

**Reproductive Health Care Services of Rural Women
in Bangladesh: A Case Study of Belief and Attitude**

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**Thesis submitted in fulfilment of the requirements of the
Master of Arts (by research) degree**

Date: 10/07/2013

Acknowledgement

The completion of this thesis would not have been possible without the contributions of a number of people. First, I would like to thank the Almighty *Allah* for giving me the strength to undertake and complete this thesis. It was my father who planted the seed of pursuing higher education in me. He would always want me to go for further studies. I dedicate this thesis to my father who has been my inspiration for undertaking this Master degree. I am ever thankful to my husband because without his support I would not have completed this degree. He has been the power of strength in my education, profession and family life. I am grateful to him. I acknowledge the contribution of my son as I should have given more time as a mother. My son has always been very understanding and he is my source of inspiration to complete my study in time. I am also thankful to my mother, my mother in law and father in law who have also supported me through their prayers and moral support. I am also thankful to Tanvir, Rasshi, Topu, Tusher and Koyal. I am thankful to Bushra who worked as my research assistant during my fieldwork in Bangladesh.

I am also grateful to my principal supervisor, Associate Professor Dr. Tahmina Rashid, for her valued and expert advice in preparing this thesis. She has been very patience and understanding throughout this journey.

I am also thankful to the office of research, Eleni, Debra and academic and administrative staff of Faculty of Arts and Design as without their support, I would not have come this far. I am thankful to Garry Collins from the Academic Skill Centre who has been so kind to provide proof-reading for various chapters of the thesis. Lastly, I am also thankful to Avro, Shikha, Deeba, Kakoli, Neeta, Ratna, Rimel, Anita, Nillufar, Mona, Nilu and Shimu for their emotional support and encouragement throughout my study in Australia. I am also thankful to all my face book friends. I am grateful to all of them.

Summary

Reproductive health care services in Bangladesh are inadequate to say the least. Rural women have little or no access to health care services and remain reluctant to consult a doctor due to lack of encouragement from family members and their tendency to rely heavily on traditional healer's medicine. As a result, the maternal mortality rate is 240 deaths per 100,000 live births in Bangladesh (UNICEF, 2012). Despite the acknowledgement of high rate of mortality by the government and non-government organizations (NGOs), there is inadequate research in regard to the causes such as beliefs and attitudes towards reproductive health among Bangladeshi women. This study examined two research questions. The first research question of the study is what are the beliefs and attitudes of rural Bangladeshi women towards reproductive health? The second research question of the study is how these beliefs do and attitudes shape rural women's understanding and their subsequent decisions about their reproductive health and the services that are available?

This study used two tiered qualitative research methodology employing in-depth one-to-one interviews and focus group discussions using semi-structured questions; to confirm and validate the data collected from three villages in Rajshahi, Bangladesh. During the fieldwork 30 one-to-one interviews and three focus group discussions were conducted using snowball sampling technique. The findings reveal three critical themes regarding rural women's belief and attitudes toward reproductive health - a strong belief in traditional healers; a firm belief of following in-laws and seniors/elders, and superstitions regarding fertility, pregnancy and child-birth.

Publications from this research

Referred Conference Proceedings

Tarafder, T., Rashid, T. & Sultan, P. (2012), “Reproductive health care services in Bangladesh: A case study of beliefs and attitudes of Indigenous women” Proceedings of the Australia and New Zealand Regional Science Association International (ANZRSAI) Conference, University of Wollongong, pp. 283-295, 4-7 December, Australia (**Received the highly commended award 2012**).

Tarafder, T., Sultan, P. & Rashid, T. (2013), “Reproductive health beliefs and perceptions among slum women in Bangladesh: Is this a challenge to MDG 5 health goal? Proceedings of the Australia and New Zealand Regional Science Association International (ANZRSAI) Conference, University of Southern Queensland, 3-6 December, Australia (**Received the best conference paper award 2013**).

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Chapter 1: Introduction

1.1 Introduction

Reproductive health is one of the major priorities of global health and is a fundamental and inalienable part of women's health due to child bearing (Patel, Kirkwood & Pednekar, 2006). Motherhood at a very young age entails a risk of maternal mortality that far exceeds the average, and the children of young mothers tend to have higher levels of morbidity and mortality (South-East Asia's Population in a Changing Asian Context, 2002). There are other factors that influence the reproductive health matters such as social status, economic position and access to resources (Patel, et al., 2006). Reproductive health is defined as an organizational framework that incorporates maternal and child health programs, family planning, infertility, sexually transmitted diseases, post-natal infection and maternal and child health related concerns (Dudgeon & Inhorn, 2004). The World Health Organization (WHO) states that reproductive health addresses reproductive process, functions and systems at all stages of life (2012). Reproductive health also refers to the right of men and women to be informed and have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice and the right of access to appropriate health care services that will enable women to experience a safe pregnancy and childbirth. In short, reproductive health addresses the reproductive process, functions and systems at all stages of life (WHO, 2013; Wisconsin Alliance for Women's Health, 2012). Reproductive health care services provide couples with the best chance of having a healthy infant (WHO, 2012). A positive reproductive health care service ensures safe pregnancy, safe delivery progress and provides unrestricted access to the full range of reproductive health care options (Wisconsin Alliance for Women's Health, 2012).

In some Asian countries for example in India, Pakistan and Bangladesh, there is a high proportion of marriage during adolescence, resulting in a high rate of adolescent childbearing (South-East Asia's Population in a Changing Asian Context, 2002). Among the South Asian countries Pakistan's women's health

indicators have not been convincing due to high maternal disease burden, high reproductive burden, low utilization levels of family planning methods, poor nutritional status and lower life expectancy (Ahmad, 2012). It has been demonstrated (Ahmad, 2012) that social, political, religious, geographical, demographic and ethnic dimensions have to be considered in understanding women's reproductive health in any country.

The scenario regarding reproductive health care services in Bangladesh is similar to the context in Pakistan. Given the shortage of qualified health workforce in Bangladesh and the inequity of their distribution, people prefer to seek health care from non-qualified providers in the informal sector, especially the poor and the disadvantaged (Ahmed, 2005). On the demand side, various barriers also impede the use of qualified providers such as lack of access to information on available services, lack of health awareness (unfelt need), lack of opportunity due to exclusion from social and health institutions, cultural factors prohibiting females from seeking care outside home from male providers, and inability to pay (Ensor & Cooper, 2004).

However, in many Asian countries, such as Pakistan, rural women tend to access private, informal health care services such as homeopaths, traditional physicians, traditional and spiritual healers, herbalists and other non-qualified providers such as medical technicians and pharmacy dispensers (Gadit, 2003; Khowaja, 2009). Similarly, rural women in Bangladesh often see traditional healers and spiritual leaders for their reproductive health and life threatening issues (Sibley et al., 2009). In Bangladesh, the reproductive health care services are inadequate and are often characterised as traditional. This problem is intensified due to a lack of sexual and/or reproductive health education facilities. Rural women and children can become marginalized due to inadequate primary reproductive health care services and education. Although the adult literacy rate has improved since 1991 from 31 per cent (Bhola, 2009) to 78.58 per cent in Bangladesh (Bangladesh Bureau of Statistics, 2010), there is still very poor literacy amongst rural women relating to their reproductive health. For example, a report by Caritas (2011) found that up to 85 per cent of Bangladeshi women give birth at home without the assistance of a

trained birthing attendant and these mothers lack the knowledge needed to ensure protection of their own health and the health of their children.

This lack of health understanding has further been intensified by the fact that rural women in Bangladesh often do not have the opportunity to access specialist doctors. Even for life threatening issues they may end up seeing traditional healers (*Kabiraj*) and spiritual leaders (Sibley et al., 2009). In Bangladesh, there are cultural and religious beliefs that impact on how an individual understands health issues. These beliefs impact on the choices made to access various health services including doctors, quacks and spiritual healers (Rafiqul, Islam, Gulshan, & Chakraborty, 2007). Impact on accessing various health services are explored in the following chapters of this research study.

