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An Ethnography of Birth: knowledge, Authority and Decision making in Childbirth Practices in the village of Kadam Rasulpur

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Abstract

The present study, 'An Ethnography of Birth: knowledge,Authority and Decision making in Childbirth Practices in the village of Kadam Rasulpur' was undertaken in order to contribute towards a greater understanding of practices, authority and decision making of childbirth in the village of Kadam Rasulpur. Childbirth in Kadam Rasulpur is often interrelated with multi-dimensional factors such as household dynamics, socio-economic factors, and interpretation of reproductive illness, therapy management groups and so forth. women's decisions regarding place of delivery largely varies with the household economic condition, availability of male member, reproductive complication occurred during and after childbirth, nature of complication, sometimes influenced by Dais, and Shastho Sebeka. Home birth is interrelated with family's economic condition, husband's profession, and number of male members in family, Mother's age and reproductive complications during pregnancy. important factor associated with Hospital birth is reproductive complications during pregnancy and childbirth, and family's perception about the illness or disceases. In Rasulpur Child Birth is considered as Natural phenomena and expected to take place in home. However, when complication arise, which cannot be alleviated in home, People seek refuge in biomedical obstetrics or hospital birth. Roles of Shastho Shebika and Dais in decision making and consulation regarding child birth has changed significantly over time and develop a new dimension. Training programs hosted by Goverrntment and BRAC changes the perception of Dai and Shebikas about childbirth as well as, villagers perceptions about them. When Complication emerges; making decision depends on some important questions such as, what type of treatment they should seek. The whole procedure of decision-making is often time consuming which sometimes create life-threatening situation for both pregnant woman and Child in Rasulpur and consequence of delaying is Fatal and

some cases patient has to pay the ultimate price of life where often these deaths were unnecessary and easily avoidable.

Chapter One

1.1 Introduction

The intent of this study is to explore the reproductive complications, decision making process regarding place of delivery and Health seeking behaviours of pregnant women and their family members during childbirth and factors associated with it. The primary objective of the study is to understand the dynamics of childbirth in a low income and poor facilitate rural area of Bangladesh where childbirth is often interrelated with multi-dimensional factors such as household dynamics, socio-economic factors. The study is to understand women's birthing experience, factors associates with delivery places, decision making power of

women, factors that influence them to receive particular mode of treatment which affect their health seeking behaviour during childbirth. The endeavour of the study is to depict a picture of constant negotiation of women and their constant struggle against all obstacles with limited access to the resources, low mobility and low decision making authority.

The study also employs to understand the underlying factors associated with their preference for home birth than hospital birth, their perception on modern obstetrics and homebirth, also their relationship with dais, TBA (traditional birth attendants), SS (Shasta Sebeka), and hospital birth attendants such as: doctors, nurses, andAayas. The study also decision making process regarding place of delivery and Health seeking behaviours of pregnant women and their family members during childbirth and factors that influence them to receive particular mode of treatment.

In presentstudy, 'An Ethnography of Birth: knowledge, Authority and decision making in Childbirth Practices in the village of Kadam Rasulpur' there will be a presentation of the Statement of the problem, Objectives of the study, Rationale of the study, Methodology, Ethical issues in chapter one, Description and socio economic characteristics of the study area and Healthcare Facilities in chapter two, Review of the existing literature, theoretical and conceptual framework in chapter Three, Maternal Health Status in Kadam Rasulpur, complication during and after childbirth in chapter Four, Women's Experiences: Homebirth vs. Hospital birth in chapter four Decision making authority during pregnancy period about health related issue of mother in chapter Five, Types of Received Treatment during reproductive complications, factors associated with received treatment and time taken for decision making and its impact in chapter Six, and Summary and Conclusion in chapter Seven.

1.2 Statement of the problem

Bangladesh is a densely populated country, with over 164.4million people living in an area of 147 570 km2.2 on average, 1114 people live in 1 km2. The estimated annual number of births in the country is 3.4 million. The adult literacy rate in the country was 48.8% in 2008 and per capita gross national income in 2009 was $5904 per annum. Life expectancy at birth is 67 years for men and 69 years for women. (UNICEF2004).

Maternal Mortality ratio In Bangladesh is very high and a major concern for many decades, not only due to the large number of such deaths, but, also due to the traumatic after-effect of such an event on the family in particular and society in general. Very often these deaths are preventable and therefore unnecessary. The high MMR directly relates to the high perinetal (new born) mortality rate in the country. The estimated lifetime risk of dying from pregnancy and childbirth-related causes in Bangladesh is around 100 times higher than that in developed countries. The tragic consequence of these deaths is that about 75% of the babies born to these women also die within the first week of their lives. Although a high proportion of such deaths are attributed to a lack of emergency obstetric services and trained personnel, 14% of deaths of pregnant women are associated with injury and violence. Although maternal deaths continue to decline steadily, the maternal Mortality rate is still high about 194 per 100,000 live births (Ahmed et al. 1995).

The Government of Bangladesh seeks to create conditions whereby people have the opportunity to reach and maintain the highest attainable level of health. Although there has been considerable success in the health services, still more than 60% of the population do not have access to basic health. Although the total fertility rate (TFR) has dropped significantly, maternal mortality ratio remains high – the latest national data shows it to be around 194 per 100,000 live births. One of the underlying factors leading to poor maternal situation in Bangladesh is that a very Low percentage of women actually seek professional medical assistance for pregnancy related Care, deliveries and complications. Only 7.9% deliveries take place in the health facilities and only 5% of the expected complications seek services of static health facilities (Ahmed et al. 1995).

As it is well known fact that the health care facilities of Bangladesh is skewed toward urban areas, in rural areas people are left with inadequate health facilities and limited access to the essential aids for reproductive purpose. In Rural Bangladesh 90% of birth take places at home (Bangladesh Bureau of Statistics 2001). Even though not every single birth need intervention or necessitate biomedical aid, in many cases pregnant women suffers from various reproductive complications which can lead towards severe complication during pregnancy even creates life threatening condition for mother and new born. And as they live in a pluralistic setting where various kinds of health care services co-exists, different classes of people seek refuge to different types of services associated with multi-dimensional factors, which affects their decision making as well as their health care seeking behaviours sometimes push them towards fatal consequences, A multi-dimensional research framework is essential for proper understanding of the health seeking behaviours during childbirth in rural areas of Bangladesh. As without a consummate understanding it is insurmountable to change some of the indigenous practices or beliefs associated with childbirth or influence them towards safe practices regarding childbirth and to reduce the gaps between the understandings between pregnant women, their family members with health service providers.

1.3 Background of the Study

Kadam Rasulpur is low health facilitated area with only a number of dispensaries and a community clinic. The Maternal Mortality rate is quite higher than any other areas in Bangladesh. Women in Kadam Rasulpur suffered from vary diseases and illness during and after childbirth and only a few of them receive treatment. In 2013, 27 childbirth and 4 maternal death and one neo netal death is recorded. The maternal mortality rate is 778 per 100000 (source: fieldwork 2013) reflects the poor health status of pregnant women. As for the poor infrastructural condition of accommodation, economic condition and for procrastination of decision making during complication often put the lives of mothers in danger. Women in Kadam Rasulpur faced double problem than their male counter parts as the weak health care system and for being a women it is often very hard for them to seek health care outside the village or even outside their homesteads. The study is a detailed account of the overall maternal health situation in the study area (Kadam Rasulpur) where women's health is exposed to life threatening danger.

1.4 Objectives ofthe Study

The **Broad** objective of the study is, to depict an overall picture of Women's reproductive health status and decision making regarding place of childbirth in the village of Kadam Rasulpur.

And the **specific** objectives of the study are:

To observe the types of complication during and after pregnancy women suffer from.

To assess, how the socio-economic factors such as household dynamics, economic condition, occupation of husband, family status affects women's' decision to choose a place of delivery

To understand, the perception of rural pregnant women and their family member's about the hospital birth and home birth.

To observe the role of Dais and Shastho Shebika in association with the types of received treatment while complication arises during childbirth.

To observe, how time taken during decision making to choose a particular mode of treatment affects the treatment procedures.

1.5 Research Methodology

Anthropological Research aims at solving problems and investigating relationship of numerous variables that exist around us. As an investigative process, research takes places at different levels of scientific sophistications. However the process of research across different branches of knowledge varies greatly.

In a social science however anthropological research is unique, since it is informal, intensive, in depth, and all, long-term. The researcher has used several anthropological techniques/ methods of data collection for the purpose of this study. Such as:

Key informant interview
Case study
Informal interview
FGD
Questionnaires
Checklist
Field note

1.5.1 Key informant interview

As a main source of data collection key informant interview technique was followed for the purpose of data collection. Kulsum Begum a 32 yrs. old Shastho Sebeka from BRAC's MNCH project was selected as key informant for following reasons:
She had work experience and easy access to the households in the village.

As she works as a Shastho Sebeka, she had daily interaction with the pregnant women and their household members as well as with TBAs and some of the Hospital birth attendants.

She has all the recent records of childbirth statistics of the village.

To gain easy access to the pregnant women and her family.

1.5.2 Informal Interview

Informal interview had been used as another great source of data collection for the study. As from informal interview some important information such as types of illness, treatment procedures, socio-economic factors associated with the health seeking behaviours and other information regarding childbirth are collected from pregnant mothers and their household members.

1.5.3 Case study method:

Case study method was one of the most important source of data collection for this research as it provide some substantial amount of important information within the timeframe relevant to the topics. Many vague conceptions, practices and beliefs, factors and their consequences were acquired from case study method.

1.5.4 Check list:

Checklist was used along with other methods of data collection for the purpose of remembering and asking the relevant, important, essential issues regarding childbirth practices.

1.5.5 Field Notes:

Field notes were used to keep record of those interviews recorded and conducted with informants. Some interviews were recorded by mobile phone recording and were taken in the written not from later on. At the end of each day's fieldwork, important discussions were written down in the notebook in summarised form.

1.5.6 Questionnaire:
A set of questions were filled for each interviewee for obtaining statistically useful and personal information from individuals for the study.

1.5.7 Focus group discussion:
Two FGDs consists of 8 women were gathered to discuss a specific topic of interest. The group of participants was introduced topics for discussion and to participate in a lively and natural discussion amongst themselves which allowed the participants to agree or disagree with each other so that it provides an insight into how a group thinks about an issue, about the range of opinion and ideas, and the inconsistencies and variation that exists in that particular community in terms of beliefs and their experiences and practices.

1.5.8 Sources of data collection:

In this research data were collected from different sources. But all these sources can be grouped into two sources:
I. Primary sources:
The data collected from the study area through key informant interviews, Questionnaires, surveys, observations, case studies and focused group discussions.

ii. Secondary Sources:
Different books, newspapers, periodicals research works library scientific and research journals, and several other reports of development agencies were taken as secondary sources of information to know the state of the art. These were considered as indirect or secondary sources in the present work.
Both primary and secondary sources of data have been used for the purpose of the study.
Tools of data Collection:
For the purpose of the study different tools were used to collect data. These include-
Notepads
Diary
Pen
Field note
Jot book
Computers
Tape recorders
Cameras

1.6 Rationale of the study

1. The study provides a synthesis and critical analysis about the existing literature on the topic about which little of systematic nature has been written.
2. This study examines the topic more thoroughly and will fill the gap in the existing literature. It will contribute to the further
3. The study reveals the experiences of pregnant mothers and their family members in both types of birth situation: Home and Hospital.

1.7 Limitation of the study:

There were some limitations during the data collection procedure were noticed. Such as:
Even though anthropological study requires long time participation and observation the research was conducted within a short period of time (10 days). Due to several unavoidable reasons, short time range the present study could not get sufficient time with the respondents that could make the research more valid. So, because of the shortage of time and resources the study has been carried out only on limited number of respondents.

During the fieldwork the respondents at first have treated the researcher as a journalist and NGO as well as government employee. That's why they were very reluctant to participate and aware about what they are sharing, but after they got convinced with the researches identity, they confided in him.

Lack of Cooperation between the interviewers and respondents as childbirth is a very sensitive issue and for a male researcher it is very difficult to gain women's confident for various reasons.

There were misunderstanding and suspicion between interviewer and respondents as the respondents were unwilling and suspicious to talk about their personal issues related with the present research.

There were tendencies of the respondents to conceal information especially regarding social status, health related problems and decision making.

These are the mentionable limitations of the study. However throughout the study all efforts were made to remain totally objective and sincere to the research.

1.8 Ethical concerns:

Some ethical issues were being considered during the fieldwork such as:

Every interviewee was explained about the purpose of the study and the intension of the researcher was explained clearly for reducing misunderstanding and hostility between researcher and informants.

No picture of any pregnant women was taken as there is a strong restriction of purdah.

Informants were asked before recording their statement and only after having their consent, interviews were recorded.

As village women usually reluctant and often forbidden to share any information about health related issues with strangers especially male, no direct questions were asked without the presence of the key informant and most of the time questions were asked by the key informant.

