad-din Fistula Ward, where they came for surgical repair of their fistula.

An obstetric fistula is a hole or tear in the tissue wall between the vagina and the bladder or rectum, or holes between them both. It results in incontinence of urine and/or faeces (Cook, Dickens and Syed 2004, p. 74). The most common worldwide cause of obstetric fistula is obstructed labour[40] with no or delayed emergency obstetric care (Hilton 2003, p. 286; Muleta 2006, p. 963; Roush 2009, p. e21). Obstructed labour is more common among young, malnourished mothers in the poorer countries of Africa and South Asia where access to pregnancy and childbirth care is limited (Bangser 2006, p.535; Miller 2010, p. 288). The suffering of mothers with fistula is indescribable, and is the most distressing and debilitating morbidity caused by obstetric complications (Ahmed and Holtz 2007, p. S10). The constant wetness and smell caused by the continuous leakage of urine not only results in physical discomfort, but also subjects the affected mother to isolation, stigma and poverty, and often results in divorce or abandonment by their family

[40] "The term 'obstructed labour' indicates a failure to progress due to mechanical problems—a mismatch between foetal size or, more accurately, the size of the presenting part of the foetus, and the mother's pelvis, although some malpresentations, notably a brow presentation or a shoulder presentation (the latter in association with a transverse lie) will also cause obstruction" (Neilson et al. 2003, p. 192).

(Bangser 2006, p. 535; Muleta 2006, p. 963; UNFPA 2003, p. 13; Roush et al. 2012, p. 787).

While the nature of the condition and its consequences have put the affected mothers in extreme need of health care to treat their health condition, they could not find a way to get treatment for many years due to a number of factors. The continued prevalence of fistula in this modern day, the social, physical and mental suffering of the affected mothers, and the insufficient treatment facilities available for fistula are considered as markers of the overall maternal health in the region, affected as they are by the underlying socio-cultural factors (Roush et al. 2012, p. 788). The lack of the availability of treatment and giving a low priority to treating this disease amounts to a gross violation of human rights and societal and institutional neglect of affected women (Cook, Dickens and Syed 2004, p. 76).

The peculiarity of obstetric fistula compared with other maternal morbidities can be seen from three perspectives. First, obstetric fistula is easily preventable by providing timely emergency obstetric care to mothers with obstructed labour; second, the only way to repair the hole caused by obstetric fistula is expensive sophisticated surgery that most affected mothers cannot afford to have; and third, obstetric fistula has a higher impact on the social life of affected mothers than any other maternal morbidity. Because of this peculiarity, the treatment-seeking behaviour of mothers affected by fistula takes on a different dimension than that of mothers suffering from other maternal morbidities. For example, while mothers

suffering from uterine prolapse have been found to have been somewhat ambivalent in seeking treatment, mothers with obstetric fistula have been found to be very eager to seek appropriate treatment. However, their precarious socio-economic condition, coupled with a lack of adequate information and access to fistula repair, creates a gigantic hindrance against treating this problem and returning to a normal life.

## 6.2: Prevalence, availability of treatment and challenges of Obstetric fistula

A situation analysis carried out by Engender Health shows that the prevalence of obstetric fistula in Bangladesh is almost 1.69 per 1,000 ever married women (Engender Health 2003, p. 29). However, in terms of all chronic morbidities suffered by the women of Bangladesh, it is estimated by Engender Health that nearly 8.76 million women in Bangladesh are suffering from chronic morbidities like vesico-vaginal fistula (VVF), recto-vaginal fistula, uterine prolapse, dyspareunia and haemorrhoids. The report particularly shows that 406,297 were suffering from VVF and 1,208,857 were suffering from recto-vaginal fistula. So, the total number of fistula sufferers was 1,615,154. This is 18.4% of the total 8,759,957 morbidities reported in the publication. Thus fistula of all forms accounted for nearly a fifth of all chronic reported morbidities.

Bangladesh has made a serious commitment to end the incidence of fistula. A National Fistula Centre was established in 2003 to provide services to patients and

training to doctors and nurses. Eight public and seven private fistula centres have been established with financial support from the United Nations Population Fund and Engender Health (Akhter 2012). As of the end of 2011, these facilities have treated 372 fistula patients free of cost. During treatment at these facilities, the women have not only had their fistula holes repaired, they also received training on income-generating activities such as tailoring, home gardening, animal husbandry, baking etc., to enable them to improve their situations after living in years of poverty and vulnerable situations into which the condition had put them in the first place (Akhter 2012). However, having treated 372 fistula mothers in 8 years, which means only 47 mothers treated in a year, does not necessarily indicate an efficient use of UNFPA and Engender Health resources.

However, there are existing challenges that need to be overcome. The first of these challenges is to prevent the occurrence of obstetric fistula and the second is to provide treatment to all the women of Bangladesh suffering from fistula. Another major challenge is the lack of awareness of obstetric fistula among health care providers, such as ante-natal care (ANC) workers to address the issues of fistula prevention and treatment (Engender Health 2003). As a result, the mothers who go for ante-natal care remain ignorant of the fact that prolonged or obstructed labour can cause obstetric fistula. In their desire to have a natural childbirth, as well their fear of surgical operations and lack of referral for emergency obstetric care (EmOC), many women suffering prolonged labour end up having obstetric fistula. Once a woman has this condition, she and her family become ambivalent about receiving timely treatment of the disease. Moreover, Bangladesh in general, and the

district hospitals in particular have a serious shortage of health providers skilled in fistula treatment, and they have poor logistics and insufficient patient beds, equipment and medicine (UNFPA 2003, p. 14). The shortage in the district hospitals compels the women with fistula to come to large cities like Dhaka (or Jessore) for treatment. For many women, this means travelling long distances. Another major challenge for the mothers is that due to their prolonged obstructed labour, they do not receive timely and adequate information about the sources and types of treatment available for the condition. This lack of information makes them suffer even longer. Molzan, Johnson & Lake Polan (2007, p.70) showed in their study in Eritrea that the mothers who became aware of their fistula while in a hospital for treatment of obstetric complications received very little information about the condition from the doctors or nurses of that hospital. A detailed discussion of this challenge is presented in the following section.

## 6.3: Mothers affected by fistula at Ad-din Hospital

There were 48 mothers of lower socio-economic household interviewed in this study. These included 11 mothers who were purposely selected for obstetric fistula. The fistula affected mothers are mostly young, poor and live in the remote and rural areas of Bangladesh. Ad-din is well-equipped with medical expertise and technical support for surgical treatment of fistula. Women who come to this hospital for their treatment not only receive free treatment, but they also receive a gown to wear during their stay (locally called *maxi*), three meals and two snacks a day, soaps, detergents etc. The efforts made by the hospital staff to make the mothers feel at home while staying in the fistula ward is appreciated by those who come for

treatment. This is reflected in Shefali's statement about the service at Ad-din Hospital:

> Everyone gets a *maxi* from hospital. They have also have given us a soap and washing powder. They give us very good food, so much food that we cannot finish. They give egg, meat, *shak* (green leaves), *daal* (lentils), rice and many other things. Also they give cha (tea) and biscuits twice a day. They do so much for us. They come to us again and again, ask if we are having any trouble. They check our temperature, pressure, give us medicine. They look after us very well. I have no complaint against them. In fact, since this disease happened to me, I have never received so much care from anyone. My husband has left me, but I am feeling good here.

The socio-economic conditions of the mothers suffering from fistula who were interviewed in this study appear to be no different from those of fistula affected mothers in other parts of the world as can be seen from other studies (Roush et al. 2012, p. 79; Cook, Dickens and Syed 2004, p. 73). These mothers are poor, they live in remote places with poor infrastructure facilities, and generally have very limited access to modern maternal health care facilities. The occurrence of fistula makes their already poor standard of living much worse, as many of them become isolated, lose their working capacity and are stigmatized by their families and the neighbours. All the 11 mothers who had fistula contracted the disease as a result of delayed or untreated prolonged obstructed labour, or eclampsia induced by hypertension. Table 6.1 shows, for these 11 mothers, the current age, age and the mother's birth order at the occurrence of fistula and other particulars such as the duration and cause of the disease, the time elapsed between the onset of pregnancy complication and the occurrence of fistula, the health facility where the disease is reported by the mothers to have developed and the number of attempts made to repair the hole.

**Table 6.1: demographic background of the mothers suffering from obstetric fistula and information about the occurrence and treatment of the disease, 2012.**

| Name of the mother suffering from fistula | Current age of the mother | Age at marriage of the mothers | Age and order of birth when fistula developed | Duration of fistula (years) | Cause of fistula | Time elapsed between the onset of pregnancy complication and the occurrence of fistula | Health facility where the fistula occurred[41] | Number of attempts for fistula repair |
|---|---|---|---|---|---|---|---|---|
| Shefali | 30 | 15 | 25 (4th birth) | 5 | Obstructed labour | 4 days | Local Clinic | 1 |
| Beli | 40 | 12 | 30 (5th birth) | 10 | Obstructed labour | 2 days | District Hospital | 1 |
| Rosy | 40 | 11 | 20 (2nd birth | 20 | Obstructed labour | 4 days | Home | 1 |
| Jobeda | 25 | 11 | 15 (1st birth) | 10 | Obstructed labour | 1 day | Home | 1 |
| Shapla | 22 | 14 | 16 (1st birth) | 6 | Obstructed labour | 5 days | District Hospital | 2 |
| Kolmi | 23 | 14 | 18 (1st birth) | 5 | Eclampsia | 4 days | District Hospital | 2 |
| Papiya | 35 | 10 | 23 (3rd birth) | 12 | Obstructed labour | 3 days | Home | 1 |
| Jahanara | 35 | 13 | 15 (1st birth) | 20 | Eclampsia | 1 day | District hospital | 2 |
| Sultana | 45 | 13 | 14 (1st birth) | 31 | Obstructed labour | 3 days | Home | 1 |
| Akbari begum | 23 | 13 | 22 (2nd birth) | 1 | Surgical fault | 1 day | Local Clinic | 1 |
| Shahanara | 25 | 12 | 14 (1st birth) | 11 | Obstructed labour | 4 days | Home | 3 |
| Mean duration of the condition= 12 years | | | | | | | | |

Source: Field work Dhaka, 2012

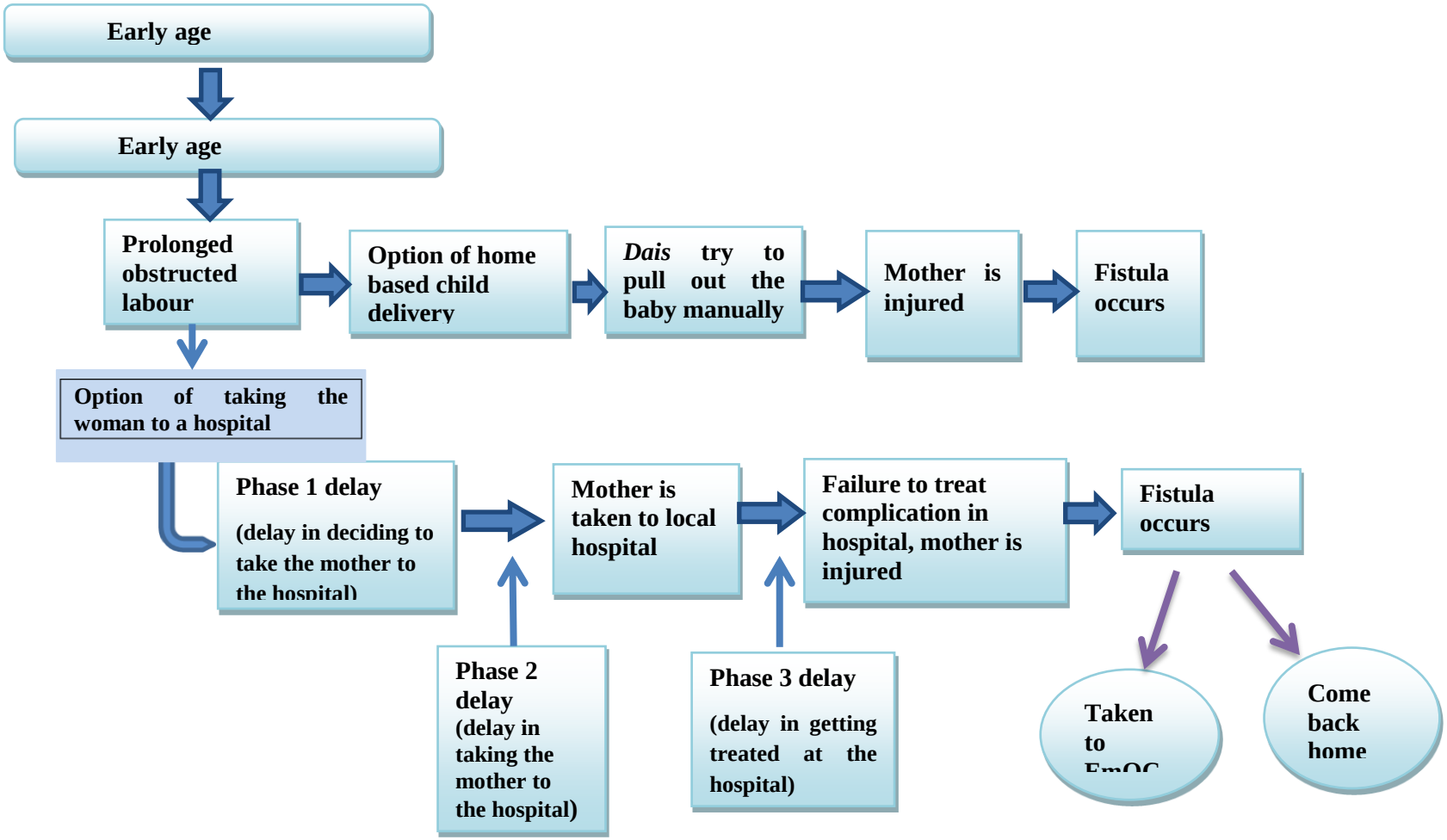
[41] As reported by interviewed mothers

Table 6.1 reveals that all the mothers except one (Akbari Begum) have been suffering from fistula for five years or more, including many who have been suffering for decades. Most of them have this condition due to long obstructed labour which could have been prevented or cured if EmOC was provided to them on time. The current age of each fistula affected mother, their age at marriage and the respective duration of suffering suggests that most of the mothers experienced fistula at an early age and remained untreated for a long time, and in some cases, for the major part of their adulthood. Early childbearing (following early marriage) also contribute to obstructed labour due to the small size of pelvis. It is also clear that more than half (six) of the mothers experienced fistula during their first childbirth, Although it is generally agreed that fistula can be closed at the first surgery, in some cases the affected mothers may need more than one operation (Wall 2006, p. 1,204). Eight of the 11 mothers had their first surgery hoping the hole to be repaired during this interview, but for the other three mothers it was their second attempt to repair the fistula.

## 6.4: Causes of obstetric fistula and the extent of sufferings

The extent of suffering of fistula affected mothers and the causes of the condition are well documented in the literature (Wall 200; Cook, Dickens and Syed 2004; Engender Health 2003). It has been mentioned before that the causes of fistula are mostly long obstetric labour, untimely or no treatment. Figure 6.1 presents a pathway describing the chain of events leading mothers to the risks of developing obstetric fistula. This figure is developed based on the interviews with fistula affected mothers studied in this research.

**Figure 6.1: Pathway to the occurrence of obstetric fistula**




Source: Drawn by the author from the interview data of the mothers suffering from fistula

The pathway to obstetric fistula, as shown in Figure 6.1, originates in a background of early marriage, early childbearing, and delays in seeking healthcare for prolonged labour and in some cases an aversion to child delivery in a health facility. All of these are ingrained in a situation characterized by poverty, lack of education and lack of knowledge about healthcare. When a woman has a prolonged obstructed labour, two options can be visualized. One option is to continue with home based delivery attended by a traditional birth attendant, who tries a manual delivery, resulting in injuries and rupture of the uterine wall and ultimately, fistula. The other option is to take the woman to a hospital but, in the process, encounter the three phases of delay (Thaddeus and Maine 1992), and ultimately resulting in fistula.

Wall (2005) identified poverty as the 'breeding point' of obstetric fistula because, usually, in a poorly resourced social setting girls remain undernourished, get married early and give birth to children early. Childbirth at an early age is a crucial factor in that in a poverty prone social setting, the pelvic bones of adolescent girls (under 16 years of age) are not mature enough to bear a child or push a baby out during labour (Ostimehin 2013, p. 1,702). As Miller et al. (2005, p. 288) stated, childbirth at a young age serves as a proxy for pelvic immaturity. As a result, the young mothers experience prolonged obstructed labour, leading to obstetric fistula.

The demographic characteristics (Section 6.3 of this chapter) show that all mothers (except one) were married at the age of 13 or 14 or, in other words, immediately after the onset of puberty or even before puberty. They started cohabiting with their

husbands and bearing children soon after marriage, and most of them had obstetric fistula during the birth of their first child. Shapla who experienced fistula at 16, was married at 14, and told me why she was married early.

According to her:

> In our area, we girls are *lojjasheel* (shy). We don't say anything about our marriage. Father-mothers and elderly people decide about this. They took decision and got me married; I had no saying in it (Shapla, aged 22).

The reason she gave is related not only to the poor economic condition of her family, but also to the age-old cultural tradition of a society where girls have hardly any say in decisions about their own marriage. This practice of early marriage places the girls in an even worse condition physically, as early marriage is often preceded by drop-out from school and followed by early childbirth, leaving girls with little chance of gaining knowledge, information and the understanding of their wellbeing and individual rights (Jensen and Thornton 2003, p. 10). Shapla, after suffering from obstetric fistula for the last six years, stated that if she was not married early she might not have had this condition; if she had had enough strength in her body, she might not have ended up with this way.

> I think in my mind if I was not sick, if my son was alive, then I could have had a happy life. Now I am afraid, whether I will be able to have any child again, whether my husband will keep me with him. Will my future days pass in fear and suffering (crying silently). If I stayed like this and if my husband married somebody else, I will have lots of suffering, I know, I still hope I will get *sukh-shanti* (happiness), if I get well.

Figure 6.1 further depicts that a number of factors are responsible for the mothers to suffer from fistula. Prolonged labour and birth injury were at the centre of the occurrence of the disease, but there were differences in the circumstances between

one woman and another. In one group of cases, prolonged labour, accompanied by the indecision to go to a hospital led to birth injury when an untrained traditional midwife (*dai*) tried to deliver the baby manually. In the other group, prolonged labour, accompanied by a delay in sending the mother to a hospital, delay in reaching the hospital and getting treatment at the hospital caused the occurrence of fistula.

The first type of scenario in which obstetric fistula happens is portrayed in Jobeda's childbirth experience.

| | |
|---|---|
| Jobeda: | I conceived in the first year of my marriage. The baby died in my womb. I was in serious pain. The pain stayed for a day and a night. My parents-in-law did not let me go to my parents' house. My parents also did not insist on taking me home. Ladies from neighbourhood were around me during my labour. They (husband and parents-in-law) did not take me to a hospital, because they did not have money. There was no hospital nearby. There was one in Hobigonj. The transport cost from our home to Hobigonj is BDT 125 |
| Researcher: | Did they not have this 125 Taka? |
| Jobeda: | Yes they had. But that's not enough. You have to spend money for every service in the hospital. A caesarean section will cost lots of money. |
| Researcher: | But CS is free in a government hospital? |
| Jobeda: | My husband and parents-in-law did not know all this. That's why they did not take me anywhere. They kept me home. The baby was stuck inside me. Then the *dai* pulled it out using her hands, after that, my pain stoped but it started leaking urine. I was unconscious then. Seeing this urine leaking, the *dai* could not say anything" (Jobeda, aged 25 years, married at age 15 and pregnant at the same age). |

As a part of their normative childbirth behaviour, Jobeda stayed at home surrounded by traditional birth attendants (TBA or *dai*), who observed and tried to deliver the baby manually. Jobeda's story depicts a similar childbirth experience to

that of mothers from the lower socio-economic households, discussed in Chapter Five. It is characterized by early aged childbirth, lack of knowledge and information about the availability of treatment and lack of awareness about the possible devastating condition of prolonged obstructed labour. This lack of awareness of a labouring mother and her family has been considered as a crucial challenge in the maternal mortality and maternal morbidity literature (Engender Health, 2003).

There could be some other context in which a birthing mother's health gets the lowest priority and might not be considered worth spending money on. The experience of Kolmi reveals this kind of situation:

> My pain started in the morning. I stayed at home for the whole day and night. The following day at the time of *Magrib* (at the time of sunset) I was taken to the district hospital. When I was home, my husband shouted at my mother and sister-in- law and said, why you are not taking her to hospital. She will die, can't you see? Are you human beings? I also said, please take me to a doctor. But my brother-in-law (husband's elder brother) and sister in law did not want to spend money for me. My brother-in-law said, why to hospital? She will deliver baby here (at home). But my husband did not agree. He shouted at them. Then my brother-in-law gave money. I was taken to the hospital by ambulance. But once at the hospital I was left by the side for the whole night. They did not even give me a bed. Then my brother-in-law gave BDT 1,000 to a staff in the hospital. Then he managed a bed for me. I was then taken to OT (Operation Theatre). The baby had already died. After taking me out from OT, they put me in the bed again. They cut the pipe (catheter) after four days of operation (Caesarean section). I saw that everyone could walk. I could not. My whole bed was getting wet. The doctors said, we cannot do anything. Take her to Dhaka. (Kolmi, aged 23 years)

The childbirth experiences of Jobeda and Kolmi highlight how the voice of a birthing mother is not heard in making decisions for seeking healthcare. Neither of them could express any choice of their own with respect to addressing their immediate needs for emergency obstetric care. This disempowering position of women in relation to childbirth (whether medicalized or natural) has been identified

as a contributory cause for obstetric fistula. Roush et al. (2012, p. 788) argue that gender inequality and oppression of women, manifested in a form of having no say in childbirth care and no scope in decisions to spend money or receive care from health facilities, initiate the risk of obstetric fistula. Oakley (1984, p. 22) argues that even in natural birth practice, the birthing mother is not considered to be at the centre of her own childbirth experience. Rather, men's responses to this incidence have been considered more important. Similarly, Jobeda and Kolmi, like many other mothers, could not fully own the birthing experience; the decisions were prescribed by the family members, particularly by the elderly. All the fistula affected mothers interviewed in this study had similar kinds of experiences to this. Women's decision making abilities have been considered as strongly linked to care seeking behaviour for maternal health care, where there is a higher level of education and household economic status is better (Dalal et al. 2013, p. 16).

In this connection, and in particular with reference to Oakley's (1984) comment about men's responses to women's maternal healthcare needs being considered more important, it is necessary to step back and consider the men's role in general and in maternal health care in particular. While campaigns against the early marriage of girls are being implemented worldwide, and should be intensified, there is no denying the fact that a social and cultural change like this takes time to bear fruit. The median age at marriage of girls in Bangladesh is 15.8 years (NIPORT et al. 2013, p. 51), which is far below the legally stipulated age of 18 years, but until the campaigns against early marriage of girls take a firm root and produce the desired results, men (the husbands of the young brides) should be

especially targeted for educating them with information about the ills of early childbearing (for both the wife and the baby) and for motivating the husbands to use contraception at least until the wife is 20 years of age before deciding to have a baby.

In other cases, some fistula affected mothers were taken to the hospital after the failure of the *dai* to pull the baby out manually when the family realized that the mother's life was in danger. The irony is that by the time she is taken to a hospital, it is too late and the baby cannot be saved, the woman has already suffered a lot and irreparable damage leading to fistula has occurred. Thus, in this situation, bringing the mother to a hospital did not help her from developing the condition. That is why we have seen, as presented in Table 6.1, that six mothers developed fistula while they were getting treated for obstetric emergency.

A study by Molzan, Johnson and Polan (2007, p. 68) showed that women in Eritrea with obstructed labour stayed at home for periods between 24 hours to five days before any medical treatment was sought. They stayed surrounded by female relatives and neighbours and a traditional birth attendant, who suggested that one should wait until women eventually deliver instead of seeking medical help, although eventually most of the women were taken to a hospital. By the time the women reached the health facility they had already suffered intensely and the damage leading to their fistula had already occurred. Similarly, in the present study the fistula affected mothers ended up staying at home for at least two days and a

maximum of four days with obstructed labour and without any medical assistance. While at home, during obstructed labour, the attending *dais* tried to pull the baby out manually and made the area surrounding the birth canal swollen and injured, as we have come to know from Jobeda's situation. A similar situation occurred with Jahanara, who had eclampsia induced by hypertension (locally known as *Gorbho tonka*). Ladies from the neighbourhood, who were present at Jahanara's childbirth, mistook her convulsion to be labour pain. While the convulsion brought the baby down towards the cervix, the *dai* tried to pull the baby out manually, tearing the area and creating a hole. Jahanara states,

> I got married at the age of 13. I got pregnant two years later. I went to my parents' house for delivery. Then I had *Gorbho tonka* (convulsion). The convulsion was so much that the baby's head could be seen at my cervix. Then the *dais*, who were present there thought the baby should be born right then. Then they tried to pull out the baby using their hands. But the baby did not come out. It died inside. I stayed conscious for the following three days. Then my family took me to the district hospital. They brought the baby out by cutting a bit in the cervix. I think that time, *peshaber tholi* (bladder) got somehow cut at that time. Soon I realised that my urine is coming out without any control. When I tried to stand up, faeces came out too. (She took a deep sigh expressing her deep sadness.)

In the case of Jahanara, the baby died and the hole was created after she was taken to the hospital.

A late intervention in receiving EmOC for life threatening obstetric complications represents one of the three phases of delay identified by Thaddeus and Maine (1994) in their three delay model (see Chapter Two). The authors argue that if "prompt" and "adequate" treatment is provided, the mothers are less likely to die or have an illness as an outcome of obstetric complications. Thaddeus and Maine identified the delay in making the decision to take the mothers with labour pain to a hospital for medical help as the first phase of delay. They note that, a Phase 1 delay

can occur due to a number of factors such as: the severity and characteristics of the illness, the woman's status in the household (including her education and economic status), the status of the household within the community, the cost of transportation, the cost of the treatment and the perceived quality of healthcare at the intended health facility (1994, pp. 1,093-1,100). In the cases of Jobeda and Jahanara (and other fistula affected mothers in this study), the delay in transferring these women with obstructed labour to a hospital can be explained by their poverty, inability to understand the severity and possible outcome of the long obstructed labour, and the women's status within the family which is characterized by the low priority accorded to the women's health and wellbeing.