Bangladesh is aiming to achieve the Millennium Development Goal (MDG 5) target that aims to reduce the maternal mortality ratio by three-quarters by 2015. However, the annual rate of decline needs to triple. Women in rural Bangladesh suffer most in terms of prolonged labour, awareness of danger signs of delivery are misinterpreted, distance to delivery service and the cost of the delivery process (Anwar et al. 2008). Stuckler, Basu, McKee (2010) have explained the reasons for being unequal in achieving MDG 5 in developing countries for example Bangladesh, Afganistan and other Sub-Saharan African countries. Stuckler et al. (2010) found that funds given from rich countries are allocated to other forms of social spending, military expenditure, or reserves, rather than to health (i.e., low health spending for each dollar of GDP). Lastly, when funds enter the health system, the government faces low absorptive capacity for spending due to lack of doctors, pharmaceuticals, or hospitals (Stuckler et al., 2010). Although there have been many limitation in terms of reproductive health care services in Bangladesh, one glimpse of hope is that the highest numbers of newborn deaths have been reduced and Bangladesh has positioned itself from 5th to 7th position since 2000-2010 (Lawn et al., 2012). In order to have a better understanding of the reproductive health care services, it is pertinent to have an overall picture of the country and to provide a broader understanding of the socio-cultural contexts of

rural Bangladesh from which the current samples are drawn for this qualitative study.

1.2 Bangladesh: A country Profile

The present day borders of Bangladesh have a historical legacy that can be traced back to the British rule in India, which ended in 1947. The region became East Pakistan in 1947 as part of the newly formed nation of Pakistan. It was separated from West Pakistan by nearly 1,500 kilometres of Indian Territory, political exclusion, ethnic and linguistic discrimination and economic negligence by the politically dominant Western wing of Pakistan. Popular agitation grew and gave rise to a secular cultural nationalist movement, which led, in turn, to the declaration of independence after the Bangladesh liberation war in 1971. In the aftermath of war and independence, the new state endured poverty, political turmoil and military coup.

Figure 1: Map of Bangladesh



Source: Google Map (as on 29th January 2013)

While commenting on the people and culture of Bangladesh, Parry and Khan (1984) noted that the peoples in Bangladesh share a common language and culture despite its diversity, with people coming from different backgrounds, such as Mongoloid, Indian, Arab and Pathan. Although Islam is the major religion, followed by more than 85 % of people, other religions are present such as Hinduism, Buddhism and Christianity. There are various ethnic groups in Bangladesh, among which Santals constitute the earliest ethnic group in Bangladesh (Debnath, 2010). They are also the largest indigenous community in the north-western belt. Despite this ethnic and religious diversity, however, there is a considerable degree of ethnic and religious harmony.

Bangladesh is known as one of the most densely populated countries in the world with a population of more than 164.4 million (UN, 2010). Most of the people (75% approximately) live in rural areas and more than 63% of employment is provided by the agricultural sector. Around 144 million people are struggling to live on less than US \$1.00 a day and more than 50% of the population earn under US \$2.00 a day (Bhola, 2009). According to Hossain, Mondal and Akter (2011), women in Bangladesh constitute half of the population and 80% of them live in the rural areas. The status of women has been ranked the lowest among the other (LDC) Least Developing Countries on the basis on twenty indicators related to health, marriage, children education, employment and social quality (Bangladesh Bureau of Statistics, 2001). The social status of women is highly influenced by cultural values and its domain has been regarded in a subordinated position compared to men especially in rural areas in Bangladesh (Rahman, 2010) In rural Bangladesh, women are generally not encouraged to work in agricultural sector due to cultural and traditional barriers and men's contribution is highly recognised (Rahman, 2010).

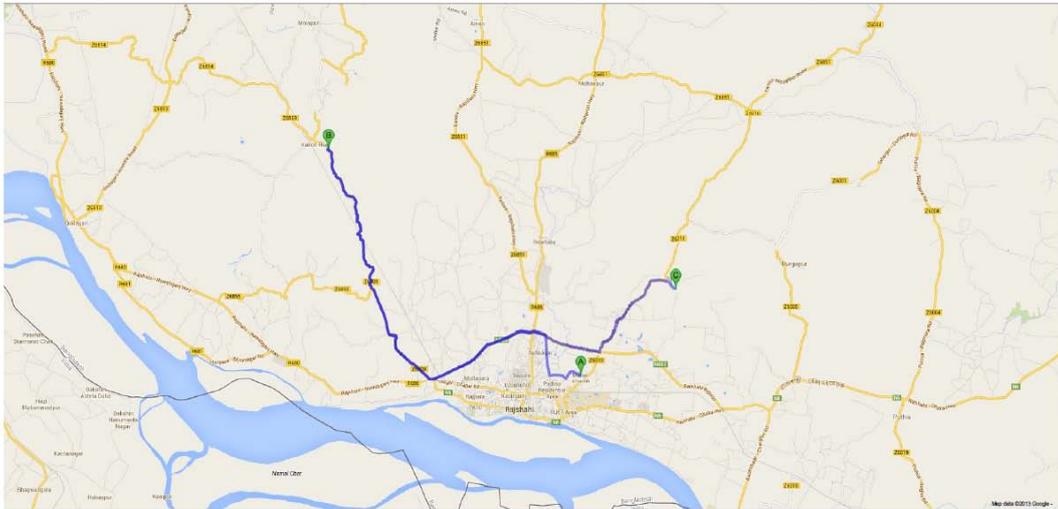
The cultural life of Bangladesh is characterised by the existence of high family values, powerful elite groups and widespread corruption and the concept of extended (look after grandparents, family stick together) family significantly wider and broader (Belal, 2001). The social setting of Bangladesh is patriarchal in nature, like other South Asian countries; men are the principal wage earners and the main

decision makers in most of the significant aspects in the family, thus gender inequality continues to dominate every aspect of social and economic life (Khan, Townsend, D'Costa, 2002). It is a well established fact that in a patriarchal society like Bangladesh, women are ascribed a lower status as men who have the sovereign power to control households and other day to day decisions, while women are often secluded in their homes (Balk, 1997). Women in rural areas in Bangladesh have limited role in decision making, low level of individual assets, heavy domestic workloads, restricted mobility and inadequate knowledge and skill that lead to women's greater vulnerability in family and society (Hossain et al., 2011). In addition, maternal mortality is higher in rural areas than in urban areas due to being unaware of reproductive and sexual rights (Hawkes et al., 2002). Findings from Jejeebhoy and Sathar (2001) suggested that lack of awareness in reproductive health care is common among South Asian women and women are largely excluded from family decision making, they have limited access to and exercise limited control over resources; their freedom of movement is highly constrained and few are free from threat and violence at the hands of their husbands.

1.3 An overview of the location

Data were collected in three different villages, namely, Kakon Haat, Khorkhori and Meherchondi. These villages are located in the Rajshahi district, Bangladesh. This section provides an overview of these villages based on the researcher's visit and insights gained from the visits, Bangladesh Bureau of Statistics and various research publications. The sample areas for this study are 'all rural' in nature. The three different communities where the interviews were conducted provided revealing insights about rural women's perceptions of reproductive health care and how they maintain it through years. The sample places were convenient and familiar to me because of their locations in the North-Western (Rajshahi division) part of Bangladesh, where I was born.

Figure 2: Data Collection Locations (proximate) in Rajshahi District



Source: Google Map (as on 12 Dec. 2013)

1.4 Location of Rajshahi

The regional town of Rajshahi stands on the bank of the river Padma (see Figure 1). The area of the Rajshahi Township is 96.69 sq km, which is both a district and a divisional town which founded in the seventeenth century and it is still expanding in terms of population. Rajshahi district has one city corporation, 7 municipalities, 93 wards and 1858 villages. The total population is 2262483, of which males constitute 51.20 per cent and females 48.80 per cent. In terms of religious affiliation, Muslims constitute 93 per cent, Hindus 5 per cent, Christians 1.5 per cent and other religions 0.5 per cent. In terms of ethnic nationals, Santals make up 2.34 per cent of the total population. One of the communities that were selected for this study is the Santals who are living in Kakon Haat village, which is situated about 40 kilometres from the northern divisional city of Rajshahi.