No direct questions about social status or other economic status were asked which could be offending to them

Chapter Two

2.1 Review of Existing literature

B Kothari, M.L & Mehta, L.A (1988) in their study, *'' violence in modern medicine''* argues, the tremendous costs of hospital services are a heartrending experience that rural, poor families face in seeking hospital obstetric care. The suddenness of expenditures put appalling demands on poor families, which they

refer to as '' Fiscal Violence'' (page.181). The combination of hospital costs and procedure on the one hand and the circumstances of poverty, on the other make rural women vulnerable to the fiscal violence of modern biomedical treatment. Paying unofficial fees is evident in many hospitals across Bangladesh and India (Chowdhury, Mahbub&Chowdhury, 2002; Jeffery & Jeffery & Lyon, 1989; Leppard, 2000). Rose-Ackerman (1999) argues that it is the self-interest or greed that provokes individuals or groups to become involved in corruption. The poor, salaried staff are a vulnerable group who are easily bribed, but corrupt practices also serve the interests of high-level officials **(Source: Rose- Ackerman, 1978)**

Sibley L, Sipe TA, Koblinsky M in their study, *'Does traditional birth attendant training improve referral of women with obstetric complications: a review of the evidence'***'**, review the effectiveness of traditional birth attendant (TBA) training to improve access to skilled birth attendance for obstetric emergencies produced mixed results. Among 16 studies that fit the inclusion criteria, there is a medium, positive, non-significant association between training and TBA knowledge of risk factors and conditions requiring referral; and small, positive, significant associations between TBA referral behaviour and maternal service use. These results cannot be causally attributed to TBA training because of the overall quality of studies; moreover, in several studies TBA training was a component of integrated intervention packages. The effort and expense of more rigorous research focusing on TBA training to improve access to emergency obstetric care are difficult to justify. The referral process is complex; the real effects of TBA training on TBA and maternal behavior are likely to be small; and while the proportion of TBA-attended births worldwide varies, it is, on average, quite low. The behavioral determinants and logistical barriers to care seeking for emergency obstetric care are generally well known.
*''Community based health Care: Lesson from Bangladesh to Boston'',*Edited by Jon Rohde and John Wyon. The symposium brought together distinguished participants who presented a wide variety of approaches to community health and development in poor and rich countries. Many of them have participated in some of the most progressive health care experiments of the past three decades chapter on Bangladesh, by Perry, is particularly instructive; Perry helps the reader understand why Bangladesh, since it gained independence in 1971, has made so much more progress than Pakistan. Chowdhury's description of the Bangladesh Rural Advancement Committee shows how a local group was able to provide a comprehensive development package to more than a million people. Other chapters describe small-scale, innovative, community-based projects in India, Haiti, Vietnam, and Bolivia. The narratives in these chapters focus more on positive description than on critical analysis. The chapter by Valdez and Devcota, on the methodology of lot quality assurance sampling, is quite good, but it seems out of place in this collection.**(Source:http://www.nejm.org/doi/full/10.1056/NEJM200306123482425, accessed in 10th May, 2013).**

G.M. MonawarHosain, Rehana Sultana, and ShahanajePervin in their study*, 'Birth Attendants during Child Delivery in Rural Bangladesh*' Identify different categories of birth attendants and the place of child delivery of pregnant women in rural Bangladesh. According to them, although most TBAs in the GK area are trained, they are still reluctant to refer pregnant mothers to a hospital and prefer to handle the cases at the village level.

In their study, '*Quality of Birthing Care from Women's Perspective'*, Kaosar Afsana and Sabina Rashid assessed the quality of care offered to rural women during childbirth at the BRAC's Health Centre. The findings revealed that the women preferred to have home birthing, because they considered childbirth a normal and natural phenomenon. On the contrary, the women sought care from the BHC when they perceived childbirth to be complicated, and related it to illness. Fear of outside birth, notions of '*lajja'* (shame), fear of surgical instruments, issues of privacy and dignity, skills of health providers, economic constraints, distance, and power relations within home and at the Centre were mentioned by the women for their preference to use the BHC services vs. home birthing care.

Jenny Jia in her study**,** *'The Future of Dais: Traditional birth attendants and biomedical cultural change in Bangladesh'* argues that, motivation of dais was highly rooted in their perceptions of their work as helping

women in need and the respect and treatment they garnered from their local community as a result of positive local perceptions of their work. In rural Bangladesh, a woman has few opportunities to become anything besides a housewife, especially if she has no secondary education; hence, prestige is elusive for rural Bangladeshi females. Since women were not expected to gain financial value, women were free to pursue activities to generate social value. Dais also took pride in their work and abilities, which engendered a feeling of empowerment that many women in their communities never experience. Knowledge and practical experience were seen as enablers to their practice. They know the women whom they help, and it is probable that they value their relationships with their patients as fellow community members more than the small and inconsistent material benefits they gain by practicing. What they do value is the respect that they garner from their local community, and that respect is closely tied to how they perform as dais. Dais adopting biomedical birth practices, such as washing their hands before delivery and abandoning risky indigenous methods.

In the book*, 'Disciplining Birth: Power, Knowledge and Childbirth Practices in Bangladesh*', Kaosar Afsana discussed birth practices among poor, rural women in Bangladesh. She has used a multidimensional framework for the study. She draws upon ideas and perspectives from history, anthropology, gender and socio-political economy to analyse experiences of self and other, which are truly impressive. It is a pioneering study where various choices available for birthing care in the country are addressed. Ironically, the author observes that there was a certain resistance of the poor, rural women to cosmopolitan obstetrics representing: authoritative knowledge of biomedical professionals and medicalised experience of birth, interpersonal relationship of doctors and nurses with birthing women, hospital costs and unpleasant experiences of childbirth in hospitals. On the contrary they prefer to adhere to indigenous birth practices comprising of: trust and dependence on daini's skills, understanding of birth, women's embodied knowledge and active participation of birthing women and other women in birth events. The author's analysis reveals that the poor, rural women of Bangladesh opted for a more supportive environment at home, which they considered more conducive to their understanding of birth. The study highlights the role of the State in promoting medical professions and in marginalizing indigenous knowledge of birth. In order to improve birthing care for poor, rural women in Bangladesh, it is crucial to strengthen women's roles in birth events, acknowledge indigenous knowledge of birth, organise community-based programmes, reorganise hospital obstetric services, de-governmentalize the State, democratise health policy and organise support at international levels for pro-women, pro-poor obstetric care. This significant study should be of interest to policy planners, medical professionals, scholars of anthropology, gender studies and public health, feminists, social activists and NGOs working with women.**(http://www.uplbooks.com/book/disciplining-birth-power-knowledge-and-childbirth-practices-bangladesh, accessed in 15th May, 2013)**

In his book,**'** *Characteristics of traditional midwives and their beliefs and practices in rural Bangladesh'*Amin R, Khan AH.Analysed the characteristics, beliefs and practices of midwives in rural Bangladesh. The midwives were mainly above age 30, married or widowed, and illiterate. Most of them learned their midwifery from informal sources such as female relatives or neighbours. Often, during pregnancy, childbirth, and post-partum period, midwives imposed dietary restriction on the mothers. Similarly, devices used in the cutting of the umbilical cord and placenta were not properly sterilized and potentially dangerous substances were applied at the navel after cutting the umbilical cord or placenta. There was a practice of withholding breast-feeding up to 3 days after the birth of a child. However, there were also some beliefs or practices among the midwives that could be regarded as based on scientific understanding such as the practice of cutting the umbilical cord by boiled razor blade or the belief that child death could occur from tetanus caused by the unsterilized device used in the cutting of the umbilical cord.

Kaosar Afsana in her book, *'Discoursing Birthing Care: Experiences from Bangladesh*', focuses on issues critical to the contemporary emphasis on gender sensitive health care for the poor pregnant women in Bangladesh. The core of the book explores the differing perspectives between rural women and health care providers regarding childbirth care and practices. The study attempts to understand women's perceptions of birthing care and their practices, the role of culture, socio-economic factors, and household dynamics as they influence women and their family's health-seeking behaviour. The strength of the present work lies in its

clear discussion of the various ways in which rural women tread between so many factors in attempting to make decisions that best suit them within their own limited resources. The book should assist health policy makers and planners to respond more sensitively to the constraints of health sector in rural Bangladesh.

Santi Rozario in her book, *'Purity and Communal Boundaries - Women and Social Change in a Bangladeshi Village'* explores the rich complexities of a central Bangladeshi village, populated by Muslims, Hindus and Christians. Through a carefully constructed theoretical framework Sand Rozario demonstrates the ways in which class and communal domination reinforce gender inequality. The position of women is analysed in terms of linkages between religious values, sexuality, economics and politics. Rozario also examines the divergence between the demands of the economy and the system of values in Bengali society. The author draws on concepts of sexual purity, shame, honour and purdah (seclusion) to make new and stimulating observations about the connections between socioeconomic changes, intercommunal tensions and specific aspects of women's contemporary experience such as increased physical mobility, and the shift from dowry to bride price. As a Bangladeshi woman, Santi Rozario is in a unique position to explore this subject. She has overcome the constraints on mobility that would normally bar local women from conducting the kind of extensive anthropological fieldwork represented here. The result is an unusual achievement - the scholarly perspective of a Bangladeshi woman on her own society.

In his book, *'Health for all in Bangladesh: Lessons in Primary Health Care for the Twenty-first Century'*bring together the most comprehensive information available about primary health care services in Bangladesh, including activities in maternal and child health care, family planning, reproductive health care, nutrition, quality of care, and health care financing. The new major policies in health, population and nutrition that have been recently adopted are reviewed along with major new national initiatives which are just now beginning. Based on this review, a comprehensive set of lessons are drawn from the Bangladesh experience to date, with the aim of creating a vision for how all of Bangladesh's citizens can attain the highest level of health possible. One of the central themes of the book is the importance of the local community, NGOs, and the Government working together, particularly in the effort of improve the health of the poorest of the poor, who need high quality primary care services the most.

SereenThaddeus&Deborah Maine in their study, *'Too far to walk: Maternal mortality in context'*focused on those that affect the interval between the onset of obstetric complication and its outcome. If prompt, adequate treatment is provided, the outcome will usually be satisfactory; therefore, the outcome is most adversely affected by delayed treatment. They examine research on the factors that: (1) delay the decision to seek care; (2) delay arrival at a health facility; and (3) delay the provision of adequate care.

In her Study, 'Women's reproductive illnesses and health seeking in a Bangladeshi village' Farhana Begum explores women's health seeking behaviours during reproductive complications in rural Bangladesh drawing on Bourdieu's Theory of Practice. Based on a year of ethnographic fieldwork in a northern village of the country, where four types of health care services—biomedicine, homeopathy, kabiraji (ayurveda), and folk treatment—are available, it explores how women define illnesses and seek therapies for reproductive health. It shows that women's health seeking and obtaining health services are influenced by their authoritative knowledge, cultural practices, therapy management groups, kin networks, household economics, education, and gender inequality. In the case of reproductive complications, women first try to understand the nature and causes of the problem based on their cultural knowledge. They categorize illnesses into four categories—osukh, dushi, jadu, and gojob—with the help of their therapy management groups. The women with high economic, cultural, and social capital are more likely to categorize reproductive complications as cases of osukh and lean toward seeking biomedical treatment while the women with low economic, social, and cultural capital are more likely to categorize illnesses as cases of dushi or jadu and lean toward seeking folk healers. When an illness is a case of dushi, jadu, or gojob, women prefer a folk healer for treatment. The women with high economic, cultural, and social capital prefer a folk healer of their same status while the women with low economic, cultural, and social capital prefer a healer who is "reliable" and "accessible". When an illness is a case of osukh, women can seek biomedicine, homeopathy, or kabiraji for treatment. The women with low economic, social, and cultural capital first pursue cheaper options like kabiraji and

homeopathy, and seek biomedicine when these options fail to cure the disease. On the contrary, the use of biomedicine by women with high economic, cultural, and social capital is influenced by their therapy management groups, household priorities, and the social capital of their households. (https://circle.ubc.ca/handle/2429/42492, accessed in 10th May)

Brigitte Jordanin her study*, 'Birth in Four Cultures: A Cross-Cultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States',* argues, While the process of childbirth is, in some sense, everywhere the same, it is also everywhere different in that each culture has produced a birthing system that is strikingly dissimilar from the others. Based on her fieldwork in the United States, Sweden, Holland, and Yucatan, Jordan develops a framework for the discussion and investigation of different birthing systems. Illustrated with useful examples and lively anecdotes from Jordan's own fieldwork, the Fourth Edition of this innovative comparative ethnography brings the reader to a deeper understanding of childbirth as a culturally grounded, bio socially mediated, and interactionally achieved event.

2.2 Conceptual Framework

Traditional birth attendant (TBA)

A community-based provider of care during pregnancy and childbirth. TBAs are not trained to proficiency in the skills necessary to manage or refer obstetric complications. TBAs are not usually salaried, accredited members of the health system. Although they are usually highly esteemed community members and are often the sole providers of

Delivery care for many women, they are not included in the definition of a skilled attendant.

"A person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants" (WHO, 1992).

Maternal mortality

According to the Tenth International Classification of Diseases, a maternal death is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes."

Maternal mortality ratio:

The number of maternal deaths per 100,000 live births measures the risk of maternal death among pregnant or recently pregnant women. A more precise measurement would be the number of maternal deaths per 100,000 pregnancies, to account for those who die from unsafe abortions. However, data on number of pregnancies are difficult to obtain.

Community Health Workers (CHW) / *Shastho Shebika (SS)*

Shastho Shebika is usually a female, socially acceptable, age 25 to 35 years, married, youngest child's age above five years, eager to do work, preferably educated, not living near a local health care facility or big bazaar. They are not paid a salary but they retain a small profit from the sale of drugs prescribed for common illnesses (Khan et al 1998, Hossain1999).

According to WHO, "CHWs are men and women chosen by the community, and trained to deal with the health problems of individuals and the community, and to work in close relationship with the health services. They should have had a level of primary education that enables to read, write and do simple mathematical calculations" (WHO 1990).

Disease, illness and Sickness

Medical anthropology often makes analytical distinction between diseases, illness and sickness. This is done to stress the different perspective s of the various factors involved in the experience of illness and healing.