Once a decision has been taken (sometimes very late) to take the pregnant woman to a hospital, her family may experience delays due to the time taken in managing the transport and in travelling the distance to the health facility. This can cause the medical condition to become further complicated and can often result in taking the pregnant woman to a local health facility where EmOC is not available. This delay is defined by Thaddeus and Maine as the Phase 2 delay. Thaddeus and Maine (1994, p 1,092) attribute the causes for this delay to physical accessibility factors, such as distribution of facilities, travel time from home to the health facility, availability and cost of transportation and condition of roads etc.

The women afflicted with fistula in this study reported that the main causes of Phase 2 delay in getting them transferred to a hospital consisted mostly of

infrastructure constraints such as the geographical distance between the women's residence and the hospital and the availability and cost of transport. The mothers were taken to local maternity wards where the child was delivered manually by hand or by cutting the cervix. Similar experiences have been noted elsewhere (Molzan, Johnson and Polan 2007, p. 70). The story of Shapla who has been suffering from fistula for five years, outlines the situation of how delays make the obstetric situation more complicated. In particular, it portrays the second pathway of how obstetric fistula may occur in a hospital (as shown in Figure 6.1). It is acknowledged that there may be other situations like surgical error that may also result in fistula (as happened with Akbari Begum, age 25). According to Shapla:

> I conceived only once. That child died. When pain started, the pain was not increasing. I stayed home one day and one night. The *dai* was around me. Then the *dai* said, she could not do anything and suggested to take me to the doctor. There is a small government medical centre close to our house. I was taken there. But still my pain was not increasing. There I waited for a day. Then I was taken to Sodor (district hospital). There I was given saline. The pain was not still induced. Sodor was three miles away from our house. I went there by a reserved *tempu* (a three-wheeled vehicle). My mother, my uncle and my husband went with me. The put a saline, pushed an injection. But still there was no pain induced. Then they tried to pull the baby out by cutting that place (cervix). Then they said, "it will not be possible by us. Take her to Sylhet if you want to save her". We came back home instead of going to Sylhet. We are poor people. We did not have enough money to go to Sylhet. Moreover, in Sodor, my uncle came to know a *dai.* That *dai* told my mother that she will be able to bring the baby out in an hour. She has connections with hospital doctors. So we came back home. I was bleeding from that cut place. It was bleeding hugely. Then I stayed home for a day. The dai could not do anything. Then, I was taken to a clinic. People call him *doctor babu* (the doctor). That *Doctor Babu* told us that he will be able to bring the baby out. Then he brought his tools. He tried to pull the baby with forceps. But he failed to pull it completely. Then again sent the baby back inside. And then he said to my uncle, take her to Sylhet as soon as possible, if you want to save her life. Then at 1.30 in the morning I was brought to Sylhet in a rented car. It was 2.30 (am) when we arrived in Sylhet. Then they saw the baby with a pipe and told us that the baby was dead already. Then they did not clear the baby. Instead, they put a saline. Next day I had pain and the baby came out. The *ayas* took me upstairs. I could not tell anything after that, I needed two bottles of blood and a few stitches. The baby was a boy, quite big. He died (at this stage Shapla sighed with deep grief and silent cry). After that I stayed in hospital for 19 days. Both urine and faeces were leaking.

> No control after the baby was pulled out. I was very sick, weak. I could not even move. (Shapla, aged 20 years)

Shapla was taken to the hospital following the failure of the attending *dai* to help give birth to the baby. She was not taken to a proper hospital equipped with EmOC facilities due to monetary constraints of her family. This demonstrates that another stage of failure to deliver the child can happen in a local hospital.

All the fistula affected mothers in this study were first taken to the local or nearby hospital to treat obstetric complications, and after failure of the *dai* to deliver the baby at home. Some mothers experienced obstetric fistula in that local health centre while the health provider was trying to pull out the baby (as was the case of Kolmi in the following quotation), or in some cases after the labouring mother was taken to an EmOC equipped hospital with an already damaged pelvic area. After the baby was removed the mother realized that there was a leakage (as in the case of Shapla). Kolmi, who had obstetric fistula after she was taken to a local clinic, gave the following statement:

> I had this disease 8 years ago during my childbirth. I had pain for four days. I suffered for four days. My husband did not take me anywhere. When my brothers came to know, they took me to a hospital. My husband did not take me there, because he wanted to marry again. He fixed his marriage over mobile (phone). My brothers took me to *Banglabazar* (the local hospital nearby). The doctor worked hard to get the baby out. He pulled out the baby *(Tana-tani).* By this time, the baby had died. Then my brothers took me home. After going home, when I lied down, I felt a flow of urine going. I was shocked. I said, what is this? Why is it like this? My brother then again took me to that doctor again and argued with doctor on what she had done with me. Doctor said, she won't be able to do anything. She said, this is *allah r hokum (*Order of God) and suggested my brothers to take me to Bhola.[42]‘‘

[42] Bhola is an administrative district in south western Bangladesh.

None of these mothers, during their pregnancy or during the time of obstructed labour, had any say about birth planning. This silence about their choice and decision making ability may reflect that mothers have been separated from their own childbirth experience. Wagner (2001, p. s25) argues that ensuring that women's experiences in giving birth are 'fulfilling' and 'empowering' is absolutely essential for making women strong, and thereby making society strong. Gender inequality, low social status and disempowerment of women have a major impact on their health, maternal health and overall access to maternal health care services. Ahmed et al. (2000) showed that the probability of seeking any type of health care was almost twice as high among men as women. This emphasizes the subjugated position of women in families, where women may find it difficult to obtain transportation, to get the money to pay for medical care services or to manage transportation to go to health facilities in an emergency. Thus the occurrence of maternal morbidity such as obstetric fistula cannot be fully explained by any particular cause or event, rather it occurs in a complex socio-economic and cultural context. This needs to be well understood to prevent obstetric fistula in the future.

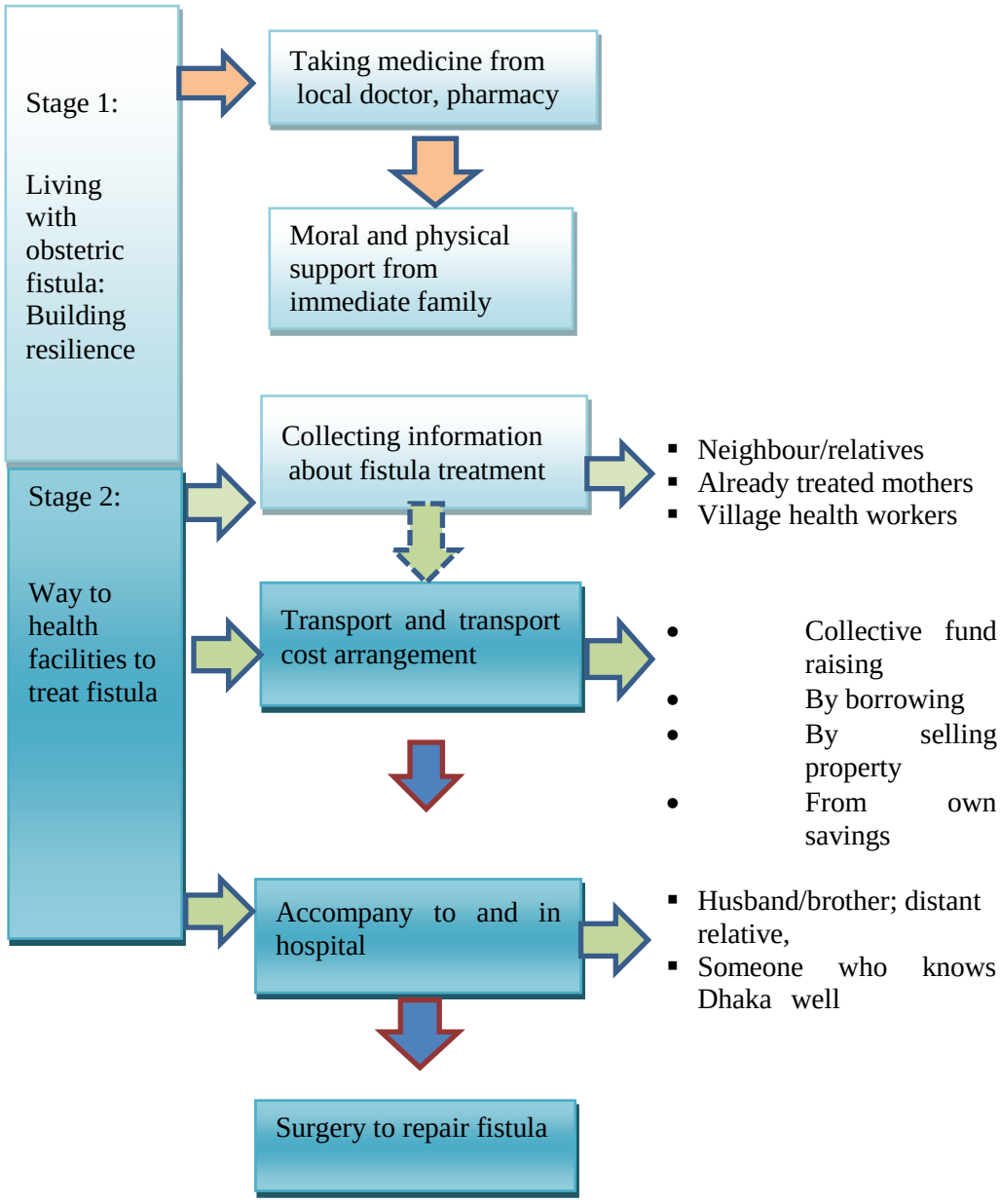
## 6.5: Health care seeking behaviour for fistula: a challenging journey towards a surgical solution

This section draws attention to what a woman does after she is affected by fistula and how, and in what ways she searches for its treatment. It has been mentioned earlier in this chapter that fistula can only be healed by a sophisticated surgical procedure for which the affected woman has to come to specific health facilities. In Bangladesh, as mentioned earlier, there are only 15 fistula treatment centres and

most of them are situated in cities. For the poor women afflicted with fistula, coming to the city for treatment is a matter of significant preparation including cost, transportation, someone elderly to accompany them and proper information about treatment.

Figure 6.2 illustrates the process that the interviewed mothers went through in getting their fistula treated. This figure is developed from the thematic coding of the interviewees' responses. Borrowing the idea from the 'illness response approach' (see Chapter Two for details) the process presented in this figure looks at how a fistula affected mother copes with everyday life and how she seeks treatment. The illness response approach adopted in this research to understand the health care seeking behaviour of mothers with maternal morbidity, holds the underlying assumption that "behaviour is best understood in terms of an individual's perception of their social environment"' (MacKian 2003, p. 8). This approach focuses on the process by which a person responds to her illness or condition and the way he/she copes and seeks treatment.

**Figure 6.2: Health care seeking journey of mothers for treating fistula.**




Source: Inspired by the illness response approach (MacKian 2003) and drawn from the interview data of the mothers suffering from fistula

The left part of diagram presents two of the stages of health care for fistula affected mothers, who may or may not find their way to a health facility to treat their condition. In Stage 1, mothers live with fistula and build resilience to the condition with medicine and support from their immediate family. In Stage 2, mothers like those who were interviewed at the Ad-din Hospital find their way to a health facility for treatment. The various steps these mothers go through, first to build resilience and then to find their way to treatment are shown on the right side of the diagram.

## 6.6: Living with obstetric fistula: building resilience

According to Engender Health (2003, p. 29), some fistula patients in Bangladesh "suffer most of their adult life before discovering the opportunity to receive care, due to their inability to locate health facilities that could provide repair service". Thus some women suffer for a long time before they receive any treatment to repair the fistula. During this time of immense physical suffering, living the life of a fistula affected mother is a real challenge. According to Yeakey et al. (2010, p. 159), this condition directly impacts on women's ability to perform their functions, particularly in relation to their daily routines and household chores. Their lives are impacted by the lack of resources necessary to care for the condition, such as time to wash their bodies throughout the day and soap to wash their clothes and beds frequently. Many women experience painful blisters on their inner thighs due to continuous leakage. In this condition, it is important that the fistula suffering mothers maintain resilience to continue life with the extra burden of maintaining their cleanliness. Bangser, referring to the work of the Women's Dignity Project in

Africa (2006, p. 535), noted such resilience among fistula affected mothers in Africa as they continued to do their household work, care for family members and keep themselves clean. The same is reflected in Akbari Begum's words, "I think my husband still loves me. Because, I try to keep him happy *(mon rekhe choli*). I always keep myself clean, so that when he comes to me, he does not get any bad smell*"*. In spite of being isolated, stigmatized and poor, it is the resilience that keeps these women's hopes high of leading a normal life. It is their resilience and strength, according to Bangser (2006, p. 535), that encourages them to spend years looking for the money to get a surgical repair. Without understanding this coping and resilience while living with obstetric fistula, it might not be possible to fully understand the health care seeking behaviour of women suffering from fistula.

The fistula affected mothers in this study try to cope with this situation of suffering in two ways (Figure 6.2). First; through mental and moral support from their circle of friends and family who sympathize with them, and second, which is more of a response to physical discomfort caused by continuous urine leakage, is to go to a local healer or to a nearby clinic to recover the physical weakness or to get rid of the blister between the inner thighs due to constant urine leakage.

### 6.6.1: Moral and physical support from immediate family members

> One disease, three *kosto* (sorrows), I have lost my son, my husband and my health. *Apa* (sister), *bonobas* (living alone in a jungle) is better than this. If I made a movie on my life, I could have earned a lot of money. That movie could have been a very sad movie and would have made people cry.

This statement by Shefali, which was accompanied by a long sigh of deep sadness, reflects not only the social consequence of a physical problem, but also the acute isolation and helplessness she went through in her life due to this condition. For all the fistula affected mothers I interviewed, the support, particularly moral support they receive, was seen as a crucial aspect that could help speed up seeking and arranging fistula treatment, reducing the mental stress of suffering mothers and thus build resilience. Yeakey et al. (2009, p. 508) argued that the impact of fistula is so acute that it might challenge a woman's definition of herself, because it diminishes her ability to fulfil her social role, resulting in psychological illness. Some fistula mothers may be resigned to their fate and powerless to seek treatment. The mental stress and suffering, with no cooperation from the family appeared to be more painful to her than the physical suffering itself. I got this impression, as I noted in my field noted, from the long pauses in her interview with me during which she wept while telling me her story and how her husband abandoned her. It is impossible to remain unmoved after hearing such a sad tale.

When the impact of obstetric fistula can be so critical and the extent of suffering so intense, it is important that the afflicted mothers should be provided with support for their mental strength, to enable them to build resilience within themselves. In this situation, the attitude of their family members is the most important factor that could prove to be a support (or hindrance) towards seeking adequate health care.

Those who received support from their family considered it as the greatest comfort they had while living with this condition. However, in this study, most of the fistula affected mothers had extremely limited mobility and social networks. All 11 mothers reported that they feared being embarrassed due to urine leakage and bad smell. Some of the mothers were not even able to maintain contact with other family members. However, fortunately for the women, they were supported by at least one person—if not a member of their family, then a person in the community or an employer. None of the women was totally isolated and unsupported (Table 6.2), and that is probably why they were able to get to Ad-din Hospital for fistula repair.

**Table 6.2: Major source of moral and financial support for treatment of fistula**

| Name of respondents | Types of support received | | | |
|---|---|---|---|---|
| | **Source of financial support** | **Source of information about fistula treatment** | **Source of moral support** | **Person(s) who accompanied the woman to the hospital and waited with her** |
| Shefali | Brothers | Woman from neighbouring village who has been already treated | Brothers | Brothers |
| Beli | By selling a cow | Another lady (Jobeda) coming here for treatment | Husband and son | Daughter-in-law |
| Rosy | Son | Son | Brother and son | Son |
| Jobeda | Brother | Distant relative and neighbour, who works in Dhaka | Brother | Alone (she knew this place as it was her second visit) |
| Shapla | Community donation | Doctor from the local clinic | Mother | Mother and husband |
| Kolmi | Husband and in laws | Sister-in-law, who works in Dhaka | Husband | Sister-in-law |
| Papiya | Borrowing from families and neighbour | Distant relative, (cousin's husband) | Husband | Husband |
| Jahanara | Savings | Cousin and Ad- din health worker from the neighbouring village | Cousins and sister | Alone |
| Sultana | Sons | Son | Husband | Daughter-in-law |
| Akbari Begum | Husband | Local clinic | Mother | Husband and husband's uncle |
| Shahanara | Brothers | Neighbour | No one | Alone |

Source: Information collected from field work, Dhaka 2012

The support which may be in various forms, e.g. social, moral, motivational, financial, providing information etc. has come to the fistula affected mothers in this study from a range of sources, namely, parental family, husband, husband's family, distant relatives, neighbours, health workers (Table 6.2). The type of support received and the person providing that support is a major factor in defining the

health care seeking behaviour of this group of mothers. In the previous chapters, we have seen how important it is to have an effective social network in shaping the health care seeking behaviour of mothers with delivery complications and maternal morbidity.

Jahanara, abandoned by her husband six months after having an obstetric fistula, has had to work hard to earn her living. She also has to look after her mother, who is frail and ailing. Since she was deserted by her husband and family, Jahanara has received help and support from her distant relatives and neighbours, who gave her advice, information, financial help, and provided clothes that she used as a pad to keep herself dry. This extent of support from her distant relatives and community members has been identified as community strength for the affected mothers. These community ties are considered as significant factors in fistula eradication initiatives (Wegner et al. 2007, p. s109). In the following sections of this chapter, we will see more examples of how communities help fistula affected mothers in getting surgical treatment.

### 6.6.2: Receiving comfort and treatment from local doctors/traditional healers

While waiting to receive surgical treatment for obstetric fistula, it is also very important for these women to address their other health and non-health problems which tend to reduce their working capacity. To do this, the fistula affected mothers sought temporary treatment from local doctors or traditional health care providers. This not only reduces the incidence of health related impacts of obstetric fistula but

also helps the fistula affected mothers to cope with their life. Jahanara states her efforts to seek temporary comfort follows:

> I have a life of severe suffering. I always have to use *taana* (old soft clothes used as pad). Whenever, any scar or sore appears, I get medicine from the doctor. The husband of one of my cousins is a doctor. He runs his practice from a pharmacy close to our house. He gives me medicine almost free of cost. He has a lot of *maya* (sympathy) for me.

### 6.6.3: Looking for treatment: seeking health facilities

It has been found in this study as well as elsewhere (Engender Health 2003; Bangser 2006) that the length of time elapsed between the onset of obstetric fistula and seeking treatment is usually more than a year. In some cases it is more than a decade. This length of time indicates that treating fistula is not an easy task by any means - for the suffering mothers as well as their families. Yeakey (2011, p.160) states:

> Successfully receiving medical treatment for fistula is challenging. It requires determination on the part of the woman to navigate the system and a great deal of time to continue following up referrals. For women who may already be marginalized in their families or communities because of fistula, this can be challenging because they may not possess the social capital to advocate for financial resources to be spent on their behalf to seek treatment.

These reasons for spending a long time before treating fistula evoke important aspects of health care seeking behaviour of mothers suffering from fistula. Unlike their health care seeking behaviour for delivery complications or other pregnancy related diseases that are related more to mothers' and their family's perception and attitude toward childbirth, the health care seeking behaviour of women afflicted with fistula involves mainly practical issues like cost, information, transport etc. The second part of the framework given in Figure 6.2 illustrates the phases and

challenges which the fistula affected mothers have to go through to seek treatment. The health care seeking experience of these mothers suggests that they have to overcome three challenges in seeking treatment:

- Collecting information
- Arranging transport and its cost
- Finding someone to accompany to the hospital and wait there

In each of these challenges the fistula affected mothers have to rely on support from others. Figure 6.2 highlights these steps and the sources of support the mothers received in seeking treatment. The long distance of a fistula repair centre from the mother's residence makes the treatment for them a far-fetched matter. This difficulty of distance is further complicated by a dearth of information, scarcity of financial support and a lack of support from family and friends, all of which tend to become worse as a result of this acute condition.

### 6.6.4: Collecting information about fistula treatment

> I did not know *Apa* (sister) where to go for treatment- (said with a blank eye and with frustration in her voice). In the meantime I saw some *Fakir* (traditional healer). But this is not that type of disease that a *Fakir* can heal. This is a disease for a doctor. When the urinary tract gets sore or has scars, then a *Fakir's* medicine can give some comfort. But *Fakir* cannot heal *peshaber tholi* r *futa (*hole in urinary bladder). Everyone advised us to go to Dhaka for operation. But no one said where to go in Dhaka. Moreover, everyone said it would need lots of money. How would we manage money? Now, my husband's sister lives in Dhaka. She works in the garment industry. She brought me here. Jobeda (aged 25 years)

> *Apa* I did not know where to go, if I knew before, I would have come earlier by managing money at any cost, now we came to know about this place and came here. My husband sold a cow for 5,000 taka and brought me here. Kolmi (aged 23 years)

The above two statements, in response to my question of why it took them so long to come to Ad-din, reveal that getting information about the appropriate place of treatment for fistula was the first and biggest challenge they experienced regarding seeking treatment. Unfortunately, there were hardly any official sources or reports by mothers about where they received information about the appropriate places of fistula repair. As revealed in Table 6.1, the mothers suffering from fistula had this condition either in health facilities or they went to seek advice and treatment from a doctor after it happened. However, only one woman received proper information from any health facility about the places, the costs and surgical procedures involved in treating or repairing fistula. For most of the women, the major source of information was distant relatives, neighbours or village health workers.

> I went to Sylhet in *Rakib Al*i (a local clinic) clinic. They did a surgery to remove stones from my gallbladder. And then they said that they are not able to repair the urine leakage. The doctor said to my husband, take her to Dhaka, there is no treatment for this here. We said, "how can we go, we are poor". The doctor said, "I will give you address. If you go there, you will get free treatment. You will not need any money". My husband did not want to take me to Dhaka. But he talked with other people and the elderly. Everyone said, "there is no benefit of sitting at home with this condition. Better take her to Dhaka and see". Then my husband took the address and all information clearly and brought me here. (Shapla, aged 22 years)

> I and that girl (showing Azida lying on the bed next to hers) came here together. That girl is also from my village. Her sister-in-law (husband's sister) works here in Dhaka as a garment worker. Her sister-in-law told her about here and brought her here. She told me, *chachi* (aunty) let's go with me. Then we came here together. We don't need money here (Beli, aged 44 years).

These sources of information for fistula affected mothers came from the wider social network of the mothers, distant relatives, neighbours and local health workers. Wegner et al. (2007, p. S110) discussed the importance of the community network where community members might use their knowledge about the

availability of health services as well as their perception about health care to influence decisions on "if, when, where and from whom women can seek delivery care and what resources can be made available for women who have obstetric fistulas or need reintegration into the community after treatment". However, support and information that fistula affected mothers in this study received from their social network does not in any way undermine the importance of the availability of access to and supply of information about obstetric fistula and its treatment in all institutionalized health care centres, so that the affected mothers can receive proper information at the beginning of their condition and get treated quickly.

Having said that, all mothers in this study except one, suffered fistula for at least five years, some for decades. Although a study done elsewhere (Engender Health 2003) suggests that the primary reason for not getting treatment was lack of money, the mothers interviewed in this study reported that the lack of appropriate information was their biggest challenge. It was important for the mothers to know that surgical repair for fistula is done free of charge in Bangladesh. The mothers interviewed felt motivated when they came to know about this opportunity for free surgery. They managed to get the transport cost to Dhaka and other arrangements from different support sources.

### 6.6.6: Transport costs and arrangements

The second challenge of the pathway to repair fistula is arranging transport costs. As mentioned before, the fistula affected mothers in this study came to Ad-din Hospital from rural, remote villages. Coming to Dhaka for treatment involved

managing long distance transport costs. Although the treatment for fistula is provided free of charge, the mothers had to raise money to meet transport costs, as well as the costs of unanticipated emerging issues.

Figure 6.2 suggests the fistula affected mothers were able to arrange transport costs from different sources, such as borrowing money, selling property, donations from the community or own savings.

> Everyone in my village donated a little amount of money to bear my transport costs. Everyone had sympathy for me. They saw me how I have suffered for such a long time. So when they came to know that I am going to Dhaka for treatment, everyone helped me. When I started from home, all my neighbours came to my house courtyard to see me off. They all said we will pray for you. (Beli, aged 40 years)

The money collection experiences of the mothers signify a great empathetic community support in Bangladesh, where informal social networks hold much importance in treating fistula. Wegner et al. (2007, p. 109) emphasize this importance of community network, including friends, family, husbands and neighbours, on the demand side, as well as on the supply side of the treatment. They argue that as most fistula affected mothers live outside the mainstream of their societies, they are even less likely than other women to know that most fistulae can be repaired, let alone where to go to for treatment. Thus, social networks serve a pivotal role in the treatment seeking behaviour for fistula.

### 6.6.7: The need for an escort

Travelling to a health centre alone is a challenge for the fistula affected mothers. Thus, the third challenge in their path to repairing fistula is to get a person who can

escort them to a fistula repair centre like Ad-din Fistula ward and do the initial formalities for admission. Table 6.2 reveals that, like other challenges, mothers received support from family members and the wider community to find an escort to the hospital. Most of the mothers in this study reported that they were accompanied by someone who knew Dhaka well, be they distant relatives or friends. Again, this highlights the significance of a social network in dealing with fistula.

### 6.6.8: Treatment of fistula: physical, social and mental healing

The mothers reported that they felt relieved and hopeful that they would get better as soon as they arrived at the Fistula Ward. Coming to the hospital gave the mothers not only hope for physical healing, but gave them reassurance about themselves by being associated with other mothers in a similar condition. They also felt happy with the level of care which they had never received before. Success in fistula repair is usually defined by medical professionals in terms of its clinical outcome. Beyond this definition of surgical repair, it is important to also understand how women perceive the intervention, even when it does not repair the condition completely (Molzan, Johnson and Polan 2007). While Browning, Fentahun and Goh (2007) found that surgical repair had a positive impact on women's mental health status, the present study also found that even being able to receive health care for fistula repair after years of suffering is a great stress reliever for the suffering mothers. Karimunnessa, lying on a bed with a catheter attached, told me with great happiness:

> *Ma go* (O my mother)[43] I am feeling very good after coming here. I am staying in dry clothes. It seems to me that I have found a new life in this world of Allah. You can't think of how much suffering I had! In this winter time, I had to wake up at midnight, wash my clothes. I got shrunk in cold. I used to make fire at mid night, dry my clothes and warm myself and then go to bed again. Now, I am not doing anything like that. I am feeling very good.

Thus, while repairing fistula is the ultimate goal of the treatment, even attempts to receive treatment has an impact on the affected mothers, not only in physical healing of their ailment but also in healing the mental sores that they acquired after years of suffering.