1.5 Purpose of this study

This study investigates the hidden beliefs and myths that are well entrenched among rural women in Bangladesh and the reasons they access traditional and spiritual healers for reproductive health care services. The research study seeks to uncover the insights of the participants in regard to multiple realities of their lives and thus provide a better understanding about Bangladeshi rural women's reproductive health seeking behaviour.

The aim of this qualitative research was therefore to investigate the varied beliefs of rural women and their diverse experiences of accessing or not accessing reproductive health care services in rural Bangladesh. The research involved a qualitative research method approach involving 30 in-depth interviews and three focus group discussions in three different villages. The research methodology used interviews and discussion as the primary research instruments. Data were collected from women whose ages ranged from 18 to 59 years old. Participants were all married. Interviews were chosen as the most appropriate form of data collection as they offered a detailed insight into perceptions of the reasons for not availing to reproductive health care service. The participants' interviews revealed particularly rich and in-depth information which was supplemented by the demographic data of the participants. The semi-structured format of the interviews and focus group discussions enabled particular contextual themes that contributed to the findings of the study. Field notes taken throughout the research were used to strengthen understandings of particular contexts.

1.6 Research Questions

The research questions investigated the understanding of the key concepts associated with the beliefs and attitudes towards reproductive health care services in rural Bangladesh. This study examined the following research questions:

- (a) What are the beliefs and attitudes of rural Bangladeshi women towards reproductive health?
- (b) How do these beliefs and attitudes shape rural women's understanding and their subsequent decisions about their reproductive health and the services that are available?

The two research questions analysed women's understandings in relation to the dimensionality of beliefs, perceptions, understanding, attitude and perspectives of reproductive health care services.

1.7 Justification of the Study

There is a personal reason that triggered and inspired me to undertake this research. One of the main reasons to choose this study was that I was very unaware of the issue of reproductive health care before I became a mother. This is such a topic that we do not discuss with our elders and also not with our peers in Bangladesh. I was described as an ignorant girl by my friends and family members as I became pregnant by not knowing much about reproductive health care. I looked after myself and read a lot about pregnant body. Finally, I did give birth to a healthy child. I was fortunate enough to understand motherhood by regular health check-ups with the gynaecologists. However, most of the women in Bangladesh do not have this opportunity to visit any sort of specialist doctor and as a matter of fact, they end up meeting traditional healers (*Kabiraj*), spiritual leaders for any life threatening issues. In Bangladesh, there are cultural and religious beliefs that have a bearing on one's own understanding of health issues and has an impact on the choices made to access various health services including doctors and spiritual healers.

Before undertaking this research, I was reading invariably regarding the rural women, homeless women, destitute women, slum area's women's perception and perspective regarding reproductive health care services in Bangladesh. I was very struck by a report that was reported regarding a four year girl being the only person to help her mother during the delivery process. This was quite sensational news in Bangladesh. A four year old girl helped her mother during the time of delivery and had to cut the umbilical cord of the newborn; undoubtedly, as a child she had to bare such horrifying experience that she should not in that very early age (*Amar desh*, 2012). This incident happened in a slum area in Dhaka, the capital of Bangladesh. Usually, women in slums and rural areas have very little options and access to better health care services. The MDG goal 5 projects that every woman should be entitled to a health check up four times during her pregnancy. A special report of the progress of MDG in the *Prothom Alo* (2012) has outlined the main barrier for reproductive health care services in the rural areas in Bangladesh that is not having skilled birth attendants during the birthing process. A World Health

Statistics (2012) report on Bangladesh, which has been republished in *Prothom Alo*, indicates that rural women are being discriminated because they are not able to receive the appropriate health care during pregnancy. This report states that in Bangladesh 13% of rural women get service from a skilled health professional during pregnancy and 37% of urban women get health care service during pregnancy and child birth. Thus proper health care service is not available in many of the rural and slum areas in Bangladesh.

The rural scenario of the Bangladesh reproductive health care services raises various questions on the quality and extent of the availability of these services. This research, however, focuses on the beliefs and attitudes of rural women towards the reproductive health care service and investigates these questions in the context of rural areas in Bangladesh. To achieve the research objectives, Amartya Sen's capability approach provides a useful research tool. This theoretical lens has been applied to gain a better understanding of the rural women's beliefs and attitudes about reproductive health care services and the way these beliefs shape their perceptions about their reproductive health care services. Sen's capability approach is grounded on the notion of human freedom. This freedom, for example, includes access to basic human needs such as health. Whether or not a person has access to better/adequate medical/health care facilities impacts on their freedom to live a 'normal' functioning life (Sen, 1999).

Capability refers to the *freedom* to enjoy various functioning (beings and doings) and functioning is an achievement of a person of what he or she manages to do or to be (Sen, 1999). In particular, capability is defined as the various combinations of functioning (beings and doings) that the person can achieve. Capability is, thus, "a set of vectors of functioning, reflecting the person's freedom to lead one type of life or another . . . to choose from possible livings" (Sen, 1992, p 40). Put differently, capabilities are, "the substantive freedoms [a person] enjoys to lead the kind of life he or she has reason to value (Sen, 1999, p. 87). Functioning relate to many different dimensions of life – including survival, health, work, education, relationships, empowerment, self-expression and culture. Sen (1999) argues that the possession of food provides the owner access to the properties of the food that

can be used to satisfy hunger, to yield nutrition and to give pleasure. Poverty limits a person's access to medical services, education and nutritional knowledge. Thus, poverty and capability have an inverse relationship. The application of the capability approach is to explore rural women's reproductive health beliefs, therefore, an appropriate approach, as this study is investigated in concern with the well-being, development and poverty and freedom and functioning of rural women in Bangladesh.

1.8 Significance of the Study

The main strength of qualitative research is that it yields data that provides depth and detail to create understanding of phenomena and lived experiences (Bowen, 2008; Bowen, 2005). Several studies (Field & Ambrus, 2008; Anwar et al., 2008; Chakraborty et al., 2003; Hadi, 2001; Amin et al., 2010; Saito et al., 1997; Rafiqul et al., 2007; Gayen & Raeside, 2010; Strobach & Zaumseil, 2007) have researched on the issues and aspects of maternal health education and reproductive health care services employing demographic studies and using quantitative research methods. However, this research concludes that there would be inadequate understanding regarding the perceptions and perspectives of rural Bangladeshi women's beliefs and attitudes about their reproductive health using a qualitative research approach. A qualitative research approach is suitable because it requires an in-depth investigation that plays an important role in planning and carrying out development projects (Desai & Potter, 2006). Subsequently, this study, using qualitative research methodology, explored the varied experiences of rural women in their pre-natal, antenatal and post-natal stages; and investigated their social, religious and rural beliefs regarding reproductive health care services.

By using both in-depth interviews and focus group discussions, this research enables some understandings of the connection between individual and social constructions of the phenomena of reproductive health care services in Bangladesh. Furthermore, this research allowed for the comparison of perceptions regarding reproductive health care services of rural women in three different villages in Bangladesh. Data gathered through qualitative methods derived from the

participants and to perceive an understanding of the thinking behind the interview responses. It is also hoped that, through an in-depth study of a small number of contexts, the observations of this research may also provide insights into the views and circumstances of women who are the target of one of the Millennium Development Goals (Goal 5) by 2015, the 'safe motherhood' programme that ensures better maternal health for all women, especially in third world countries.