Diseases refer to the doctor's perspective on ill health. This view is based on scientific rationality and assumes that disease are universal inform. This perspective does not include the social or psychological dimensions of diseases the context in which it appears or it's culturally defined. **(Brown J. Peter, 1998, p-11)**

Illness reflects the patient's perspective. It is influenced the cultural, social and emotional context in which it occurs and by an individual's background and personally illness may be present where disease is absent**.(Brown J. Peter, 1998, p-11)**

The term Sickness refers to the influences of the society at large on illness and the individuals suffering from ill health. **(Brown J. Peter, 1998, p-11)**

Medical Pluralism

Medical Pluralism means the coexistence of multiple Traditions of medicine, including what are called folk sectors, popular sectors and professional sectors (Kleinman, 1980) which present multiple choices of therapeutic traditions to the individual **(Durkin Longley, 1984; Minocha, 1980).**

The Existence of several therapeutic traditions in a single cultural setting, is an especially important feature of medical care in the developing world (Leslie, 1978). Patients May feel uncertain as to what type of care provider can cure their illness, leading them to consult different medical therapists. Or they may decide that treatment of certain illness requires more than one type of assistance. Generally Care is sought from several types of providers and medical traditions concurrently or sequentially. The Practitioners of different medical traditions may interact with each other in a variety of ways -At times they borrow the ideas and knowledge from one another, compete with and oppose the other system, they may co-operate with one another developing referral systems or they may simply coexist independently of one another **(Kleinman, 1980: Levitt, 1988: Subedi, 1989)**

Kleinman (1978: 422, cited in Helman 2001) suggested that, in looking at any complex society, one can identify three overlapping and interconnected sectors of health care; the 'popular' sector, the 'folk' sector and the 'professional' sector. The popular sector includes all the therapeutic options that people utilize, without any payment and without consulting either folk healers or medical practitioners. Among these options are: self-treatment or self-medication, advice or treatment given by a relative, friend, neighbour or workmate, or consultation with another lay person who has special experience of a particular disorder. The folk sector is especially large in non-industrialized societies; certain individuals specialize in forms of healing that are either sacred or secular, or a mixture of two. These healers are not part of the official medical system, and occupy an intermediate position between the popular and professional sectors. The professional sector comprises the organized, legally sanctioned healing professions, such as modern Western scientific medicine, also known as allopathy or biomedicine. In most countries a special form of health care-alternative or complimentary medicine-overlaps both folk and professional sectorsthere are two trends found in this study: firstly, poor people usually visit or choose the alternative healers, and the rich rely on modern medicine. In other words, economic affordability and the level of modern education make a difference in healer choice. Secondly, after the failure of alternative healing practices, poor people go to the modern physician.

Study among the villagers of Kadam Rasulpur also finds similar findings, like in most of the cases Women don't go to any medical practitioners, just consults with relatives, friends, neighbour who has particular experiences. And they seek refuge to different types of medical systems in terms of their etiological understanding of a diseases/illness.

2.3 Theoretical Framework

Theory is a guide to practice no study, ethnographic or otherwise can be conducted without an underlying theory or model; whether it is an explicit anthropological theory on an implicit personal model about how this is worked, researcher's theoretical approach helps define the problem and how to tackle it **(Fetterman 1989, p-15).**
Some theoretical approaches are selected, which found relevant and important with this present study on 'Ethnography of Birth: knowledge,Authority and decision making in Childbirth Practices in the village of Kadam Rasulpur'.

TheCritical Approach in medical Anthropology

The critical approach in medical anthropology emerged as a distinctive theoretical conceptualization, mainly for two reasons. Firstly, as a criticism against the interpretive approach, and secondly, as an attempt to redirect the analysis of the medical anthropology towards broader societal and economic dimensions, much in the line proposed by the political economy of health**(Brown J. Peter, 1998, p-16)**. Indeed, what of late is called the critical approach in medical anthropology was introduced by SoheirMorsy in 1979 in a paper titled "The missing link in medical anthropology: the political economy of health" (Morsy 1979). This was an early effort to bring the analysis of political economy of health into the anthropological perspective. This theoretical endeavour aimed to overcome the inherent shortcomings of the one sided and macro perspective of the political economy of health.

Morsy (1990) gave an account of the developments of the critical Medical anthropology, stressing its particularities and differences with the political Economy of health. The critical medical anthropology retained emphasis on the connection of health related issues with the economic order and social forces. However, this concern has gone beyond merely focusing upon 'grand' and modern capitalist orders to address the nature of health-related issues in indigenous and pre-capitalist societies, as well as socialist oriented-state societies. The emphasis on individuals and the place culture has come to signify within the critical analysis, had not been present either in political economy of health. The focus on linkages between individual actions and social/structural determination is based upon the understanding of individual actions as "culturally informed interactions between social actors and political economic relationships as dialectically related" (Morsy 1990:22). The centrality of culture is also manifested in the relation with 'the Other' seen as "different but connected; a product of a particular history that is itself intertwined with a larger set of economic, political, social and cultural process" (idem). Culture is seen in the critical approach as a system of symbols of an institutional order. The interpretation of these symbols, Morsy argues, involves simultaneous consideration of the political context where these symbols are inscribed. Culture is, therefore, understood in connection with issues of "power, control, resistance and defiance surrounding health, sickness, and healing" (ibid: 23).

Critical medical anthropology describes that, social stratification, social transformation; social inequality, colonialism etc. affect human health and creates different diseases. Thus, critical medical anthropology creates a critical theoretical debate including postmodernism, Marxism, and deconstructionism. Critical medical anthropology emphasizes the importance of political and economic forces, including the exercise of power, in shaping health, diseases, illness experience and health care **(Singer and Baer 1995:5).**

In Kadam Rasulpur, It was observed that, Women's birth experience is a social process which is largely associated with family structure, husband's profession, household economy which affects their decision making regarding place of childbirth.

Three Delay Frameworks

Thaddeus S, Maine D (1994) in their study, 'Too far to walk: maternal mortality in context; Social Science and Medicine' focused on those that affect the interval between the onset of obstetric complication and its outcome. If prompt, adequate treatment is provided, the outcome will usually be satisfactory; therefore, the outcome is most adversely affected by delayed treatment. They examine research on the factors that: (1) delay the decision to seek care; (2) delay arrival at a health facility; and (3) delay the provision of adequate care.The literature clearly indicates that while distance and cost are major obstacles in the decision to seek care, the relationships are not simple. There is evidence that people often consider the quality of care more important than cost. These three factors—distance, cost and quality—alone do not give a full understanding of decision-making process. Their salience as obstacles is ultimately defined by illness-related factors, such as severity. Differential use of health services is also shaped by such variables as gender and socioeconomic status.

Patients who make a timely decision to seek care can still experience delay, because the accessibility of health services is an acute problem in the developing world. In rural areas, a woman with an obstetric emergency may find the closet facility equipped only for basic treatments and education, and she may have no way to reach a regional centre where resources exist. Finally, arriving at the facility may not lead to the immediate commencement of treatment. Shortages of qualified staff, essential drugs and supplies, coupled with administrative delays and clinical mismanagement, become documentable contributors to maternal deaths.**(S. Thaddeus, D Maine, 1994)**

Based on the three-delay framework, as developed and implemented by the Prevention of Maternal Mortality network states three major factors that contribute to maternal death including:

1) Delay in recognizing complications and deciding to seek care
2) Delay in reaching a treatment facility, and
3) Delay in receiving adequate care and treatment at the facility.

This present study conducted in Kadam Rasulpur, also supported this three delay model, as in several cases, such as story of Khotte and Taslima suggested these delays not only increases complications but also in several occasion costs valuable lives.

Therapy Management

The concept of therapy management group, as originally defined by Janzen (1978) refers to "a community of persons who take responsibility from the sufferer and enter into brokerage relationships with specialists." **(Janzen 1978:7; 1987; 1992)** The therapy management group is comprised chiefly of "the family members who piece together the picture of therapeutic process and decide the next step of action."**(Janzen 1978:7-8; 1987; 1992)** The process of therapy management involves diagnosis and the negotiation of illness identities, the selection and evaluation of therapeutic options, and the lending of support to the afflicted **(Janzen 1978:7-81; 1987; 1992; Nichter 2002:82)**. The role of therapy management groups is not only one of support and assistance for the afflicted but one of social control of the patient and ideological control of the values implicit in therapy and illness behavior. This is worked out in the process of deciding which treatments to use and in which order, as well as which are inappropriate and to be ruled out."**(Csordas and Kleinman 1996:11).**

Therapy management invites analysis of transactions that are at once influenced by cultural values, social roles and institutions, power relations and economic circumstances that influence the ways in which illness is responded to in context over time **(Nichter 2002).** Social risk (risk to social relations and social identity) is clearly a factor that mediates cultural response to physical risk. To alienate a family member during illness was not only thought to increase suffering and contribute to ill health, but was seen as a failure to acknowledge debts of gratitude (*utangnaloob*) to the person for past sacrifices and favours. Micro economic

factors are also important in health seeking. Nichter has focused on the influence of such factors in health seeking and therapy management.
Nichter based his arguments by presenting two different case studies from different context. The first one is based on participant observation in impoverished Filipino household. Exposed to an infectious and socially stigmatized disease by a sick relative, household members are faced with physical risk while obliged by cultural values to extend routine hospitality. The second case is constructed out of interviews with an Indian patient and impressions of the patient shared with him. The case consider the health seeking behaviour of an Indian who has returned from working in the gulf and who is not visibly ill but it engaged in a search for diagnostic.
Nora's case illustrates the extent to which households are sites of cooperation as well as conflict and competition for scarce resources. Sickness provides a context in which to witness the social relations of each. "Seeking security through interdependence rather than independence''. Efforts made by family members to deflect any responsibility that Nora's aunt might feel toward the child's state of ill health. Even though Nora's aunt and her daughter were exposed to TB and it is stigmatised in Philippines, it doesn't destabilize social relations within the family.
Ali's Case --Gulf Syndrome – rise in the use of diagnostic tests in the medical practice of town-based doctors – Test fetishism – Tests have come to represent an expression of truth in the face of growing about doctor's diagnoses.Diagnosis by treatment and Visual Literacy. The study of therapy management entails not only what people do (and can do) and reasons for actions taken, but what they are unable to do and what underlies apparent passivity, acceptance, or fatalism. Failure to appreciate this side of therapy management contributes to simplistic impressions that ignorance underlies "irrational health behavior" in contexts where other factors are involved **(Nichter 2003:101).**
Data collected from the present study in Kadam Rasulpur also supports the patterns of Nichter's study. Case study of Nahar presented in the study, where her husband after returning from Middle East, became concerned about her health and seek hospital care and check-ups, despite of the fact that Nahar gave birth of her 1st child at home without any intervention or treatment and faced no health complication.

Chapter Three

3.1 The Study Area
Kadam Rasulpur Village is situated in Gafargaon Upazila in Mymensingh district and encompassed by Rasulpur village on east, on south by Shoyani Rasulpur, North by Babupur, and west by Horirumpur village. The village is situated on the bank of Sutiya River.

3.2 Village Landscape
The village of Rasulpur is directly connected to Dhaka by Dhaka-Mymensingh highway and 101 kilometres away from Dhaka. There are direct bus service from the Village Market to Dhaka and Mymensingh. The village is surrounded by Cultivating lands and encompassed by four other villages even though there is no visible boundary between these villages. Kadam Rasulpur lies in the northern part Gafargaon Union adjacent to Nandail Union, in union no. 1, under ward no. 3 in Rasulpur Union.
Unlike other villages of Bangladesh, Rasulpur is sporadically populated. There can be found generally three different types of household like Brick wall and Tin houses, Houses made with earth and Strews and *Kucha-pucca* houses made of bamboos and tins. People lives in those houses with closely connected relatives
Rasulpur is predominantly a Muslim Village with only a few Hindu families. Women were traditional Sharees and young girls wear *Payjama* or Skirt and Men usually wear Lungi and *Genji,*Shirts or *Panjab*i.
In terms of gender relationship, unlike other villages the culture of male dominance is pervasive. The restriction of women and restriction of purdah directly associated with families' status as well as occupation. For example: women belonging to high status family are relatively more confined and bound to obey the rule of purdah than relatively lower status household.
The transportation condition is relatively poor. During the rainy season, villagers have to walk as most of the roads are *Kuccha*. A single electricity line runs the parallel to the road as far as the Upazila centre. There is only 2 Kilometre *Pucca* Brick road of LGED (Local Government Engineering Department) from the

Highway to village market. Many Middle class household who works as garments worker or company job as well as Rich household have cycle, and most of the wealthy families have Motorcycles. Rickshaws, cycle van, CNG are only means of transportation around the village.

3.3 Population

Total population is 3356; male 1880 and female 1, 50,755. Population density is 695 per sq. km. The total number of families is 484. Annual growth rate of population is 1.54 %**(source: http://www.mymensingh.gov.bd/, accessed in 15th April, 2013)**

3.4 Literacy Rate & Educational Institutions

There are only two primary school, and three Madrasas in the village. Literacy rate in Kadam Rasulpur is 46.40% (male 47.20%, female 45.50%).**(Source: http://www.mymensingh.gov.bd/, accessed in 15th April, 2013)**In comparison with national literacy rate59.82%**(source: http://www.mymensingh.gov.bd/, accessed in 15th April, 2013)** it's relatively low.

3.5 Occupation

Most of the inhabitant of Kadam Rasulpur is associated with agricultural activities. They are mostly rice cultivator and engaged with one-crop., two-crop and three- crop cultivation *(Aaus, Amon, Boro*) over the whole period of time.
Besides agricultural activities, foreign remittance is also an important source of income for many families, as a significant number of people from many family (most of the cases the household head) stay abroad and work as labour in Middle Eastern countries. Their houses can be easily identified because of relatively new urban style brick walls and other designs. And most of them have Motorcycle, TV, etc. and in most of the cases, where the household head live abroad, members of the family live in extended or joint household.
Also a great number of people in the village are associated with non-agricultural activities such as Business, Government service holder, teacher, company job, day labour, business, and Garments worker.

In many families two or three family members are at the same time engaged with more than one economic activity and contribute to the family income. For example members of an extended household or joint household there are often more than one aged person who can engage himself or herself in different kinds of activities like in a joint family one brother is rice cultivator while other is a small businessman and both of them earn for their family. In Rasulpur, almost every family has agricultural land in which they give sharecrop or cultivate themselves, and meanwhile engage themselves with other economic activates.

Women in Rasulpur usually work as homemaker. And only a few of them are engaged in external income generating activities such as Teacher, NGO service (*Shastho Sebeka),* Garments Worker and so on. During the time of cultivation most of the women work besides their male family members in agricultural activities such as rice husking and others. Two women in the village work as Dai (NHW- New-born health worker).

3.6 Weather

The weather of Kadam Rasulpur is moderate with equable temperature, high humidity and plenty of rainfall. Average temperature is maximum 38.6 degree, minimum 9 degree, annual rainfall 1584mm (source: BBS, Gafargaon Upazila)

3.7 Village Market

There is one permanent Village market in Kadam Rasulpur Village called 'Kadam Rasulpur Bazar' situated at the south-western side of the village. There are a few permanent Grocery shops, two electronic shops, one hardware shops, three Pharmacy, tea-stalls and many temporary shops On 'Hat Day' at Friday and Saturday.

It is, in fact, the primary centre to meet people and to buy and sell daily necessities. The market is situated by the side of Mymensingh highway. The village Pharmacies are only source to buy medicines and open every day 10.00 a.m. to 7 p.m. The village market is also a medium of entertainment for men as in the afternoon they sit outside tea stalls and engaged themselves in gossips and watch Television with their friends.