## 6.7: Health care seeking fistula treatment: a way out through social networks

The above discussion suggests that the major underlying factor that played a pivotal role in making it possible for the mothers to treat their fistula was their social network. The mothers received hardly any information about the treatment of fistula from any healthcare institution, particularly where they first contracted the disease where they went for advice or initial treatment of fistula. Moreover, living in precarious social and economic situations with restricted mobility, it was very unlikely that they could receive the right information about the treatment of fistula. In this context, the mothers interviewed in this study were supported by their social network, which consisted of intimate family members, near and distant relatives, neighbours, friends and village health workers. They received support at every step of every challenge they experienced towards receiving fistula repair, be it in the form of motivational support, physical support to accompany them to a fistula

[43] In Bangladeshi culture, out of affection, elder people often call younger women as 'mother' (*ma*). Kamrunnessa did this to the researcher, during the interview.

repair centre, financial support to bear the travel cost, or support with information about the availability of treatment for fistula repair. In other words, it was the informal social networks of the fistula affected mothers that played the fundamental role for them to seek the treatment they needed.

The 'Social network' theory developed during the 1950s by a number of British anthropologists, established its links with health outcomes (Berkman et al. 2000, p. 845). Network analysis focuses on the structure and composition of the network, and the contents or specific resources which flow through those networks (Berkman et al 2000, p. 845). They argued that one of the ways through which the structure of the network ties influences health is through the provision of social support, which may take the form of emotional, appraisal and instrumental support. The sources of such supports can be different, for example, intimate family, distant relatives, neighbourhood, and voluntary or religious organizations etc. The importance of the social network is also highlighted in the discussion of links between "social capital" and "health" (Grootaert and Bastelaer 2001, p. 5). In the social capital discussion, social networks of such a kind are categorized as 'structural social capital', which is defined as resources that can be gained and available through social networks. In fact, social network is one of the three components of structural social capital. Story (2014, p. 73) highlights the importance of social capital in the form of social networks between communities and among community members for maternal health service utilization.

For fistula affected mothers who live in the remote areas of developing countries where surgical procedures for fistula are unavailable in many health establishments,

'social networks' can play a pivotal role. They make people aware of the availability of maternal health services, existing perception barriers against receiving health care, provide costs and transport to health facilities etc.

In the previous chapter, we have also seen the crucial role of the social networks in urban slums in shaping the health care seeking behaviour of mothers with delivery complications and post-partum maternal morbidity problems. The support network that the mothers in the slum have, largely defined when, where and from where they should seek treatment for childbirth complications or emergent maternal illness (See Chapter Five). However, while the theoretical discussion of the 'social network' as well as 'social capital' theories mainly focused on the structured network ties in different phases (Grootaert and Bastelaer 2002; Berkman et al. 2000), the social network from which the mothers in this study received support in different phases of their maternal health care plight was quite informal and loosely structured, and mostly built on community empathy towards the mothers. As social networks seemed to play a crucial role in shaping the health care seeking behaviour of these mothers, a more structured network within the community in which the mothers live, might be a stronger source of support for them. That network might not only provide information, moral, physical and social support to the maternal health care seeking mothers, but also give them a platform to empower and educate themselves in terms of maternal health. Story (2014, p. 83) identifying the importance of such networks, argues:

> Promoting diverse, heterogeneous networks that include individuals with decision making power, may give communities better access to resources and information, as well as to voice their claims and negotiated support.

## 6.8: Conclusion

This chapter, based on the interviews with the 11 fistula affected mothers in Ad-din Hospital, addresses first, the situation of the suffering of fistula affected mothers and, the context and the reasons of their contracting fistula, and second, their journey towards the surgical repair of fistula, and the challenges encountered in this journey and the way out of those challenges. In this respect the analysis of the health care seeking behaviour for fistula adds another dimension to this thesis about maternal health care seeking behaviour for complications during childbirth and the post-partum period. Similar to the findings of Chapter Five, the social and neighbourhood network has been found to be in the centre of shaping the health care seeking behaviour of mothers suffering from obstetric fistula. The health care seeking behaviour for childbirth for the mothers discussed in this chapter was similar to that of mothers discussed in the previous chapter. However, unfortunately these mothers ended up having obstetric fistula. We have also seen in the previous chapter that the severity of the health problem is considered as one of the determining factors of whether to seek treatment or not. Given this, the present chapter discussed how a mother overcomes the challenges of her lack of information, costs of treatment and transportation and access to treatment for a severe maternal morbidity like fistula.

The discussion suggests that the mothers did not have the apprehension that some mothers had regarding seeking care for childbirth (see Chapter Five). Rather, the fistula affected mothers were found to be very keen in treating their illness. However, as this research studied only those fistula affected women, who had come

to health facilities to treat, the level of apprehension and fear of those who had not sought treatment from facilities is yet unknown. Their major challenges in seeking care for fistula was gathering information about where to go for appropriate treatment. The other challenges consisted of arrangements of cost and transport. The major support for these mothers to overcome these challenges and seek treatment came from their network of family, neighbourhood or the community. The importance of building a more structured social network has been mentioned before for providing mothers with treatment for fistula. However, the availability of information should also remain within the reach of the fistula affected mothers. While it may not be practically possible that health service centres or hospitals at the local level could be equipped for sophisticated surgical procedures for repairing fistula or treating other morbidities, they should be equipped with a strong and effective support mechanism. In the case of all fistula affected mothers, once they had this disease, they went to the local clinic, health centre or district hospital for treatment. If they had received accurate information during their visit to those places, they might have treated their problem much earlier. Earlier treatment (within three months of the onset of the problem) for obstetric fistula repairs the hole more effectively (Wall 2006, p. 1,204). That is why the support mechanism in local health centres and within the community, and communication between both, might help the fistula affected mothers in Bangladesh to quickly find health care options for this severe condition.

# Chapter Seven

# Use of maternal health care services by the mothers from upper socio-economic households: Does money justify overuse?

Women make childbirth choices in a complex culture of birthing discourse, characterized by competing knowledges and claims regarding the "ideal birth". At one end of the spectrum are traditional medical views, which emphasize the benefits of medicalization, technology, and risk management. At the other end of the spectrum, natural or alternative birth advocates argue that the medicalization of childbirth takes control and power away from women and places it in the hands of obstetricians. (Malacrida and Boulton 2012, p. 749)

## 7.1: Introduction

The mothers from the upper socio-economic households presented contrasting features from those of the lower socio-economic households in terms of their health care seeking behaviour during childbirth and post-partum period. While, as shown in Chapter Five, the mothers of lower socio-economic households are apprehensive about seeking modern health care and do not use the health facilities as much as they should, the mothers of upper socio-economic households tend to overuse such facilities. The apprehension regarding childbirth and health care, the choice and appreciation of control over childbirth decisions, the experience with and practice of health care during and after childbirths differ considerably between the two groups of mothers.

The presence of post-partum morbidity is rare among the mothers from the upper socio-economic households; except for a few cases of post-partum depression and backache (see Table 7.2). As mentioned in Chapter Two that the urban richer women tend to see childbirth as a medical event and follow a bio-medical process. All the mothers from upper socio-economic households in this study also took the same view and preferred childbirth in the private maternal clinics or public hospitals with highly qualified medical professionals.

In this respect, they appear to follow the recommendations of the Millennium Development Goal Five (MDG 5) about childbirths being attended by skilled birth assistants[44]. However, all the mothers had caesarean childbirth either by choice or necessity. Chapter Two discussed that the higher rate of CS as well as their high preference for bio-medical process of childbirth has often been criticised as overuse of medical resources and thereby further widening the inequality. The health impact of over medicalization of childbirth has also been ignored in this regard. In spite of all the criticism, women themselves often choose medical and technological solutions to minimize the perceived physical hazards of childbirth (Earle and Letherby 2007, p. 235; Fox and Worts 1999, p. 328). As argued by Earle and Letherby (2007, p. 235), these choices, "must be understood within the context of women's lived experiences and within the specific time/space continuum in which these decisions are made".

[44]One of the targets of MDG 5 is to Increase the proportion of births attended by skilled birth personnel to 50 % by 2015 (GOB and UN 2005, p. ii).

Against this backdrop, this chapter sets its main objective as to present the perception and experience of the mothers from the upper socio-economic households in the Dhanmondi area of Dhaka, with respect to maternal health care during delivery and in the post-partum period. To be specific, this chapter aims to understand how, given the affluent socio-economic position, the perception and experience of the mothers regarding childbirth and maternal health care shape their decision of time, place and type of maternal health care they seek during delivery and after childbirth. In addition to that, the perspective of health care providers, who usually provide services in the private clinics/hospitals in Dhaka are also presented and analyzed in relation to the perspective and experience of mothers. Similar to Chapter Five, based on the basic framework presented in Chapter Two, the present chapter contains a thematic analysis of the information collected through interviews with the above mentioned mothers about their

1. perception of childbirth and maternal illness
2. experience of mothers at home and in health facilities
3. practice of maternal health seeking for childbirth.

The two main features of the upper socio-economic household mothers are that (i) they reported more pregnancy and delivery related complications compared with those reported by the mothers of lower socio-economic groups and had they treated in a timely manner which caused less post-partum morbidity, and (ii) their childbirth experience was centred on health professionals and health facilities they attended. Thus, the analysis and understanding of health care behaviour of the upper socio-economic mothers is predominantly focused on the perception and

experience in relation to the health care centre and health care professionals they received treatment from.

The health care behaviour needs to be understood in the context of 'lived experience' (Earle and Letherby 2007, p. 55) of mothers, the perception and experience that emerge from the upper socio-economic socio-economic condition and affluent life style of the mothers comprise the main focus of the findings presented in this chapter.

## 7.2: Perception regarding childbirth and maternal illness

All of the mothers from this group started seeing highly qualified professional gynaecologists in urban private maternity clinics from the very onset of their pregnancy. Moreover, they visited the maternity clinics more frequently than the recommended number of visits.[45]. All of them had caesarean deliveries either for a medical reason or by choice. In this section, the perception of mothers in relation to their leaning towards bio-medical birth process is presented in three interrelated sub-themes; apprehension regarding home based delivery; preference for private maternal clinics; and preference for a caesarean section as a childbirth procedure.

[45] The World Health Organization (WHO) recommends that under normal circumstances a pregnant woman should make at least four ante-natal care (ANC) visits to a health centre during her pregnancy (WHO 2006, p.1).

### 7.2.1: Apprehensions regarding home based childbirth

All 30 of the mothers from the upper socio-economic households reported that they went to see a doctor as soon as they knew they were pregnant by performing strip tests[46] at home. Some of the mothers saw a doctor the very next day after the strip test. None of them even thought of giving birth at home or of not being looked after by any medical expert.

> I cannot even think of that (giving birth at home). It's good to have family members around during childbirth. But, now, you know, those days are over (days when women used to give birth at home). Now there is lots of technology available, which is good and risk free. Now we have good doctors and hospitals. So, why take risk? Moreover, when I became pregnant, I was 30+, I could not take any risk (by giving birth at home). (Fatima aged 39 years, mother of one child).

Similarly, Piya stated,

> That (giving birth at home) happened in old days. That time people used to have less health problem. Now-a-days, everything becomes complicated. But, that time I heard that women died more during childbirth due to lack of this facilities. Now that all facilities (modern childbirth technology) are available, we better not take any risk (Piya, aged 31 years, mother of one child)

These comments from Fatima and Piya in response to my question of why they never thought about giving birth at home, illustrate the modern mind set of the mothers with respect to maternal health care. The way these two mothers presented their perception about home based delivery in the past and at present reflects their

[46] Home pregnancy tests (HPT) work by checking for the presence of HCG (human chorionic gonadotropin), the so-called "pregnancy hormone", in urine. One of the HPT format comes in a test strip, which a mother needs to dip into a sample of morning urine for a few seconds. After removing the strip from the urine sample, the appearance of one line on the strip indicates a negative result, while the appearance of two lines (even if one is very faint) indicates a positive result (Early-Pregnancy-Tests.com 2014)

understanding of the temporal changes in childbirth practices that characterize home based child delivery as olden days' standard and bio-medical childbirth at health facilities as belonging to the present. The above statements also portray the home based childbirth as a risky event that needed to be avoided if alternatives are available. The socio-demographic backgrounds of the mothers also influenced their views. Both the mothers cited above are educated to the tertiary level.[47]. They know first order births at a late age[48] may cause complications that could be avoided or treated by having a bio-medical childbirth. These findings are in clear contrast to the perception of the mothers of lower socio-economic households, who fear facility based childbirth and are more inclined to follow the practices of their previous generations in having home based births (see Chapter Five). Furthermore, the mothers belonging to upper socio-economic households consider home based childbirths incompatible with modern day reproductive behaviour.

### 7.2.2: Preference for private clinic/hospital based maternal health care

In addition to apprehensions about home based childbirth, the mothers of upper socio-economic households also have concerns about having a delivery in one of the popular public hospitals of Dhaka. They would simply not have their baby in a public hospital even if the same doctor, who examined them in a private maternity

[47] Education of mothers has already been established as an important determinant of maternal health care seeking behaviour. (see Amin, Shah and Becker 2010, p.3; Chakraborty et al. 2003, p. 328; Elo 1992, p. 49)

[48] Hansen (1986, p. 726) defines older age of pregnancy as mid-thirties and beyond. The mothers from the upper income households in this study also considered pregnancy after the age of 30 years as late age pregnancy.

health care clinic, would also see them in the public hospital.[49] While the reasons for this might lie mostly in convenience that the visiting schedules of public hospitals might not be compatible with their work and family commitments, there could also be a salient social class factor influencing these mothers' options. This is well reflected in the statement of a mother from upper middle class households, Eshrat, a working mother from Dhanmondi, in response to the question of why she chose a private medical clinic instead of a public hospital replied:

> The first reason may be public hospital is time bound. To receive a service you have to go there at a certain time, such as between 9 am and 2 pm. Or you have to wait in a long queue. I cannot afford to do that, because I cannot spare time from my (office) work. Moreover, the service that is provided in a public hospital, I think, is average (gorporta). To me, this is not up to the mark. So these are the reasons… Mainly time is the big factor. In a private hospital you can receive treatment after your office time in the evening. The clinic and doctor I chose is not that much expensive. His fee was only 300 BDT, which I could easily afford. (Eshrat, aged 39 years, mother of one child).

Eshrat's statement brings out the fact that visiting a private clinic for pregnancy and childbirth is a matter of convenience for educated, working mothers as well as a matter of quality of maternal health care. The convenience of seeing a doctor after regular working hours in a private clinic as well as the better quality of care in a private hospital (compared with public) are identified as the main reasons for Eshrat for choosing a private medical clinic instead of a public hospital. However, it is also important to consider that the affluent socio-economic condition of Eshrat allowed her to afford to pay 300 BDT to obtain the quality of health care at her convenient time. Thus, an advantaged class position in terms of socio-economic

[49] It is common for many public hospital doctors to also practise in private maternity health care clinics.

status seems to be the most influential factor here. Eshrat was able to afford the convenience and quality of health care without jeopardizing her work because she was able to pay the fee and cost for the diagnosis test suggested by the doctor.

Apart from the convenience, there seems to be an implicit matter of showing off one's high social class in choosing the place of childbirth. As stated by a gynaecologist from Ad-din Hospital:

> There is a false issue of prestige among the people of Bangladesh. People link their prestige to the type of the place of childbirth. Everyone knows that Ad-din is a low cost hospital. Even though it provides a very good quality service, delivering a child at Ad-din does not sound prestigious to the richer women of the society.

By and large, it is taken for granted by the mothers in Bangladesh that, regardless of socio-economic class, private maternal health clinics serve the rich women the most, whereas public hospitals are meant for the poorer sections of society. This is confirmed by the higher proportion of childbirths attended by skilled health personnel in the highest wealth quintile (63%) and a much lower proportion of the same in the lowest wealth quintile (12%), reported in NIPORT et al. (2013, p. 131).

Since the private maternity clinics in Dhaka are fully dependent on the income from their clients and since they are not subsidized in any other way, the clients need to pay more to receive health services from these clinics (Andaleeb 2000, p. 96). As a result, the service receivers feel assured that private clinics are more inclined to provide quality health services than public hospitals to attract more

affluent service receivers (Andaleeb 2000, p. 96). Moreover, it may seem appropriate that the richer women should not take up the places in the low cost hospitals providing health care service to the poor. Nevertheless, it is important to watch that the private sector hospitals are upholding their quality and justifying the large amount of money they receive from the health care receiver. Because as NIPORT et al. mentioned (2012, p. 66) in the Bangladesh Maternal Mortality and Health Care Survey, 2010:

> The private sector is poorly regulated and very little information is available through the MOHFW routine MIS system on the number of deliveries taking place in this way and whether or not the procedure is medically indicated. There is also very little information on the certification of these private clinics or on the training of their staff to carry out this surgical procedure.

The quality of services, particularly the relations and communications between the doctors and mothers in the private maternal health facilitates is further discussed later in this chapter.

### 7.2.3: Preference for delivery by Caesarean Section (CS)

The mothers from upper socio-economic households participating in this study were apprehensive about normal delivery, and all had caesarean section for their most recent childbirth. Seven mothers had a CS on the recommendations of the doctor but reported that they did not know the medical reason for their CS, 11 mothers deliberately chose to have a CS even though they had no medical indications for doing so and 12 mothers had to do a CS because of childbirth complications (Table 7.1). This result is consistent with that of a nation-wide Bangladesh Maternal Mortality and Health Care Survey (BMMS), 2010, conducted

by the NIPORT et al. (2012). The report expressed concern that while some women, who need childbirth by a CS, may not get it. On the other hand, some other mothers, who do not need it, are getting it. According to BMMS 2010, among women who reported no complications, 9.4 percent had a C-section, presumably for the convenience of the women or the provider (NIPORT et al. 2012, p. xxiv). This report argued: "The provision of C-sections generates income for many providers, two-thirds of which are done in the private sector, so care must be taken not to allow commercialization of this valuable procedure, to the exclusion of the poor" (NIPORT et al. 2012, p. xxiv).

**Table 7.1: Reasons given by mothers of upper socio-economic households for having a CS the most recent childbirth, Dhaka, 2012.**

| Reason for having a CS | Number and percentage of mothers | |
|---|---|---|
| | Number | Percentage |
| Recommended by the doctor, but do not know the medical reason for having a CS | 7 | 23.3 |
| Chose to have a CS even though there was no medical indication | 11 | 36.7 |
| To treat pregnancy complications | 12 | 40.0 |
| Total | 30[50] | 100.0 |

Source: Computed from the data collected during Fieldwork, 2012

Similar information was obtained from an interview with a maternal health care provider, who stated that the private hospital where she works in Dhaka performs 50% caesarean sections on request. While the rate of CS is considered to be an indicator of EmOC coverage in a country (UNICEF, WHO, UNFPA 1997, p. 25), the increase in the rate or preference for CS by mothers or medical professionals

[50] All the mothers from upper socio-economic households had CS for their last childbirth in the last five years preceding the field work of this study.

does not necessarily indicate a wide and consistent coverage of EmOC among a section of the population (Anwar et.al. 2008, p. 257). Lazarus (1994, p. 28) argues the use of CS is a good example of the technology boom that has changed childbirth. Because a CS is often viewed as an income generating procedure for many a provider, it is often targeted to the richer mothers even though there might not be a valid medical reason for it. Consequently some poorer mothers, who might actually need a CS might be deprived of this life-saving surgical procedure (NIPORT et al. 2012, p. xxiv; Parkhurst and Rahman 2007, p. 399). However, one of the crucial ethical points of medical practice, as stated by the Federation of Gynaecology and Obstetrics (FIGO) is that physicians have "to allocate health care resources wisely to procedures for which there is a clear evidence of a 'net benefit to health'" (FIGO 1998, quoted in Christilaw 2006, p. 263).

Where private clinics tend to earn money from the affluent mothers by doing CS without a valid medical reason, the poorer people of urban Dhaka cannot afford the required live saving EmOC service due to financial impediments, as seen in Chapter Five. That is why, an increase in CS should be monitored to stop "commercialization of this valuable process" (NIPORT et al. 2012, p. xxiv) and to watch out for possible financial exploitation (Koblinsky et.al. 2006, p. 1,378). Apart from the financial issues concerned, the rising trend of CS, among the mothers from the affluent parts of the society has raised a major concern for women's empowerment and reproductive rights, particularly, in the situation where the mothers do not take childbirth decision based on factual information. The

charter of Sexual and Reproductive Rights includes the rights, among others, of liberty, autonomy, confidentiality, factual information and education, equality and non-discrimination into its framework. This is particularly pertinent to decision making about birth (IPPF 2003).

The following sections elaborate on the perception of the mothers from upper socio-economic households in relation to their preference for (CS). It is to be noted that the following discussion focuses mainly on the choice of CS without any medical reason. The perceptions presented here are captured in the thematic analysis of the interviews with mothers from upper socio-economic households.

All the 30 mothers from upper socio-economic households had apprehensions about home based childbirth and all of them preferred to have their deliveries in private maternal clinics. Further, although all the 30 mothers had their deliveries by CS, 18 of them had deliberately chosen CS for the different reasons, such as,

fear of labour pain, heard/seen stories of obstructed labour, conformity to class culture, conformity to the practice of clinic or the doctor being consulted, convenient (for doing CS) family and financial flexibility, birth planning and demographic consciousness.

### 7.2.4: Fear of labour pain: lack of physical and mental courage to withstand labour pain

Piya had planned to have a CS right from the beginning of her pregnancy. She stated at the interview:

> In fact I had a desire for CS from the beginning. I am a bit weak type lady. From the very beginning I thought, Allah, normal delivery must be very hard, don't

> know what will happen if I have normal childbirth. I was fearful that when something has to come out from the bottom how much pressure I will be able to push. If I lose my confidence half way through what will happen then? I heard that for normal delivery you will need lots of courage and strength. If I fail to gather that courage, then both mine and baby's condition will be bad. (Piya, aged 31, mother of a 4 year-old girl)

Piya's statement reflects that her fear of normal delivery came from a fear of the unknown. She was distanced from the understanding that the "act of childbirth is a normal, natural phenomenon" (Afsana and Rashid 2009, p. 124). Rather she understood it as a medical problem, the remedy for which is "to have a technical and medical solution" (Earle and Letherby 2007, p. 235). However, she was aware that gathering the strength that Afsana (2009, p. 126) called as "combination of "mental strength or physical vigour" is the key to delivering a baby naturally and normally. Piya's fear comes from her lack of confidence of gathering that double courage. This fear is not uncommon among urban richer women. The gynaecologist interviewed in this study also echoed this fear as contributing to the increasing rate of CS. This fear in not only confined to the delivering mothers, but also their families seem to be fearful about normal delivery. According the interviewed gynaecologist:

> We provide counselling to the mother who wants CS for childbirth on request. But you know, for normal delivery the mother needs mental strength to push down the baby. If a mother cannot gather that strength at all, we have nothing to do. In fact, not only the mother but also the whole family, like husband, mothers etc. also come with the delivering mother to request for CS. Even, sometimes it happens that the mother wanted for normal delivery. But when the pain started, they could not stand it and earnestly request for CS. It happens that I have to give a pause in seeing patients and go for doing the CS for that mother. Altogether, we have 50% of all CS on request.

In a similar statement, one gynaecologist from Ad-din Hospital argued:

> Now-a-days mothers do not like to accept normal labour pain at all. I think, people are losing their patience. If we ask them not to do CS, many mothers say, "OK, if you do not agree, we will go to different hospital". I think there are three reasons behind this. One, there is a misconception among the mothers behind this. Now-a-days people think that CS is the safest delivery. But that is not true. Normal vaginal delivery is the safest. Second, mothers do not like to bear labour pain, they cannot keep patient and number three, they do not get proper counselling during ante-natal care. Not only mothers, but also doctors do not like to have enough patience (to allow mother enough time to wait for normal delivery) now-a-days.

Both the doctors' statements, who have experience in providing services to the richer mothers, reflect the present day tendency of the richer mothers to choose CS as a childbirth method. This is backed up by inadequate counselling as well as trends of responding to the 'class culture' (a phenomenon described later in this section) of childbirth. The fear of failure to perform in labour, of not being able to breathe and/or push during the actual birth process and the feeling of powerlessness has been found in the context of other western and urbanized societies (Fisher, Hauck and Fenwick 2006, p.68). Though, it is normal for a birthing mother to experience some fear and anxiety as stated by Zeidensten (2013, p. 5), those who have deep fear of normal birth, need to be provided with proper counselling by the health providers to lift the fear.

### 7.2.5: Fear of labour pain: stories of labour pain from others

The physical and mental courage for vaginal birth processes which the women in this group may lack could also be caused by hearing the childbirth stories from other mothers. Rokeya Rahman developed post-surgical complications and she is still (during the interview) suffering from that complication. But, if she looks back

to the past on her decision to have a CS, she does not regret that decision at all. In her own words:

> I have seen some other ladies, who did normal, it is extremely painful. It's bad that I have this problem now. But I could not have thought of anything else except doing CS. The normal labour pain seemed very unbearable to me". (Rokeya Rahman, aged 30 years, mother of two children)

Rokeya's statement can be explained by what Fisher, Hauck and Fenwick (2006, p.68) identified as 'horror stories'. These authors showed in their study in Western Australia that being a first time mother, listening to or being exposed to the stories of previous mothers can make women very fearful about a natural delivery. Rokeya was also horrified at seeing and hearing about the intensity of labour pain in natural births and rejected the idea of having her baby naturally even before she had conceived her first child.

Thus, the mothers of upper socio-economic households lack in the combined "mental strength or physical vigour" which traditionally helps women through a normal delivery (Afsana and Rashid 2009, p. 126). Like Rokeya and Piya, many other respondents stated that they had not had enough confidence in themselves from the beginning that they would be strong enough to have a normal delivery and that this could cause a serious risk for the baby and the mother. While the main reason for this decision could be a 'fear of the unknown' (also in Fisher, Hauck and 2006) and bad previous experience, an urban affluent socio-economic class position of these women could be at the root of all such decisions. No mother from the lower socio-economic households reported or expressed such fear of natural birth.

Rather they showed an intense fear of having childbirth in hospital and in the hands of doctors, whether male or female. The fear of the unknown is also present among the mothers from the lower socio-economic households. However, their fear of is for the hospital based childbirth. It can be deduced that the effort to summon of "mental strength and physical vigour" required for normal delivery are very much influenced by the socio-economic status of the woman.