As a researcher, I refrained from making judgements on the choices women make. My point is not to devalue the traditional practice of reproductive health care in rural Bangladesh. As a researcher, I am investigating the beliefs, attitudes, perception, and indigenous knowledge regarding pre-natal, antenatal and post-natal health issues. As such, the research benefits poor women of rural Bangladesh whose pregnancy and birth experiences are often embedded with inadequate treatments. This study is worthwhile for local, national and international implications for women and health care practitioners. The issues arising from this study have both national and international implications, not only for academic and programmatic interest, but also the interests of women, health care practitioners and policy makers

Chapter 2: A review of current literature

2.1 Culture and social structure in Bangladesh

Bangladesh has a stratified society (Ingham & Kalam, 1992). It is an over populated, resource-poor, and patriarchal and class-based society. About 89.5 percent of total population is Muslim in Bangladesh (Bangladesh Demographic Index, 2013). With a population of over 160 million in only 55, 100 square miles of land, Bangladesh is one of the poorest countries in the world. At least 45 million people in Bangladesh, almost one third of the population, live below the poverty line, and a significant proportion of them live in extreme poverty (IFAD, 2012). Many people have an inadequate diet and suffer from periods of food shortage. Research reports that half of all rural children in Bangladesh are chronically malnourished, nearly half of the rural households are landless, one third of all the adult population in Bangladesh are literate, and about 14 per cent suffer from acute malnutrition (Hossain, Mondal & Akter, 2011). In general, people in Bangladesh need access to education, preventive health care services, women's rights, access to safe water, sanitation, governmental and non-governmental facilities (Strobach & Zaumseil, 2007).

Forty nine percent of the Bangladeshi population are women and seventy-five percent of them live in rural areas (Country report, 2006). Women in Bangladesh have a diverse background in terms of socio-economic status, cultural background, level of education, area of dwelling and social and geographic mobility (Van Schendel, 2009). In most instances, Bangladeshi women performs roles such as, child bearing and rearing, cooking, household chores and care for elderly; whereas men play an instrumental role, for example, cultivating, farming, managing and decision-making (Uddin, 2009). Culturally, most Bangladeshi women hold a position that is subordinate to men in terms of education, literacy, mobility and occupational options in all spheres of their lives and society (Nahar & Richters, 2011).

Culture and belief system in every society influences marriage, family relationship, family authority, and schooling, working and earning (Uddin, 2010). Culture specific outcomes are shaped by values, norms, attitudes, language and customs (Dyer, 1983). For example, cultural belief system of the Muslim and Santal community differently reflects family structure in the agrarian economy of Bangladesh. Bangladeshi Muslims are predominantly Sunni; ethnically they are mixture of different races and culturally have diverse folk traditions, beliefs and ideas. They usually speak in Bengali language which is written in Sanskrit script. Religiously, they believe in Monotheism (*Tawhid*), the Holy Quran as the divine law and principles, and the Prophet Muhammad (sm) as the nominated last Prophet (Aziz, 1979; Alam, 1995). On the other hand, the Santal is the largest tribal group of Aborigines. Racially, they belong to Proto-Australoid stock and speak in Pali. However, Bengali is their second language. They believe in several *Bongas* which means animating nature's worship (Uddin, 2007, 2008, 2009). These fundamental belief systems of the communities influence their respective family structure in rural Bangladesh context. Studies found that the Santali women in Bangladesh play an instrumental role in agriculture and in other fields of operations that require manual labour such as working at the construction sites of building and roads, harvesting and work as a farmer in paddy fields (Gomes, 1988; Ali, 1998; Uddin, 2009). Studies have found that the Santali women's' working life starts much earlier than the majority of the population in Bangladesh due to mass poverty and slow cultural change and modernization (Uddin, 2007; Sattar, 1984) in this cohort.

Although the Muslim and the Santal communities have different culture and belief systems, both of these communities' social systems are patriarchal in nature. For example, the newly married couples are expected to stay with the husband's family and this is referred to as patri-local system (Uddin, 2009). Based on the patri-local norms every married woman in both Muslim and Santal communities becomes a member of her husband's family (Naher, 1985; Rahaman, 1995). Most of the families in Bangladesh follow more patri-local marital residence. Santals who reside mostly in the rural areas are usually married within their village or their adjacent villages due to small number of marital partners or residential instability

or migration from one village to another for economic and social security reasons (Uddin, 2009). This is also evident in other South Asian countries including India and Pakistan (in particular, the Punjab state of both of these countries) are typically patriarchal and patri-local in nature and women in these states have relatively little freedom of movement and limited inheritance and limited opportunities for control over economic resources (Jejeebhoy & Sathar, 2001).

2.2 Challenges of rural Bangladeshi women

This section discusses the predicament of culture and social structure that upholds reproductive health beliefs in rural Bangladesh. The current literature suggests that rural women face critical challenges in accessing reproductive health care services; such as distance to health care centres, cost of services, technical qualifications of health practitioners, the socio-economic status of users, concerns that delivery may take place on the way, ineffective experience and a lack of autonomy in household decision making (Cladwell, 1986; Cleland & Ginneken, 1988; Elahi et al., 2006; Levin, Rahman, Quayum, Routh & Barkat-e-Khuda, 2001, Anwar et al., 2008). One study, in particular, finds that older women seek more reproductive health services and use modern medicine as opposed to younger women (Chakraborty et al., 2002). It is also evident in the current literature that women from large family members access less health care services during the period of pregnancy in rural Bangladesh and Philippines (Wong, Popkin & Gullkey, 1987).

Mother-in-laws play a major role in the socio-cultural contexts of rural Bangladesh, especially, in decisions relating to childbirth and care related to pregnancies (Piet-Pelone, Rob & Khan, 1999). In most instances, mother-in-laws decide how the delivery will take place, whether it is by a Traditional Birth Attendant (TBA) or by a health facilitator (Piet-Pelone et al., 1999). However, co-residence of mother-in-law and daughter-in-law is also common in Bangladesh, India and Pakistan (Jejeebhoy & Sathar, 2001).

In Bangladesh, motherhood appears to be the main or only culturally available social identity for many rural women. Van Balen and Bos (2009) highlighted the

sufferings of childless women in a resource poor country like Bangladesh. In particular, Nahar and Richter's (2011) study stated that the barren or childless women suffer rejection by her husband which can impoverish a woman mentally and physically as husbands and in-laws try to find fault in everything. Thus, there is a sense of guilt among the barren women in the socio-cultural contexts of Bangladesh (Greil, 1991).

Thus, the socio-cultural structure of rural Bangladesh has an impact on women's choices of accessing reproductive health care services. Beliefs and attitudes are found as the dominant drivers that shape rural women's access to reproductive health care services. In rural Bangladesh, belief, attitude, tradition and customs are being looked after by the immediate elders of the family members and neighbours, and passed those on to the next generation (Ahmed, 2006).

2.3 Reproductive health beliefs in rural Bangladesh

This section discusses the current literature on specific beliefs in relation to women's reproductive health in rural Bangladesh. In a rural Bangladesh context, cultural specific beliefs play a key role whether or not to seek professional reproductive health services. Literature finds that young women are shy to show their pregnant bodies (Hira, Bhat, and Chikmata, 1990). Thus, they are less likely to seek care from a doctor, nurse, or midwife compared to urban women, as they depend more on their husband's and in-law's decisions (Rafiqul, Islam, Gulshan, & Chakrabarty, 2007). Rural women's dependence on their husband's attitudes towards health services often determines their ability to access those services in Bangladesh. Husbands are influential factors for women's reproductive health outcomes (Dudegeon & Inhorn, 2004). Studies in this context, suggested that women, whose husbands were not concerned about pregnancy complications, had been one and a half times less likely to seek care from a health professional (Rafiqul et al., 2007; Gertler et al., 1993; Dujardin et al., 1995).

Health related beliefs also depend on cultural norms such as *Purdah* (veil) restrictions that can often prevent women seeking healthcare services from outside

their home for themselves and their children in Bangladesh (Rashid, Hadi, Afsana & Begum, 2001). The fact that Bangladesh is a predominantly Muslim country, the concept of *pardah* often governs women's lives to different extents (Nahar & Richters, 2011) that reduce a pregnant woman's movement (Darmstadt et al. 2006). This has further been supported by Anwar et al.'s (2008) study that found that women in rural areas are not seeking health care services during pregnancy period because they do not want to be attended by a male physician.