3.8 Healthcare Facilities

There are only a few health care facilities in the village such as: Community Clinic, BRAC MNCH project office and three pharmacies in the village, Gafargaon Upazila health complex is 12 kilometres away from the village.

Community Clinic

The only community clinic is situated in the centre of the Rasulpur village. It is an old one storied building with two rooms, one bathroom and a veranda. Currently there is no doctor but only three CHCP (community health care provider). They attended a 3 months long training programme in Upazila Health Complex. Medication are provided for some illness and diseases such as Anaemia, Cold, Dysentery, Asthma and twenty five other diseases. Also 29 kinds of free medication are supplied to the villagers.

Picture 3.1: Kadam Rasulpur community clinic

Gafargaon Upazila Health Complex

Gafargaon Upazila health complex is 50 bedded hospital which is 12 kilometres away from the village. And only way of transportation is by van or rickshaw. There are seven listed doctors in this health complex but often they are unavailable. Patients who are suffering from long term diseases are taken here. If patient's condition became critical, doctor refers them to Mymensingh medical college hospital.

Picture 3.2: Gafargaon Upazila Health Complex

Mymensingh Medical College Hospital

Mymensingh Medical College Hospital is a referral hospital which has established in the year 1962. It is 48 kilometres away from the Upazila health complex and the mode of transportation is bus, CNG, Car, Auto rickshaw and etc. In 2003 it was upgraded from 500 bedded to 800 bedded hospital and very recently it has been upgraded to 1000 bedded hospital. With the limited space and capacity this hospital is handling 1500 to 1800 indoor patients and 2500 to 3000 daily. Near about 2 and a half crore peoples of greater Mymensingh and surrounding districts are dependent on this hospital for tertiary level healthcare. Presently there is one Ambulance in the hospital.
During 2012 Total Number of Deliveries took place in the hospital is 9267.No. of Maternal Death recorded is 24 which means Maternal Mortality Ratio (MMR) (January-December, 2012) is 258.51 per 100,000 live births. Whereas Present MMR of Bangladesh is 194 per 1, 00,000 live birth. Above MMR is very high and does not reflect the national standard because patients from surrounding districts come to this hospital in a very critical state either directly or as a referred case which contribute to numerator but this hospital does not have the statistics of total live birth of the same area and year. (Source: Mymensingh Medical College Hospital Health Bulletin 2012)

Maternal, Neonatal and Child Health Project (MNCH)

In 2005, the Maternal, Neonatal and Child Health Project (MNCH), a project with a focus on maternal, neo-netal and child health, in order to reduce persistently high mortality and morbidity rate of mothers and children in Bangladesh. Key features of this programme included capacity development of human resources in community health promotion, the empowerment of women and appropriate support groups, provision of maternal, neonatal and child health services and development of referrals to health facilities nearby. In Kadam Rasulpur, MNCH project was initiated in 2008, currently covering the whole area of Gafargaon Upazila including Kadam Rasulpur.

Shastho Shebika

Shastho Shebika plays a vital role in maternal health in the village of Kadam Rasulpur. There are presently 2 Shastho Shebika working in the village, who works under BRAC's MNCH project
The SSs are given foundation or basic training on essential health care, which lasts for 21 days, at 4 days per week at the regional office. Then refresher training is given for one day every month for two years **(BRAC website, Khan et al 1998)**

Pharmacy
There are three dispensaries in the Village market and also a grocery store in which some medicines are also sold. Owner of these dispensaries attended a 2 months training programme and prescribes medicine themselves. There is no doctor's chamber in these dispensaries.

Picture 3.3: A village dispensary

Dai
In Kadam Rasulpur, Dai plays an important role in the process of childbirth primarily during the delivery of child. Presently there are 2 trained dais in village, who are also known as NHW (New born health worker). They receive 150 taka for per delivery from BRAC. They received 6 months training program and became NHW from traditional birth attendant. Training helped them in various ways as now they can anticipate impending danger during childbirth and tell the pregnant mother and family members what to do when complication emerge.

Folk Healers

There is presently only one Kabiraaj in Kadam Rasulpur named Raja Mia. He gives treatment for many illnesses like jaundice, fever, cold, blood pressure, pain and etc. he charges 15-50 taka or a limited amount of rice for treatment. He also gives amulets for several diseases associated with supernatural or evil spirit. He doesn't have any academic knowledge about Kabiraji. He learnt it from his father, who was a kabiraj. Raja Mia uses different kinds of herbal plants for making medicine. Patient suffering from many skin irritation, weakness, sexual disease, fever stomach pain seek his treatment. He charges 50-150 taka or small amount of rice for medications and treatment purposes.

Map: Gafargaon Upazila

(Source: Http//:www.janlewala.com, accessed in 10th march 2013)

Map: Mymensingh District

(Source: Http//:www.janlewala.com, accessed in 10th march 2013)

Chapter Four

4.1 Maternal Health Status in Kadam Rasulpur

In 2013, Twenty seven birth s took places in the village, among them only 2 took place s in hospital and the rest were homebirth. Four death s of mother s and one death of newborn w ere also recorded.In Kadam Rasulpur, women's reproductive health seeking behaviour and place of delivery largely varies with the household economic condition, decision making authority, reproductive complication occurred during and after childbirth, place of birth and their relationship with Dais, Shastho Sebeka and Doctors (biomedical authorities) and their perception about them. During the period of fieldwork, 13 women who recently gave birth (within 3months) were taken as respondents and the endeavour of the research was to depict a picture where factors such as age, sex, economic condition, reproductive complication, decision making authority, place of birth are interrelated and the experience varies between different economic classes.

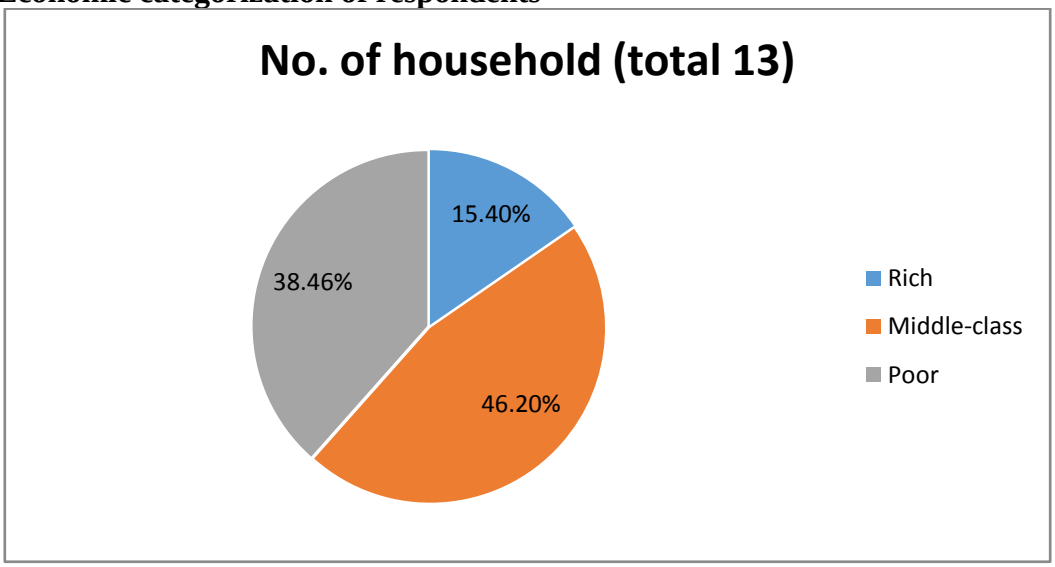
Category of Economic classes	Acquired land size (acre)	No. of household (total 13)
Rich	1-1.5 or more	2
Middle-class	0.5-1.0	6
Poor	0 .5 -none	5

4.2 Economic Status of Women

Among the 13 women taken as respondents, 2 belonged to the rich families, 6 from middle class, and 5 representatives of poor families. The economic status of each family depends on the house pattern, acquired land and the types of economic activities family members are associated with. The families living in houses made of brick, cement and tin (pucca), and members associated with economic activities such as government service holder, businessman, remittance from abroad, and owner of 1-1.5 acre of land or more are considered in the rich category. The families having houses made of Tin and Bamboos, associated with small business such as shop keeper, teacher, company job etc., and possess more than 1 acre of land belonged to the middle class. And thirdly, families living under extreme poverty, with
small portion of land less than 0.5 acre or no land, house made of strew, mud, bamboos, and whose members are associated with economic activities such as Sweeper, cleaner, shopkeeper, garments workers, and unemployed are consists the poor category.15.4% of the respondent belongs to the first category and 46.2% belongs to the Poor category.

Table 4.1: Category of Economic classes
(Source: Fieldwork 2013)

Figure 4.1 : Economic categorization of respondents



(Source: Fieldwork 2013)

The ecomioc conditon of the pregnant women affects their childbirth practices and experiances. Experiences of different classes varies with their economic condition.

4.3 Complication during Pregnancy Period

In Kadam Rasulpur, most of the pregnant mothers suffer from various complications during the pregnancy period, and in most of the cases they suffer from a number of complications, such as: persistent vomiting, weakness, fatigue, pallor, cough, pain all over the body, jaundice, acute abdominal pain, blurriness, less fetal movement etc. Among the 13 respondents, 5 of them suffered from persistent vomiting, 9 from weakness, 8 from fatigue, 4 from jaundice, 2 from prolonged fever and etc.

Table 4.2 : No. of women suffered fromReproductive complications during pregnancy period

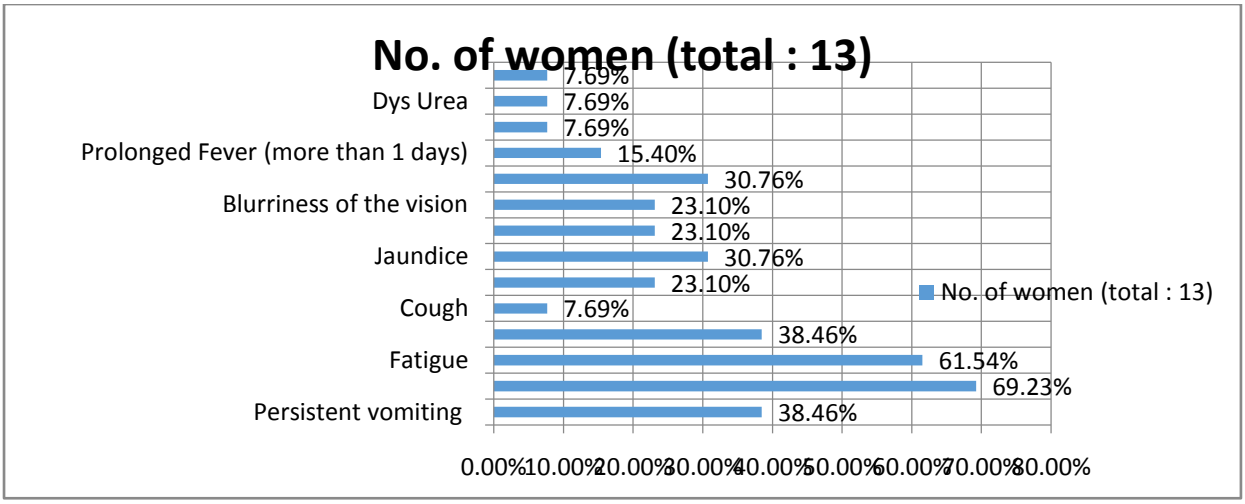
Complication during pregnancy period	No. of women (total : 13)
Persistent vomiting	05
Weakness	09
Fatigue	08
Pallor	05
Cough	01
Pain all over the body	03
Jaundice	04
Acute abdominal pain	03
Blurriness of the vision	03
Less Fatal movement	04
Prolonged Fever (more than 1 days)	02
Dizziness	01
Dyes Urea	01
Foul smelling virginal discharge	01

.

(Source: Fieldwork 2013)

Among the 13 respondents, 38.46% suffered from persistent vomiting, 69.23% from weakness, and 61.54% from fatigue, 30.76% from jaundice, 15.4% from prolonged fever and etc.it was observed that, among all these complecations pallor, fatigue, weakness are relatively common, and women's treatment seeking choices depends on their perception about the diseases as well as their economic consideration. For example, among the 4 women who suffered from jaundice, 3 of them consulted with a folk healer (Fakir) and used amulets and received other medication. In two of the cases they didn't have any money to take the patient to the hospital and when receiving treatment from a folk healer like a Fakir, they don't have to pay him immediately and the payment is often very low in comparison to biomedical or other forms of treatment. There is also a shared cultural perception about this particular disease and for diseases which they consider as life threatening—like less fetal movement or acute abdominal pain—they seek refuge to the biomedical treatment.

Figure 4.2: percentage of women suffering from complication during pregnancy period.



(Source: Fieldwork 2013)

4.4Receiving Treatment from Folk healer

Case Study: Story of Bilkish Begum

Bilkish Begum a 25 year old women who suffered from various illness during her pregnancy, such as pallor, weakness, fatigue, acute abdominal pain, blurring of the vision, jaundice and less fatal movement. Her husband Ali Mustafa Ali who works in a private company doesn't earn more than 7 thousand taka per month. As they live in an extended household with her in-laws and her four brothers-in-law and Ali is the only earning member of his eight member family, they couldn't save any money for her wife's health-related emergency because of household expenditures for food, clothes and education. So even though she suffered from various diseases she couldn't go to a doctor or seek any other biomedical aid as it will cost her money to buy medication. So when she suffered from jaundice her husband went to Kobiraaj's house and he gave him an amulet and asked him to tie it to his wife's left arm. When she was asked, why his husband went to the Kobiraaj while there are many other folk healers like homeopathy or biomedical treatments, she replied that the amulets only cost her husband 150 taka and Kabiraaj lives near their house and they didn't have to pay him immediately. Her husband paid for the amulets in the next month. So for flexible payment options and as they don't consider jaundice as a life threatening disease, they seek 'Kobiraaji' treatment. But when she suffered from acute abdominal pain for 5 days during her pregnancy period, which she couldn't endure anymore, she was taken to 'Gafargaon Upazila Health Complex' for treatment, as they thought it life threatening for her and their unborn child.