### 7.2.6: Preference for CS: conforming to the trend of peer group

While Rokeya and Piya and several other mothers from the upper socio-economic households cited the fear of natural birth as a reason for choosing a CS, other mothers from this group followed their peers (family and friends) in their decision about having a CS. They never considered any other method of childbirth than a CS, because "*sobai to kore*" (everybody does it) or *"Private Clinic gula te to suni* CS *prefer kore"* (I heard, that private clinics prefer a CS) or "in our family everyone had a CS, therefore what else would I go for?" This confirms their inclination to follow what tends to happen among the mothers of similar socio-economic status, sometimes even ignoring their own judgement based on their own health status. The mothers in the lower socio-economic households also showed some inclination to conform to what others are doing in their neighbourhood, as discussed in Chapter Five. For the mothers in the upper socio-economic households, the choice of the health care provider and the medical professional is based on a similar need to conform. Anisa, who also deliberately chose to have a CS out of a fear of labour pain, stated:

> From the very beginning my target was to see Dr. B (name withheld). She did my elder sister's CS. She also did CS for many of our relatives. Her clinic is in Baily Road. I talked to my husband about it. My mother-in-law also gave consent. From then on I used to come to my mother's house in Rampura every month, stay there for 2/3 days, see the doctor and go back home. (Anisa, aged 39 years, mother of two children)

Anisa's situation could be explained by the urban based individualistic socialization background of the mothers, where they have a very limited amount of what Hoeger and Howard (1995, p. 384) describe as "culturally stored knowledge of childbirth". Most of the participating mothers in this study reported living in a nuclear family, having extended family members in different towns or villages. In this situation, the mothers from upper socio-economic households might not get enough opportunity to consider "the physiological and bodily experiences of childbirth as a collective power" (Afsana and Rashid 2009, p. 126), which has to be transmitted to them from previous generation, as it usually happens in the rural areas of Bangladesh. Hoeger and Howard (1995, p. 384) argue that "within the context of limited culturally stored knowledge of childbirth women do not seek alternatives or investigate issues involved in childbirth care options". The construction of childbirth in this way in the urban upper income context may contribute to the mothers' fears that vaginal childbirth is a fearful event. To get rid of this fear, they prefer CS delivery as a better and safer alternative. Their advantaged class position facilitates their choice of CS.

In some cases, the tendency to choose a CS over natural child birth can be encouraged by the nature of service provided in a private clinic or hospital. The consultant in one of the prominent private hospitals near Dhanmondi explained

how the scope and limitation of health facilities as well as the expectation of service receiving mothers leads to CS.

> When I do caesarean delivery, my assistants also happen to be either a Fellow or an MS student. They have to work extremely hard for long hours, day and night. When I go home, if any vaginal delivery happens, they can assist comfortably and skilfully. Even they can do CS. But as CS is a surgery, we usually do not leave our patients to anyone else. Moreover, we have the manpower to skilfully handle normal delivery 24 hours round the clock. However, there are many clinics in Dhaka, where no consultant works at night. The consultant, who works in those clinics, might have had a day long work in a public hospital during normal working hours, examines patients in a private clinic in the evenings and then doing surgery in the late evening. In this situation, if he/she leaves any pregnant mother waiting for normal delivery at night and that doctor needs to come again at the middle of night or 3 o'clock in the morning to assist with that delivery that is not humanly possible. So, the doctor may not like to leave the patient and the patient may not also feel comfortable to give birth without the presence of the consultant doctor. So, the doctor and patient both prefer to do the CS before the doctors go home at night. This is an important practical reason. That is why, I think, in clinics, the service providers hardly have any options other than doing CS. And in the case when patient also expect that the consultant will look after everything, normal delivery is not possible. Because, normal delivery does not follow any fixed time table. Some deliveries may occur be at 3 am, some others at 5 am. Can a doctor stay in hospital all that time? That is not possible.

The above statement highlights some practical problems involved in medical practice in private maternal health facilities; first, not all private maternal clinics provide continuous/all time services for childbirth (either vaginal or CS), therefore mothers attending those health facilities need to deliver their child during the time the service is available. Second, mothers get attached to a particular doctor for their care and treatment during the childbirth journey. Therefore, they want to fix the time of their childbirth according to the availability of that doctor. Deciding on the time of childbirth in this way is not possible for a normal childbirth. Third; many private clinics are staffed by the doctors, who hold several jobs in the public and private sectors and spend limited time at each centre. This makes the women keener to have their childbirth within working hour of their doctors in the clinic.

In addition to the above explanations for the preference of CS as the method of childbirth by the mothers from the upper socio-economic households, there are other practical matters of convenience and support with household work that prompt these women to opt for a CS. These are described below.

## Support with household work

Most of the mothers from upper socio-economic households have the means to employ an 'all time maid' to do household chores. In particular, heavy household chores that need physical strength are usually done by the maids and not by the mothers themselves. This enables these mothers to opt for a CS without having to worry about abstaining from doing heavy work after the surgery.

Fatima mentioned in her interview:

> Heavy work…. Hmm, after CS you are not allowed to do heavy work for two months. But I did not need to worry about that as my maid does all the work in the house. I just have to take care of my baby. But I also had another maid to look after my child. (Fatima, aged 39 years, mother of one 5 years old son)

Unlike Fatima who can count on a domestic helper, the mothers from lower socio-economic households have to carry out all the physical household work themselves. They also have to do hard laborious jobs to contribute to family income. It is explained in Chapter Five that concerns about resting from heavy work after a caesarean section prevent the low socio-economic earning mothers from seeking delivery care at a health facility.

## Birth planning

The upper socio-economic household mothers appear to have adopted a clear birth plan to suit their personal and family lives. In most cases, the mothers, who work as 'secondary' breadwinners of the family leave their jobs during their pregnancy and until after delivery to look after their children. They plan to limit their number of children to a maximum of two and space them to suit their lifestyle. In some cases, the mothers had aborted an unplanned pregnancy. Having a caesarean section at a health care facility helps these mothers achieve their plans.

For example, a career woman like Hasna (aged 42, mother of one child) wanted to schedule her birth with the minimal disruption to her work and continuing health status. As she stated: "I chose to have a CS, because I know that I will have only one child, I don't want any more babies. So why take so much hassle of labour pain?" For her, giving birth was a planned, one off activity in life; therefore she chose to have a CS in order to avoid the uncertainty of labour pains. Interestingly, as discussed in Chapter Five, the mothers from the lower socio-economic household also wanted minimal interruption to their daily households and money earning activities. That is why, unlike the mothers from the upper socio-economic households, they chose not to have children at health care facilities or by CS. Even if the objective of the two groups of mothers were the same, the socio-economic context as well as pattern of jobs leads them to different decisions regarding childbirth.

## Family structure: types of family support

Some studies (Rothman 1982; Fisher, Hauck and Fenwick 2006; Fox and Worts 1999; Campbell and Porter 1997) suggest that a woman's successful transition to motherhood and the decisions that she makes during the course of her labour, delivery and after delivery largely depend on the type and amount of social and family support she receives. Childbirth has historically been seen as a social event in life (Fox and Worts 1999, p. 329), a rite of passage (Parkhurst and Rahman 2007, p. 392), and considered as a milestone event in a woman's life. Family and social support have always been an integral part of this process. The absence or presence of family support plays a significant role in determining the health care seeking behaviour of mothers during pregnancy, childbirth and after childbirth. Even to induce normal labour and help women keep control of their own body, the role of husbands/partners and families have been seen as being integral to the whole process (Gibbins and Thomson 2001, p.17).

Nevertheless, as discussed earlier, scholars, particularly feminist and post-modernist sociologists, have recently argued that these roles have been changing, as birth practice and maternal health care are being turned more and more into medical events, in which husbands, parents and families have little or no role to play.

Similarly, among the mothers of upper socio-economic households, the role of parents, parents-in-law and husbands in childbirth and post-childbirth matters was found to be passive. They hardly took any part in the decision making in such

matters. As all these mothers depended on the doctor's recommendations, the family had little to do in providing any advice or guidance which was the tradition or is still followed in the urban lower socio-economic households. Thus, the mothers from upper socio-economic households were readily influenced if they saw any indication of the medical providers' preference for CS. In addition, the nuclear structure of urban families, in which some of these mothers lived, provided them with very little opportunity to receive advice and support from their parents or parents-in-law or other members of their extended family, who did not live with them. Many mothers from the upper socio-economic households reported that they had very little support from family other than their husbands, during their pregnancy, childbirth or in the post-partum period as most of the extended family members live outside Dhaka and are not able to come to the city to help. These mothers felt the absence of a *murubbi* (elder and experienced family member) who could give them advice at different stages of pregnancy, delivery and the post-partum period and thus give them courage. The absence of a supportive family network close by makes the mothers fully dependent on bio-medical clinic based birth processes and eventually leads them to choose a CS for their childbirth. Dolly, who lives with her husband in Dhaka and has no one in the family to advise her on what to do and what not to do during pregnancy and child delivery, expressed her frustration about this:

> I started seeing a doctor 20 days after my conception. I used to see the doctor very frequently (almost once every 15 days). I had no one else, like a *murubbi*, who could have advised me what to do or what not to do. So, I saw the doctor more frequently if I had any confusion or any concern (about pregnancy). Sometimes I called her; sometimes I went to the central hospital. …..In fact I had a CS, because I was scared. I thought that I am pregnant at a late age. I have no one around me like a guardian. I was confused what will happen. I had no one else to even tell me

> that it is just a normal event. The doctor also told me that everything was OK. But I was really scared about what would happen? Then I discussed it with my husband's friend, who is a doctor. She said, well as the patient is scared, there is nothing to do but to have a CS. Do what she wants. So I took the decision one night and went for CS. The doctor left the decision to me. She asked me to think. Then I did CS 15 days before the expected delivery time. (Dolly, aged 37, mother of one child)

This statement by Dolly brings out her fear of the unknown and unpredictability about childbirth, which is further reinforced by the absence of friends and families, who could have advised her and helped lessen the fear. Her statement also highlights the fact that spending money on private health care does not necessary ensure the access to information and counselling that a mother may require to make informed childbirth decisions. Dolly expressed that she did not receive enough information from her doctor.

In summarising it can be said that the perception of mothers of upper socio-economic households regarding childbirth and health care for maternal illness is characterised by some apprehensions and some preferences: Apprehension for home based childbirth, public health care facilities and normal childbirth and preferences for private maternal health facilities and Caesarean Section. These apprehensions and preferences are opposite to those of mothers from the lower socio-economic households. As discussed in Chapter Five, mothers from the lower socio-economic households preferred home based normal childbirth and were fearful of hospital (both public and private) based and CS childbirth. This opposition indicates the critical importance of the socio-economic context of a mother in building a particular perception regarding childbirth and maternal health

care. It also confirms the need to study the health care seeking behaviour of mothers from a social constructionist lens.

While due to their favourable socio-economic condition, mothers from the upper income households preferred to have CS in private clinics for their childbirth, it is of interest to see next whether and how the CS and private clinic based maternal health care provide them with the care they expect to have. In order to know this, the following sections discuss the experience of health care seeking of mothers and examine how the socio-economic context also shapes their maternal health care experience.

## 7.3: Experience of health care seeking of mothers from the upper socio-economic households

The thematic analysis suggests that the experience of mothers from the upper socio-economic households regarding their childbirth care is complex. It does not follow the straight path of going to the clinic regularly and receiving care. Instead, it involves the others' concern regarding the quality of service, information provided, impact of her own empowerment status within the family on her maternal health care and so on. The following sections discuss this in detail.

### 7.3.1: Knowledge received from the health service and informed choice

As part of the right to factual information and education regarding sexual and reproductive health (IPPF 1995), receiving information and gaining sufficient knowledge regarding the available options and choices have always been

considered as essential tools for mothers to feel themselves more prepared and confident with a sense of control in a situation about which much is unknown to them (Gibbins and Thomson 2000, p. 307; Lazarus 1994, p. 30). However, some of the mothers from upper socio-economic households participating in this study revealed that they did not receive adequate information about the matters referred to above. Seven of the mothers who had CS at the advice of their doctors said that they did not know why they had CS. Some of them were undecided about what to do but went for CS without adequately knowing its consequences, advantages or benefits.

Instead of providing sufficient information to the mothers regarding available options of birth procedures, the service provider specialists (doctors) often ask them what type of medical procedure they wished to have without explaining to them when and why each such procedure should be performed, and what its benefits or consequences could be. Making the decision to have a CS without having sufficient information about the procedure was regretted by some of the mothers. Anisa, who decided to have a CS out of fear of labour pain, stated:

> I still have back pain. This is the problem of CS. Moreover, that cut place (where the incision was made) still hurts much. Now I feel that if I could gather enough courage to go for normal, then I might not need to cut my tummy again. This problem might not happen. I am not saying that I feel any guilt after having chosen a CS, but sometimes *afsos* (regret) does come to my mind (Anisa, aged 39 years, mother of two children).

Similarly, Dolly chose to do a CS without any knowledge of its possible consequences or of medical information about the procedure. She commented:

> I had no idea that after CS I would not able to do the regular day to day work for quite a long time. I did not even ask the doctor about it, neither did the doctor give me any information. At that time it was the month of Ramadan (Muslim fasting

> month). It was close to the *Eid* holidays. The doctor could not give us enough time. Everyone seemed to be very busy. Now I think if had anyone who could make me understand about it (CS). I also did not ask the doctor. I think, the doctor did not say anything, because it involves a lot of money. In private clinics, there is hardly any normal delivery. Now I think, if I had a normal delivery, it would have been better. For example, when our body hurts some in some parts, we take medicine and it goes OK. Similarly, with a normal delivery pain, once the baby is born everything becomes OK. But for CS I had to carry its consequence for long time. If I conceive again and if everything remains OK, I will go for a normal delivery

Anisa and Dolly's statements reveal that they made the decision to have a CS without being fully informed about birth procedures. As the mothers reported, the medical practitioners made little effort to provide them with full information and education about the options of birthing and their possible consequences.

Interestingly, a few of the mothers interviewed also seemed reluctant to gather information regarding birthing procedures from the practitioners. Dolly mentioned, "I had no idea that after CS I would not able to do the regular day to day work for quite a long time. I did not even ask the doctor about it, neither did the doctor give me any information". This indicates an inadequate understanding of the care receivers the service and information they could expect to receive from the health care service providers. Rather, some of the mothers, in spite of their very regular visits to maternity clinics, were found to have been reluctant to gather information about the details of childbirth. Fisher, Hauck and Fenwick (2006, p. 68) relate this kind of reluctance to a lack of 'cultural store of knowledge' that allows them to know which questions they should be asking. So, while it appears that the mothers from the upper socio-economic households are choosing CS as their birth procedure themselves, at least some of them were well informed, educated or made

aware of CS before taking their decision. Thus, the decision of the mothers to opt for a CS, in many respects, does not reflect confidence and empowerment, but rather portrays them as a less competent 'self' unable to bear the loads of labour pain and the uncertainty of the birthing procedure. Christilaw (2006, p. 266) explains it this way:

> To be truly self-determined, an individual has to be fully empowered, and aware of all available options. A fully empowered woman, therefore, will make her choice understanding the benefits of vaginal delivery, having confidence in her body, not facing economic pressure, and not being worried about possible cosmetic effects. A fully empowered woman will consider her bodily integrity, and her life-long reproductive career, along with other aspects of her physical, spiritual, social, and cultural wellbeing. It becomes apparent that optimizing obstetrical care involves advocating for more than surgical excellence. It involves creating and supporting all the structures needed to ensure empowerment, from good ante-natal care to reasonable maternity benefits for women

Christilaw's statement identifies the need for mothers to be self-determined and fully empowered to extract the best of maternal health care. For this, making childbirth decisions after being adequately informed and aware of the regarding birthing procedures and possible impacts of those procedures, bodily integrity and being free from financial concern are important things for the mothers to know.

### 7.3.2: Relationship between doctors and patients

The power of medical experts is comes from their high educational attainment and socio-economic (Malat 2001, p. 361). Physicians are seen to hold the authority on medical knowledge (Lazarus 1994, pp. 25, 30). Lazarus stated:

> Medical knowledge, like most knowledge, is inseparable from social relationships and social experiences. It is uniquely distributed, therefore, and connected to matters of power and control. In biomedicine, control is limited by the power held by the medical profession and more and more by medical institutions.

Thus, it is not unusual for there to be an asymmetric relationship between the doctor and care receiving women, although many of the mothers participating in this study might belong to the same economic class as the medical doctors. But it the higher expertise and superior knowledge of the doctors nevertheless creates a power differential between them and patients (mothers in this case). This differential may create a social distance between the medical professionals and the mothers, which has an impact on the childbirth service chosen by the mothers. This is portrayed in the following conversation between a mother Lubna (aged 32 years) and the researcher about Lubna's relationship with her gynaecologist:

| | |
|---|---|
| Researcher: | How did you feel when you visited her? |
| Lubna: | (she replied after a little bit of thought) you know Dhaka is a commercial area. She is a very busy doctor. She just used to listen to only one or two sentences from the patient. After that, from her own understanding she gave a prescription for the medicine. But,for my eldest child I went to a hospital in Bogra (a small town in northern Bangladesh). That doctor was really friendly. |
| Researcher: | What did you mean by the word friendly? On what basis you are saying that they are 'friendly' or 'not friendly? |
| Lubna: | Usually patients are a bit afraid of doctors. You know they (doctors) have a '*bhaab*' (such as an air of superiority). Many doctors like to talk less with the patients, appear to be in an irritated mood *(khitmite mejaj)*. I felt like that with doctor M. I felt a bit scared/shaky *(ektu bhoy bhoy).* I did not feel comfortable talking with her during my visit. I felt that I was never able to say everything I wanted to say to her. |
| Researcher: | What kind of '*bhoy'* (fear) *Apa*? |
| Lubna: | It seemed to me that the doctor was a bit '*jotjoldi sobhaber'* (always in a hurry*)*. If I said something about any of my problems she just remained silent. She did not reply. She could have told me something, like not to worry or something like this to reassure me, (*ekta je santona deya).*, We expect that a doctor will tell us what to do or whether to worry or not or will give us some reassurance (*ashshash*). But I hardly found anything like this when seeing her. |

Lubna felt discouraged from asking questions and offering information and reassurance by her doctor's busy and uncommunicative behaviour. Some other mothers, in this kind of situation, responded to this problem by moving from seeing a prominent gynaecologist to a midlevel gynaecologist. Belli (aged 34 years, mother of two sons) wanted to make sure that she did get the time and space to share all her problems with her doctor. Her former doctor was assisted by a number of nurses, who used to check the patient's weight, blood pressure, and other signs and symptoms related to pregnancy. The doctor took a very quick look at the patients only at the end. This did not satisfy Belli, who wanted more space and time from her doctor; first, to share their experience and physical condition, and second, to justify the money she is spending to see the doctor. Choosing a less prominent doctor helped Belli to achieve this goal.

The health care experience of Lubna and Belli could be explained in terms of the social distance between the doctor and her patients, originating from the hierarchical power relation between the doctors and care receivers. In this encounter, power is located in the hands of the bio-medical professionals. For both Lubna and Belli, the doctors have appeared as authorities on childbirth knowledge, powerful enough that the service receiver mothers may feel intimidated to talk freely with such authorities on childbirth. At the same time, the mothers felt disempowered as they had to gauge the doctor's mood before deciding to share their problems or fears and avoid annoying them, as their life now depended on them.

It is obvious that mothers seeking medicalized childbirth experience some extent of imposition of authoritative knowledge by their doctors. Medical knowledge, like any other knowledge, involves unequal distribution of power and control (Lazarus 1994, p. 30). However, the rights of factual information and education as stated by IPPF (2003, p. 17) demands that the mother will have all information related to childbirth adequately explained. In the context of Bangladesh, the main source of information and awareness is health care service providers. Thus, it is very important that the health care providers are trained well enough and are given time and space enough to make the service receiving mothers well informed and less fearful about childbirth. Initiatives should come from both sides i.e. service receivers and service providers to minimize this asymmetry and authoritative distance.

### 7.3.3: Maternal health care experience within the family: women's empowerment status

Although it has been discussed in Chapters Two and Five that access to income and education influences the health care seeking behaviour of mothers, belonging to an upper socio-economic household does not necessarily guarantee women autonomy within the families. The position and status of the mothers may be dependent on different dimensions of understanding and may need to be analyzed in terms of factors which are not socio-economic in nature. For example, for some mothers from the upper socio-economic households, indifferent behaviour of their family members (including their husbands) put great mental stress on the women

(mothers), which in turn leads to post-natal depression and other health risks. This indifferent attitude comes from a preference for sons, which is surprising because such preference is not expected in urban, higher socio-economic households. Chameli, a university graduate housewife, who is married to a high ranking government official, described her husband's reaction after finding out that their second child was also going to be a daughter. As Chameli described

> Just two days prior my *caesar* (CS), I took an ultrasound test and came to know that it's a girl. After coming home, I said to my husband at night that, 'this time also you are going to be father of daughter'. Hearing this, my husband turned his face away and did not say even a single word to me. Seeing his reaction I could not eat anything, I cried all night. I was surprised my husband did this to me (she was crying silently!) I could not sleep even the night before I went to have the CS. When I was taken to post-operative care after my caesarean delivery, the thought of my husband's reaction came back to my mind again and again. I started having convulsions after that. The doctor said I might have been in some mental stress that was causing this problem, otherwise physically I was well. (Chameli, aged 42, mother of two daughters)

The indifference of her husband and her inability to share her mental pain with a confidante has put Chameli into silent mental stress. This stress has contributed to her serious chest pain after the baby was born. Although the doctor she saw during her pregnancy and childbirth was her distant cousin who provided her with a satisfactory service, the indifference of her husband turned her childbirth experience into a painful event. Her whole experience of pregnancy and the birth of her second child turned into a nightmare for her. For another mother, the post-partum experience turned into a nightmare when her mother-in-law turned her face away after seeing a daughter was born. She received no post-natal support from her parents-in-law because she gave birth to a daughter. This shows that male preference of still practised in upper class families, giving us a contrasting picture

of a modern trait (e.g. bio-medical dependency for childbirth) and a traditional attitude (preference for sons) existing side by side in the same household. However, it also implies that women are considered eligible to receive care and attention as long as they conform to the expectations of their family. This reflects the paradox that women's ability to give birth without submitting to unnecessary medical control rests on their access to strong social and family support – that is, it occurs in the context of 'heightened dependency' (Fox and Worts 1999, p. 330). Here the right to receive care during delivery and in the post-partum period is subject to conformity to family expectations regarding childbirth. This paradox asserts that access to high quality maternal health clinic does not necessarily guarantee improved health care for the mother.

### 7.3.4: Experience of care during post-partum morbidity

It was noted at the beginning of this chapter (and also in Chapter Four) that the mothers from upper socio-economic households reported more pregnancy and delivery related complications and illnesses and less post-partum morbidity compared with lower socio-economic households mothers. As they received timely delivery care in health facilities and were assisted by expert gynaecologists, most of the mothers managed to avoid post-natal maternal morbidity which they would have suffered from had they not received skilled birth assistance. However, some of the mothers still reported some maternal morbidity after giving birth, including post-natal depression (PND), chronic backache, and post-caesarean complications.

**Table 7.2: Post-partum maternal morbidity among the mothers of upper socio-economic households of Dhaka, 2012**

| Name of the mother | Disease and duration | Morbidity during pregnancy and childbirth | Reported reason for post-partum morbidity | Treatment sought and received |
|---|---|---|---|---|
| Eshrat (39) | Backache and pain in the area of suture (6 years) | High blood pressure pre mature water break | Mistake done by doctor while doing CS delivery. Although doctor fixed the problem later, it was not fixed properly and caused pain often. | No treatment can be done as stated by the doctor. |
| Opola(33) | Post-natal depression (PND) (3-4 months) | High blood pressure | Illness of newborn child (later diagnosed as autistic) | No treatment was sought, PND ended gradually. |
| Neena (38) | Post- natal depression (PND) (1 year) | No morbidity reported, CS by choice | Over cautiousness and repenting over not having the baby with the expected birth weight. | Consulting with psychiatrist and taking medicine |
| Dolly (37) | Backache (4 years) | No morbidity reported, CS by choice | Caesarean delivery | No treatment sought as it would not help heal this pain. |
| Soma (32) | Backache and Short term PND | No morbidity reported, EDD[51] was over | Caesarean delivery; over work and stress due to lack of family support | No treatment was sought. Husband helped to recover from the depression during the post-partum period |
| Piya (31) | Backache and pain in the area of suture | Water broke before child delivery | Caesarean delivery | No treatment was sought |
| Chemali (42) | PND (One and a half years) and High blood pressure (5 years) | Pre-eclampsia | Uncomfortable relationship with husband over the news of birth of girl child. | Counselling received from a psychiatrist. |
| Rokeya (30) | Post CS complication (3 years) | No morbidity | Mistake by doctor while doing CS | Visiting doctor regularly and taking medicine |

Source: Field work, Dhaka, 2012

[51] Expected Delivery Date

Several inferences can be drawn from Table 7.2. First; some of the mothers, who reported having had post-natal depression (PND) after childbirth, said that it was caused by the unfavourable behaviour of their families at the news of the birth of a girl. However, the mothers, who suffered from PND managed to get over it sooner or later with the help of a counsellor/psychiatrist or with the support from their family members, mothers, sisters etc. One of the noteworthy aspects of this is that expectation of a boy child by the family members and a failure to meet that expectation develops a conflict between the birthing mother and other family members, thus leading to PND. Mothers need attention and moral support (if not physical support) in order to cope with the changed status of their life after a child is born. The absence of such support or a caring husband, particularly with controlling and powerful in-laws, can lead to post-natal depression (Chan et al. 2002, p. 571). Second: those, who were suffering from backache and having difficulties doing household chores and other work, reported that the CS itself, or any error in performing CS by the doctor, were the main reasons of their condition. A previous study by Mogren (2007, p. 120) showed that elective caesarean is significantly associated with an increased risk of persistent lower back pain after childbirth. However, in terms of treating that problem, the mothers did not do anything as they took it somewhat for granted that CS may cause this kind of backache.

## 7.4: Practice of maternal health care of upper socio-economic mothers: is there a class culture in childbirth?

From the analysis of perception and experience of mothers regarding childbirth, the practice of maternal health care of the mothers from the upper socio-economic household can be described as total dependence on private health facility based, bio-medical intervention in childbirth. As we have seen, all the participating mothers in this group had a CS (many of them with no apparent valid medical reason). Overuse of ante-natal care and screening by some mothers may define dependency. The awareness and knowledge that the mother from upper socio-economic households have about the risk of obstetric complications and about the importance of monitoring and getting treated is considered as positive and contributory for the improvement of maternal health status, reducing the incidence of maternal death and illness. However, choice and decision to have a caesarean birth regardless of the medical reasons indicates the unconditional dependence of the mothers in this group on bio-medical intervention of childbirth. This dependency on private health facility based childbirth care for upper socio-economic households, and the inclination to avoid normal vaginal delivery (for those who do not have any medical cause for do CS) can largely be explained by the socio-economic condition in which the mothers live.