There is a tendency and perception of the male members of the family that it is a waste to spend money on female health, especially in rural Bangladesh (Schuler et al., 2002). Research finds that male members in the family often do not like their females to go by themselves and see a doctor due to their traditional attitude towards female's limited mobility (Schuler et al. 2002). Mobility during pregnancy is restricted due to having a rural belief in malicious, 'evil spirit' or 'free ranging spirit.' It is believed that evil spirits are believed to overpower and possess a woman when she travels alone outside her residence, especially in the early morning, at noon and at dusk (Edmonds et al., 2011). Sibley et al.'s (2009) study further explained this and found that rural women believe that evil spirits (*Alga batash*) are the cause of excessive bleeding and that women should seek help from a traditional healer (*kabiraj*). In their study, Chakrabarty, Islam, Chowdhury, Bari and Akther (2003) found that about 46% did not seek any care for excessive bleeding soon after their delivery, and another 21.8% went to a 'village doctor' (*kabiraj*, a practitioner of herbal medicine and has spiritual knowledge) and other traditional sources for post-natal health care. Chakrabarty et al.'s (2003) study demonstrates the role and acceptability of a village doctor in treating life-threatening conditions, such as excessive bleeding amongst the rural women in Bangladesh, compared to available and professional health care services. Thus, health related beliefs, individual attributes and socio-cultural constraints make a strong contribution to the treatment of women's reproductive health in rural Bangladesh.

There is a higher rate of female child mortality than male child in many developing countries. This infant mortality rates has been attributed to childcare or healthcare

practices that selectively disfavour females (Hossain et al., 1988). Male child is given more importance due to a deeply rooted socio-cultural practice that reflects the superior social status, greater economic importance of males and parental neglect for female children (Koenig & D' Souza, 1986). Thus, sex biased health and nutrition behaviour discriminates female children, and thereby causes a deviant female predominance in the childhood mortality rate (Chen, Huq, & D'Souza, 1981).

2.4 Current status of reproductive rights in rural Bangladesh

Access to professional reproductive health services is one of the rights, Amin & Hossain (1994) suggest that reproductive rights help build a base for social change. The concept of reproductive health rights is rooted in the modern human rights system developed under the auspices of the United Nations and reproductive health and rights are fundamentals for sound economic development and poverty alleviation (Hossain et al., 2011). Reproductive rights depend on the recognition to the basic rights of all human beings and couples to decide freely regarding the number and spacing of their children, and to have information and rights to attain the highest standard of reproductive health services (Amin & Hossain, 1994). Although knowledge of family planning is widespread in Bangladesh, its practice is limited and most often rural women are ignorant of their basic reproductive rights.

Reproductive health education may act as a proxy variable for a number of background variables representing a woman's higher socio-economic status, thus enabling her to seek proper medical care whenever she finds it necessary (Chakrabarty et al., 2002). Reproductive health education, as an intervention, could play a vital role to improve the current status of reproductive health in rural Bangladesh. Chakrabarty et al. (2002), in this connection, states that reproductive health education plays a vital role in the utilization of health care services by enhancing women's knowledge about maternal morbidity and thus creates an awareness of women's health. Recognition of danger signs such as prolonged labour, postpartum bleeding, obstetric complications, obstructed labour during the

birthing process, reflects a low awareness of the pregnant woman and her family as immediate medical attention is required to respond to this life-threatening complication (Anwar et al., 2008). There is a general reluctance to prepare for the delivery or to seek care during pregnancy in rural Bangladesh as there is a belief that this would make further delay of the delivery of the child. It is also considered an embarrassment for the woman (Darmstadt et al., 2006).

Education is a resource that enhances women's access and ability to negotiate institutional resources (Chitrakar, Maddox & Shrestha, 2002; Betts, 2010). Lack of awareness regarding health care services impacts on women's access to resources and proper information about child birth details (Maddox, 2005). The current literature found that education of mothers led to increased decision-making power, increased awareness of child welfare, and was strongly related to a reduced child mortality rate (Mosley & Chen, 1984; Gayen & Raeside, 2010). Rural women in Bangladesh have little knowledge of pre-natal and post-natal health care services and are often at higher risk during child birth (Anwar, Akther, Chowdhury, Salma, Rahman, & Anwar, 2008). Ensor and Cooper (2004) suggested various intervention programmes aimed at improving health education and information in community and rural areas, so that rural communities could convince families of the need to obtain reproductive health care and facilitate admission to hospital in emergencies.

Rural women's perceptions and perspectives regarding reproductive health care services rely upon various aspects. The research questions of this study are aimed at investigating the beliefs and attitudes of rural Bangladeshi women towards reproductive health. This research is also aimed at investigating beliefs and attitudes that shape rural women's understanding and their subsequent decisions about reproductive health. In order to investigate the two research questions, it is also pertinent to evaluate rural women's capacity to access reproductive health care services and the degree of freedom in terms of mental and physical state that enhances or decreases her choice for accessing proper health care services. In order to evaluate rural women's capacity for accessing reproductive health care, Amarty

Sen's 'capability approach' is explored to find out well-being, development and poverty, and freedom and functioning of the participants of this study.

2.5 Theoretical framework: capability approach

A theory is a 'thinking tool' to contextualize the research problem of a study (Webb, Schirato, and Danaher 2002). The aim of this study is to gain a better understanding of the rural women's beliefs about reproductive health and the way these beliefs shape the perceptions about their reproductive health. The theoretical root of this study is based on the concept of 'capability approach' (Sen 1987, 1990, 1992, 2001; Sen & Hawthorn 1988). As Amartya Sen states:

...the well-being of a person may plausibly be seen in terms of a person's functioning and capabilities: what he or she is able to do or be (e.g. the ability to be well nourished, to avoid escapable morbidity and mortality, to read and write and communicate, to take part in the life of the community, to appear in public without shame... (Sen, 1990, p. 126).

Sen's 'capability approach' is grounded on human freedom; both intrinsically and extrinsically. This freedom, for example, is an access to basic human needs such as health. One would be incapable of functioning a normal life if (s) he is deprived of or not having access to better medical facilities. Having the knowledge of medical facilities, for instance, and be able to use them, puts any disadvantaged person into an advantaged position, which ensures the capability (functioning) of a person; and this in turn ensures happiness (well-being).

Sen further argues that having an access to better resource and leading a comfortable life style do not define the capability of a person. It is freedom in terms of both physical and mental state that represents the capability of a person. Sen (1999) argues that health is among the most important conditions of human life and critically significant constituent of human capabilities which have reasons to value because health of a nation only improves during economic prosperity. Sen also states that poverty is interlinked with the stages of functioning or doing, and

well-being of a human being. Poverty puts a limit on accessing commodities, activity levels in daily social life, access to medical services, one's ability to participate in economic activity and have education and nutritional knowledge. Thus, poverty and capability has an inverse relationship. Poverty is another alternate version of inequality (Sen, 1983). The capability approach explains the notion of poverty, inequality or well-being. Sen (1983) claimed that absolute deprivation in terms of a person's capabilities relates to relative deprivation in terms of commodities, incomes and resources (Sen, 1983).

The findings from the literature review reveal that cultural beliefs and health-related beliefs have an impact on shaping rural women's attitudes toward accessing reproductive health. In other words, rural women in Bangladesh have limited freedom because they have to follow traditional myths held by their families. The notion of capability not only refers to a broad range of opportunities, for example, to avoid poverty or to meet or exceed thresholds of well-being, but also to serve as a framework for policy evaluation or inequality measurement in non-poor and poor communities (Sen, 1987, 1992). These beings and doings, which Sen (1990) calls achieved functioning, together constitute what makes a life valuable. Functioning includes working, resting, being literate, being healthy, being part of a community, being respected and so forth. Another aspect that to the notion of functioning with this study is the state of well-being and doing that an individual can undertake. Well-being and doing is discussed in this study for rural women who are not availing themselves of reproductive health care and the opportunities they can undertake to improve the health of mothers and children.