4.5Antenatal Care in Rasulpur

During pregnancy, women suffer from various diseases and illness and it is important to have regular check-ups which is called *antenatal care.*It is absolutely necessary because a woman's health and illness in pregnancy affect her baby.Antenatal check-ups prevent most medical problems. Even if there is a problem, early detection helps to control the problem better.

In Kadam Rasulpur, the scenario of antenatal care of pregnant women is very poor as most of the pregnant women don't receive any antenatal check-ups, or one or two during pregnancy period.

Among the 13 respondents, the only one of them that had the maximum number of antenatal check-ups (4 times) belonged to a rich household. Her husband worked labour abroad, and they insisted that she should go to doctors for check-ups.

Only three of the thirteen respondents had three antenatal check-ups, two of them got their check-ups in their parent's household where they came to give birth to the child in their 7th and 8th month of pregnancy.

Table 4.3: Antenatal care situation in Rasulpur

No. of Antenatal check-ups during pregnancy	No. of women (total=13)
No Antenatal check-ups	05

One Antenatal check-ups	03
Two Antenatal check-ups	04
Four Antenatal check-ups	01

Complication After child delivery	No. of women (total : 13)
Persistent vomiting	05
Weakness	09
Fatigue	07
Pallor	06
Cough	01
Pain all over the body	03

(Source: Fieldwork 2013)

Within the 13 respondents, four of them had two antenatal check-ups, two of them had their check-ups while they came to their parents' house to give birth of child, and rest belonged to middle class household. And lastly, among the 13 respondents, 5 of them didn't have any antenatal check-ups or receive any types of treatments.

4.6 Complication after child delivery

In Rasulpur, it was observed that, in most cases women suffer from several complications at the same time. Such as: pallor, vomiting, abdominal pain, jaundice, dizziness, weakness, blurriness of the vision and etc. among the 13 respondents 7 suffered from fatigue, 5 from persistent vomiting, 9 from weakness, 1 from bleeding, and one from retained placenta.

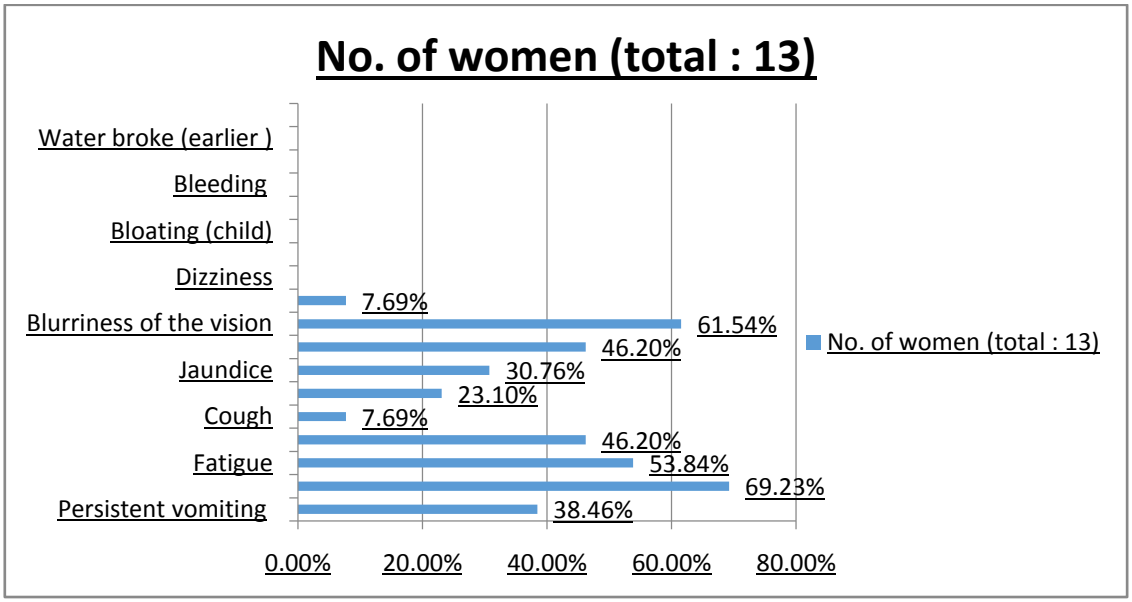
Table 4.4: Complication after child delivery (no. of respondent)

Jaundice	04
Acute abdominal pain	06
Blurriness of the vision	08
Prolonged Fever (more than 1 days)	01
Dizziness	01
Foul smelling virginal discharge	01
Bloating (child)	01
Infection In umbilical stump	01
Bleeding	01
Retained Placenta	01
Water broke (earlier)	02
Strangulation by umbilical cord (child)	01

(Source: Fieldwork 2013)

In Rasulpur, women's health seeking behaviour and types of received treatment depended on the complications they were suffering from. 69.23% of the respondents suffered from weakness and 61.5% from blurriness. They considered these types of complications as natural and found it unnecessary to seek any types of treatment.

Figure 4.3: Complication after child delivery (%)



(Source: Fieldwork 2013)

4.7The changing pattern of Women's health seeking behaviour during childbirth

The study shows that the maternal health Status in Kadam Rasulpur is relatively low like other rural areas of Bangladesh, and the maternal mortality rate is quite higher than other areas in Bangladesh. The number of antenatal check-ups received by pregnant woman is inadequate and often put their and their child's life in danger. As government and NGOs' like BRAC take many initiatives to reduce maternal mortality and improve the health status of pregnant women. Shastho Sebeka and NHW (New born health worker) formerly known as Dais plays an important role, changing, raising awareness as well as improving maternal health practices and health seeking behaviour.

4.8Account of a Shastho Sebeka:

KulsumAra a 32 years old woman worked as a *Shastho Sebeka* in BRAC's MNCH (Maternal, Neonetal and Child health program) since 2008, shared her vivid experiences working with in pregnant women's belonging to different classes and status. Kulsum took that job when her husband Hafiz Alam, who worked in Bangladesh Army, became paralyzed and had to retire from his job involuntarily. This unexpected unemployment put their family in jeopardy. So Kulsum as she lives in a joint with her In-laws and her three children desperately needed money to support her family and she took the job and started working as *a Sebeka*. According to her, 'at the beginning, the circumstances was quite different from now. It was very hard to get access in any household, as no one seems to take it normally and I almost every day heard the same annoying questions like why don't you do any real job?, Don't you have any important thing to do other than stalking women?' she also mentioned the fact that she had to work in a hostile environment and at first, she was humiliated while collecting blood, urine sample and measuring blood pressure of pregnant woman. She stated as, 'in many houses when I went to go to check on pregnant women, family members asked me, ''why you came again?' we told you not to come again. One mother in law of a pregnant women once told me, 'look at me, I gave birth of seven children, and I did it all by myself without any doctor or medication, and nothing went wrong. And if I want to take my blood pressure, we can go to Amritola Bazar and it will only going to cost us 20 taka. We don't need any of these helps''. She was recalling the scenario of the past by saying, 'only a few people were sympathised towards Shasto Sebeka back then. At beginning most of them were so reluctant to bring any chair to sit or any beverages to drink; at first they were very doubtful of our intension.

When she was asked how exactly the scenario changed and to what extent? She replied, '' now situation is completely altered, not a single birth in Rasulpur takes places without our acknowledgement, almost every family is now co-operative with us, even they call us when one of their family member became pregnant, consults with us about what should they do?. Now they offer me hot beverages or *shorbot* (juice),*pani* (water) and refreshment whenever I visit them.

She disclosed to the researcher about how changes occurred by saying, 'at beginning I felt so bad as I had to work in a hostile environment, eventually I began to explain to them, what exactly my job is, and how I can help them free of cost. I told them, ''if u go to pharmacy, it will cost you time and money to measure your blood pressure or other tests, but I am doing it for free, saving your time and money. And by using our connection you can get medication free or half of charge (for poor and middle-class). They have seen us saving lives of mother and child. They saw us helping them to get admitted in the hospital by talking to my manager (MNCH programme manager) when life threatening condition arise. So as they see us saving lives of poor women, getting them free treatment and medication, slowly they comprehended our importance. They realised, we are not intruders rather a great helper who helps them anticipating any impending danger and gradually they realised we are trained and our knowledge can both save lives and money.

When she was asked, ''How much this job meant to her and if this job help her to achieve status or improvise her economic condition?''. She replied, now everyone in the village know about her work and consult her about childbirth related issues and health related complication of mother and ask seek her prudence asking what to do?, when and how to do it ?. And as she is also now can help her family economically which is not a big amount but enough to manage a living. She finished by saying, ''people loves us because we are indemnifying pregnancy''.

Chapter Five

5.1 Place of childbirth

In Rasulpur Child Birth is considered as Natural phenomena and expected to take place in home. However, when complication arise, which cannot be alleviated in home, People seek help from biomedical obstetrics. Having said that, it is not a straightforward process as there are many factors influences their decision-making such as Place of Delivery, Types of complication, household dynamics, power relationship and decision-making authority. The whole procedure of decision-making is often time consuming which sometimes create life-threatening situation for both pregnant woman and Child.

5.2 Categories and associated factors

Data collected from the study area suggests, among the thirteen respondent, eleven of them took place on house, four of them in pergnant woman's parents house and seven of them took place in prengnant women's in-law's home. From the collected data, home birth canbe categorized into two types:
Pregnant Mother's Parent's home
In-law's house or Husband's house

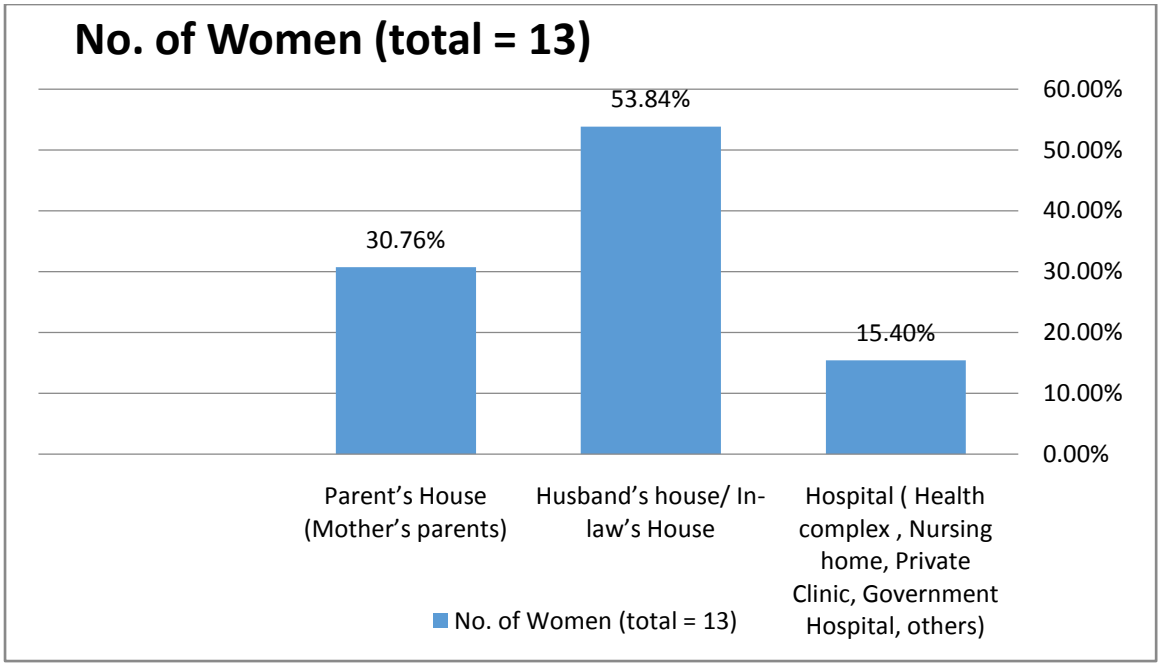
Table 5.1: Place of Delivery (no. of women)

Place of Child Delivery	No. of Women (total= 13)
Hospital (Health complex , Nursing home, Private Clinic, Government Hospital, others)	02
Husband's home/ In-law's Home	07
Parent's Home (Mother's parents)	04

(Source: fieldwork 2013)

Among the 13 respondents, 7 gave birth in their in-law's houses as for 4 of them, it was not their first child and 2 of them belongs to economically solvent family so their in-law's family hired extra hand to look after her and provided her with extra food, so they didn't have to go to their parent's house.

Figure 5.1: place of delivery (%of women)



(Source: fieldwork 2013)

Among 13 respondents 30.76% of birth took places in mother's parents house, 53.84% of birth took place in husband or in-law's house, and only 15.40% took place in hospital.

In Kadam Rasulpur, it was observed that, type of home birth is interrelated with family's economic condition, husband's profession, and number of male members in family, Mother's age and reproductive complications during pregnancy. For example: home birth is largely associated with number of active members in the family for taking care of mother.

Household economy

Data collected from the 13 respondents suggested that, as during pregnancy period, taking good care of mother's health is considered as an important factor and to keep her healthy, it is important to provide mother with more nutrient food, protein than usual, so household economic condition plays a vital role. Husband's family's financial condition is linked with the possibilities to cater for the mother with extra food, which cost more money than usual. Therefore, in a poor family, this extra expenditure for food is not always possible so in those cases mother moves to her parent's house for extra food and reduce the expenditure of her husband's household.

Husband's occupation

Husband's profession and household dynamics also determines the types of homebirth, for example: if husband work as garments worker, or work abroad, and there is no member to take care of the pregnant women or nobody capable to take her to hospital if complication appears, women are encouraged to go to her parents for the delivery.

5.3 Pregnant woman's Age as a factor

Another important consideration regarding place of delivery is mother's age and number of children she already has. As it was noted from the interviewes with two of the respondents that it is a tradition that, they will give birth of their first child at their parents house as they feel more comfortable and autonomous, and where the atmosphere is much more familiar. women's experience is an important factor as they already gave birth of more than one, their ages and birth experiences gave them the authority to make decisions regarding childbirth.