Several studies (Martin 2001; Nelson 1986; Lazarus 1994) established that class position has a profound effect on the decisions regarding childbirth care. Apart from the knowledge and awareness that pregnancy and childbirth are events, which

need to be monitored and treated on time for preventing complications, there are some other factors particular to the upper socio-economic status of the mothers that also affect their maternal health care seeking behaviour. These factors are fear of labour pain supported by the given affluent condition; the availability and affordability of help and support with household work; planned and limited number of children; marriage and childbirth at late age and following trends of family and peers (of doing CS or seeing a particular medical expert. All these factors are particularly prevalent among the affluent upper socio-economic households, which facilitate the choice of childbirth in private clinics and the use of CS for delivery. We have seen in Chapter Five that the poverty of the mothers from lower income households ruled out all of these facilitating factors which could make them dependant on modern private health facility based bio-medical childbirth processes. Thus, the maternal healthcare behaviour of the mothers from upper income households may be aptly termed as a 'class culture of childbirth'.

I define class culture of childbirth as that in which a particular practice of childbirth is followed by paying no particular attention to the medical condition of the mothers, but mainly by considering the socio-economic position of the household to which the mother belongs. The culture of depending on the private, clinic based bio-medical birth procedure and the over use of childbirth intervention is peculiar to the upper income households. This is confirmed by studies conducted elsewhere. Population difference in the medical intervention of childbirth (particularly Caesarean Section) follow social class characteristics and, as

suggested by Hurst and Summey (1984, p. 628) "appear to follow an inverse care law operative throughout the obstetrical history; the lower the social class, the higher the medical risk and the lower the medical intervention". The private maternal health facilities, where the participating mothers went for childbirth and post-partum care, to some extent, helped develop this culture. As mentioned earlier, the fixed working hours of medical experts in a private clinic and coupled with the expectation of delivering mothers to be handled by their chosen medical expert go in favour of doing a CS during the regular working hours of the doctor. Unlike the mothers from lower socio-economic households, who do not go to health facilities for childbirth due to their fear of medical intervention, the mother from upper socio-economic households cannot help but depend on the private facility based bio-medical intervention of childbirth. Consequently, a culture of dependence on bio-medical intervention (which is particularly manifested in doing CS without any medical reason) tends to develop among the upper income households mothers.

## 7.5: Conclusion: Does money justify care?

From the discussion presented in this chapter a number of key points emerge. For some of the mothers from upper socio-economic households their inclination to use specialized medical care in private health facilities arose mostly from their apprehensions about home based or public hospital based childbirth. All the mothers in this category had Caesarean Sections. While some of the mothers had pregnancy complications that required CS for a safe childbirth, others chose to do this on their own even if their condition did not warrant it. Some mothers had a CS

as per their doctor's instructions, but they did so without knowing the medical reasons of doing CS. The choice of CS without any medical reason was mainly due to the mother's fears of normal birth procedures. The fear of childbirth as the main reason for a woman's request for CS on medical ground has been found in previous studies of other countries (Hildingsson et al. 2002; Sjogren et al. 1997; Saisto, Ylikorkala and Halmesmaki 1999; Ryding et al. 1998). However, Hildingsson et al. (2002, p. 622) found in Sweden that the request for CS is not associated with the well-educated urban women, which is contrary to findings of this study. Rather, they found that the less well educated mothers are more inclined to request CS.

The mothers from upper socio-economic household also indicated that they could not gather enough mental and physical vigour for a natural birth. Further, because these mothers had the financial capability to have a CS, they did not need to make any effort to overcome their fears about natural birth. It is acknowledged that in order to ensure safe motherhood, a woman with obstetric complications must receive emergency obstetric care and have a CS, if necessary. However, having a CS by choice or merely at the doctor's instructions, sometimes without making sure that the women are aware of the causes and consequences of the available birth procedures, raises doubts about the empowerment of women in terms of their right to information and decision making by informed choice.

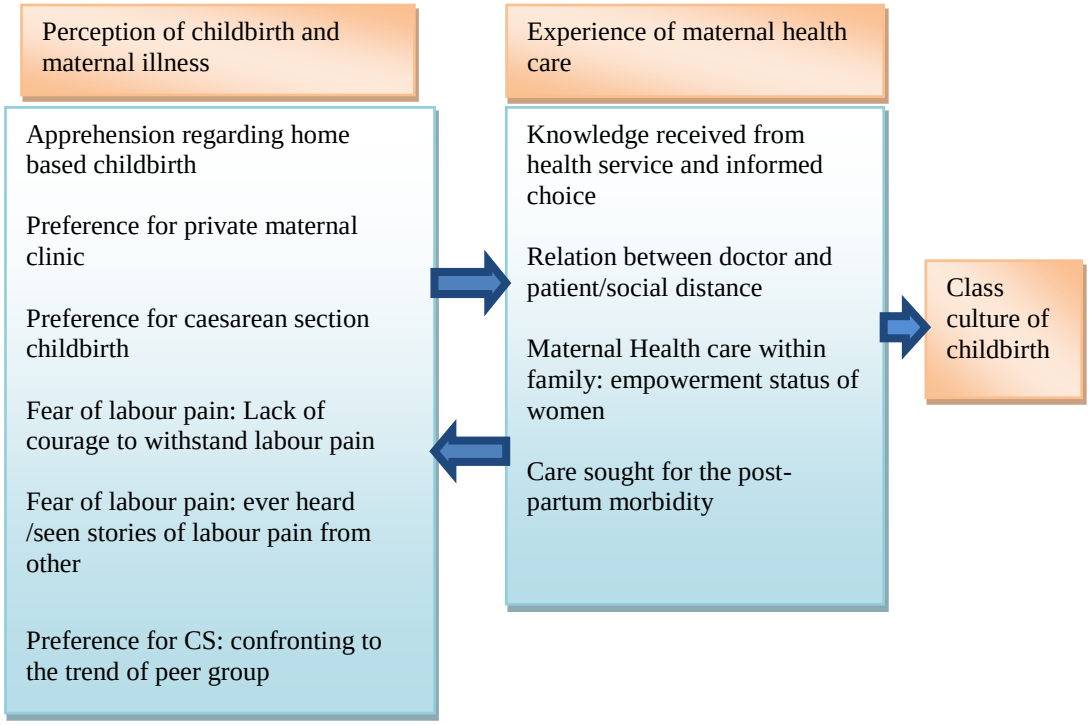
The difficulties felt by the mothers in communicating with their doctors as well as their perceived image of the doctors as being too busy, hard to reach and less communicable reflects the asymmetric power-relation between the service

providers and receivers (Lazarus 1994, p. 30). The perception as well as the experience of mothers about doctors holding the authority of knowledge but not obliged to share this knowledge makes the mothers disengaged from the birthing process.

The role of family members in the whole process of childbirth is found to be minimal, particularly compared with the mothers of lower socio-economic households. However, the families of some of these mothers wanted to make sure that the birthing mothers conformed to social expectations such as giving birth to a son. Failure to meet these expectations, in some cases, led to damaged relationships within the family that impacted on the health of the mothers after giving birth.

Although the presence of post-partum morbidity was less prevalent among the mothers from the upper socio-economic households, the only post-partum morbidities found among them were post-natal depression (PND), backache and some post CS complications. However, all of the mothers who had these morbidities received timely treatment from health facilities and got over those problems. Figure 7.1 presents a summary the main findings as discussed in this chapter.

**Figure 7.1: Summary findings of in-depth interviews with the mothers of upper socio-economic of households of Dhaka, 2012.**




Source: Field work2012

In conclusion, the foremost reason for the mothers from upper income household to receive timely, facility based maternal health care for the delivery and post-partum period is their financially affluent socio-economic condition. Compared with their poorer counterparts, in terms of accessing and receiving maternal health care, they definitely belong to the more privileged group. Nevertheless, the discomfort and dissatisfaction that some of the mothers reported in relation to the service they received from the health facilities, particularly the reported uneasiness in communicating with the health care providers even in an expensive private clinic, reflect a violation of their rights to receive factual information and informed choice of maternal health care. As noted earlier that this right to factual information of

causes and consequences of all sorts of treatment available and informed choice is part of human rights and one of the eight rights in the 'Framework of Sexual and Reproductive Rights' (IPPF 1996). In explaining the right to information and education as 'positive rights' Christilaw (2006, p. 265) stated

> It is our responsibility … to assure that women have the best available information and that they do not make biased of coerced decision. Surely, then, if a woman requests a CS due to fear of pain in labour, for example, it is our duty to address her fears and counsel about available pain control option. If a CS is requested for fear of foetal distress, it is our responsibility to counsel her that vaginal birth is safe for vast majority of babies and that CS may bring with its own risks to the baby.

The lack of information and absence of informed choice is (i) making them disengaged and disempowered from the birth procedure and surrendering themselves merely on doctors' instruction; (ii) giving them ambivalent feelings and opinions that many people have in relation to medicine (Lupton 1997, p.248); (iii) making excessive use of bio-medical resources and (iv) eventually the power and control of the birth process is being transferred to the hands of experts from the hands of birthing mothers and families. This transformation has been addressed by the Foucauldian critique of medicalization as a central paradox whereby medicine, despite its lack of complete effectiveness of healing wide range of condition and side effects, is becoming increasingly influential and powerful by rendering more aspects of social life as medicalized problems (Lupton 2005, p. 246).

Hence the findings drawn from the interviews with mothers from the upper socio-economic households lead us to concern as to if this group of mothers are receiving the care they are paying for. Based on the analysis of the perception and experience

of mothers receiving maternal treatment from private health clinics of Dhaka, it can be concluded that despite providing modern maternal treatment and assistance in delivery, the right of mothers to access choice and information on the basis of factual information is not necessarily ensured. The holistic notion of improving maternal health is yet to be established.

# Chapter Eight

# Fear and fashion in modern maternal healthcare: a tale of two diverse groups of women in urban Dhaka

## 8.1: Introduction

This chapter presents a comparative analysis of the health care seeking behaviour of mothers from lower socio-economic and upper socio-economic households of Dhaka. The analysis presented in this chapter is based on the findings presented in Chapters Five and Seven, which provide a contrasting picture of these two groups of mothers in relation to their perceptions and experiences of childbirth and post-partum care. While the mothers from the lower socio-economic households expressed unwillingness to receive childbirth and post-partum care from modern maternal health care facilities (private or public), the mothers from the upper socio-economic households displayed an overwhelming sense of trust and dependence on such health care facilities, particularly the private maternal health care clinics. Both the groups of mothers gave their reasons for their preference for a particular type of health care provider. These reasons are based on their own experience or the experience of their close acquaintances. The two groups of mothers and their respective families differ from one another with respect to their perceptions and experiences about maternal health care. These perceptions and experiences operate through a few common factors to influence the mothers' decisions to avoid or to depend on modern maternal health care. These common factors are crucial in

identifying the type, the place and the timing of maternal health care received by the mothers during childbirth and in the post-partum period.

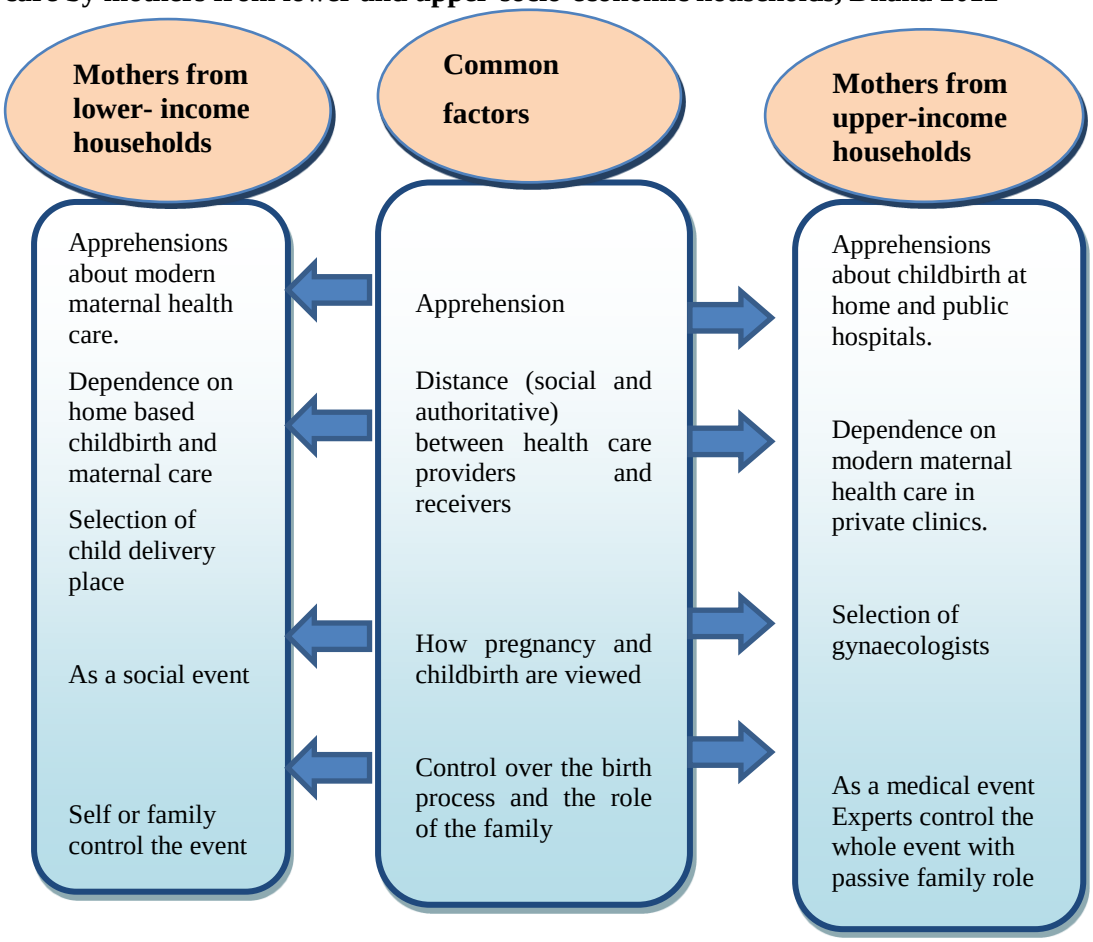
This chapter extracts four factors from the findings presented in Chapters Five and Seven, namely (i) apprehension regarding childbirth and health care; (ii) social and cultural distance with the health care providers; (iii) perception of pregnancy and childbirth as social events or medical events; and (iv) choice of, and control over the process of childbirth. Although there were more factors presented in Chapter Five and Seven that contribute to shaping the health care seeking behaviour of mothers, the four factors mentioned above are shared by the mothers of both the groups, but they work in opposite directions for the two groups of mothers in shaping their health care seeking behaviour. It is argued here that these four factors make the facility based care a matter of fear for the mothers from lower-socio-economic households, and a matter of 'fashion' for the mothers from upper-socio-economic households.

The discussions presented here focus only those mothers of the upper socio-economic households who chose, without any medical reason, to have a caesarean delivery and those mothers from the lower socio-economic households who did not want to go to a health care facility for child delivery. In the following section, I propose a framework (Figure 8.1) that explains the four factors which work in opposite directions for the two groups of mothers.

## 8.2: Common factors operating in contrasting ways: decisions by mothers from lower socio-economic and upper socio-economic households

Figure 8.1 illustrates how a number of common factors influence the mothers from the two groups to make different decisions about their health care seeking behaviour during childbirth and the post-partum period.

**Figure 8.1: Factors operating in contrasting ways: decisions about maternal health care by mothers from lower and upper-socio-economic households, Dhaka 2012**




Source: Field work, Dhaka, 2012

## 8.2.1: Apprehension — a barrier to hospital based or home based deliveries

The contrast in the preferences for hospital versus home based child delivery between the two groups of mothers can, as mentioned previously, be explained by the levels of their apprehensions about childbirth and related complications. Mothers from both the socio-economic groups demonstrated apprehensions about the place and type of delivery. The mothers from the lower socio-economic households expressed apprehensions about hospital or facility based childbirth,

whereas the mothers from the upper socio-economic households conveyed their concerns about home based, natural childbirth. These worries, along with a number of socio- economic factors, lead the two groups of mothers to opposite directions in deciding the type, place, and timing of maternal health care during childbirth and the post-partum period. It was seen in Chapter Five that the apprehensions of the mothers from the lower socio-economic households is borne out of a fear of the lack of knowledge about modern health facilities and prevailing perceptions about childbirth. To many lower socio-economic mothers, the hospital is a place where unfamiliar and uncomfortable technological intrusions are carried out in what they perceive as a natural process, such as childbirth. Their perceptions are that hospital deliveries lead to caesarean sections (CS), that doctors do not wait to see if the baby can be delivered normally, that CS will make them unfit for carrying out their labour-intensive day-to-day work to make a living, and that hospital based childbirth will expose their body to an outsider male health care provider. These perceptions discourage them from seeking facility based maternal health care for childbirth. They feel that because of all this, there is no need to go to a hospital if there are no complications. Many of the women, like Reshma from Sona Mia Slum and Jhumur from Karwan Bazar Slum, who had to go to health facilities for their delivery or for treating complications, were cited as examples of the worst cases of childbirth in the neighbourhood.

Apprehensions about childbirth prevail also among the mothers from upper socio-economic households. However, unlike the mothers from the lower socio-economic households, their apprehensions are centred on possible complications of

pregnancy during childbirth and the post-partum period. To the richer mothers, this apprehension seems reasonable as many of them have given birth at a high-risk age.[52] Therefore, to ease their concerns, these mothers have their deliveries in private clinics/hospitals as the best assurance of avoiding/treating maternal morbidity or any complications. In addition to that, they tend to choose CS to avoid labour pain and the relative unpredictability of childbirth. Thus, 'apprehension' is a factor that influences the mothers in deciding the place where they will give birth depending on their socio economic context.

The apprehensions of the two groups of mothers should be seen in the context of their respective socio-economic and cultural situations. In this context, the mothers of the upper socio-economic households expressed their preference for private maternal clinics in urban Dhaka, because they could afford the costs of modern maternal clinics. Thus, they were able to take the decision to have their deliveries by CS and not worry about it. The mothers the from lower socio-economic households may also have had apprehensions about complications during childbirth and the postpartum period similar to their richer counterparts, but they did not express this fear because they were aware that, because of their weaker socio-economic status they had no choice but to opt for the free or very low cost home based childbirth with an untrained birth attendant. Due to the difficult demands of meeting their basic needs of life and struggling with poverty, they were not able to

[52] Usually pregnancy at age 35 or more is considered to be high risk. A study found that this age is an independent risk factor for certain adverse pregnancy outcomes (Jolly et al. 2000, p. 2,435). However, the upper socio-economic mothers in this study considered pregnancy at age 30 or more as being of high risk.

bring their fear and preference for a modern, facility based maternal healthcare to the forefront. Rather, they expressed their fear of facility based deliveries because of their high cost, lengthy stays in a hospital bed, and the possibility of remaining physically unfit to return to heavy manual work for long periods. However, the irony for some of these mothers is that, due to not receiving obstetric care when they needed it, their health deteriorated further with complications such as uterine prolapse, rendering them unfit for work, both inside and outside the home.

Thus the apprehension regarding childbirth takes different directions with respect to the type and place of delivery care according to the socio-economic context of the mothers. However, this also reflects the inadequate information and awareness of mothers of both the groups regarding what should be done to ensure a safe pregnancy and childbirth. Previous studies have found similar apprehensions, but in the context of Bangladesh this apprehension of upper socio-economic mothers has not been investigated or discussed. With the increased of rate of facility based childbirth care and deliveries by caesarean section and their concentration among the urban, richer sections of the population, such apprehensions should be further explored to find out why they lead one group of mothers towards modern, facility based maternal health care and the other group of mothers away from it.

### 8.2.2: Choice of birth attendant: and social distance with the health care providers

The findings presented in Chapters Five and Seven reveal that mothers from both groups of households consider social distance from health care providers (doctors,

nurses) as an important factor in their childbirth experience. The mothers from the lower socio-economic households tend to avoid going to a health care facility or avoid seeing skilled health personnel due to the social distance and prefer to continue going to their familiar traditional birth attendants. But the mothers from the upper socio-economic households, whose socio-economic situation may predispose them to go to a health facility and see a trained birth attendant or doctor, can still have a social distance with the health care provider and accept their recommendations without properly understanding why a particular line of treatment has been recommended. Originally developed by Bogardus in 1993, the term social distance can be defined as the "degree of reciprocity that is believed to exist within a social interaction" (Hoffman, McCabe and Smith 1996, p. 654). However, in health care, the concept may take a different form. In the present study, social distance has been seen mostly from the perspective of mothers. Put simply, social distance for these mothers implies whether they were satisfied with the explanations of their maternal health condition and advice given by the health care provider. Mothers from both the groups wanted to ensure that the birth attendants, who provide care, are easy to access and consult with and have the time to listen to their problems. The impression of Lubna, mentioned in Chapter Seven that the 'doctor is someone to fear', has come from this kind of distance and lack of comfort in communicating with her, even when sitting face-to-face and visiting her almost every month during her pregnancy. A study has shown that people often rate health care providers in terms of the extent of social distance they experience (Malat 2001, p. 360). Social distance in doctor-patient communications is an

important issue to consider because it involves interaction between individuals in unequal positions, and it has an influence on patient wellbeing, such as satisfaction of care, adherence to treatment, and health status (Ong et al. 1995, p. 903). Donabedian (1988, p. 1,744) highlighted informed choice, empathy, concern and sensitivity as important virtues to expect in doctor-patient communications.

While some forms of social distance between health care providers and health care receivers may always be present, this may vary according to the socio- economic class and gender of the health care receivers. The extent of social distance may also depend on the knowledge and awareness of the health care receivers, and the cultural context of the health care practice. Thus, for the mothers from the lower socio-economic households, social distance is much greater between them and the health care providers. The socio-economic background of these mothers, characterized by low levels of education, insufficient information about maternal health care and its availability and their low position on the economic ladder of society, make them more fearful about facility based maternal health care and instil in them a fear of being lost in the institutionalized process of childbirth in the hospital system. As an example, Hasna Banu (aged 20 years, mother of one daughter) from *Sona Mia* slum stated:

> Hospital is a big place, lots of people. We might be lost. We don't know where and whom to go for what. We are poor and illiterate. Do we understand all these?

This comment tells us that their socio-economic condition is not compatible with the institutionalized system of health care and is considered to be a psychologically (rather than spatially) distant place for them. Her view is reflected in the social

constructionist view of medical power "that medical power not only resides in institutions or elite individuals, but is deployed by every individual by way of socialization to accept certain values and norms of behaviour" (Lupton 2012, p. 13). Thus it becomes difficult for the poorer mothers to make themselves suitable for the values and norms of behaviour appropriate for the modern health care system.

Lack of respectful and open communication by health care providers towards service receiving mothers can also create a social distance between them, further discouraging the mothers from seeking modern health care. As revealed in Chapter Five, the mothers appeared to be sensitive to the behaviour of and communication with the doctors. Previous studies confirm this. For example, Van Hollen (2003, p. 127), in her study conducted in Tamil Nadu, India, and Afsana and Rashid's (2000) study in Bangladesh, also showed how condescending comments serve to create a social distance between the medical staff and the patients. Nevertheless, the mothers from the lower socio-economic group believed that if they had money, receiving treatment in a hospital would be easy and would present no fear for them. This is exemplified in the statement of Jhumur (aged 18 years) from Karwan Bazar slum in relation to the delivery care she received from Ad-din (see Jhumur's statement in Chapter Five).

Due to this perceived and experienced social distance between themselves and health care providers, the mothers of the lower-socio-economic group preferred to stay at home and treat their maternal health problems in their own way. At home,

they find a horizontal relationship[53] (Afsana and Rashid 2007, p. 72) with the traditional birth attendant, who is usually their neighbour, aunt or an acquaintance.

The mothers from the upper socio-economic households also had social distance concerns in deciding on the gynaecologist they wanted. For these mothers, social distance was not caused by economic or educational disparities and may not have been very significant. Rather, in their case, the distance between them and the maternal health care providers was caused by the superiority of the knowledge that the doctor might have intended to impose. Social distance turned into an issue of concern for these mothers because, in spite of their personal wealth and a fair degree of education, they felt uninformed, unanswered and dissatisfied with the powerful imposition of authoritative knowledge by the doctors or gynaecologists. The mothers from the upper socio-economic households try to get appointments for childbirth assistance and maternal health care with those doctors who are easily accessible and who have 'time' to listen to their problems. It was seen in Chapter Seven that some of the mothers from upper socio-economic households (the cases of Beli and Chameli) changed their gynaecologists because they were not satisfied with the explanations of their health problems and the advice received. Moreover, some mothers from the upper socio-economic households (e.g. Lubna) felt quite hesitant or fearful in discussing their problems with the doctor. The reported reason for this was the non-welcoming and reserved attitude of the doctor. Mothers often

[53] The relationship between the birthing mother and the *dai* is horizontal in the sense that there is little difference in socio-economic status and knowledge between the mothers and the *dai'*s.

seek references from relatives or friends to check if the doctor that they are going to see is easily accessible and communicative.

While the mothers from both the groups considered social distance as a criterion for choosing their health care provider, the selection of the type of health care provider(s) based on this criterion is different for the two groups. For the mothers from the upper socio-economic households, social distance becomes an important factor in choosing the gynaecologist from among the many available in urban Dhaka, because they believe that they must stay under the supervision of a gynaecologist throughout their pregnancy, childbirth and post-partum care. Naturally, they would choose the gynaecologist with whom they perceive the social distance is the least. For the mothers of the lower socio-economic households, social distance becomes a criterion for deciding whether they should have their delivery and postpartum care at home or in a health facility.

Thus, social distance between the health care providers and healthcare receivers (the mothers) becomes a factor in deciding the place of childbirth and post-partum care for the mothers from lower socio-economic households, and in deciding the gynaecologist for the mothers from upper socio-economic households.

### 8.2.3: How pregnancy and childbirth are viewed: as a medicalized event or as a social event?

The proclivity of the mothers of upper socio-economic households to lean towards the bio-medical process of childbirth, and that of lower socio-economic mothers to stay away from the same, implies that the two groups hold contrasting views towards pregnancy and childbirth. As identified earlier, for the mothers of lower socio-economic households, childbirth is a social event, while for the mothers of upper socio-economic households, childbirth is a medical event. Lowis and McCaffery (2004, p. 8) argue that 'medical event' and 'social event' of childbirth form a continuum of the degree of privacy that a person or community wants to attach to childbirth. According to these authors, in industrialized societies (and also in the richer sections of the population in developing countries), childbirth is regarded as a formal medical process involving only health professionals and close relatives. At the other end of the privacy continuum childbirth is seen as a social event, 'openly accepted by the community'.