2.6 Summary of the literature review

Maternal health has been given priority in achieving MDG because maternal mortality continues to claim the lives of more than 500,000 women a year (Mckay & Vizard, 2006). The maternal mortality results from poverty, malnourishment, disease, multiple pregnancies and lack of access to adequate health care services (Mckay & Vizard, 2006). The current review has provided an understanding of various beliefs about reproductive health issues in rural Bangladesh. The review

found that the current studies were mainly based on mixed-method using a cross-sectional survey, where multiple-regression analyses were often used. However, there is still an inadequate understanding of the beliefs and attitudes towards reproductive health care services in Bangladesh using a qualitative research approach. An in-depth qualitative study provides a better understanding by producing rich data with detailed description (Merriam, 2009). This study has pointed out an in-depth investigation of rural women's insights into their experiences of belief and attitudes towards reproductive health. The qualitative data of this research highlighted the multiple realities of rural women's perception regarding accessing reproductive medical services. In particular, this study explored the rural women's beliefs about their reproductive health and explores the degree of freedom of the female participants for availing reproductive health care services. Thus, the current study uses in-depth one-to-one interview and focus group discussions to uncover the current phenomena of reproductive health related beliefs, perceptions, and attitudes of rural women in Bangladesh. The following chapter discusses the research paradigm that allows interpreting rural women's beliefs and attitudes towards reproductive health care services through interviews, focus group discussion and socio-demographic data and developed an understanding of their experiences.

Chapter 3: The Research Method

3.1 Introduction

The chapter discusses and justifies the research methods employed in this. The research methods included methodological triangulation, following a qualitative investigation of the phenomena. Details about qualitative data collection process are discussed in this chapter, including: selection of the in-depth interview participants and focus group participants, the interview process and the data analysis procedure. The major findings of the qualitative data analysis are discussed in chapter 4. The locations of the research sites are introduced to provide a detailed understanding of the analysis of the themes that derived from the coding process.

3.2 Location of the Study

The three locations (sample areas); namely, Kakon Haat, Khorkhori and Meherchondi of Rajshahi district (Bangladesh) are discussed in detail in the following section.

3.2.1 Kakon Haat Community

Kakon Haat is situated in the Northern part of Rajshahi district. Kakonhat is mainly an agricultural based rural town. Most of the population living in Kakon Haat are predominantly Santals (often called '*Adibashi*' in Bengali). According to the National Encyclopaedia of Bangladesh (2006), the Santals are indigenous people, one of the earliest groups of settlers in the subcontinent, and are described as the maintainers of the agricultural production system and agro-based culture.

There are 30 families living in the Kakon Haat village (see Figure 2, map of Kakon Haat below), and most of them are daily labourers and paddy field workers, apart from one woman who is a school teacher. Most women in this community are

uneducated and have not completed their Primary schooling. However, they can write their names. These Santal women marry at an average age of 15 years.

Although the role of women in the family is by no means insignificant, the domination of males is also prominent in Santal society. Santal women take a leading role in earning a livelihood or in farming work (Samad, 2006). Santal women are very hard working; though they are less paid than men, as found in this research. For example, men are paid 120 Taka (\$1.5) per day and women are paid 80 Taka (\$1.00) per day as daily labourers in the paddy fields and in construction work (Samad, 2006). Santali women in Bangladesh play an instrumental role in agriculture and other fields of operation, and work as manual labourers side by side with men (Uddin, 2009).

The Santals believe in several gods, and their main god is the 'god sun.' They also express their gratitude to the 'god of crops' during festivals and this is also a part of local practice. They organise festivals with dance, songs, music and flowers, along with foods and drinks for participants. The chorus dance of Santal women takes place in the evening to celebrate the completion of the day. The main food items of Santals are rice, fish and vegetables. They eat crabs, pork, chicken, beef and the meat of squirrels. Pork is their cheapest source of protein and they keep pigs in their home yards.

Santals are the descendants of the Austric-speaking Proto-Australoid race (Shahidullah, Mujahidee, Nasir Uddin, Hossan, Hanif, Bari & Rahmatullah, 2009). Their complexion is dark, and they are medium built, with black curly hair and full lips. They have distinctive features, such as being long-headed and broad-nosed. They believe in communal administration and they like to stick together for any issue that they face. They love dancing, singing and music. They have their own language named '*Pali*' which is almost an extinct language in Bangladesh. '*Pali*' no longer has its own script, and the alphabet is in Romanised form. Most of the Santali women are married within their village or adjacent villages due to the small number of prospective marital partners in the community (Uddin, 2009).

The Santals live a poor life; they dig the soil, carry loads, or engage themselves in work similar to that of day labourers. Santal are the poorest of the poor (Uddin, 2010). They are accustomed to hard work. These women carry their own children if they are little on their backs during their working hours. Most of the Santal population are Christian, while some maintain their traditional faith and they believe in *Bongas*, animating nature worship. Christian missionary social welfare work and preaching of the message of spiritual peace accelerated their conversion to Christianity.

The houses of the Santals are small, but their yards are very clean. Artwork on earthen walls of the houses is evidence of the Santali women's liking for beauty and of their artistic nature. The furniture in the house is very simple reflecting their simple lifestyle. The Santal community has not been able to free themselves from the rule and exploitation of landowners and moneylenders (Samad, 2006). The Santal community relies heavily on the traditional healer¹ or spiritual leader for medical purposes. According to Shahidullah et al. (2009) the traditional healer combines within one person; the healer as well as the diviner who has the ability to drive away malevolent spirits and deities, determine the cause of disease and administer remedies based on their considerable practical knowledge of medical plants. Traditional healers are invariably and always men by tradition. Traditional medicine is highly developed and practiced among the Santals and this knowledge extends to more than three hundred medical plant species available in Bangladesh (Shahidullah et al., 2009).

The Santal community who were selected for this study live in Kakon Haat. They have a distinct religion, culture and food habits. They are the minority group within the majority Muslim population in Bangladesh. According to Uddin (2010, p. 2), “The *Muslim* in this country (Bangladesh) is the dominant group, while the Santal are the non-dominant group.” The Santali have marginal bargaining power in terms of land rights. A similar study in Pakistan also found that the religious minorities

¹ In rural places traditional healers are known as ‘*Ojha*’ or ‘*Kabiraaj*.’

have marginal bargaining power to negotiate with the state, have limited access to employment options and their existence is denied and “relegated to a sub-human status” (Rashid, 2011, p. 8). The Santali people are less interested in having education and because they do not have qualification and professional skill, therefore, they have limited employment options (Uddin, 2012 & 2010). In most instances, the jobs they do include cleaning and working as daily labourers, and construction workers.

Figure 3: A typical Santali home



3.2.2 Santali women’s reproductive health care

The findings of the interviews reveal that it takes a while for the Santali women, who were the participants of this study, to become pregnant. Most of them become pregnant after many years of their marriage. These women told me that they did not use any contraceptives. They believe that due to undertaking heavy workloads in the paddy field and construction sites, their reproductive system aged quickly and they were unable to get pregnant in their early years of marriage.

Santali women rarely mingle with women outside of their tribe; they regard themselves as the ‘other’ and have not been integrated with the mainstream community due to their differences in language, religion, beliefs and social norms

(Samad, 2006). The Santali and other communities, such as women from Khorkhori and Meherchondi who are non-indigenous, were chosen for this study in order to compare and contrast women's beliefs about reproductive health care services in rural Bangladesh.

3.3 Khorkhori

3.3.1 Community

Khorkhori is one of the *Mohallas*² in the Rajshahi division. Most of the population in Khorkhori are Muslim. Men are the breadwinners in the family and they work mainly as daily labourers in the paddy fields and in the construction sites. Women are the homemakers and look after family members and raise chickens, goats and grow vegetables in their own little gardens to support their families. Most of the houses in Khorkhori are made of mud. Mud houses are common and famous in North-western (Rajshahi division) due to low rainfall in the rainy seasons (Rashid, 2007).

Women in Khorkhori are more aware about their reproductive health than women from Kakon Haat and Meherchondi. This is because there is an active Non-Governmental Organization (NGO) working in this area. In the following discussion women's reproductive health care aspects will be elaborated on.