No of Respondent (total 13)	Respondent's Age (pregnant women)	Number of children	Birth place of Last Child
1.	21	1st	In-law's home
2.	27	3rd	In-law's home
3.	32	5th	In-law's home
4.	33	4th	In-law's home
5.	30	2nd	In-law's home
6.	25	2nd	parent's home
7.	28	1st	parent's home
8.	17	1st	Parent's home
9.	23	2nd	Hospital
10.	22	1st	parent's home
11.	22	1st	In-law's home
12.	23	2nd	Hospital
13.	20	2nd	In-law's home

Table 5.2: Relationship between place of delivery and age

(Source: fieldwork 2013)

From the Table, it canbe seen that among the 4 birth took places in pregnant's mother's parent's house 3 of them took place in pregnant women's parent's house as they felt vulnnurable and scared because of their first time pregnancy and in their parents' home they feels comforted and more autonomous than in their In-law's house.One respondent gave birth of her 2nd child in her parent's household because of the hostility between her and her In-laws. From the table it can also be observed that, 7 out of the 13 delivery took places in In-law's household where only in 2 cases, mothers were 1st time pregnant and rest of them already gave birth one or more than one child.

Conversely, only 2 birth took places in Hospital because of emergence of life Threatening condition which they couldn't disentangle at home.

5.4 Case Study: Story of Jakia:

Jakia a 17 years old woman came to her parent's home for her 1st childbirth. Her Husband Hasan is a Madrasa Teacher. She lives in an extended family with her In-laws. When she was asked if there any particular reason for coming to parent's house or any cultural obligation to give birth of ther 1st child at her parent's house, she replied, there is no obligation but they always do that as she herself saw her elder sister to the same. And her husband is a Madrasa teacher, so it would be very hard for him to cater for her all the protein and nutritious foods as those will cost extra money. And as she came to her parents, now her younger brother and elder sister can take care of her and if any emergency arrives they can take necessary steps. So considering these realities she came to her parent's house for delivery. She also said as her In-laws lives in the neighbouring village which is 15 mins walking distance from Kadam Rasulpur, they can visit anytime they want.

5.5 Hospital Birth Context &Decision making

Among the thirteen responents, only two of the birth took place in Gofargaon Upazila Health complex, which is only 15.40% of the total population. As it is mentioned erlier that, the process of childbirth is considered as a natural phenomena and expected to take place in House unless any Complicated Situation arise.

In Kadam Rasulpur, important factor associated with Hospital is reproductive complications during pregnancy and childbirth, and family's perception about the illness or disceases. For example : if any impending life threatening complication occurs which put them in a indispensable position to take the pregnant woman to hospital for delivery to save her life as well as her child. In Rasulpur, two among thirteen respondents, gave birth in hospital: one of them suffered from premature repture of membrane,and another from less fatal movement which they considered as life threatening.

5.6 Decision making authority during pregnancy period about health related issue of mother:

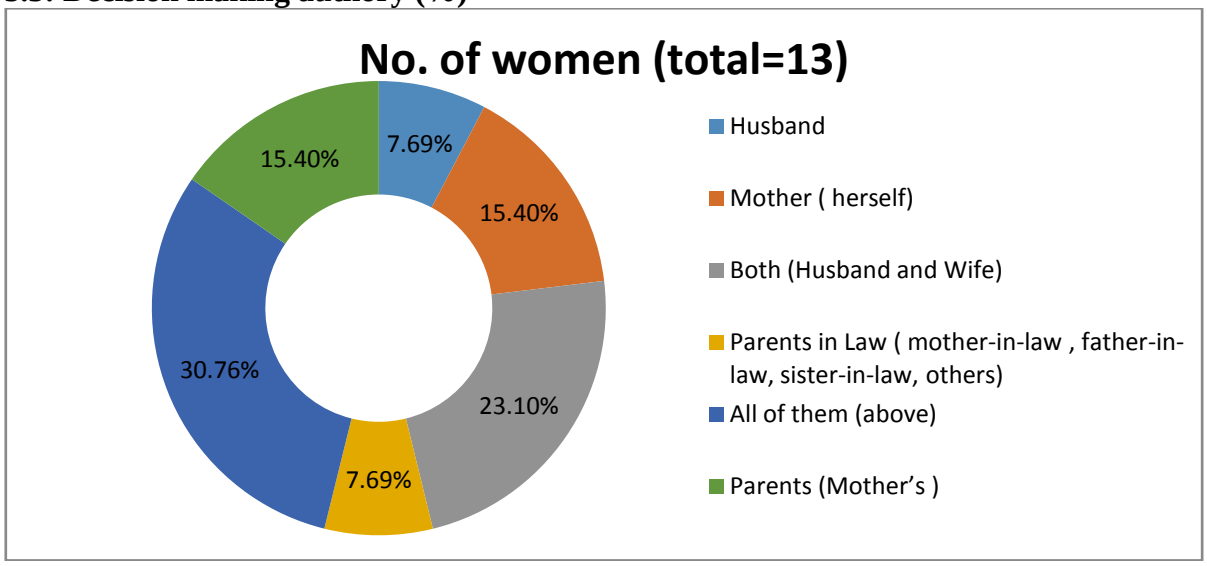
In Gafargaon, the Decision making power and authority regarding childbirh, depents on household dynamics, economic factors, cultual perception of illness, types of complication and are made by different members like Parents-in-laws, husband, wife(herself), parents (mother's), others (neighbours, relatives, *Dais*, Doctors, Shastho Sebeka).Most of the cases more than one person. Many factors such as Mother's age, economic condition, household dynamic, number of family member influences their decision concerning childbirth.

Table 5.3: Person who Responsible for Decision making regarding childbirth

Person Responsible for Decision making regarding childbirth	No. of women (total=13)
Husband	01
Mother (herself)	02
Both (Husband and Wife)	03
Parents in Law (mother-in-law , father-in-law, sister-in-law, others)	01
All of them (above)	04
Parents (Mother's)	02

(Source: fieldwork 2013)

Figure 5.3: Decision making authory (%)



(Source: fieldwork 2013)

According to data collected from the study area, most of the decision regarding childbirth such as (place of delivery, types of receievd treatment, delivery types) were taken by more than one family member (30.76%).

5.6.1 Decision made by Pregnant women herself:

In only 2 cases the decision were made by the mother herself (15.4%), as they already gave birth of more than one or two children and one of them is 34 years old and other 39 years. Their ages and birth experiences gave them the authority to make decision making regarding childbirth.

Case Study:Story of Jhorna:

32 years old Jhorna Biswash lives in an extended household with her In-laws. Her husband Tuku Biswash runs a small business . Jhorna got married when she was 14 years old and already gave birth of 4 children. She makes all the decision regarding childbirth as she already gave birith four times. As she mentioned, ' I already gave birth of 4 children and I didn't had to go to hospital for once. I know everything about childbirth so no one asks me what to do? I took my decision myself and I would know myself if anything wrong with my child as I already gave birth of so many. She went to community clinic all by herself to receive iron tablet. Even though she suffered from Fatigue, weakness, pain all over the body, she didn't feel to go to hospital for treatment as she thinks these are natural in pregnancy period. She was implying that, as she have already successfully given birth of four children without any medication or biomedical aid and didn't cost any trouble or money of her husband, her previous birth experience gave her the authority to take decisions regarding childbirth herself.

Among the 13 respondents, in 23.10% cases, decision were made by both husband and wife. It is noteworthy that, as they belonged to nuclear family and live without any parents or guardians gives them the privilages to make decision on their own.

5.6.2 Decision made by Pregnant woman's Parents:

Pregnant Mother's parents only make decision, when their daughter comes to her parents' house for delivery. In 15.40% of the family, Pregnant woman's parents made the decision regarding childbirth such as treatment types, place of birth etc.

Case Study: Story Of Salma :

Salma a 25 years old women who was 2nd time pregnant, gave birth of her 1st child in her In-law's house 5 years ago. Her husband Anarul lives in Dubai where he works as a driver. When Salma was 3 months pregnant, her husband had to leave Bangladesh again for his professional duties. Meanwhile his brother-in-law, named Asad came home in Vacation from Madrasa. Salma receieved one antenetal check-ups from BRAC's Shasto Sebeka in this three months but arrival of her brother-in-law changed the whole situation as Asad completely forbid any of these check-ups and persuaded her mother not to let any of Shastho Sebeka from BRAC or any types of treatment. As he mentioned, these government and International NGOs' are Selling all these personal information of pregnant women and pictures to foreign countries (USA). Eventhough Salma's mother-in-law never reacted or showed any kind of oppositon against these check-ups, she started to react this time and for 4 months she didn't let any of Shasto Sebeka enter in her house. But Salma was also desparate for having these check-ups because last time during her 1st pregnancy and realised these check-ups are important for her unborn child so she took the mobile number of Sebeka and went to her own parent's house to give birth of her child. She received three more antenetal check-ups in her parents house with the little help from Shebika and went to hospital twice to do an ultrasound to know the condition of her child.

5.6.3 Decision made by parents-In-laws:

In 7.69% cases, decision making authority relies on the hand of parents in law, in families where preganat wife lives with her husband in an extended or joint family. As more than one member of husband's family has experience regaeding childbirth and all of their decision counts and being considard.

Case study : Story of Nahar

23 years old Nazun Nahar lives in a joint family with her husband, parents – in-laws, two married brother-in-law with their wives and children . Her husband Kasem Uddin is a businessman. She was 2nd time pregnant and gave birth of her first child five years ago at her parent's home because her husband was in Dubai during her pregnancy and where he worked as a labor his two brothers were very young to take care of his brother's wife. She had a normal delivery in her 1st time and couldn't have any ante netal check-ups for dearth of money. But situation entirely changed this time, as her husband established business in Gafargaon and bought some substantial amount of land and became one of the wealthiest families in the village as Kasem managed to send his 2 younger brothers to Dubai as labor and they send substantial amount of money every year for household. Kasmen and his parents keep insisting her to have check-ups at 'Digital Private Hospital' in signboard Bazar because they don't have any problem of money. After two visits, Nahar found it very intimedating and threatening for her heath as they used to draw her blood every two weeks as well as tests her stool and urine sample and ultrasound. She was not comfortable with all these medical prosedure and felt discomfited of these excessive, constant invasion on her body and subsequently inferred that something must be wrong with her and her child. She tried to resist againt going to hospital check-ups by saying she is fine and just like her 1st delivery. But her husband and parents-in-laws keep insisting that she must visit doctor regularly as it is very important for her and her child. They also asked her to do exactly what doctor said to her for her unborn child's sake. Her parents – in-law didn't let any Shasto Sebeka to visit Nahar and asked them not to visit her as they are having the best treatment one could every get. Even though she found all these check-ups and medicine unnecessary she took them because she was asked to by the doctor and her husband. One week before her due date, she felt acute pain and her water broke and within one hour she gave birth of a girl in her In-law's house one week before her due date. `

5.6.4 Decision influenced by Sebeka, Dai and Neighbour:

Decision making regarding childbirth also inflluenced by neighbour, shasto shebika, dais as they plays an important role by lending money or sharing their experience and influential contracts .

Case Study: Story of Hafiza:

Hafiza a 23 years old woman who came to her parenr's home for delivery in her 8th month of pregnancy. Her husband Belal has a company job and they both live in a nuclear family in Vatipara. Hafiza sufffered from abdomen pain, weaknness and pallor during her pregnancy but didn't have any ante netal check-ups. Problem occurs when her baby's hand prolapse (came out first instead of head). Dai who was assisting the delivery asked them to take her hospital immediately but they waited for Hafiza's sister named Sufia to come home for consultation as she works as Shasto Sebeka of BRAC's MNCH project in Vatipara. Sufia arrived after 3 hours and also agreed with the dai and asked them to arrange money for hospital. As both Hafiza's parent's and in-law's financial status was quiet poor they consulted with their neighbour, who gave them 2000 taka loan and also suggested to take her to hospital. So after 6 hours they reach Gofargaon Upazila Health complex and doctor said she needs an operation and that will cost them 7000-8000 taka. Even though they could arrange the money her sister Sufia opposed to this and convinced her family member not to let them do the operation. She said, 'if they cut her once she will have to give birth in hospital everytime and will never be able to have a normal delivery. When Sufia was asked what exactly doctor told them? She replied doctor said she need immediate operation and they will do a *Episiotomy*(side kattae

hobae). From what doctor said it to them and what they understood, it was quiet clear that there was a gap of understanding existed between the doctors and Hafiza's family member. As by side Kattae hobae, Sufia and her family member thought it as Caesarean section. And they didn't have the idea about the difference between Episiotomy and Caesarean section. When Sufia was asked, if she shared her belief with the doctor about the procedures of episiotomy? She replied, 'No, because they are always too busy and never had time to listen what we have to say.'

After two and a half hours of constant attempts Hafiza gave birth of a healthy girl without any operation. Sufia very proudly shared her opinion with researcher. According to her if they would have agreed with the doctors and let them to do an operation, they had to pay at least 9000-10000 taka in total. And lending that much money and to reimburse the loan would jeopardize their families economic status. She was very happy that, she didn't let them do the operation and they only had to spend 2300 taka in total for treatment, accommodation and medication purpose. They also been able to get the quick and best service they could get as Sufia managed to bribe an Aaya 500 taka, for taking care of her sister.

From the Case study, It was quiet clear that, there is a gap of understanding exists between the doctors and patient's family. As taking example from Hafiza's case: Sufia and her family member believed if Hafiza has one caeserean section, she will need operation for her next delivery. But clearly, She misinterpreted the term episiotomy and thought it as an caeserean section. They were lucky that Hafiza managed to give birth normally. They had no idea how much dangerous consequences could have emerge. and doctors were also not been able to make them understand the procedures of episiotomy as Hafiza would face no problem giving birth next time normally without any operation.

Chapter Six

6.1 Types of Received Treatment

In a pluralistic setting like Kadam Rasulpur, where more than one types of medical system exists (Kabiraaji, Folk, Biomedical) people seek different types of treatments regarding childbirth which is most of the time influenced by their economic condition, types of complication, and their cultural perception of the disease.

From the data collected from the fieldwork, among the 13 occasion only 2 birth took places in Hospital because of emergence of life Threatening condition which they couldn't disentangle at home.