In the present study, the health workers provide continuous support for maternal health services such as antenatal care (ANC), delivery care, and post-partum care to the mothers of lower socio-economic households. These mothers see childbirth as a social event in the sense that they like to avoid medical intrusion in the birthing process. They believe that external technologies such as CS will instigate further health and social complications. They prefer to see the event of pregnancy and childbirth as a "rite of passage" (Kitzinger 2012, p. 304) to be observed at home, surrounded by family, friends, and neighbours. Although, the mothers from lower

socio-economic households in this study appeared to be positive about receiving antenatal care, they preferred to receive it in surroundings where they felt at home. Having said that, if there were any complications with their pregnancy or childbirth, these mothers would consider getting medical assistance including the intrusion of medical technology as a last resort.

Conversely, the mothers from upper socio-economic households, who view childbirth as a 'medical event', regard it as a condition that requires continuous and close supervision of a gynaecologist. Some of these mothers, as reported in Chapter Seven, chose to have their delivery by Caesarean Section for non-medical reasons. Given that one of Bangladesh's main maternal health goals is to increase the proportion of births attended by skilled birth attendants (UN 2011, pp. 28-29), adopting a medical view of childbirth is a positive sign. But attendance at childbirth by skilled health personnel is not prevalent among the mothers of lower socio-economic households and possibly among large sections of the poor and lowly educated population, implying that this particular goal of maternal health is fulfilled only for a small percentage of the population, comprising mostly the rich and the well-to-do. Previous studies (Koblinsky, Anwar and Mridha 2008, p. 283 and NIPORT et al. 2013, pp. 129-131) show that, the richer and highly educated women in Bangladesh use professional maternal care at a far higher rate than lower socio-economic mothers. Second, the mothers from the upper socio-economic class tend to fear labour pain and the perceived 'uncertainty' involved in normal delivery. Both fears lead them to choosing CS, even by ignoring the fact that CS may also lead to post-partum complications. The CS rate is increasing more quickly

in private clinics for relatively wealthier women who may not require the procedure for medical reasons (Koblinsky et al., 2008, p. 285; Bhuiya 2009, p. 22)[54]. As discussed previously, due to this unnecessary use of CS, Koblinsky, Anwar, and Mridha (2008, p. 285) argue that the procedure has lost its value as a "measure of met need of obstetric care" and as a "measure of equity".

### 8.2.4: Control over the childbirth process

The mothers, particularly those from lower socio-economic households believe that they may be made to stay in a health facility following delivery for longer periods than what they would consider normal. Consequently, they feel that they would not be able to resume their daily work in and outside their homes to earn a living and help with household duties. This may be termed as 'control over the childbirth process', which influence their decision to choose or not to choose a particular health care facility and a health care provider. For the mothers from lower socio-economic households, control over the childbirth process means that they like to keep it (the process) within their domain of knowledge, information and homely atmosphere. This is also implied by the social view of childbirth. As suggested by several authors who criticize the medical view of childbirth (Kukla 2008; Oakley 1984; Kitzinger 2012), medicalized childbirth tends to take control over women's bodies, disempowers and alienates the mothers from the entire experience of

[54] In Chapter Two, the rates, the trends of professional delivery care, and C-section delivery were discussed in regards to the socio-economic context of the households under study.

birthing and promotes capitalism. However, in the context of Bangladesh, concerns over choice and control in childbirth may not entirely mean what the critics of medicalization wanted to establish. The mothers from lower socio-economic households need to keep themselves fit for hard manual work such as housekeeping, construction work or heavy household chores including carrying water. They may need to start working in and outside the home only a few hours or days after the baby is born. That is why, any medical input into childbirth, which may require longer rest and careful movement is not welcomed by the poorer mothers. They try to keep childbirth as non-intrusive an event as possible so that the regular income generating work of the family members (e.g., husband, mother-in-law) is not hampered. They fear that once the doctor takes over the process of childbirth they, themselves will lose control of the birthing process and will not get to know what is happening with their body. However, as mentioned before, a minimum level of medical intervention, particularly during pregnancy, as part of antenatal care is usually welcomed by these mothers. As we have seen that almost all of them had received some sort of ante-natal care (ANC), namely tetanus toxoid injections, blood tests, blood pressure checks, intake of folic acids, etc. Even for childbirth, some mothers were happy to give birth in the nearby maternal health centre or birthing centre (Rehana, aged 20 years, Sona Mia slum and Lolita (aged 18 years, Karwan Bazar slum). Some of the mothers called Unqualified Allopathic Practitioners (UAPs) from the neighbourhood pharmacy to give injections or saline to induce labour or to soothe the pain after childbirth.

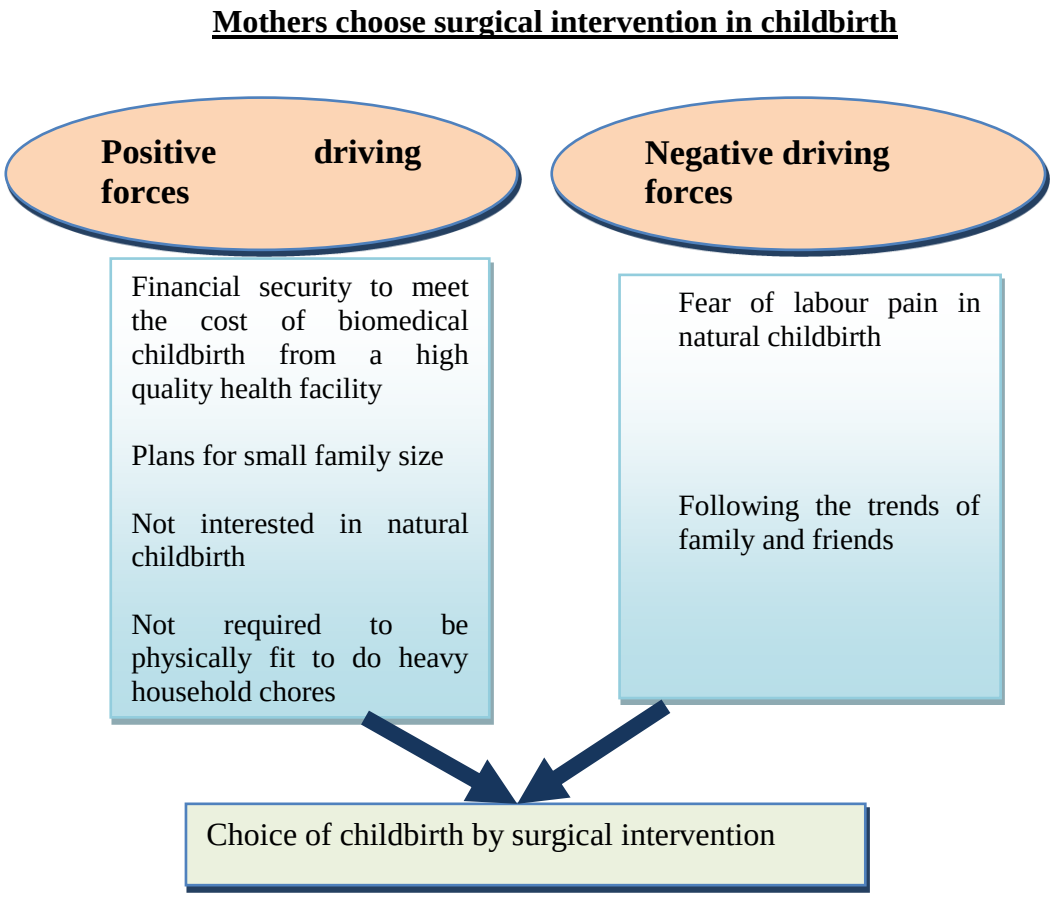
Whenever the question of taking birthing mothers to a hospital arose, the feelings of insecurity and a preference for possible alternative choices came to the forefront. For example, Lolita went to a nearby health centre (locally known as the 'Russel Club') to give birth with the assistance of a health worker. After observing Lolita for half a day with not enough pressure to push out the baby and her labour not progressing sufficiently, the health workers suggested that she should go to Dhaka Medical College which was 20 minutes away. Lolita's mother ignored this suggestion and brought medicine from the nearby pharmacy to induce the labour and the baby was born normally in the health centre. Studies conducted elsewhere in rural Bangladesh report similar findings (Parkhurst and Rahman 2007). The case of Lolita indicates that, in terms of medical care in childbirth, mothers only tend to go as far as the point to which they can keep the situation within their own control. Going to a large hospital for childbirth, such as the Dhaka Medical College, would make them lose control over their own body and their working capacity.

Concerns about control over the birthing process do not appear to be a similarly major issue for the mothers from upper socio-economic households. They have already agreed to depend on the medical experts for their safety in pregnancy and childbirth and accepted medical or surgical interventions required. For them control over the birthing process is limited to the information and services they receive from the doctors in the clinics or hospitals. However, as mentioned earlier, some mothers from this group chose a CS without receiving adequate understanding and information about it.

The choice of childbirth in this way reflects the lack of information and awareness about the childbirth process among mothers. Malacrida and Boulton (2014, p. 42) argued, "[t]here is a recurring assumption that women have or should have choices over the kinds of births they will experience and they can or should manage those choices by planning or preparing responsibly". The information and knowledge required to make those responsible choices appeared to be missing among most of the mothers interviewed from both the groups.

Against this backdrop, it is important to explore what drives the mothers of the upper socio-economic households to adopt a medicalized view of childbirth and choose a surgical intervention without any medical reason. Figure 8.2 summarizes the positive and negative factors that drive these women to view childbirth as a medical event.

**Figure 8.2: Driving forces behind the choice of childbirth by surgical intervention: mothers of upper-socio-economic households of Dhaka, 2012.**




Source: Drawn by the author based on interviews with mothers from upper socio-economic households, Dhaka 2012

The positive driving forces that are presented in Figure 8.2 are derived from the socio-economic conditions of the mothers. I have identified the positive driving forces as those which helped the mothers make a conscious and informed decision about the type of delivery care they wanted, and the negative forces as those which led them to take a medical view of childbirth without adequately understanding the health reasons. These women are from the higher socio-economic group, therefore financial barriers to a CS are reportedly not an issue, as evident from the interviews

with these women. Rather, their financial flexibility worked as a major impetus to choose a CS.

An important contributing factor for the mothers of upper socio-economic households in this section is that they tend to limit their fertility to one or two children. In the context of Bangladesh, high fertility is negatively related to the education and economic status of women and the family (NIPORT et al. 2013, p. 62). In keeping with this, as discussed in Chapter Seven, the mothers of upper socio-economic households stated that they desired to limit the number of their children to two. Therefore, they do not have to worry that they would lose their physical capacity to work by having too many children by caesarean section. Moreover, these women generally do not have to do as heavy a physical work as do women from lower socio-economic households. Nor are they usually required to do heavy household chores. For the women of lower socio-economic households (as seen in Chapter Five), the fear of losing their fitness for daily work in and outside their houses is one of their biggest concerns stopping them from seeking maternal health care in the modern health care system. The mothers from upper socio-economic households are able to employ household help to do the household chores, which the mothers of lower socio-economic households cannot afford this.

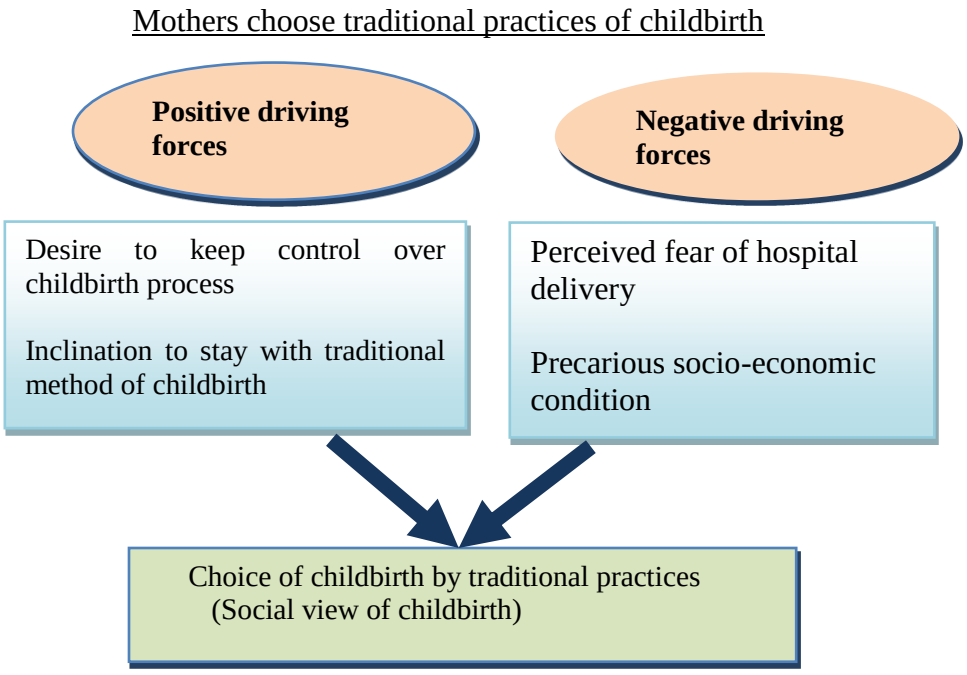
Thus, the mothers of upper socio-economic households make a conscious decision to have a CS since they evaluate the impacts of a CS to be minimally adverse because (i) their ability to perform their daily work would not be compromised (household work is done by hired help and their own professional work is not

physically demanding), (ii) the potential overall impact of a CS would be low because of their limited family size (one or two children) and (iii) they were able to afford the cost of a CS and related medical expenses.

Nevertheless, not every mother made her birthing decision based on her informed options and awareness, which leads us to consider the negative driving forces that made these richer mothers choose medical intervention in childbirth without any medical reason, and without having an adequate understanding of the possible impacts of that intervention. The mothers from the upper socio-economic households have a fear of labour pain associated with natural childbirth which motivates them to ask for childbirth by CS (Melender and Lauri 1999, p. 181). The reason that mothers choose CS for child delivery could also be that they might not have got enough information about the possible health hazards that a CS could cause. They are also following the trend of their peers and relatives in the same economic groups, which has been explained as a class culture of childbirth and is another driving force encouraging these mothers to choose surgical intrusion in childbirth.

The factors which drive the mothers of lower socio-economic households to hold a social view of pregnancy and childbirth stem from their socio-economic conditions and the lack of adequate information about modern maternal healthcare.

**Figure 8.3: Driving forces behind the choice of childbirth by traditional practices: mothers from lower socio-economic households in Dhaka, Bangladesh**




Source: Drawn by the author based on interview of mothers of lower-income households, Dhaka 2012

Figure 8.3 presents the positive and negative driving forces that lead mothers choose traditional practices of childbirth. Among the positive driving forces, intention to have control over the birthing process and to stay with traditional method of childbirth are important. The control over birthing process that is required for the lower socio-economic mothers to make sure that any external medical intrusion does not jeopardize their working capacity, has been discussed earlier. At the same time their inclination to be at home during childbirth also reflects the willingness to share the childbirth event socially, as stated by Sheher Banu "it's always good to have the child delivered at home. Having people around at home is a matter of joy". These are considered as positive forces because of the

mothers' understanding of their practical situation of life and cultural orientation that needed to be valued in the childbirth process, whether at home or hospital.

The negative forces, drive these mothers to choose traditional childbirth practice are the perceived fear of hospital delivery, lack of information and precarious socio-economic condition. The fear of hospital based childbirth, implies lack of information and counselling about facility based childbirth provided to the mothers. On top of all of these factors, their precarious socio-economic condition is the one which plays a role as a context as well as a driving force to choose the type and place of maternal health care for mothers of lower socio-economic households.

Although in western literature, natural birth[55] and home based childbirth have been romanticised by feminist health activists who have advocated for home based natural births, the situation of poor households in Bangladesh tells a different story. In urban Bangladesh, most of the poor people live in precarious housing conditions (Baker 2007, p. xix), and 37.4% of the population lives in slum areas with a population density of 220,246 persons per square kilometre (Angeles 2004, p. 9). The mean income of the lower socio-economic mothers in this study is BDT 305/day (USD 4) for the average number of family members for an average family of four. The mothers also live with a dearth of information about the services that are available for city dwellers (see Chapter Four for details on the socio-economic conditions of the respondent mothers). In this context, home delivery may be quite unjustified for them. While these mothers are respectful in expressing their

[55] Natural birth advocates share a commitment to the active participation of birthing women in the process of giving birth (Dick-Read 1951; LeBoper 1975; Kitzinger 1986).

inclination to stay at home and follow the tradition of home based delivery, in reality giving birth to a child at home in their precarious living conditions can cause morbidity for the mother and the newborn child.

## 8.3: Conclusion: fear and fashion of modern treatment

So far, I have discussed four factors that work in opposite directions for the mothers from the two socio-economic groups, particularly in deciding about the place and type of childbirth and maternal health care provider. For the mothers from lower socio-economic households, apprehension about health facilities, the perceived and experienced social distance between them and the healthcare providers, the social view of childbirth and the issue of choice and control over the childbirth process incline them towards giving birth at home and preferably, without any surgical intervention because their lifestyle and need for a quick return to work lead them to the health care seeking behaviour in this direction. On the other hand, the mothers from the upper socio-economic households were able to ignore the concerns about possible health hazards of undertaking childbirth involving surgical interventions, because their advantaged financial, structural, and social position helped them to step out of the traditional view of childbirth and render them dependent on medical experts. Thus, the socio-economic status of the mother made the modern facility based approach to childbirth a fashion for the upper socio-economic mothers and a matter of fear for those from the lower socio-economic households.

The fear related to childbirth decisions for both the groups of mothers was associated with the extent and quality of information and education the mothers were provided with. The childbirth decision which comes from a particular apprehension and perception does reflect inadequate information about childbirth and maternal health care and education among the mothers. Neither the mothers of the upper socio-economic households nor those of the lower socio-economic households were adequately -informed about the healthcare they received (or did not receive). To ensure the empowerment of mothers in the maternal health care setting, it is important that mothers and their families make their maternal health decisions consciously based on factual information and knowledge, not out of fear or apprehension, nor by following the trend of their peers. To help them to make such informed, conscious, and responsible decisions, the maternal health care centres and health care providers must provide services that are sensitive to the socio-economic situation of the mothers. In particular, the medical practitioners should adhere to the ethical requirements of the Federation of Gynaecology and Obstetrics (FIGO) (IPPF 2003). In line with the recommendations put forward by Saisto and Halmesmäki (2003, p. 206), in Bangladesh midwives and nurses, as well as general practitioners and obstetricians, need education on how to provide information and counselling to care-receiving mothers, so that they can make childbirth decisions based on knowledge, rather than on any perception or apprehension.

# Chapter Nine

# Conclusion

## 9.1. Introduction

This study has added a deeper insight into the health care seeking behaviour of women from two diverse socio-economic groups in urban Bangladesh. The findings of this study are based on an analysis of information gathered through in depth interviews of a selected group of mothers from lower and upper income households of Dhaka, carried out in 2012. The mothers from lower socio-economic households comprised those selected from two informal settlements (slums) of Dhaka and patients coming to two urban health centres, while the mothers from upper income households were selected from a well-to-do locality of Dhaka. These two groups of mothers represented a lower socio-economic class and an upper socio-economic class respectively. In-depth interviews were also conducted with selected health care providers.

In this study, 'health care seeking behaviour' involves an understanding of how the women from lower and upper socio-economic households in Dhaka view the process of childbirth (whether as a social event or a medical event) and how they perceive, experience and practise the health care associated with childbirth and the post-partum period. The main argument developed in this thesis is that maternal health care for childbirth and post-partum morbidity is perceived and experienced

in contrasting ways by the two groups of mothers and that this contrast is not merely due to the socio-economic advantage/disadvantage of the groups, but also due to their contrasting views of childbirth and contrasting approaches to facility based maternal health care.

The illness response approach (MacKian 2003) is applied in this study as a lens to understand the health care seeking behaviour of the mothers interviewed in Dhaka. This approach assumes that behaviour is best understood in terms of an individual's perception of their social environment. Moreover, the use of 'social constructionism' as a research approach sets the platform for this study to emphasize how mothers are creating childbirth and maternal health care knowledge from the backgrounds of their respective context and culture. This approach has also guided me in reflecting on the mothers' maternal health care experience as it appears from their own voice.

The research questions designed for this study required an exploration of various factors pertaining to the perception and experience of the mothers of Dhaka in terms of maternal health care during childbirth and the post-partum period. The said perception and experience have been explored through in-depth interviews of the mothers and selected health care providers at different levels, comprising traditional birth attendants and gynaecologists from popular expensive health care facilities.

The study findings revealed a complex selection of interrelated perceptions and experiences of mothers about how their concepts of childbirth and related health care are construed, and how they lead the mothers towards a particular practice of maternal health care. Despite living in the same city, the mothers from the lower and upper socio-economic households exhibited very contrasting pictures of childbirth and related health care seeking behaviour, which is also partly a reflection of their contrasting socio-economic backgrounds.

The heart of the thesis comprises five chapters dedicated to the analysis of qualitative data, with the aim of fulfilling the objectives of the research, which were as follows:

1. To understand the socio-economic situation of mothers in which their maternal health care seeking behaviour for childbirth and post-partum illness is shaped.
2. To analyze the perceptions and experience of mothers childbirth and maternal health care of mothers from lower and upper socio-economic groups, influence each other and lead them towards a particular practice of maternal health care for childbirth and post-partum illness.
3. To understand how the health care seeking behaviour is shaped for chronic post-partum maternal morbidity.
4. To compare and contrast the perception and experience of childbirth, motherhood and maternal health care during childbirth and the post-

partum period between the mothers of the lower socio-economic and upper socio-economic households.

## 9.2. Summary of findings

The findings about the socio-economic background of the mothers interviewed in this study clearly show the contrasts between the two groups of mothers in terms of residence, income and employment status, current age, age at marriage and age at first childbirth, and the type of maternal health care the mothers received during pregnancy and childbirth. For example, the mothers of lower income households lived in informal settlements (popularly known as slums or *bosti*) with poor infrastructure, poor hygiene and overcrowded housing, whereas the mothers from upper socio-economic households lived in one of the high-class localities in Dhaka with better living conditions. The mothers from lower socio-economic households were on average 23.5 years old, had their first childbirth at age 16 years on average and had given birth to two children on average. In contrast to this, the mothers of upper socio-economic households were aged 35.5 years on average, had their first childbirth at the age of 28 years, and had borne 1.2 children on average. In terms of maternal health care seeking behaviour, the mothers from lower socio-economic households tended to rely on traditional birth practices whereas the mothers of upper socio-economic households favoured modern maternal health care and surgical child deliveries like caesarean sections. This contrast is obvious, because these two groups were purposely chosen to examine the maternal health care behaviour of women from two diverse groups.

Thus, one group of mothers belonged to an advantaged socio-economic class, while the other group of mothers was, in some cases, living below the poverty line. The poor maternal health condition of the lower socio-economic mothers tends to push them further into more precarious socio-economic situations. The city of Dhaka has a large number of health facilities funded by the government, NGOs and the private sector. The facilities run by the government and NGOs provide free or low cost maternal health care, and they can be found in close proximity to almost all residents in Dhaka. Yet, the mothers of lower socio-economic households generally did not use these facilities. For them, lack of money or difficulties in transportation to health facilities are not the only barriers to seeking health care in modern facilities, but there are other impediments. Therefore, this study has attempted to unravel this paradox by looking at several non-monetary factors underlying their social, structural and cultural contexts, as well as their lived experience from which their health care seeking behaviour has been formed.

Conversely, the mothers from upper socio-economic households tend to follow a modern and urban influenced health care seeking behaviour during pregnancy, childbirth and the post-partum period, resulting in most cases, in an overuse of maternal health care in private maternal health care facilities. The pattern of maternal morbidity amongst these mothers is also different from that among the mothers from lower socio-economic households. While the mothers from lower socio-economic groups reported more childbirth complications and cases of post-partum morbidity, mothers from the upper socio-economic households tended to

report more complications during the ante-natal period, particularly due to more thorough and more regular monitoring of their pregnancy.

In terms of health care seeking behaviour, the mothers of lower socio-economic households expressed significant concerns towards institutionalized childbirth. Their concerns arose from their perception that institutionalized childbirth would involve surgical interventions which would jeopardize their health, weaken their capacity to work, and require them to bare their bodies to unknown persons. These mothers consider pregnancy and childbirth as natural events which, according to them are best taken care of at home and in the hands of *dai* (traditional birth attendants) and female relatives. Many of these mothers are migrants from rural areas, and although some have been living in Dhaka for considerable lengths of time, they have hardly been able to change their traditional perception of childbirth and maternal health care since adopting urban life. This is reflected in their preference for viewing childbirth as a social rather than a medical event, associating it with rituals and practices, '*lojja*' (shame/modesty) and honour, and enduring a culture of silence during labour pain and post-partum morbidity. This view of childbirth is further powered by the perceived and experienced difficulties in receiving health care from health facilities. Such difficulties stem from perceptions about social and authoritative distance between the health care providers and receivers, undocumented user fees, and culturally insensitive behaviour of the healthcare staff. Being poor and barely educated, these mothers also find it hard to receive the information provided and follow the procedures for

institutionalized childbirth and maternal health care. Thus, in spite of living in close proximity to health care facilities, the mothers from lower socio-economic households perceive hospital based maternal health care as very distant (socially and culturally). In these circumstances, maternal health care sought by the mothers of lower socio-economic households is largely determined by the advice, guidance, assistance and support of their social and neighbourhood network.

While Chapter Five concentrated on the reluctance of the mothers from a lower socio-economic class to receive institutionalized health care for childbirth or immediate post-partum care, Chapter Six highlighted the eagerness of the same mothers to receive treatment for long-term obstetric complications such as obstetric fistula. Their eagerness to treat obstetric fistula is linked to the much adverse consequences of the condition which these mothers face. The consequences are not only physical pain and discomfort, but also social isolation and in many instances, abandonment by their husbands.

The reasons for developing obstetric fistula are early child bearing and small stature leading to prolonged obstructed labour, for which no treatment is provided. In some cases when treatment is provided, it is much delayed. However, other contributing factors to these reasons for fistula are poverty, lower socio-economic status of women, infrastructural barriers, prevailing cultural connotations of childbirth practice and lack of information. But once contracting this disease and being subjected to untold physical and social consequences, the poorer mothers endeavoured to treat obstetric fistula with utmost effort. Given their very limited

physical mobility and precarious socio-economic conditions, as well as lack of adequate information for fistula treatment in nearby health facilities, receiving treatment for obstetric fistula involved a complex array of challenges. With the support of their limited social and community network, the mothers interviewed in this study were able to overcome these challenges and go for treatment of their conditions. It is acknowledged that there may be many more women suffering from obstetric fistula who were not so fortunate in obtaining treatment for their disease, but I deliberately studied this small group of women who came to Ad-din hospital so that their experiences can be used for the benefit of many more hapless women who are still languishing in the dark in search of a cure from this dreadful disease.

