

Reproductive Healthcare in Rural Bangladesh: Socio-Economic and Cultural Perspectives of Decision-Making

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ABSTRACT

Women inhabit more than half of the entire population in Bangladesh. Rural women belong to the most deprived section of the society and go through a number of troubles including social oppression and gender inequality. Therefore, their access to the supplies of life, including reproductive health care is minimal. Most of the women in rural Bangladesh suffer from reproductive complications during whole lifetime, though reproductive health is one of the most significant facets in the life of women. Access to reproductive care is challenging for women due to existing socio-cultural, economic and environmental hindrances fabricating obstacles for women to take decisions independently. A number of studies suggest that women's socio-economic and demographic characteristics and social settings are closely related to reproductive health service. This study investigates the scenario of rural Bangladeshi women in terms of reproductive health care and their role in the decision-making process. The study has been conducted in a rural village (Majra) which is situated in a district of Bangladesh called Gopalganj. The main argument of the paper is that socio-economic and cultural factors like various social practices and shyness are the barriers for getting information regarding reproductive health care. In this regard, lack of facilities, socio-economic and environmental factors reduce women's ability to take decisions independently.

KEYWORDS: Rural Women, Reproductive Health, Contraception, Gender Inequality, Decision-Making.

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I. INTRODUCTION

As women are one of the most neglected and under privileged groups of the society, their health issues are also neglected. This occurs frequently in traditional societies especially in the rural areas. With experiences of the traditional societies, women's reproductive health complexities are one of the major health problems in Bangladesh. According to Karmakar (2005), women's health status in Bangladesh is low due to poverty. Social and cultural beliefs and practices, gender based violence, gender inequality, lack of education and inadequate health care are responsible for women's poor health as well as their reproductive health. Perry (2000) described health as a basic requirement to improve the quality of life. According to him, access to the highest standard of health is one of the fundamental rights of every human being. The socio-political and economic context of women's lives as well as their biological construction determine women's health. Having said that, women's health involves their emotional, social, spiritual and physical well-being (Navarro and Shi, 2001). Approximately 56% pregnant women and 43% of all women suffer from iron deficiency anemia (Allen, 2000). "Every year about 10 million women endure life-threatening complications during pregnancy and childbirth, sometimes leading to long term disability (WHO, 2013). And as the rate of maternal mortality is higher in rural areas, the rural women have lower access to skilled assistance during deliveries" (WHO, 2011).

Begum (2015) reviewed the six major areas about reproductive health: availability of health care services and women's socio-economic status in using them during reproductive complications, cultural interpretation of the female body, infertility and the role of reproductive technologies, etiological explanation of illness, the influence of knowledge and actors in childbirth and cultural interpretations of childbirth practices.

Many studies show the reasons of not getting biomedical health care services during reproductive complications in the non-western context. In the case of Namibia, because of unequal availability of maternal services around the country, women deprive getting maternal services (Zere et al., 2010). In Kathmandu, Nepal, decision-making power was very important for getting biomedical services among the high caste of Hindu women. Women of the group couldn't use biomedical services as they did not have any decision-making power (Brunson, 2010). Women's autonomy as well as economic status, education and costs are important factors in this regard.

The prenatal and postnatal care in Bangladesh are so poor. On the other hand, during pregnancies period and delivery time, trained personnel to assist is not available. These factors have dramatic influences on women in seeking maternal services during the reproductive complications. In this country, especially in rural areas, cultural norms and ideological beliefs are very important for seeking reproductive services. For this constructed reality, sometimes individuals' reproductive health care seeking behavior are determined by cultural and ideological assumptions. Ideologically pregnancy period is thought so normal here and C-section delivery is used as a trendy solution of giving birth. This study is an attempt to explore the socio-cultural explanation of women's decision-making power on getting reproductive health care. This study aims to depict different factors, education, employment, age, number of children, economic status etc. which have pivotal role in women's decision-making power. In this regard, the main question of the study is 'can the rural women really take the decisions on getting reproductive health care?'