3.3.2 Khorkhori women's reproductive Health care

BRAC (Bangladesh Rural Advancement Committee) is the only operating NGO in the area. There is a female health worker who comes in every month to check the pregnant women. The female health worker (called a doctor *apa*) checks blood pressure, heart rate and pulse. She also examines women's eyes and gives them vitamin and iron tablets. When the pregnant women are due to deliver their babies,

² Quarter of a village or town

the family members give the '*doctor apa*' a call to take the expectant mother to the nearest health clinic. Usually, the family members only need to pay for the medicine if it is a normal delivery. If it is a caesarean section, the BRAC office provides 2000 Taka (\$25) to the family and the rest of the cost is covered by the family, which is affordable. Those who are extremely poor only have to pay 1500 Taka (\$10.2) for a caesarean section (FGD1) and obstetric surgery is a necessary component of the safe motherhood services under the Millennium Development Goal (MDG 5) (Koblinsky et al., 2008). Like other NGOs in Bangladesh, BRAC is working to reduce maternal mortality and achieving the MDG 5 by three-quarters between 1990 and 2015 (Anwar et al., 2008; Strobach & Zaumseil, 2007).

Unlike women in Kakon Haat, Khorkhori women are aware of their health needs. These women take decisions regarding access to health needs. They also know how to manage a medical emergency. They are aware of their reproductive health due to regular visits from the BRAC health worker. Women in Khorkhori raised concerns about the authenticity of traditional medicine of the traditional healer as they are more likely to access medical care. The central feature of an NGO like BRAC is their emphasis on service quality, with particular attention to the interpersonal aspect of service quality and rural people in Bangladesh choose to use NGO (BRAC, Grameen Bank and ASHA) services because they get good value for their money, taking into account travel costs as well as fees at the clinics (Schuler et al., 2002).

3.4 Meherchondi

3.4.1 Community

Meherchondi is situated in the district of Rajshahi. It is a slum area and has a small rural market. Those who are living in Meherchondi reside beside the rail line. These people are slum dwellers and do not have a house of any kind and their houses are made with leaves and straw. This area is the most poverty stricken of the sample areas in this research project. They live in a very miserable situation as

they do not have electricity and clean drinking water for their everyday consumption.

3.4.2 Meherchondi women's reproductive health care

Elderly women in Meherchondi work as Traditional Birth Attendants and provide support to the pregnant women. The elderly women from the neighbourhood assist when help is needed during childbirth. Women in Meherchondi rely fully upon the traditional healers or spiritual leaders for their medical needs and these women have blamed poverty for the extent of their miseries; their financial limitations do restrict their access to health care services. The sampled Meherchondi women are also unable to access reproductive health care services due to their distance from health care services. Thus, the 'amulets,' 'holy water' and 'holy oil' are used as alternative medicines for the women in Meherchondi, which are provided by the traditional healers or spiritual leaders.³

The qualitative approach of the study provided richer description of the data set. This study explored multiple realities of varied experiences of belief, perception, and attitude that inculcate a fatalistic tendency among rural women of not seeking care for their reproductive healthcare. A detailed description of qualitative approach is outlined in the following discussion.

3.5 The Research Paradigm

This study inquired into the multiple realities of the participant's lived experiences that were socially constructed regarding social and cultural beliefs. The process that facilitates the interpretation of multiple realities of different participants is described as an interpretive paradigm (Sarantakos, 2005).

³ Holy water and holy oil means that reciting holy versus on water or oil, which is then given to the patients.

Multiple realities were disclosed in this study as each participant revealed their different perspectives and opinions of their experiences of attaining reproductive health care. In order to attain reproductive health care services, the participants of this study had to be capable in functioning as independent human beings. It was very important to identify whether the participants had any restrictions in accessing reproductive health care or not. In order to explore what are the restrictions or barriers that impedes women's access from reproductive health care, first of all it was pertinent for me as a researcher to investigate whether the participants of the study are capable to function freely as having a normal life? Therefore to contextualise the aim of the study it was important to gain a better understanding of the rural women's beliefs about reproductive health and the way these beliefs shape the perceptions about their reproductive health.

The participants of the study were invited to express their varied beliefs of diverse experiences of availing or not availing to reproductive health care services in rural Bangladesh. As a researcher, my task was to interpret the realities experienced by the participants of the study, which meant interpreting their realities extracted from the textual data. The experiences that were encompassed by the participants provide the ontological perspective which is one of the philosophical assumptions of the study (Sarantakos, 2005). On the other hand, the epistemology of the study details the process employed to investigate and discover knowledge (Punch, 2004). To confirm the epistemological assumption of knowledge (Bryman, 2012) this study had involved field study, where the participants lived and worked (Cresswell, 2007). The epistemological perspective of this study was exemplified by the perspectives of the participants that I had in the in-depth interviews and focus group discussion, which revealed their beliefs, knowledge, perception and understanding of the reproductive health care services in rural Bangladesh.

3.6 Methodological perspective

Qualitative study generates detailed data that permit formulation of new hypothesis and inform further study of practice (Powell & Single, 1997). The basic requirement for valid research, either qualitative or quantitative, is exemplified in

the engagement with people, which is open to learning from what is told, observed and experienced (Brockington & Sullivan 2003). Qualitative research is centrally concerned with how people experience, understand, interpret and participate in the social and cultural world and aims to collect data that is contextualised (Lankshear, 2004).

The main strength of qualitative research is that it yields data that provide depth and detail to create understanding of phenomena and lived experiences (Bowen, 2008). There are various ways for interpreting and inquiring the real life experiences in qualitative research such as grounded theory, case study, ethnography, narrative inquiry, and discourse analysis (Laws, Harper & Marcus, 2003; Cresswell, 2008). The perspective of this study favours a qualitative, methodological (case study) approach because only female participants who were married (bounded in a case, Yin, 2003) were encouraged to tell their stories, reflect about their experience of pregnancy, childbirth and sexual issues.

This study sought to explore, inquire and understand the beliefs and attitudes of the phenomena of reproductive health care for rural women in Bangladesh. Participants, who were in their reproductive years, from 18-45, were given the opportunity to reflect upon their experience of pregnancy, miscarriages and other issues that dealt with reproductive health matters. During the fieldwork process, I kept in mind that I was investigating a social phenomenon that needed introspection, understanding and explanation. There was no place for assumptions which might lead towards bias towards a particular party that could create a paradoxical situation in qualitative research, as both the participants and the researcher have the ability to control personal information (Baez, 2002). Usually, the research questions in case studies are introduced by 'how' and 'why' (Yin, 2003), as is the case in this study. This study attempted to answer the following research questions:

- What are the beliefs and attitudes of rural Bangladeshi women towards reproductive health?

- How do these beliefs and attitudes shape rural women's understanding and their subsequent decisions about their reproductive health and the services that are available?

A qualitative mode of inquiry was deemed appropriate for answering these research questions. The research questions investigated the factors that prevented women from getting enough information and access to reproductive health care services in rural Bangladesh. The research questions attempted to discover the rural women's beliefs and attitudes towards reproductive health care services by applying case study methods. The interpretations of the qualitative inquiry were done by the process of data analysis in the next chapter.

3.7 Case Study Approach

Case study methodology provides descriptive details that emphasize the importance of the contextual understanding of social behaviour (Bryman, 2012). Case study involves in-depth analysis of an organization, person, a group or an event, allowing an understanding of complex phenomena, such as communities. Case study is a useful methodology for focusing on relationship, every day practices in natural settings, placing attention on a local situation (Stake, 2013). The case study is useful to investigate an issue in-depth and "provide an explanation that can cope with the complexity and subtlety of life situation" (Denscombe, 2010, p. 55).

The case study method has a wider range of implications in the real life context and has proven particularly useful for studying educational innovations, for evaluating programs and for informing policy (Desai & Potter, 2006). A case study is an empirical inquiry that investigates a contemporary phenomenon in greater detail within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident (Yin, 2008). A case may be an event, a process, a program, or several people and it involves the study of an issue explored through one or more cases within a bounded system (Yin, 2008). As case study is applied as a method in this research, therefore, it has to be bounded by a

case. The case is bounded by time, place, people or contextual material in the setting (Cresswell, 2008).

The case study method has the flexibility to have an in-depth description and analysis of a bounded system (Merriam, 2009). This study is bounded in rural women who have their own beliefs and attitudes towards reproductive health care services. Since case studies have geographical parameters (Cohen et al., 2000), this research was conducted in the Rajshahi district so as to gain insights into rural women's beliefs and attitudes with diverse demographic and socio-economic characteristics relating to reproductive health care services.