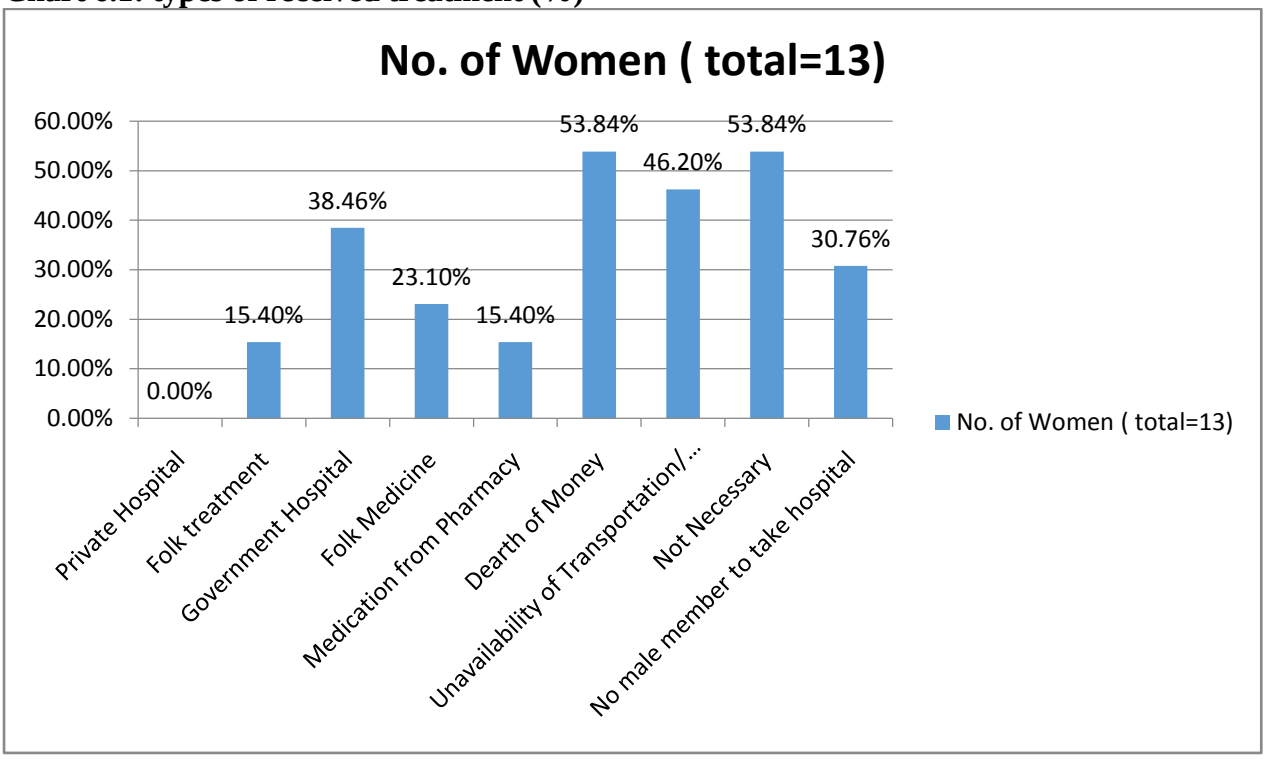
Table 6.1: types of received treatment (no. of respondents)

Types of received Treatment	No. of Women (total=13)	(%)
Private Hospital	None	(0.0%)
Folk treatment	02	(15.4%)
Government Hospital	05	(38.46%)
Folk Medicine	03	(23.1%)
Medication from Pharmacy	02	(15.4%)

(Source: fieldwork 2013)

15.40% of the respondents seek folk treatment when complication occurs (jaundice), 38.46% went to government hospital as one of the respondent faced severe life threatening complication (retained placenta), 53.84% of the respondents didn't seek any treatment for dearth of money , even though they know they can have free treatment from government hospital, one of the respondents mentioned that, it costs more than 250 taka to take patient Gafargaon Upazila health complex, and they have to spend money for foods and medicine. One of the respondent, who gave birth in Gafargaon Upazila health complex disclosed that, her husband had to spend 9 thousand taka for food, medication and accommodation purpose as they had to stay at hospital for 25 days, which threw them in such position that they cannot find a way to reimburse to their relatives and neighbour from whom they had to lend money.

Chart 6.1: types of received treatment (%)



(Source: fieldwork 2013)

Table: 6.2 Reasons for making separate selection

Dearth of Money	07	(53.84%)
Unavailability of Transportation/ Distance	06	(46.2%)
Not Necessary	07	(53.84%)
No male member to take hospital	04	(30.76%)

(Source: fieldwork 2013)

6.2 Factors Associated with Types of Received treatment during reproductive complication :

In Rasulpur, many factors such as availability of transportation, availability of Male member, economic condition, types of complication, household dynamics affect the decision making regarding reproductive complication.

6.2.1 Economic Status of the household

Economic condition of the household affects the types of received treatment as among the 13 respondents, 15.4% of them bought medicine from the pharmacy for complication such as acute abdominal pain even though they were suggested by dais and Shastho Sebeka to take the patient to hospital.

53.84% of the respondents most of the cases, couldn't go to hospital for treatment even though they know they should consult doctor or go to hospital as it would put their family in deficit position. As they have to borrow money from their neighbour or relatives and to reimburse them, they have to struggle even more

6.2.2 Availability of Male member

Availability of male member in family plays another important role, as in Rasulpur most of 30.76% of the respondents couldn't go to hospital as there was no male member to take them and most of the time among the 5 respondents 2 of their husband works as garments worker and couldn't manage any gap between works to take them.

6.2.3 Cultural conception of Reproductive complications

Cultural conception of diseases/illness also affects the choices of treatment system. For example, even though 4 of the respondents and 2 of their new-born child suffered from jaundice, instead of seeking any medicine or taking them to hospital they seek folk treatment for it. And as it is mentioned earlier, illness like pallor, weakness, dizziness, abdominal pain etc. are considered as natural for pregnant women, even though suffering from a few of these complications.

6.2.4 Availability of Transportation

Unavailability of transportation also affects the treatment seeking behaviour as most of the time when complication arises, it is not possible to take the patient in rickshaw and van is only means of transportation in Rasulpur. Among the 13 respondents, 46.2% of them couldn't find any appropriate transportation for seeking healthcare in hospital. 7 among the 13 respondent did not go to hospital or doctor as it would jeopardize their family's economic condition.53.84% of respondents didn't find it necessary to seek treatment for such illness.

6.3 Time Taken for Decision making while complication occurs:

Among the 13 respondents, all of them suffered from several reproductive complications however not in a single case, decision was made instantly when a life threatening condition occurred for both mother and new-born. The ultimate price of procrastination was paid as one of pregnant women died of retained placenta, as the decision to take her to hospital was taken after 4.5 hrs. after the delivery and it was too late as she died on her way to the hospital, a new-born boy died as his father couldn't made up his mind whether to take him or not to hospital despite of the fact that his neighbours, Shasta Sebeka from BRAC, Dai insisted to take the child to hospital immediately, but it took him more than 12 hours to decide and that poor child (suffered from cyanosis) died.

Even though, Women in Kadam Rasulpur or their family member don't have any specific records or account of time about the time taken for decision making because they don't actually use watch for keeping accurate account of time. Data given below about time taken for decision making while complication arises was collected from Shastho Shebika from MNCH programmeswho is responsible for taking account of time. Because if any occurrence of mother or neonatal death could cause her job for irresponsibility.

Table 6.2: time taken for decision making while complication arises (no.)

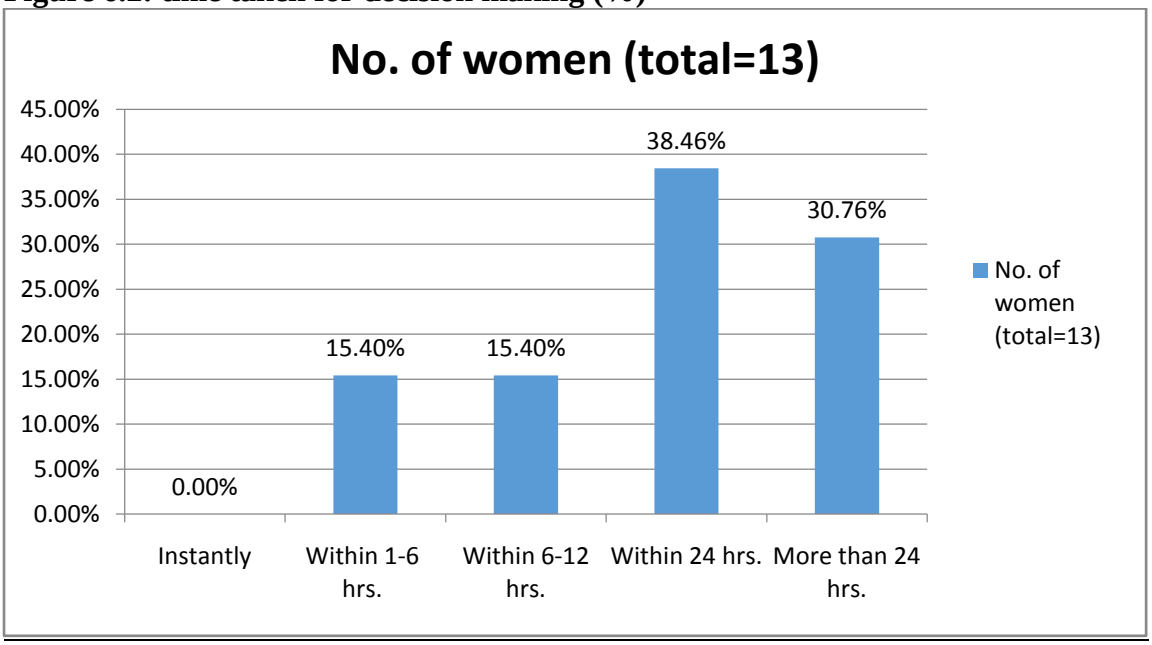
Duration	No. of women (total=13)
Instantly	None
Within 1-6 hrs.	02
Within 6-12 hrs.	02
Within 24 hrs.	05
More than 24 hrs.	04

(Source: fieldwork 2013)

Interviewing with the thirteen respondents and their family member reveals that, when complication emerges; making decision depends on some important questions such as, what type of treatment they should seek. If she had to take to the hospital who will go with her? How much money it's going to cost them? How long they have to stay at hospital? How they are going to arrange the money or from whom loan would be taken? How will they reimburse the loan? Whom they will consult with about what should be done? How the patient will be taken to the hospital?

Seeking answer of those question often cost them vital time, which often put the mother's and new-born's life in jeopardy. In Rasulpur, It was observed that, in many cases, especially respondents belonging to poor economic condition, in two cases middle class, who suffers from complication like bleeding, weakness, fatigue, abdominal pain, even though dais and Shastho Sebeka urged them and their family member to go to hospital, they wait way more than 24 hours, in 3 cases more than 2days to take the mother or the new born to hospital.

Figure 6.2: time taken for decision making (%)



(Source: fieldwork: 2013)

In Rasulpur, while complication occurs during or after the childbirth, 15.4% of the respondent took 1-6 hrs. 15.4% took 6-12 hrs. 38.46% took decision within 24hrs and 30.75 % of the respondent took more than 24 hrs. To take decision and majority of the section contributed by poor and middle class who struggles to arrange money.

Case study: Story of Taslima

Taslima a 22 years old woman who lived with her husband in Vatipara village adjacent to signboard Bazar, as both of them worked together in a nearby garment as garment workers. She came to her parents' house to give birth two weeks before her due date with her husband as she and her husband lived in nuclear family so no one was there to help her during childbirth. As she worked as a garments worker she never had time to have any antenetal check-ups before her delivery or any medication such as Vitamin or Iron Tablet. The problem started when she came to her parent's house for delivery as her water broke earlier (pre mature rapture of membrane) before her expected due date. In that time there was no Dai as only Dai of the village went to attend another delivery in another village. So they called an Aaya, named Rebeca who works in Gafargaon Upazila health complex as assistant nurse. Rebeca ensured them that nothing bad will happen as she saw this type of cases a lot in hospital. At 10 p.m. of night Taslima gave birth of a healthy girl but her placenta retained in her womb. After trying for one and half hours, Rebeca (aaya) finally asked them to take her to hospital immediately. Her husband immediately took her to Gafargaon Upazila Health complex by van and reached there at 2 a.m. of morning. But there was no doctor to attend them so they asked to take her to Mymensingh Medical Collage Hospital which is 16 Kilometres away from the health complex. But they already took a long time and for a long time Taslima was not treated and unattended by any doctor. So on their way to Mymensingh Medical Hospital, Taslima couldn't make it through and died.

Case Study: Harrowing Tale of Khotte

Khotte is a 22 year old mother belonging to a very poor family. Her husband Sobuj works as a sweeper and her father is a cleaner. She lives in an extended household with her in-laws. Considering their economic

condition, it was very obvious that she didn't receive any antenatal check-ups or medication even though she suffered from pallor, weakness, fatigue and less fatal movement. She gave birth to a boy at her in-law's house at 5 a.m. According to the Dai, the boy was alive but he wasn't crying and didn't move much. So Dai and other family members tried many indigenous techniques like rubbing oil on his chest, blew air into his mouth, they also massaged his umbilical cord but nothing happened. The boy was left there this way till 8 a.m. and then they gave the child his mother's breast milk in spoon, after two or three sip the boy started vomiting blood. There was a Shastho Sebeka from BRAC's MNCH programmes and Dai, both of them insisted the family members take the child to the hospital. But the father was insistent about his decision that he is not taking the boy to the hospital. He pointed out look at the boy he is already blue (skin colour) and will be dead soon, so I am not going to waste my money on him. Khotte started crying and the other family members also urged him to take the child to hospital but he persisted on his decision. So totally left untreated the boy died at 11 p.m.

During an FGD session, this particular story was repeated by *Sebeka* and*dai* as the death of the child put their job in jeopardy. *Sebeka*divulged to the researcher that she had to face questioning from the higher authority and if she had been found guilty then she could have lost her job. According to her, ''that man is a lunatic, we tried to convince him to take his son to hospital but he refused to listen to any one, he knew the fact that he could get free treatment from hospital and medicine from BRAC. All he has to do is to pay for the accommodation which is not more than 200 taka." When they were asked why no one came forward and helped that poor man to pay for the accommodation''? She replied,'' of course we would if we could, we are poor people and he had money but he was just reluctant to pay for his child.