II. PERSPECTIVE OF THE STUDY: DECISION MAKING AND ROLE OF WOMEN

A prominent social thinker, Pierre Bourdieu, developed his thoughts on human agency and social structure. Bourdieu tried to decline the dichotomy between structure and agency by his theory of practice. He focused three concepts like habitus, field, and capital in his theory. He presented the relationship among these concepts through an equation-

$$[(\text{Habitus}) (\text{Capital})] + \text{Field} = \text{Practice}, (\text{Bourdieu}, 1984:101)$$

It shows practice as the result of relations between (habitus)(capital) and field. Bourdieu (1977:72) refers habitus as a '*system of durable and transposable disposition*' that creates the principles of generating and structuring of individual and collective practices in the society. According to Bourdieu (1984: 243), people can utilize three types of capital: (i) economic capital- something that is immediately and directly convertible into money such as material wealth), (ii) cultural capital- educational qualifications such as creative and intellectual skills and iii) social capital- social obligations and mobility. Existing or potential resources can dispose because of their social connections or networking.

British social anthropologist Edwin Ardener in his book 'Beliefs and the Problem of Women' (1972) argues that 'the dominant group in the society generates and controls the dominant mode of expression'. He mainly focuses on power practices. Ardener further adds, "muteness is the product of the relation of dominance which existed between the dominant and sub-dominant group in the society(1972). Ardener's study shows that, men are the dominant group who have mainly produced ideas and knowledge regarding the world. As a result, the voices of women have been ignored and muted (cited in Moore, 1988:3).

In this study, Bourdieu's theory of practice has been explored to know how forms of capital of rural women in Bangladesh are using to carry out their health seeking practices and decision-making process in the healthcare field. This theory helps to analyze the social, cultural and economic context of women's experiences with reproductive health decisions. According to this theory, this study endeavored to explore the forms of capital which rural women in Bangladesh possess and how they use their capital to take decisions. And also, how the decision-making power supports them on getting their reproductive health care services in the healthcare field. How healthcare system operates in a developing country has been extracted through emphasizing on the dichotomy between wealthy people and vulnerable groups regarding health services. Developing nations deprive vulnerable and marginal groups such as working class, women and ethnic minorities. The analysis helps us to explain and makes us aware of social inequality and the role of class and gender.

Women's autonomy and decision-making process within the household are important factors which affect their reproductive healthcare. According to World Bank report, gender equality is a development objective which means to promote growth, income, reduce poverty and promote better governance (World Bank, 2011). The social position of women still needs much attention, especially in the developing world.

This study focuses on the socio-economic and cultural factors on getting reproductive healthcare of rural women and its need to understand their position and observe their decision-making power. In our study area, it is found that most of the uneducated, unemployed, and even some educated rural women play their muted role. In rural Bangladesh, it is commonly observed that men impose their power on women in decision-making; the state or government imposes their role on the state people especially women on getting reproductive health care like contraception. Foucault (1998:63) considered bio-power as a form of power which works over biological life. State practice bio-power through several institutions like family, community, educational institutions, defense, judiciary and so on. It reflects the voice "*power is everywhere and comes from everywhere so in this neither an agency nor a structure*" (Foucault, 1998:63).

The economic status varies from person to person without distinction of age, gender, class etc. and it affects the modes of livelihoods of the people in our research area. Due to poverty stricken socio-economic condition, some parents cannot give their children proper health care, education and that is why they have lack of knowledge about sexuality and reproduction. The practice of Purdah (veil) culture affects women's

reproductive health care and seeking behavior in rural areas. In the case of health seeking behavior, especially in the sector of sexuality and reproduction, most of them cannot make interaction with a doctor without the permission of their husbands. A few number of women become able to take decisions jointly with their husband on their reproductive health issues.