As the fistula affected mothers interviewed in this study have been suffering from this severe condition for long periods of time, they have come to realize that they need to pay much more attention to treating fistula than the attention they could give to their childbirth or the obstetric complications arising from it. Therefore, they spared no effort to get treatment for their fistula, in some cases even travelling long distances from the villages to Dhaka. In relation to this, the role of social and community networks, both for childbirth and immediate post-partum complications and for treatment of obstetric fistula has been profound in shaping the health care seeking behaviour of these mothers.

For the mothers of upper socio-economic households, as discussed in Chapter Seven, the view of childbirth and related health care, the choice and control over the childbirth process and decisions and the experience and practice of health care

during and after childbirth differ considerably from those of the mothers of lower socio-economic households. Fear of normal labour pain, preference for CS in a private expensive clinic, advantageous and affluent family circumstances, as well as awareness of possible health risks involved in childbirth lead the mothers from the upper socio-economic households to view childbirth as a medical rather than a social event, and to seek clinical maternal health care with a surgical intervention. Thus, the mothers of upper socio-economic households tend to ensure their improved maternal health and safe childbirth.

However, the use of medical intervention such as a caesarean section (CS), regardless of whether it is necessary and without adequate information and knowledge given by the doctor to the mothers, raises two concerns. First, CS is considered as a proxy measurement of the coverage of emergency obstetric complication of a population[56]. However, higher rates of CS in a particular section of the population (richer groups in this case) without any valid medical reason question the validity of CS as an indicator of emergency obstetric care (EmOC). Second, preferring CS without adequately understanding why a CS is performed and what might be the consequences of a CS means that they are not making an informed choice. This has implications for the empowerment of women in the reproduction process.

[56] Caesarean section is one of the components of Emergency Obstetric Care (EMOC) and often considered as a proxy indicator of women's access to health care for complicated delivery (NIPORT et al. 2009, p. 118).

Chapter Eight highlighted the similarities and differences among the two groups of mothers. Each holds a particular and often paradoxical pattern of knowledge and experience and is subjected to a set of common factors that shape their maternal health care seeking behaviour. Their responses to these common factors through their perceptions and experiences and those of their families are crucial in deciding the type, place, and timing of maternal health care used by the mothers during childbirth and post-partum period. These common factors are (i) apprehension, (ii) distance (social and authoritative) between the health care providers and care receiving mothers, (iii) view of pregnancy and childbirth, (iv) Ccontrol over the birth process and the role of the family The responses to these factors from the mothers of the two groups work in opposing directions to determine their behaviour, which turns modern maternal health care into a matter of fear for the mothers of lower socio-economic households and fashion (rather than a necessity required for safe delivery) for the mothers from upper socio-economic households.

Returning to the original aim of this study, which is to compare the two groups of mothers in terms of their perception, experience and practice for health care in childbirth and post-partum morbidity and analyze the difference of between them, it has been found that there are multiple interacting factors that emerged from a particular socio-economic context, and shaped the mothers' health care seeking behaviour. The relationships among these factors are too complex and challenging to narrow them down to a simple framework of maternal health care, i.e. hospital based bio-medical event or home based social event. Although a bio-medical

childbirth with surgical intervention may ensure safe childbirth (in terms of managing obstetric complications), in many cases it is not based on informed choice of the mother and therefore impinges on her empowerment in terms of knowledge, understanding and self-engagement in the childbirth process. This applies to the mothers of upper socio-economic households. On the other hand, as skilled birth attendance is considered key to safe childbirth, the unwillingness of the mothers of lower socio-economic households to consider bio-medical childbirths puts this assistance out of their reach. Maternal health services are not compatible with the lives of the poorer mothers in urban Bangladesh and their understanding of childbirth as a natural process, which should not require external medical intervention that may interrupt their daily work in and outside the home. In this circumstance, the argument of this study is in favour of a maternal health care process where the mother can appreciate her empowered participation in the childbirth process, and make choices and decisions that are based on adequate information and awareness in a sensitive and respectful atmosphere. To ensure this, the healthcare providers at all levels must be sensitized to the traditions, feelings and wishes of the mothers.

## 9.3: Limitation of this study and research implications

This study opens the door to understanding the socio-cultural context of the mothers at both policy and practice level in order to ensure the health and wellbeing of mothers in childbirth. However, this study was limited to only mothers from two socio-economic groups in urban Dhaka. Moreover, as the study was conducted

among a very limited number of women, the perceptions and experiences portrayed here may not necessarily represent that of all mothers in the lower socio-economic or upper socio-economic households of Dhaka. Wider scale research, particularly incorporating mothers from other socio-economic groups, may give a more representative scenario. A separate study on the perception and experience of health care providers at different levels could also be necessary to understand the supply side of maternal health care. A large scale quantitative research program may also be needed to complement the findings from qualitative research and bring out some wider population information regarding maternal health care seeking behaviour in urban Dhaka.

## 9.4: Policy Implications

The discussion presented ascertains that maternal health care behaviour for childbirth and the post-partum period involves a complex array of interrelated factors. This study also asserts that there are many non-monetary factors which, individually or in relation to monetary factors, contribute to decision making about maternal health care in urban Dhaka. These factors, as found in this study are: perception and view towards childbirth, the availability and extent of family and social networks; information provided to the mothers by the health care providers; gender relations and empowerment status within the family, which is influenced by the education, economic and mobility status of the women, and a sense of pride or humility of going or not going to a hospital for maternity care.

Taking all these findings into consideration, this study makes the following policy recommendations:

- **Strengthening the social network:** For mothers in both the studied groups, the availability and extent of the family and social network have been found to be the most effective sources and determinants of health care information, and physical and moral support during childbirth and post-partum conditions. Making this network more structured and better informed and involving more people in this network will be a stronger source of support for the mothers. The network might not only provide information, moral, physical and social support to the maternal health care seeking mothers, but also give them a platform to access better resources and information (Story 2014, p. 83), empower and educate themselves in terms of maternal health.
- **Engaging Unqualified Allopathic Practitioners (UAPs) in raising awareness:** The urban mothers from the lower socio-economic households largely depend on the unqualified allopathic practitioners (UAPs), if any medical intervention is needed. As suggested by Wahed, Moran and Iqbal (2010, p. 9), UAPs "could be used as change agents by local health programs to encourage referral to health facilities". Incorporation of UAPs into the maternal health awareness building program within the communities and making it possible for the UAPs to work as an official source of information and support for health care will bring more fruitful use of UAPs and for the improved health of mothers.

- **Providing working-hour-friendly health care service:** Many mothers in the lower socio-economic households in Dhaka work outside the home to earn their living during the time health services and information are provided in the health care centres. While richer mothers can choose and afford their time-convenient service in a private clinic, the poorer mothers cannot, and are left out of this service provision. Therefore, time-convenient services for the working mothers need to be arranged in the health care facilities.
- **Sensitization Training:** Filippi et al. (2006, p. 1,537) emphasized the importance of understanding the perceptions of maternal health care, when providing services to them. She stated "women need health services that respond to the health problems they perceive". As the mothers from lower socio-economic households perceive childbirth as a social event and highly value the cultural connotations associated with it, the health care providers, including doctors, should be provided with sensitization training to accept and value cultural beliefs and practices during hospitalized childbirth. The health care providers also need to be trained to communicate with mothers so that the meaning of health and health care information is conveyed to mothers appropriately. Basu (2014, 32), stated that the meaning of language "lies in the mind of speaker and listener" and in health care service it is important that the health care providers and service receivers share the same meaning of the information. A training of the health care providers on interpersonal communication would go a long way in addressing this

problem. Such training should be given to the healthcare providers at regular intervals.

- **Monitoring the quality:** The private maternal health clinic may need to strengthen their monitoring of the quality and quantity of the services they provide. It is important to make sure that the service allows for doctors to give enough space and time to each mother to share their problems, and ensure the mothers do not feel passive throughout the whole process.
    - **Counselling and information:** Counselling and information provision in the maternal health care programs needs to be strengthened, so that mothers and their families are well informed about the positive and negative aspect of all forms of childbirth so they can make an informed decision. To ensure the quality of services in this regard, Bruce's explanation of interpersonal communication between the health service providers and receivers can be followed. As mentioned in Chapter Five, Bruce (1990, pp. 74-75) argued for a high level of communication between the health care providers and receivers. When this occurs, a trust in the competence of the health care providers and in the information provided can be developed among the receivers.
- **Building awareness and education:** Giving birth at an early age is one of the important reasons for maternal morbidity among the mothers of lower socio-economic households. Although there are efforts from both the government and non-governmental organizations to raise the age at marriage of women in Bangladesh, it may take longer than expected to

achieve a change in marriage norm such as this. Therefore, until the ages at marriage and childbearing of women, especially those in rural areas are raised to safe levels, awareness needs to be developed among the husbands of young brides to use family planning and avoid making their young wives pregnant until they are 20 years of age. In addition to this, the husbands need to be more educated and involved in the childbirth decisions, particularly in arranging maternal health care for their wives before and after the women give birth.

- **Dissemination of information for fistula treatment:** The information concerning about the sources of treatment for maternal morbidity conditions (like fistula) needs to be disseminated widely and locally. This would enable mothers from the far remote areas to access adequate information to assist them to reach the treatment facilities earlier, and reduce the length of their suffering.

- **Improvement of socio-economic conditions:** Overall, the socio-economic condition of the mothers needs to be improved by creating better working opportunities, education and strengthening social networks.

To conclude, maternal morbidities during childbirth and post-partum period are preventable, avoidable and treatable if proper maternal health care is provided. To ensure proper maternal health care support in the form of health care, information, counselling, moral and physical support should be channelled

towards the mothers in need from various sources. These sources are health care providers, health care facilities, family, social networks, counselling bodies and so forth. Thus, ensuring good maternal health care requires everyone to work together. Childbirth support needs to be trusted, mothers needs to be informed and educated and the socio-cultural dimension of childbirth needs to be valued and respected, be it home based or hospital based childbirth. Therefore, this study argues for establishing trust and respect, strong support network within communities, and developing shared understanding between the care receiver mothers and care providers.

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# Appendices

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# Appendix 1: Approval Letters

## Ethics Approval and Permission Letter

**APPROVAL NOTICE**

Project No.: **5535**

Project Title: Health seeking behaviour of women with maternal morbidity in Dhaka, Bangladesh

Principal Researcher: Ms Sanzida Akhter

Email: sanzida209@yahoo.com

Address: Unit 6, 795 Marion Road
Mitchell Park SA 5043

Approval Date: 30 April 2012 Ethics Approval Expiry Date: **31 October 2014**

The above proposed project has been **approved** on the basis of the information contained in the application and its attachments with the addition of the following comments.

**Additional information required:**

1. Please clarify whether participants will be given a copy of 'field notes' or their 'interview transcript' on request as this was unclear (item F5).

**RESPONSIBILITIES OF RESEARCHERS AND SUPERVISORS**

**1. Participant Documentation**

Please note that it is the responsibility of researchers and supervisors, in the case of student projects, to ensure that:

- all participant documents are checked for spelling, grammatical, numbering and formatting errors. The Committee does not accept any responsibility for the above mentioned errors.
- the Flinders University logo is included on all participant documentation (e.g., letters of Introduction, information Sheets, consent forms, debriefing information and questionnaires – with the exception of purchased research tools) and the current Flinders University letterhead is included in the header of all letters of introduction. The Flinders University international logo/letterhead should be used and documentation should contain international dialling codes for all telephone and fax numbers listed for all research to be conducted overseas.
- the SBREC contact details, listed below, are included in the footer of all letters of introduction and information sheets.

*This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 5535). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au.*

**2. Annual Progress / Final Reports**

In order to comply with the monitoring requirements of the *National Statement on Ethical Conduct in Human Research (March 2007)* an annual progress report must be submitted each year on the **30 April** (approval anniversary date) for the duration of the ethics approval using the annual progress / final report pro forma which can be downloaded from the website. *Please retain this notice for reference when completing annual progress or final reports.*

If the project is completed *before* ethics approval has expired please ensure a final report is submitted immediately. If ethics approval for your project expires please submit either (1) a final report; or (2) an extension of time request and an annual report.

Your first report is due on **30 April 2013** or on completion of the project, whichever is the earliest.

**3. Modifications to Project**

Modifications to the project must not proceed until approval has been obtained from the Ethics Committee. Such matters include:

- proposed changes to the research protocol;
- proposed changes to participant recruitment methods;
- amendments to participant documentation and/or research tools;
- extension of ethics approval expiry date; and
- changes to the research team (addition, removals, supervisor changes).

To notify the Committee of any proposed modifications to the project please submit a Modification Request Form to the Executive Officer. Please note that extension of time requests should be submitted prior to the Ethics Approval Expiry Date listed on this notice.

Change of Contact Details

Please ensure that you notify the Committee if either your mailing or email address changes to ensure that correspondence relating to this project can be sent to you. A modification request is not required to change your contact details.

**4. Adverse Events and/or Complaints**

Researchers should advise the Executive Officer of the Ethics Committee on 08 8201-3116 or human.researchethics@flinders.edu.au immediately if:

- any complaints regarding the research are received;
- a serious or unexpected adverse event occurs that effects participants;
- an unforseen event occurs that may affect the ethical acceptability of the project.

Andrea Fiegert (nee Mather)
Executive Officer
Social and Behavioural Research Ethics Committee

# Approval letter from Ad din hospital

**Ad-din Foundation**

4 August 2012

**Ms. Sanzida Akhter**
Assistant Professor
Department of Women and Gender Studies
University of Dhaka
PhD Student, Flinders University, Australia.

**Sub: Permission for data collection from Ad-din Hospitals.**

*Ref: Your letter and documents sent by e-mail on 1.8. 2012.*

Dear Ms. Sanzida Akhter,

With reference to the above, the Management of Ad-din is pleased to authorize you to collect data for the research study **'Health Care Seeking Behaviour of Women suffering from Maternal Morbidity in Bangladesh'** in the Gynae Ward of Ad-din Medical College Hospital, 2 Bara Maghbazar, Dhaka and Ad-din Sakina Medical College Hospital, 15 Rail Road, Jessore with the following terms and conditions:

1. You will work under the guidance and supervision of Prof. Sayeba Akhter, Professor of Obs/Gynay department and Academic Director of Ad-din Women's Medical College (AWMC), Dhaka.
2. You shall take permission from Dr. Nahid Yasmin, Assistant Director and consent from the Ward Officer/ In-charge of the Gynae Ward before starting your day's work at Ad-din Hospital Dhaka.
3. You shall take permission from Dr. Shila Podder RMO and consent from Ms. Subashi Biswas, Manager or Ms. Shahina Yasmin, Deputy Manager before starting your day's work at Ad-din Hospital, Jessore.
4. During using a patient as a sample of your study, you have to brief the patient on its purpose and take consent from her.
5. You have to maintain confidentiality of data/information received from the Patients and Hospitals.
6. All ethical issues related to this work must be followed during data collection.
7. The study shall not hamper patient's services of Ad-din hospitals.
8. There will be a credit line for Ad-din Hospital in your theses paper.
9. Ad-din will get a copy of you theses paper.

We thank you for your interest to receive such support from Ad-din Hospital.

Yours sincerely,

**Prof. Dr. Md. Aliquor Rahman**
Executive Director (Acting)

Copy:

1. Prof. Sayeba Akhter, Professor, Obs/Gynay and Academic Director for AWMC, Dhaka
2. Dr. A J Faisel, Country Representative, EngenderHealth, Dhaka
3. Dr. Nahid Yasmin, Assistant Director, Ad-din Medical College Hospital, Dhaka.
4. Dr. Shilla Podder, RMO, Ad-din Sakina Medical College Hospital, 15 Rail Road, Jessore
5. Ward Officer/In-charge, Gynae Ward, Ad-din Hospital, Dhaka/Jessore

2 Bara Maghbazar, Dhaka-1217, Bangladesh, Phone : 9353391-3, Fax : 88-02-8317306, E-mail: info@ad-din.org

# Appendix 2: Interview Schedule

## In-depth interview schedule for mothers

**Respondent's unique ID (to be filled in later):**

| Area (1 column) | House number (Two columns) | | Respondent's line number (Two columns) | |
|---|---|---|---|---|
| **1** | **1** | **4** | **0** | **7** |

**Introduction**

1. Exchange of greetings and researcher's introduction
2. Giving letter of introduction, information sheet and consent form.

**Area:** Upper Middle class (1)

Lower class (2)

Household address:

Respondent's name:

**1. Household information**

| No. | Name | Relationship to household head | | education | occupation | Income | Marital status |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**3. Information about the house**

- Material of roof and floor
- Source of drinking water
- Toilet facility
- Source of lighting
- Cooking fuel
- Number of rooms

**4. Information relating to reproduction and childbirth**

- Age at marriage
- Age at first sexual intercourse

| Preg No. | Age at pregnancy | Outcome of pregnancy | Ante-natal period | | Delivery | | | Post-partum period (pp) | |
|---|---|---|---|---|---|---|---|---|---|
| | | Live birth/ Miscarriage/abortion/still birth[1] | Number of ANC visits | Who assisted | Place | Who assisted | Any complications? Yes/No[2] | Place | who assisted |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

1.Miscarriage M; Abortion A; Still birth S. 2. If yes, fill out the details in the table number 4.

**Maternal morbidity information**

| Pregnancy number | What was the complication | Symptoms | Medical name | Duration of suffering | Treatment sought | |
|---|---|---|---|---|---|---|
| | | | | | yes | No |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**5. Accessing maternal morbidity health care information: Barriers and opportunities from the family**

- Did you seek any treatment for the complication: Yes/No
- If yes

-From where?
-From whom?
-What type of treatment?
-For how long?
-Has the illness been completely cured?
-Why did you choose that health care provider?
-Who took the decision to seek this health care?
How far is the health care facility from your home?
-How did you arrive at health care centre? (mode of transport)
-Did anyone accompany you? Yes/No.
If Yes, who accompanied you?

- If not

-Why not?
-Was there any particular incidence/reason that hindered you in accessing care?

- When you were ill/ in a morbid condition, was there anyone who helped you with your work and household chores?
- What type of support /help you receive from family?
- Who provided you the support within the family? Who took care of your children or dependants in the family, while you were off to receive health care?
- Was there anyone who opposed/ prevented you from going to maternal morbidity care?
- Have you had regular sexual activities during your illness? Yes/No

If Yes, were these activities voluntary or forced?

**6. Receiving maternal morbidity health care: barriers and opportunities – from the health care providers**

- What type of health care did you choose for your illness? (e.g. Health care centre/hospital/ traditional healer)
- Why did you choose that particular type of health care provider? Your own preference/your family's preference
- Once at the health care provider's place, did you have you had any difficulty in getting to the provider? Yes/No

If Yes, what was the difficulty?

- Once you were seeing the health care provider, did you feel free to talk about your illness with the provider? Yes/No

If Yes, what made you feel comfortable?

If No, what do you think stopped you from talking freely?

- Were you told what type of treatment would be provided?
- What was the cost? Was this cost affordable to you and your family?
    - Are you happy with the treatment and other service provided by the health care provider? Yes/No
    - If not, was there any particular reason that left you unhappy with the service?

**7. CS and others: Ask these questions for each pregnancy during the last five years:**

- Did you have a normal delivery/Caesarean delivery
    - If caesarean

- When did you decide you wanted a Caesarean delivery?

Why did you choose a Caesarean delivery?

(eg medical problems, convenience, family or friends pressure, fear of pain, etc.)
-Where was the CS done?
-Who took the decision to have the CS? Doctor/Your family/yourself

- If not a Cesarean

-did you have any complication during pregnancy, childbirth or during post-partum period
If yes
-Had anyone suggested a CS for you? Yes/No
If Yes, why was a CS not done? (eg. desire for normal delivery/fear of a CS/ cost was too much/ any other factor)

## Interview Checklist for health care providers

**I. Introduction**

8. Exchange of greetings and researcher's introduction
9. Giving consent form, letter of introduction and information sheet

**II. Main interview**

1. Basic information regarding health care provider
   - Type of health care provider (public hospital, private clinic, local health complex, traditional healer or other)
   - The staff arrangement/ organogram of the institution (within the institution who is accountable to whom)
   - Source of funding (government/ personal/ charity/ private/others)
   - Detail of logistic support (equipment for treating severe complication)
   - Detail of fees taken from the patients coming for treating maternal morbidity (how much for each visit/how much for regular diagnosis/ tentative amount of fees for complicated medical procedure)
   - Detail of the salary structure
   - Is there any issue in this health centre that cause you dissatisfied? – (salary, incentives, structure, work pattern, work load, overall quality of service)

2. Detail of provided maternal morbidity health care in the health care centre
   - How many women per week come here for receiving maternal morbidity health care
   - How many persons provide health service to them?
   - For what types of complication do most of the women come to seek health care? – (pregnancy, delivery or post-partum maternal morbidity, sequlae of near miss)
   - Waiting time - on average how long they have to wait for receiving health care

3. The pattern of the relationship between the health care provider and the women coming for treating maternal morbidity
   - How much time do you allocate for seeing each patient?
   - Do you explain the illness and treatment procedure in detail to the patient?
   - Do you think the time you spend for each patient is enough for seeing each patient- yes/no

     If no

     Why?

Do you suggest any alternative to this?

- Do you think the women coming for treating maternal morbidity can freely discuss their health problems with you? Yes/no

  If not, why?

- Do you think that the cost of treatment in your health care centre is well justified? Yes/no

  If yes, how? If not, why?

4. Type and amount of medical treatment provided in your health centre (CS)
   - How many normal deliveries occur per week in your institution?
   - How many caesarean sections done in this health care centre per week?
   - Did all women, who had caesarean section, have complication that led you to do CS?
   - 'Some women go for CS without any reason of pregnancy complication or illness'- in your opinion what are the factors that lead them going for CS without any complication? (fear of delivery pain/ social status/just a personal choice/influence from health providers or others)
   - Do you think any other reason except pregnancy/delivery complication should be reason for CS? Yes/no

     If yes, why? If no, why?

5. Perception of motherhood
   - 'Motherhood' is very highly respected in society and in all religion':
     - Are you aware of this statement
     - Do you agree with this statement? Yes/No.

     If Yes, why? If No, why?

   - As a health care provider, how do you perceive 'motherhood'? (Nothing in particular because it is a part of nature/it's a fulfilment of women's life/ it's respected and should be respected)
   - When you render health care service to the women, do you think your perception of motherhood is properly reflected in your service?

## Appendix 3: Brief questionnaire with letter of request

Dear Sir/madam

*Salam* and greetings.

My name is Sanzida Akhter. I am a Ph.D student in Flinders University, Australia. In Bangladesh, I work as Assistant Professor in the Department of Women and Gender Studies, University of Dhaka. My Ph.D topic is 'Maternal Health Care Seeking Behaviour of Women from Lower and Upper Socio-Economic Groups of Dhaka, Bangladesh – Fear or Fashion?' In this research, I would like to explain the socio-cultural factors that are associated with the health care seeking behaviour of women, who have suffered or are suffering from maternal morbidity in upper middle class and poor class households of Dhaka city.

The purpose of this letter is to identify the households where there is any woman who has become pregnant and/or delivered child in the last 5 years. After identifying the households, with your permission, I would like to come and do an interview with that woman. The purpose of the interview will be to know the socio-economic background of the interviewee women, their experience with pregnancy and child delivery and related health care, morbidity (if any happened) and related health care etc.

Please note that a **letter of introduction from my supervisor, an information sheet** is attached with this letter. After going through all those documents, if you agree to participate in the in-depth interview with me, you will be given a consent form to sign it.

Could you please now answer the following questions (please circle the answer)

1. Name ..... …….. Address.....
2. Has any woman in this house had any pregnancy and/or child delivery during the last 5 years?

Yes No

3. If yes, has she had any complication during pregnancy, during delivery and/or after childbirth.

   Yes No

4. Are you happy to spend a couple of hours for me for an in-depth interview?

   Yes No
5. If yes, please mention your convenient time and date, when I can come and do the interview

   Date..... time.....

   Please note that I am attaching a returned envelop with this letter. If you please return the question-answer part in this envelop to the following address, I will be ever grateful to you.

   Sanzida Akhter
   (researcher's address)

   For any further query, please call me at .... (researcher's contact number)

   Thank you very much for your kind support

# Appendix 4: Consent forms

## Consent form for respondent mothers

Maternal Health Care Seeking Behaviour of Women from Lower and Upper Socio-Economic Groups of Dhaka, Bangladesh – Fear or Fashion?

I ….....

aged ..... years hereby consent to participate as requested in the in-depth interview for the research project on 'Health Care Seeking Behaviour of Women with Maternal Morbidity in Dhaka, Bangladesh'

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to audio recording of my information and participation.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:
    - may not directly benefit from taking part in this research.
    - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
    - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
    - Whether I participate or not, or withdraw after participating, will have no effect on any treatment or service that is being provided to me.
    - I may ask that the recording be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.
6. I agree/do not agree to the tape/transcript being made available to other researchers who are not members of this research team, but who are judged by the research team to be doing related research, on condition that my identity is not revealed.
7. I have had the opportunity to discuss taking part in this research with a family member or friend.

**Participant's signature/thumb impression ……**

**Date……...**

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

**Researcher's name…….…….....**

**Researcher's signature……..Date…….**

**Researcher's signature……..Date…….**

*NB: Two signed copies should be obtained. The copy retained by the researcher may then be used for authorisation of Items 8 and 9, as appropriate.*

8. I, the participant whose signature appears below, have read a transcript of my participation and agree to its use by the researcher as explained.

**Participant's signature/ thumb impression……Date……...**

9. I, the participant whose signature appears below, have read the researcher's report and agree to the publication of my information as reported.

**Participant's signature/ thumb impression ……Date……...**

## Consent form for respondent mothers (translated into Bengali)

আমি .....