Data collected from fieldwork suggests that, no immediate decision was made when complication emerged, this often lead them towards serious consequences and some cases, cost valuable lives of mother and child.

According to the three delay model presented by Sereen Thaddeus and Deborah Maine in their study, **'Too far to walk: Maternal mortality in context'**that the outcome of treatment is most adversely affected by delayed treatment. They examine research on the factors that: (1) delay the decision to seek care; (2) delay arrival at a health facility; and (3) delay the provision of adequate care. In both cases of Taslima and Khotte who had to pay the ultimate price because of the consequences of delay in decision making about the mode of delaying in the provision of adequate care and delay in decision pursuing are both presents in this case.

6.4 Risk Management at Home

Data collected from the fieldwork suggests that in Kadam Rasulpur, where in most cases women give birth at home and take no safety measures, and almost every birth takes places with aid of a Dai. Dais plays as an integral part of every delivery even though the expediency of is often questioned when it comes to risk management. Presently in Kadam Rasulpur there are two Dais who have attended almost every home birth for the last five years and have been part of many complicated occurrences of the birthing process. One of them shared her personal experiences with birthing procedures during an interview session.

6.5 The critical Roles of Dais

From time immemorial, Dais are considered as an integrated part of the childbirth procedures in Kadam Rasulpur even though their importance in birth process was often considered insignificant in the past. Interview with Malekadai reveals in past dais were associated with pollution cleaning, cleaning mother and child, moping the place where birth took place and etc. interview suggests that in past role of dais were not as technical knowledgeable person rather as a pollution cleaner and as assistant in birth process.

But in past few years, the scenario is completely altered. A few years ago, they (dais) took a six month during course and became trained as (CHW). This new technical knowledge helped them in various ways as now they can anticipate impending danger during childbirth and tell the pregnant mother and family members what to do when complication emerge. This training not only helps them gaining social acceptance also helps them achieving a better economic condition.

Account of a Dai (NHW)

Malekaa 65 year old women working as a Dai for last 25 years. Sudden death of her husband forced her to work for her survival. When she was asked why she chose this profession when she had other choices,' she replied: "After my husband's death, I had nowhere to go and was forced to live with my Aunt. I was an

ordinary housewife, and didn't have any skill or experience with working. My aunt set me up with one of her relatives who worked as a Dai and my aunt consulted with her. Both of them agreed to the fact that it would be the perfect profession for me. So I started working with her, going to houses watch her assisting in delivery, then after one year, she let me assist her in a birth procedure. I was very scared at first, and then I managed to gather all my courage and did it without any difficulty." When she was asked what extent her economic condition has changed from the past, she explained: "At the beginning, I had to live a derogatory life with very low status, and most of the cases I only got food or clothes. I had to live a life of uncertainty without any fixed income. I had no choice of negotiation, only took whatever the mother's family give me. Sometimes I had to clean the room where the birthing take place. And on several occasions, I didn't get anything: no money, no food or no clothes as families were too poor. I just helped them for the sake of humanity."

During the interview session, she was asked what kind of relationship she has with the pregnant women and their family members. She answered: "There were no relationships or connections between her and pregnant women's family members." She never even sees them before the birthing day. According to her: ''back then, there were a number of women who worked as dais, and everyone knew where to find one when they need one. They contract with the dais when the time comes. Occasionally, when I desperately needed money, I used to visit door to door and asked the family members of pregnant woman to call me for the job."

When she was asked 'when and how she managed to lift up her economic and social status, she replied: "In 2008, BRAC started working in the village, and we participated in their six month long training program. They taught us how to use kits during delivery to cut the umbilical cords, how to check new-borns after birth, what to do if any complications emerge--like if the child is not breathing properly or not crying after birth." She was holding a dummy baby in her hands and showing the researcher some of the techniques she learned from the training program. She was massaging the dummy's chest and back, demonstrating what she exactly does when a new born is not crying after birth. She said, "Now I get 150 taka per delivery from BRAC. I don't have to visit door to door for jobs." She was indicating her Sari (Bengali Traditional dress) and said: "I used to wear old saris which people give me or only could buy one in a year, now I can buy one every month if I want. I built a house last year for me. Now I earn double even three times more than I used to earn earlier. In the past, I had to manage many things just not only helping in the birth process such as bathing the baby immediately, shaving new-born's head, putting honey or sweet in the new-born's mouth, cleaning the room, cleaning the mother etc. Now we don't perform these activities, and I can anticipate any impending danger, know about the danger signs and know many techniques which I can apply to new born if complications emerge. (E.g. massage).

"In the past, we tried to deliver every child at home because most of them belong to poor families and they won't be able to afford the costs. But now after finishing training, I know about the danger signs for mothers and new-borns. We stopped performing stupid rituals *(bokarmoton)* such as: bathing the baby immediately, shaving new-born's head, put honey or sweet in new-born's mouth, cleaning the room, cleaning the mother, cutting the umbilical cords with whatever is provided by the family members: etc. Now we use our own clean kit for cutting umbilical cords and if we anticipate any impending danger, we immediately refer them to hospital, because if the mother or child dies, BRAC will accuse us, and our job will be at risk." She mentioned the story of Khotte: after Khotte's child died, she and Shebika both faced questioning for weeks. "Now we don't have to do any other work for earning livelihood, as there are only 2 trained *dais*(NHW) in the village, they are often very busy with delivery procedures. In a busy day, I assist in 6-8 deliveries in one day. In the past, we didn't have any actual knowledge about health related issues so family members didn't pay any heed to our opinion, but now after completing this training, it gives us a new position. There are only two trained dais in the village now, and family members of pregnant women take our opinion seriously as they know we are trained." She was explaining the fact that this training elevated her economic rank and social status, not any substantial position but new knowledge gives her a new authority where she can also make decisions and suggestions to the family members of patient.

Chapter Seven

Summary &Conclusion

The present study, 'An Ethnography of Birth: knowledge, Authority and Decision making in Childbirth Practices in the village of Kadam Rasulpur' was undertaken in order to contribute towards a greater understandingof practices, authority and decision making of childbirth in the village of Kadam Rasulpur. In Kadam Rasulpur, like other rural areas of Bangladesh, has Pluralistic medical system such as: Biomedical, Folk medical system. In Rasulpur Childbirth is often interrelated with multi-dimensional factors such as household dynamics, socio-economic factors, and cultural interpretation of reproductive illness, therapy management groups and so forth. The study also focused on to depict a picture of constant negotiation of women and their constant struggle against all obstacles with limited access to the resources, low mobility and low decision making authority. The study also highlights factors that associated with their preference for home birth than hospital birth, their perception on modern obstetrics and homebirth. The study also reveals how the role of dais and Shastho shebika changes these years.

Kadam Rasulpur is low health facilitated area with only a number of dispensaries and a community clinic. Criticalpatients are often referred to Gafargaon Upazila Health complex and Mymensingh Medical Collage and Hospital by CHCP (community health care provider) for better treatments. There is presently, only one kabiraaj in the village Raja Mia who practices both Kabiraaji and Folk treatments for some common diseases such as: Fever, Diabetics, Pain, Skin irritations, Jaundice and etc. it is observed that, even though there are more than one medical system in Kadam Rasulpur, Biomedical system is prevalent now a days. Villagers seek biomedical care from community clinic for diseases like common cold, blood pressures, fever, headache, diarrhoea, cholera and etc.

In 2013, 27 childbirth and 4 maternal death and one neo natal death is recorded. The present maternal mortality rate (2013) of Kadam Rasulpur is 778 per 100000 reflects the poor health status of pregnant women. Women in Kadam Rasulpur sufferer from a number of diseases and illness during and after childbirth, and only a few of them receive treatment As for the poor infrastructural condition of accommodation, economic constraints and most importantly for procrastination of decision making during complication often put the lives of mothers in danger. Women in Kadam Rasulpur faced double problem than their male counter parts as the weak health care system and for being a women it is often very hard for them to seek health care outside the village or even outside their homesteads without the assistance of male.

it was observed that, women's decision s regarding place of delivery largely varies with the household economic condition, availability of male member, reproductive complication occurred during and after childbirth, nature of complication, sometimes influenced by Dais, Shastho Sebeka, neighbour and Doctors (biomedical authorities). Women in Kadam Rasulpur suffers from various diseases such as: Pallor, Fatigue, Acute abdominal pain, bleeding, persistent vomiting, less fetal movement, pain all over the body, jaundice, blurriness in the vision during and after childbirth period,don't seek any types of treatment as they find these illness natural for pregnant women. It was also observed, women only consults or seek medical care when where sufferings are unendurable and life threatening for mother and child such as: Less Fetal movement.

It was also observed that, In Rasulpur Child Birth is considered as Natural phenomena and expected to take place in home. However, when complication arise, which cannot be alleviated in home, People seek refuge in biomedical obstetrics or hospital birth. Having said that, it is not a straightforward process as there are many factors influences their decision-making such as Place of Delivery, Types of complication, household dynamics, power relationship and decision-making authority. In Kadam Rasulpur, type home birth is interrelated with family's economic condition, husband's profession, and number of male members in family, Mother's age and reproductive complications during pregnancy. For example: home birth is largely associated with number of active members in the family for taking care of mother. During pregnancy period,

taking good care of mother's health is considered as an important factor and to keep her healthy, it is important to provide mother with more nutrient food, protein than usual, so household economic condition plays a vital role. Husband's family's financial condition is linked with the possibilities to cater for the mother with extra food, which cost more money than usual. Therefore, in a poor family, this extra expenditure for food is not always possible so in those cases mother moves to her parent's house for extra food and reduce the expenditure of her husband's household.

Husband's profession and household dynamics also determines the types of homebirth, women are encouraged to go to her parents for the delivery if her husband works as garments worker, or work abroad, and if there is no member (mostly man) to take care of the pregnant women or nobody capable to take her to hospital if complication appears. But belonging to rich family where in-law's family can hire extra hand (servant) to look after her and provided her with extra food, preganant woman don't have to go to their parent's house for delivery.

Mother's age and number of children she already has, is another important consideration regarding place of delivery in Kadam Rasulpur. As it was noted from the interviewes with two of the respondents that it is a tradition in Kadam Rasulpur that, they will give birth of their first child at their parents house. It was noted that in pregnant womens often prefer theirparents household for their first childbirth, as they feel more comfortable and autonomous, and the atmosphere is much more familier and friendly. women's birth experience is also an important factor as they already gave birth of more than one, their ages and birth experiences gave them the authority to make decisions regarding childbirth.

In Gafargaon, the Decision making power and authority regarding childbirh, depents on household dynamics, economic factors, understanding of illness, types of complication and are made by different members like Parents-in-laws, husband, wife(herself), parents (mother's), others (neighbours, relatives, Dais, Doctors, Shastho Sebeka).Most of the cases more than one person. Many factors such as Mother's age, economic condition, household dynamic, number of family member influences their decision regarding childbirth.

Pregnant Mother's parents only make decision, when their daugher comes their house for delivery. Decision making authority relies on the hand of parents in law, in families where preganat wife lives with her husband in an extended or joint family. Decision making regarding childbirth also inflluenced by neighbour, shasto shebika, dais as they plays an important role by lending money or sharing their experience and influential contracts .

Data collected from the study area during the Interviews sessions, FGDs and Case studies suggests, the role of Shastho Shebika and Dais in decision making and consulation regarding child birth develop a new dimension. From the interviews with pregnant women and their family members, Shebika and Dai , it was quite clear that role of dai and shebikas has changed significantly over time. Training programs hosted by Goverrtment and BRAC changes the perception of Dai and Shebikas about childbirth as well as, villagers perceptions about them. It was quite clear, that Dais and Shebikas in the village manage to escalade their socail status and acceptability among the villagers. It is true that, this new forms of knowledge doesn't provide them a substantial social rank but give them a whole new stance. As during one interview session, Maleka dai was showing corroborations about her new status by indicating which she managed to build a house with her income and buys clothes every months, which was quite impossible few years ago. The training program changes peoples perception about them as now she has a authority to take decisions regrading childbirth and her opinion ares valued among the patient's family members. Shastho Sheikas in Rasulpur also find a new autonomus place among the villagers and among their own family members. Interview with two Shebika reveals the fact that they entered in this profession only due to poverty and first few years of experience were gruesome. But after a while, when people realize, their knowledge and connection with biomedical authority can be a great aid during complication, they stated to seeking their helps and now Shebika's knowledge and opinions are valued like a family member regarding child birth.

Patients who make a timely decision to seek care can still experience delay, because the accessibility of health services is an acute problem in the developing world. In rural areas, a woman with an obstetric emergency may find the closet facility equipped only for basic treatments and education, and she may have no way to reach a regional centre where resources exist. Finally, arriving at the facility may not lead to the immediate commencement of treatment. Shortages of qualified staff, essential drugs and supplies, coupled with administrative delays and clinical mismanagement, become documentable contributors to maternal deaths. (S. Thaddeus, D Maine, 1994)

When Complication emerges; making decision depends on some important questions such as, what type of treatment they should seek. If she has to take to the hospital who will go with her? How much money it's going to cost for treatment? How long they have to stay at hospital? How they are going to arrange the money or from whom loan would be taken? How will they reimburse the loan? Whom they will consult with about what should be done? How the patient will be taken to the hospital? Seeking answer of those question often cost them vital time, which often put the mother's and new-born's life in jeopardy. The whole procedure of decision-making is often time consuming which sometimes create life-threatening situation for both pregnant woman and Child In Rasulpur, It was observed that, in many cases, especially respondents belonging to poor class, who suffers from complication like bleeding, weakness, fatigue, abdominal pain, even though dais and Shastho Sebeka urged them and their family member to go to hospital, they wait way more than 24 hours, and in 3 cases more than 2days to take the mother or the new born to hospital. The consequence of delaying was Fatal and the patient had to pay the ultimate price of life. And in both cases thedeaths were unnecessary and easily avoidable.

This study has revealed and broandened the scope for further research on decisision making process regarding place of childbirth. Further directions for research on childbirth issues need to recognize the importance of changing roles of dais and shastho shebikas regarding place of childbirth. Future research also need to address the strength and weakness of NGO's Programmes on improvement of metarnal and neonatal health. From the findings of this research,it is recommended that, these following areas need to be accentuate to create a supporting context of childbirth.

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