Reproductive health issues like menstruation, abortion, contraception are very sensitive issues for women in developing countries like Bangladesh. Most of the women in our study area feeling shy to share contraception related issues which are more related to their reproductive health. And husbands influence them in this regard. In Bangladesh, especially in rural areas, reproductive health care is a sign of cultural practice that is guided by various social norms as well as politico-economic factors. Overall, reproductive health conditions of the rural Bangladeshi women make us concerned to work on this field for our study area and this anthropological study helps us to understand the real socio-economic and cultural explanation of women's decision making power on getting reproductive health care.

III. OBJECTIVES OF THE STUDY

The broad objective of this study is to examine the association of socio-economic and cultural explanation of women's decision making power and reproductive health care. The specific objectives are summarized as – i) to understand women's knowledge of sexual and reproductive health including maternity health, birthing care, family planning, abortion, menstruation hygiene and contraception, ii) to explore socio-economic and cultural context on getting reproductive health care and iii) to find out the factors of women's decision making on getting reproductive health care.

IV. RESEARCH AREA AND METHODOLOGY

This paper is based both primary and secondary data. Fieldwork was conducted in a village named Majra located in the district of Gopalganj in Bangladesh in 2019. We found 120 households in the given village. Qualitative data were used in this study. By using purposive sampling method 20 households were selected for collecting data. We collected primary data through semi-structured interviews and two case studies from the women of the village. Focus Group Discussion (FGD) was conducted among 20 individual women dividing into 2 groups in terms education and occupation. To apprehend sexual and reproductive health, women health seeking behavior and their decision-making power, it demands to conduct such kind of intensive study with the women.

In secondary sources, we went through books, newspapers, periodicals, journals and reports. This study explored the data compiled by national and international NGOs. Additionally, we contemplated published research reports and articles while developing arguments and these sources helped us to analyze different dimensions on women's reproductive health care.

V. REPRODUCTIVE HEALTH CONCERNS OF RURAL WOMEN

The lives of women and girls have improved in the last twenty years in Bangladesh. There is a remarkable change in the reproductive sector as maternal mortality rates are declining, fertility rate is falling and gender equity in school enrollment (Ahmed, et.al, 2011). This is the macro scenario of the country's maternal health, the reproductive health service scenario of rural women in Bangladesh is different. Most of the women in rural areas they don't get proper treatment in their reproductive time. When conducting the study in a rural village in Gopalganj, it is found that the reproductive health services are very limited and also availability of some reproductive health care like- contraception, sterilization, abortion are dependent on social, cultural and religious norms.

Firstly, respondents expressed their shyness about their reproductive health issues, because they consider pregnancy, maternity health, birthing care are very normal and it goes on as a natural process in every woman's life. They are incapable to take any decision for receiving prenatal or antenatal care because in their pregnancy period their healthcare service dependent on their therapy management groups¹ or husbands.

The availability and accessibility of healthcare services determine women's health seeking behavior during reproductive illness. It is also important to look into socio-economic and cultural factors such as purdah, gender disparity and costs. The cultural interpretation of the female body, infertility, child birth and etiology of disease and the role of therapy management groups influence healthcare decision making. The WHO assessed in 2008 that "reproductive and sexual ill health accounts for 20% of the global burden of ill health for women and 14% for men" (WHO, 2008).

In the study area, most of the women have no formal education about reproductive health. They said that they can manage their pregnancy and child birth by their social and cultural knowledge. They added that they have learnt this manageable power from their past generations. In the time of pregnancy, a woman can get valuable information from elderly and aged women. The cultural interpretation of a 'perfect woman' refers someone who can manage her own pregnancy. 80% of women in the study area took their pregnancy related

suggestion from their elderly women and took help from their family members and Dais (traditional birth attendant) helped them in their delivery time. And the rest 20% of women took bio-medical services like C-section delivery from the hospitals. In this area, women who have well economic condition and formal education are willing to seek biomedical services. However, socio-economic and cultural capital influence the women for seeking biomedical practitioners. The role of husbands, mother in laws and the culture of the family influence of getting biomedical services. In this regard, it can be argued that only high economic capital can't afford biomedical services. It also depends on cultural and social capital.