এই গবেষকের অনুরোধে তাঁর 'ঢাকা শহরে মাতৃত্ব জনিত সেবা গ্রহণ সংক্রান্ত আচরণ' শীর্ষক উচ্চতর গবেষণা কর্মের উপাত্ত সংগ্রহের নিমিত্তে তাঁর পরিচালিত 'নিবিড় সাক্ষাৎকার' এ অংশ গ্রহনে সম্মতি জ্ঞাপন করছি।

উল্লেখ্য আমার বয়স ১৮ বছর এর বেশি এবং আমি নিম্নলিখিত বিষয় গুলো জ্ঞাত হয়ে সচেতন ভাবে এই সম্মতি প্রদান করছি।

১। বিস্তারিত গবেষণা পদ্ধতি এবং এর সাথে জড়িত ঝুঁকি সমুহ আমাকে বাখ্যা করে হয়েছে।

২। আমার প্রদত্ত তথ্য এবং সাক্ষাৎকার এর অডিও রেকর্ডে আমি সম্মত I

৩। আমি জ্ঞাত যে আমাকে প্রদত্ত তথ্য-পত্র ও সম্মতি পত্র আমি ভবিষ্যৎ রেফেরেন্সের জন্য রেখে দেব।

৪। আমি জ্ঞাত যে

- এই গবেষণা কর্ম থেকে আমি সরাসরি উপকৃত না ও হতে পারি।
- আমি যে কোন সময় সাক্ষাৎকার বর্জন করতে পারি এবং যে কোন প্রশ্নের উত্তর দিতে অস্বীকৃতি জানাতে পারি।
- এই সাক্ষাৎকারে সংগৃহীত তথ্য থেকে যদি কোন প্রকাশনা হয়, সেখানে আমার বাক্তিগত পরিচয় অপ্রকাশিত থাকবে।
- এই সাক্ষাতকারে আমার অংশগ্রহন করা বা না করা, অংশগ্রহন থেকে নিজেকে সরিয়ে নেয়া আমার কোন অসুবিধা র কারন হবে না।
- সাক্ষাৎকার গ্রহনের যে কোন সময়ে আমি অডিও রেকর্ড বন্ধ করতে বলতে পারি অথবা সাক্ষাৎকার চলাকালীন যে কোন সময় আমি সাক্ষাৎকার বন্ধ করতে বলতে পারি।

৫। যারা এই গবেষণা দল এর সদস্য নয় কিন্তু যারা একই বিষয়ে গবেষণা করছে বলে এই গবেষক মনে করেন, তাদের এই শর্তে অডিও রেকর্ড/তথ্য ব্যবহার করতে সম্মতি/অসম্মতি দিচ্ছি যে আমার কোন বাক্তিগত তথ্য/পরিচয় প্রকাশিত হবেনা।

৬। আমার পরিবারের সদস্য বা বন্ধু র সামনে এই গবেষণা কর্ম নিয়ে আলোচনা করবার সুযোগ হয়েছে।

**অংশগ্রহণকারীর সাক্ষর/টিপসই……তারিখ……...**

আমি স্বীকার করছি যে আমি এই অংশগ্রহণকারী কে আমার গবেষণা প্রকল্প টি বুঝিয়ে বলেছি। আমি বুঝেছি যে অংশগ্রহনকারী তাঁর করনীয় বুঝতে পেরেছেন এবং অনশগ্রহনে সম্পূর্ণ সম্মতি প্রদান করেছেন।

**গবেষকের নাম/ সাক্ষর …….....**

## Consent form for health care providers

I …..... aged ..... years hereby consent to participate as requested in the in-depth interview for the research project on Health Care Seeking Behaviour of Women with Maternal Morbidity in Bangladesh

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to audio recording of my information and participation.
4. . I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:

    - I may not directly benefit from taking part in this research.
    - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
    - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
    - Whether I participate or not, or withdraw after participating, will have no effect on any treatment or service that is being provided to me.
    - I may ask that the recording/observation be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.

I agree/do not agree to the tape/transcript being made available to other researchers who are not members of this research team, but who are judged by the research team to be doing related research, on condition that my identity is not revealed.

**Participant's signature/thumb impression……Date……...**

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

**Researcher's name…….…….....**

*NB: Two signed copies should be obtained. The copy retained by the researcher may then be used for authorisation of Items 8 and 9, as appropriate.*

# Appendix 5: Information sheet

## Information Sheet (for mothers)

Maternal Health Care Seeking Behaviour of Women from Lower and Upper Socio-Economic Groups of Dhaka, Bangladesh – Fear or Fashion?

**Investigator:**
Sanzida Akhter
Ph.D researcher
School of the Environment
Flinders University, Adelaide, Australia
Ph: + 61 421 176778
And
Assistant Professor
Department of Women and Gender Studies
University of Dhaka
Ph: +88 01711082211

**Description of the study:**
This study is part of the Ph.D research project entitled 'Health Care Seeking Behaviour of Women with Maternal Morbidity in Dhaka, Bangladesh'. This project will investigate the factors that determine the health care seeking behaviour of women who are suffering from any maternal illness in poor class and upper middle class households of Dhaka city. This project is supported by Flinders University, Adelaide, Australia.

**Purpose of the study:**
This project has the following objectives.

1. To identify and analyze the factors influencing maternal morbidity among the upper middle class and poor women of Dhaka.

2. To analyze the factors that facilitate or hinder access to and success in obtaining health care by women with maternal morbidity.

3. To analyze the socio-cultural, economic and structural factors within the health facilities that influence the health service providers to render satisfactory health service to the women seeking health care for their maternal morbidity.

4. To unfold the gap between the perception of 'motherhood' and practice regarding maternal health care, for the mothers and their families and for the health care providers.

5. To explain the perception of women from poor and upper middle class households and that of health care providers regarding the type and amount of medical treatment in relation to pregnancy and childbirth.

**What will I be asked to do?**
You are invited to attend a one-on-one in-depth interview with the principal researcher who will ask you a few questions about your demographic, social and economic background information, the detail of your pregnancy, child delivery and post delivery information, any perceived and experienced obstacles against health care seeking for maternal morbidity, the perception and experience of treatment received from health centre in terms of quantity, quality and level of satisfaction; your perception and experience regarding the amount of treatment you received during pregnancy or delivery; your perception of 'motherhood' in relation to maternal health. The interview will take about 2 hours. The interview will be recorded using a digital voice recorder to help with looking at the results. Once recorded, the interview will be transcribed (typed-up) and stored as a computer file. This is voluntary.

**What benefit will I gain from being involved in this study?**
The sharing of your experiences will help find some important factors that influence the health seeking behaviour for maternal health in urban Bangladesh. The information, that will come up from the interview will help improve the planning and delivery of future maternal health care program in Bangladesh.

**Will I be identifiable by being involved in this study?**
We do not need your name and you will be anonymous. Once the interview has been typed-up and saved as a file, the voice file will then be destroyed. Any identifying information will be removed and the typed-up file stored on a password protected computer that only the principal researcher will have access to. Your comments will not be linked directly to you.

**Are there any risks or discomforts if I am involved?**
The investigator anticipates few and low risks from your involvement in this study, like disclosure of personal health problems, time risk etc. If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the investigator. To avoid discomfort of talking to an outsider, you are welcome to join the interview in presence of any family members with whom you are comfortable with. However, if any risk to your anonymity or confidentiality is perceived, I will ask any present family member to keep the interview confidential. But if the incidental person happens to be someone in the presence of whom you are not comfortable to talk, then I will explain the research objectives to this incidental person and request him/her to leave the place so that the interview runs smoothly. Even after that, if the incidental involvement of anybody cannot be avoided, I will propose you to stop interview to avoid the risk of any loss of anonymity and confidentiality.

**How do I agree to participate?**

Participation is voluntary. You may answer 'no comment' or refuse to answer any question and you are free to withdraw from the interview at any time without effect or consequences. A consent form accompanies this information sheet. If you agree to participate please read and sign the form.

**How will I receive feedback?**

Outcomes from the project will be summarised and given to you by the researcher if you would like to see them.

**Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.**

## Information Sheet for mothers (translated into Bangla)

গবেষকঃ
সানজীদা আখতার
পিএইচ ডি গবেষক
স্কুল অব Environment
ফ্লিন্ডারস বিশ্ববিদ্যালয়, অ্যাডেলেইড, অস্ট্রেলিয়া
ফোনঃ + ৬১ ৪২১ ১৭৬ ৭৭৮
এবং
সহকারী অধ্যাপক
উইমেন অ্যান্ড জেন্ডার স্টাডিস বিভাগ
ঢাকা বিশ্ববিদ্যালয়, ঢাকা, বাংলাদেশ
ফোন: +৮৮ ০১৭১১০৮২২১১

### গবেষণা বর্ণনা

এই পি এইচ ডি গবেষণা র শিরোনাম 'ঢাকা শহরে মাতৃত্ব জনিত অসুস্থতায় সেবা গ্রহণ সংক্রান্ত আচরণ'। ঢাকা শহরের অতি দরিদ্র শ্রেণী এবং উচ্চ মধ্যবিত্ত পরিবারের মায়েদের মাতৃত্ব জনিত অসুস্থতার চিকিৎসা সেবা গ্রহনের ক্ষেত্রে যে বিষয় গুলো নির্ধারক হিসেবে কাজ করে সেগুলো বিশ্লেষণ করা এই গবেশনার উদ্দেশ্য। ফ্লিন্ডারস বিশ্ববিদ্যালয় এই গবেষণা টি আর্থিক ভাবে সহযোগিতা প্রদান করছে।

### গবেষনার উদ্দেশ্য

এই গবেষনার উদ্দেশ্য গুলো নিম্নরূপঃ

১। ঢাকা শহরে অতি দরিদ্র এবং উচ্চ মধ্যবিত্ত পরিবারের মায়েদের অসুস্থতার পিছনে যে বিষয় গুলো অবদান রাখে সেগুলো নির্ধারণ ও বিশ্লেষণ করা।
২। ঢাকা শহরের অতি দরিদ্র শ্রেণী এবং উচ্চ মধ্যবিত্ত শ্রেনীর মায়েদের মাতৃত্ব জনিত স্বাস্থ্য সেবা গ্রহণের ক্ষেত্রে যে বিষয় গুলো নিয়ামক বা অন্তরায় হিসেবে কাজ করে সে গুলো বিশ্লেষণ করা।

৩। মাতৃত্ব জনিত অসুস্থতায় সন্তোষ জনক স্বাস্থ্যসেবা প্রদানের ক্ষেত্রে যে আর্থ-সামাজিক, সংস্কৃতিক, অবকাঠামো গত বিষয় গুলো স্বাস্থ্য সেবা প্রদান কারী ব্যক্তি বা প্রতিষ্ঠানের বেলায় গুরুত্ব পূর্ণ নিয়ামক হিসেবে কাজ করে সে গুলো বিশ্লেষণ করা।

৪। 'মাতৃত্ব' সম্পর্কে সমাজে বিরাজমান দৃষ্টি ভঙ্গি এবং মাতৃত্ব জনিত প্রদেয় স্বাস্থ্য সেবা- এ দুই এর মধ্যে যে গ্যাপ রয়েছে সে সম্পর্কে মা, তার পরিবার ও স্বাস্থ্য সেবা প্রদান কারী প্রতিষ্ঠান গুলো মতামত ও দৃষ্টি ভঙ্গি বিশ্লেষণ করা।

৫। আধুনিক চিকিৎসা ব্যবস্থায় গর্ভধারন ও সন্তান জন্মদান সংক্রান্ত চিকিৎসার ধরণ ও পরিমাণ সম্পর্কে উচ্চ মধ্যবিত্ত এবং নিম্নবিত্ত পরিবারের মায়েদের ধারনা ও অভিজ্ঞতা, একই বিষয় সম্পর্কে তাদের পরিবারের সদস্যদের এবং স্বাস্থ্যসেবা প্রদানকারী দের ধারনা ও অভিজ্ঞতা বিশ্লেষণ করা।

### আপনাকে যা করতে হবে...

আপনাকে আমি একটি নিবিড় সাখাৎকারে আমন্ত্রন জানাচ্ছি। এই সাক্ষাতকারে আপনাকে কয়েকটি বিষয় নিয়ে প্রশ্ন করা হবে। যেমন; আপনার সামাজিক, অর্থনৈতিক এবং ডেমোগ্রাফিক তথ্য, আপনার গর্ভ ধারণ ও সন্তান জন্মদান বিষয়ক তথ্য, মাতৃস্বাস্থ্য চিকিৎসা কেন্দ্র চিকিৎসা গ্রহণ সংক্রান্ত কোন সুবিধা/অসুবিধা, 'মাতৃত্ব' এর ধারনা এবং এই ধারনা র আলোকে মাতৃ সাস্থসেবা বিষয়ে আপনার মতামত, আধুনিক চিকিৎসা ব্যবস্থায় মাতৃ স্বাস্থ্য সংক্রান্ত চিকিৎসার ধরন ও পরিমাণ নিয়ে আপনার মতামত ও অভিজ্ঞতা। সম্পূর্ণ সাখাতকার গ্রহনে আনুমানিক ২ ঘন্টা সময় প্রয়োজন হতে পারে। সম্পূর্ণ সাখাতকার টি অডিও রেকর্ড করা হবে। পরবর্তীতে অডিও রেকর্ড টি লিখিত রূপে রুপান্তর করে গবেষকের একান্ত বাক্তিগত কম্পিউটার ফাইল এ রাখা হবে। এই সাক্ষাতকারে আপনার অংশগ্রহন সম্পূর্ণ ঐচ্ছিক।

**এই গবেষণা সাক্ষাতকারে অংশগ্রহন করে আপনার লাভ**

এই সাক্ষাতকারের মাধ্যমে প্রাপ্ত আপনার তথ্য গুলোর বিশ্লেষণ থেকে এমন কিছু বিষয় বেরিয়ে াস্তে পারে যে গুলো ঢাকা শহরে মাতৃত্ব জনিত অসুস্থতায় সেবা গ্রহণ সংক্রান্ত আচরণ ব্যখ্যয় গরুত্বপুরন অবদান রাখতে পারে। প্রাপ্ত তথ্য গুলো, বাংলাদেশের মাতৃস্বাস্থ্য সেবার মা উন্নয়নে অবদান রাখবে।

**আপনার নাম ও পরিচয় কি প্রকাশিত হবে?**

এই গবেষণার কোথাও আপনার বাক্তিগত পরিচয় প্রকাশিত হবে না। সাক্ষাৎকার অডিও রেকর্ড হয়ে যাবার পর তা লিখিত রূপে রুপান্তর করা হবে। সাক্ষাৎকারে প্রকাশিত যে কোন ব্যক্তিগত পরিচয় অপ্রকাশিত থাকবে। সাক্ষাৎকারের লিখিত রূপ গবেষকের ব্যক্তিগত ফাইল এ পাস ওয়ার্ড সংরক্ষিত থাকবে।

**এই গবেষণায় আপনার কোন ঝুঁকি বা অসুবিধা আছে?**

এই গবেষণায় অংশগ্রহন কারী হিসেবে আপনার সামান্য কিছু অসুবিধার ঝুঁকি থাকতে পারে। যেমন; ব্যক্তিগত স্বাস্থ্য ও পারিবারিক বিষয়ের প্রকাশ, কাজের সময় ক্ষেপণ ইত্যাদি। এ বিষয় গুলো নিয়ে যদি আপনার কোন জিজ্ঞাসা থাকে, তবে এই গবেষকের সাথে বিনা সংকোচে আলোচনা করতে পারেন।

**সম্মানী:**

আপনাকে এই সাক্ষাৎকারে অংশগ্রহন করে আপনার মুল্যবান সময় ব্যয় করার জন্য আপনাকে ৩০০ টাকা সম্মানী হিসেবে প্রদান করা হবে।

**আপনি কেন এবং কিভাবে গবেষণায় অংশগ্রহন করতে সম্মত হবেন?**

এই গবেষণায় আপনার অংশগ্রহন সম্পূর্ণ ঐচ্ছিক। এই সাক্ষাৎকারে আপনি যে কোন প্রশ্নের জবাব দিতে অসম্মত হতে পারেন, যে কোন সময় সাক্ষাৎকার বর্জন করতে পারেন। এর সাথে একটি সম্মতি পত্র সংযুক্ত রয়েছে। আপনি যদি এই সাক্ষাৎকারে সদয় সম্মত হন, তবে দয়া করে সম্মতি পত্রে স্বাক্ষর করুন।

**আপনি কিভাবে গবেষণার ফিডব্যাক পেতে পারেন?**

এই গবেষণার ফলাফল সারমর্ম করে আপনাকে দেয়া হবে, যদি আপনি চান।

সময় করে এই তথ্যপত্রের বিস্তারিত পড়বার জন্য আপনাকে অশেষ ধন্যবাদ এবং আশা করছি আপনি দয়া করে সাক্ষাৎকারে অংশগ্রহন করতে সদয় সম্মতি জ্ঞাপন করবেন।

## Information Sheet for health care providers

### Maternal Health Care Seeking Behaviour of Women from Lower and Upper Socio-Economic Groups of Dhaka, Bangladesh – Fear or Fashion?

**Investigator:**
Sanzida Akhter
Ph.D researcher
School of the Environment
Flinders University, Adelaide, Australia
Ph: + 61 421 176778
And
Assistant Professor
Department of Women and Gender Studies
University of Dhaka
Ph: +88 01711082211

**Description of the study:**
This study is part of the Ph.D research project entitled 'Health Care Seeking Behaviour of Women with Maternal Morbidity in Dhaka, Bangladesh'. This project will investigate the factors that determine the health care seeking behaviour of women who are suffering from any illness, which have been caused or aggravated by pregnancy and/or childbirth. This study will cover both the poorer and richer households. . This project is supported by Flinders University, Adelaide, Australia.

**Purpose of the study:**
This project has the following objectives.

1. To identify and analyze the factors influencing maternal morbidity among the upper middle class and poor women of Dhaka.

2. To analyze the factors that facilitate or hinder access to and success in obtaining health care by women with maternal morbidity.

3. To analyze the socio-cultural, economic and structural factors within the health facilities that influence the health service providers to render satisfactory health service to the women seeking health care for their maternal morbidity.

4. To unfold the gap between the perception of 'motherhood' and practice regarding maternal health care, for the mothers and their families and for the health care providers.
5. To explain the perception of women from poor and upper middle class households and that of health care providers regarding the type and amount of medical treatment in relation to pregnancy and childbirth.

**What will I be asked to do?**
You are invited to attend a one-on-one in-depth interview with the principal researcher who will ask you a few questions regarding your opinion of the structure and logistic

support in the health centre for providing health service for maternal morbidity, referral system, your opinion on pattern of relationship between patient and health providers, your perception regarding quantity and quality of treatment providing to the patient, your perception regarding motherhood in relation to maternal health care. The interview will take about 1hour. The interview will be recorded using a digital voice recorder to help with looking at the results. Once recorded, the interview will be transcribed (typed-up) and stored as a computer file. This is voluntary.

**What benefit will I gain from being involved in this study?**
The sharing of your experiences will help find some important factors that influence the health seeking behaviour for maternal health in urban Bangladesh. The information, that will come up from the interview will help improve the planning and delivery of future maternal health care program in Bangladesh.

**Will I be identifiable by being involved in this study?**
We do not need your name and you will be anonymous. Once the interview has been typed-up and saved as a file, the voice file will then be destroyed. Any identifying information will be removed and the typed-up file stored on a password protected computer that only the principal researcher will have access to. Your comments will not be linked directly to you.

**Are there any risks or discomforts if I am involved?**
The investigator anticipates few and low risks from your involvement in this study, like disclosure of confidential institutional issues, time risk etc. If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the investigator.

**How do I agree to participate?**
Participation is voluntary. You may answer 'no comment' or refuse to answer any question and you are free to withdraw from the interview at any time without effect or consequences. A consent form accompanies this information sheet. If you agree to participate please read and sign the form.

**How will I receive feedback?**
Outcomes from the project will be summarized and given to you by the researcher if you would like to see them.

**Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.**

# Appendix 6: Letter of introduction

## Letter of introduction

Dear Sir/Madam

This letter is to introduce Ms. Sanzida Akhter who is a PhD student in the School of the Environment, Flinders University. She will produce her student card, which carries a photograph, as proof of identity. She is undertaking research leading to the production of a thesis, or other publications, on the subject of Maternal Health Care Seeking Behaviour of Women from Lower and Upper Socio-Economic Groups of Dhaka, Bangladesh – Fear or Fashion?

She would be most grateful if you would volunteer to assist in this project, by granting an interview, completing a questionnaire, agreeing to observation which covers certain aspects of this topic. No more than two hours of your time would be required to complete the interview.

Be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting thesis, report or other publications. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.

She intends to make a tape recording of the interview, she will seek your consent, on the attached form, to record the interview, to use the recording or a transcription in preparing the thesis, report or other publications, on condition that your name or identity is not revealed, and to make the recording available to other researchers on the same conditions. It may be necessary to make the recording available to secretarial assistants for transcription, in which case you may be assured that such persons will be advised of the requirement that your name or identity not be revealed and that the confidentiality of the material is respected and maintained.

You will, if you wish be able to view your responses after the interview is completed. A copy of the summary of findings of the study will be available when completed and you will be welcome to read the same.

Any enquiries you may have concerning this project should be directed to me at the address given above or by telephone on Telephone: (+61 8) 8201 2429, Fax: (+61 8) 8201 3521 or Email: gour.dasvarma@flinders.edu.au

Thank you for your attention and assistance.

Yours sincerely

Dr. Gouranga Dasvarma

**Associate Professor in Population Studies**

**Principal Supervisor of Sanzida Akhter**

## Letter of introduction (translated into Bangla

জনাব,

শুভেচ্ছা নিবেন। এই পত্রের মাধ্যমে আমি অস্ট্রেলিয়া র ফ্লিন্ডারস বিশ্ববিদ্যালয়,এর শিক্ষার্থী গবেষক সানজীদা আখতারকে আপনার কাছে উপস্থিত করছি। তিনি তাঁর স্টুডেন্ট কার্ড টি আপনার কাছে তাঁর পরিচয় এর প্রমাণ হিসেবে ব্যবহার করবেন। সানজীদা আখতার 'ঢাকা শহরে মাতৃত্ব জনিত অসুস্থতায় সেবা গ্রহণ সংক্রান্ত আচরণ' শীর্ষক একটি পিএইচডি গবেষণা করছেন। এই গবেষণার ফলাফল একটি থিসিস এবং একাডেমিক প্রবন্ধ হিসেবে প্রকাশিত হবে। গবেষক এই গবেষণার উপাত্ত ও তথ্য সংগ্রহের জন্য নিবিড় সাক্ষাৎকার পদ্ধতি অবলম্বন করবেন। আমি আপনাকে এই পত্রের মাধ্যমে উক্ত সাক্ষাৎকারে অংশগ্রহনের জন্য সবিনয় অনুরোধ করছি। এই গবেষণায় আপনার সদয় ও স্বতঃস্ফূর্ত অংশগ্রহন আমাদের কে

আপনার কাছে চির কৃতজ্ঞ করবে। সম্পূর্ণ সাক্ষাৎকারে আনুমানিক ২ ঘন্টা সময় ব্যয় হবে।

আপনাকে এই পত্রের মাধ্যমে আর ও নিশ্চয়তা প্রদান করছি যে, এই সাক্ষাৎকারে প্রদত্ত আপনার যে কোন ব্যক্তিগত তথ্য গোপনীয় থাকবে, এই গবেষণায় অংশ নেয়া কোন ব্যক্তির নাম,পরিচয় ও ব্যক্তিগত তথ্য গবেষণা প্রবন্ধ বা থিসিসে প্রকাশিত হবেনা। আপনাকে আরও নিশ্চয়তা প্রদান করছি যে সাক্ষাৎকার চলাকালীন যে কোন সময় আপনি সাক্ষাৎকার বর্জন করতে পারেন বা যে কোন প্রশ্নের উত্তর দিতে অস্বীকৃতি জানাতে পারেন।

সানজীদা আখতার এই সাক্ষাৎকার টি টেপ রেকর্ডিং করবেন। টেপ রেকর্ডিং করার জন্য এবং প্রাপ্ত তথ্য গুলো গবেষণা থিসিস বা প্রবন্ধে প্রকাশের জন্য আপনার সদয় সম্মতি প্রার্থনা করে এই পত্রের সাথে একটি সম্মতি পত্র সংযুক্ত করা হল। আপনার ব্যক্তিগত নাম পরিচয় কোথাও ব্যবহৃত বা প্রকাশিত হবে না, এই শর্তে আপনাকে সম্মতি পত্রে স্বাক্ষর করার জন্য আমি বিনীত অনুরোধ করছি। যদি রেকর্ডকৃত সাক্ষাৎকার টি ট্রান্সক্রিপ্ট করার জন্য কোন সহযোগী নিয়োগ করা হয়, তবে তাঁকেও আপনার ব্যক্তিগত নাম পরিচয় অপ্রকাশিত রাখার জন্য এবং আপনার প্রদত্ত তথ্যের সর্বচ্চ গোপনীয়তা রক্ষা করার জন্য নির্দেশনা দেয়া হবে। গবেষণার উপাত্ত সংগ্রহ শেষে গবেষক উপাত্ত ও তথ্যের একটি সারাংশ তৈরি করবেন। আপনি চাইলে যে কোন সময় লিখিত সারাংশ অথবা ফিল্ড নোট দেখতে পারেন।

এই গবেষণা বা গবেষক সম্পর্কে আপনার আর কিছু জানবার থাকলে + ৬১ ৮ ৮২০১২৪২৯ নম্বরে ফোন, অথবা + ৬১ ৮ ৮২০১৩৫২১ নম্বরে ফ্যাক্স অথবা gour.dasvarma@flinders.edu.au এই ঠিকানা য় মেইল করতে পারেন।

আপনার সহযোগিতা র জন্য আপনাকে অসংখ্য ধন্যবাদ।

আপনার বিশ্বস্ত,

ডঃ গৌর দাসবর্মা,

সহযোগী অধ্যাপক, স্কুল অব The Environment

# Appendix 7: Conference Proceedings

1. Health Care Seeking Behavior of Women with Maternal Morbidity in Dhaka, Bangladesh: Annual HRD Conference of School of International Studies, Flinders University, November, 2013.

2. Fear and fashion of modern medical treatment: Differences in health care seeking behaviour for maternal illnesses between women of lower and upper income households of Dhaka, Bangladesh, Annual HRD Conference of School of International Studies, Flinders University, November, 2013.

3. Health Care Seeking Behaviour of Women with Maternal Morbidity in Dhaka, Bangladesh, Annual Conference of Canadian Association for the Study of International Development, June, 2014.

4. Fear and fashion of modern maternal treatment: Difference in health care seeking behaviour of women for maternal morbidity in Dhaka, Bangladesh, The Australian Association of Sociology Conference, University of South Australia, November, 2014.

5. Fear and fashion of Modern treatment: Inequality in maternal health care in Dhaka, Bangladesh, International Conference of Women's Studies, Colombo, Sri Lanka, July, 2013.

6. Health Care Seeking Behavior of Women with Maternal Morbidity in Dhaka, Bangladesh: Annual HRD Conference of School of International Studies, Flinders University, November, 2013.

7. Health Care Seeking Behavior of Women with Maternal Morbidity in Dhaka, Bangladesh, Annual HRD conference, School of the Environment, November, 2014.

8. Fear and fashion of modern maternal health care – A tale of two groups of mothers of Bangladesh, 3MT thesis competition, School and Faculty round, Flinders University. July, 2013.

9. Health care seeking behaviour for maternal morbidity in Dhaka, Bangladesh: Does only money matter? Accepted for oral presentation at the 3rd Asian Population Association Conference to be held on 27-30 July 2015, Kuala Lumpur, Malaysia.