In the relevant study area, women believe that infertility² and miscarriages³ are complications of the women during child birth which may happen due to 'kharap batash'⁴, 'jadu tona'⁵. In that case, women seek suggestions from their elderly women who have knowledge and experience in dealing with such illness. They also visit *Kabiraj*⁶ and *Hujur*⁷ for taking healing treatment and use *Pani Pora* and *Tabij*⁸. They seldom go hospitals for these cases.

Here, women's decision-making power on getting reproductive health care depends on their socio-cultural and economic capital and availability of health care services and biomedical health service cost.

During the FGD⁹ sessions, it was predominant that women were feeling shy to share issues relating to family planning¹⁰, abortion¹¹ and contraception¹². There are various discourses on sexual and reproductive health of women. It is thought that a girl becomes sexually naive and sexual discussions before marriage is termed as shamelessness. Most of the women are conscious about family planning but their planning becomes failed in most of the cases due to improper contraception method. Women failed to take modern contraception without their husband's permission. Some respondents use traditional contraceptive methods like rhythm, calendar rhythm, and withdrawal. In most cases, we found that women have no power and authority to express their opinions like- using contraception or abortion. In Bangladesh, the social construction is that women are considered inferior to men and men are superior. As a consequence, women become transformed into a muted group in functional programs of society. In cases of taking decisions on making abortion or using contraception, women can't take any decision and they considered as voiceless even they have no argument over others.

However, we found that, in rural Bangladesh most of the women's position is still vulnerable. They have little knowledge about their reproductive health and most of the cases they don't take any decision about their reproductive health care due to their constructed socio-cultural and economic arrangement. Here, it can be pointed out that women hardly ever speak, always the men speak".

VI. REPRODUCTIVE HEALTHCARE DECISION-MAKING: SOCIO-ECONOMIC AND CULTURAL FACTORS

Rural women and girls around the world who live below the poverty line experience restriction on getting information regarding their reproductive health services and rights of decision-making. Some of the factors regarding sexual and reproductive health rights including discrimination, stigma, traditional beliefs, restrictive laws and policies model obstacles for women accessing reproductive services. In this background, women should create the way to access sexual education that will ease them to control their body as well as health services they require. Moreover, most of the women treated as the product or the commodity in a capitalist market because they are subjected to domination by their male counterpart. Women have fewer anticipations to express themselves and raise voices, participate in familial decisions and they have limited chance to take part in public arena compared to the male counterpart. In our society and cultural practices, women are guided by their husband as well as father and brother. Even, at the final stage of life, most women are to depend on their male children. "Women usually experience discrimination in every stage of their lives. In addition, a large number of women do not have decision-making power and opportunities to move outside of the family for various purposes including healthcare services" (Afsana et.al., 2000)

In our study, we found that socio-economic and cultural factors independently associated with the reproductive health care decision-making by women (Figure 1).



Figure 1: Schematic Illustration from the Fieldwork Experience, (2019)

Through our intensive observation and frequent interviews, it is found that socio-economic and cultural characteristics have played an important role in the growth of knowledge and help to take decisions on getting women's reproductive health care.

Women's age, educational qualification, occupation, yearly income, employment, modern facilities, their geographical location of residence have been considered as the socio-economic factors related to reproductive health care and decision-making power

Approximately 75% of the respondents do not take any decision to use contraception. Here, husbands decide their contraceptive method. 20% uses contraception by mutual decision. Only 5% of economically solvent women are empowered and educated. They can easily take the decision about using contraception without their husband's concern. Women who are economically solvent they are empowered in family and take decisions about reproductive health care. They also get hold of priority on their opinion and also get facilities in taking decision on household activities. One of our respondents said-

"I am a primary school teacher and my husband is a businessman. We have two children and we are happy family. My family members ask me and take my decision in any kind of matters. My husband and me took our family planning decision jointly. He always respects my decision."

Women's education, empowerment and income make them self-dependent and confident and through this process women can hold all the power and authority to make any kind of decision on getting reproductive health care service.

The geographical location of residential area is one of the important socio-economic factors of women's reproductive health services. And this location is also related to their decision-making process. There is a huge gap between urban and rural areas regarding communication system. The urban areas are privileged getting better communication system and modern facilities. This advance communication system does women a good turn to move to the health center and easily take the services. On the other hand, village is located far away from the administrative center and the communication system and facilities are very poor. For this reason, poor women are deprived of modern reproductive health services and hence communication barriers make them unable to take a proper decision of getting biomedical health services on their reproductive health.

Treatment or health service cost, the distance of the health care service, communication system, availability of health care system and quality of care is momentous factors for women's health care decision-making process. As a consequence, illiterate and poor rural women have little opportunity to go outside from home and take proper treatment. Most of the time, the member of a poor household gives priorities to their household and spend resources rather going to the hospitals. The economic capital of the household plays an important role in women's health seeking and decision-making process. In this regard, economically solvent women can easily make decisions on her reproductive health related issues compared to the poor women.

According to political economy approach, in a capitalist society, healthcare system only benefits wealthy people who have economic solvency and deprives rural poor women.

However, gender disparity, people's perceptions, beliefs, attitudes towards women's reproductive health issues, religious and social norms have been considered as the cultural factors which are related with women's reproductive health care decision-making process. According to Nazneen (2005), gender disparity begins at the earliest stage of life, and then home plays a vital role affecting women's health. The study found that a daughter treated as an economic burden and a son as the future breadwinner. Nazneen's study fundamentally represents the whole scenario of the patriarchal society in Bangladesh.

Rural people's perception, beliefs, attitudes and purdah¹³(political weapon of superiority) hinder women's access to cosmopolitan healthcare services. Women can rarely go outside due to the practice of purdah. This practice isn't constant, this can be changed depending on the women's economic status as well as household condition (Bartocci, 1995). In this study, it is evident that some respondents were forced pregnancy and didn't allow to leave home without purdah. Women's access and ability, decision-making power are very limited. One of our respondents expressed,

"I am not allowed to leave home or go anywhere without male relative or husband. I can't take any medical treatment from male doctor during my pregnancy period for maintaining religious norms properly and practicing my purdah."

It is translucent that cultural and ideological assumptions and practices play a principle role in individual use of health care services influencing women's decision-making on reproductive health services.

VII. CONCLUSION

On the basis of the arguments placed above it can be argued that women and girls around the world especially in developing countries like Bangladesh are facing reproductive complications. Though women's knowledge about sexuality, family planning, maternity health, abortion, natal care, post-natal care is crucial for reproduction they have been remained faint. Some issues like socio-economic and cultural factors work as the influencers. Social practices and shyness are also the factors making barriers among the women and girls for knowing reproductive care. Due to shyness, girls and women do not ask anything about sexuality, family planning and abortion etc. to their elders. On the other hand, socio-economic and environmental factors reduce women's ability to take decisions independently. For this, women are not empowered properly on sexuality and other factors of reproductive care. Rural women suffer severely due to lack of proper services. Though some aspects are negotiated for family planning services, conditions have not been highlighted yet. In a nutshell, it can be concluded that major socio-economic and cultural factors must be addressed to take initiatives in order to improve women's position and find out the factors responsible to promote reproductive health care of the women in rural Bangladesh.

Notes

1. "A therapy management group may include close kin, extended kin, healthcare specialist and even the whole clan" (Janzen, 1978)
2. Infertility means inability to conceive children
3. Pregnancy loss, natural death of fetus before birth
4. The bad wind which is considered harmful for pregnant women.
5. Black magic, is used to make harm and unnecessary problems in people life.
6. Folk healer.
7. Religious leader and practitioner of Muslim.
8. Amulet
9. A research method where people are represented from different social classes to discuss a specific topic of interest.
10. Process of birth control that helps to determine the number of children based on own interest.
11. Abortion refers to the deliberate ending of a pregnancy at an early stage.
12. The deliberate use of artificial method or other techniques to prevent pregnancy as a consequence of sexual intercourse.
13. Purdah: Religious and social practice as well as physical separation of women from outsiders

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