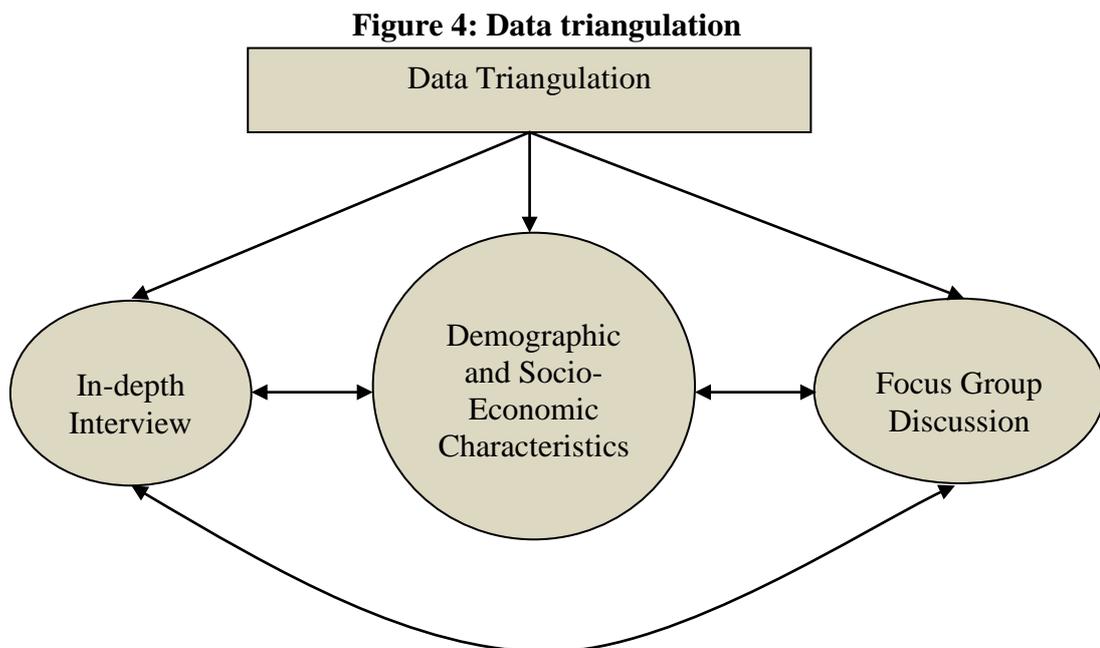
The current study is bounded by rural women, who have a set of beliefs and perceptions about their reproductive health; and also by a timeframe as this research collected data in September, 2012. This particular cohort of women is married, have had several miscarriages, and can be infertile or pregnant. Another reason for applying the case study method is because this study is dealing with the issue of reproductive health care, which is pertinent to policy makers and government officials (Desai & Potter, 2006). In other words, it is a current phenomenon that exemplifies a woman's decision making ability (Sen, 2000) to look after herself by accessing reproductive health care services.

3.8 Triangulation of the study

Triangulation is a means of corroboration of multiple sources and multiple methods (Bowen, 2005). Triangulation is defined as "...the practice of using more than one methodology, method, sample, times, and/or researcher within the context of the same study" (Sarantakos, 2005, p. 434). In a qualitative study, credibility depends less on sample size than on the richness of the information gathered and on the analytical abilities of the researcher (Patton, 2002). Triangulation is all about drawing multiple methods to establish trustworthiness of the data (Stake, 2013). The process of establishing credibility is called triangulation. Credibility depends less on sample size than on the richness of the information gathered and on the analytical abilities of the researcher (Patton, 2002).

Triangulation can be completed by certain ways as Patton (2002) identified four types of triangulation: (1) method triangulation; (2) data triangulation; (3) triangulation through multiple analysts; and (4) theory triangulation.

This study employed data triangulation in that the content of the in-depth interview and focus group discussion was cross-checked. This was further validated by the researcher and the participants after collecting and transcribing the dataset. The researcher went back to the participants who had volunteered in the one-to-one interviews and focus group discussions to further clarify the contents of the transcriptions. The demographic and socio-economic data that established the credibility and validity of the dataset are age, income status, profession, education and ethnicity.



3.9 Ethical clearance of the study

Since this research involved human participants, it was necessary to gain ethical clearance for the study to proceed in its present form. Therefore clearance was obtained from Human Research Ethics Committee, University of Canberra. Prior to conducting the field study, necessary ethical clearance was obtained from the Human Research Committee of the University of Canberra (APPROVED - Project

number 12-70 (See Appendix). The interview questions followed the necessary protocols stated in the ethical clearance. The respondents were assured of the confidentiality of their responses. They were also informed of their rights (i.e. their rights to quit during the interview process). The informed consent form was written in plain language so that the participants could comprehend the meaning of my project description. The interview questions were in simple Bangla and no personal questions were asked that could harm or hurt them emotionally or psychologically. As in all ethical research, it is important to consider the confidentiality of the participants. Within this research, the confidentiality of the participants as well as the information provided was protected. In the final thesis and, in any other relevant publications based on this research, participants' identities will be kept confidential via the use of pseudonyms to preserve the anonymity of the participants.

Raw digital data and subsequent transcripts have been stored in a locked filing cabinet so as to protect the dialogue and identities of the participants. Information was entered in a personal computer for which the user name and password was only known to the researcher. In accordance with the University Code of Conduct, five years after the completion of the research project, the data will be disposed in a manner described by the University of Canberra. Digital recordings of participant responses were erased upon completion of the transcription. In addition, identifiable details such as names and locations were also erased from the publicly available record to protect the identity of the participants.

3.10 Fieldwork experience

3.10.1 Building Rapport

This research aims to study rural Bangladeshi women's beliefs and attitudes toward reproductive health care services. This study did not attempt to gain statistically significant results, instead it attempted to study rural women's perceptions and beliefs that they form either from family or society, and their attitudes towards those beliefs. This study is qualitative in nature, and getting to know the participants was necessary to generate insights and reflect upon the

experiences (Brockington & Sullivan, 2003). An ethnographic researcher, Alejo (2003) contends that researching on a local issue is an added advantage of studying the unheard and marginalised voices of the community. Therefore, this study targeted a diverse range of rural Bangladeshi women living in the Rajshahi district who might have different beliefs and attitudes, based on their experience and context, regarding the available reproductive health care services (Desai & Potter, 2006).

During data collection, I maintained regular contacts with my supervisors through e-mails and discussed my day-to-day experiences and progresses of my fieldwork. I have experienced various difficulties such as financial constraints, transportations and distance, and travel to the data collection sites. Following the current literature (Rashid, 2006), I had also realistically examined the resources needed to conduct and complete the data collection successfully. Thus, I restricted this research project to three villages of Rajshahi district, only, as it was easily accessible by road.

In a qualitative study, this is very common to have difficulties in getting acceptance from research communities (Rashid, 2006). I faced a similar situation as the participants were initially reluctant to participate in this study, however, their refusal and lack of approval did not deter me from persuading them. The three villages that I have visited took a few days to open up to me. During the first few days, I just went to introduce myself to them, familiarize myself with the community and build a relationship with them. The participants thought that I was a family planning officer who had been coming to give them contraceptive pill. While other participants thought that I was a doctor who had been coming to talk about birth control method. Some participants also thought that I was from a television channel that had been coming to make a documentary film on the lives of rural women in Bangladesh. I came to know all about these when I started the in-depth one-to-one interviews and focus group discussions, and enjoyed these observations and initial apprehensions with the participants of this study.

The rural women who I interviewed had no idea of the meaning of this research, nor did they understand the core issue of this research, ‘reproductive health and related beliefs.’ In order to make them clear, I told them that I am writing a book on the lives of rural women in Bangladesh, where I would be discussing about their health, pregnancy and related beliefs. In the beginning, I faced difficulties to gain trust from the participants from all the three villages. When I revealed my intention that I did not go to them to change their beliefs and attitudes about reproductive health instead wanted to understand their reproductive health beliefs, I was rather accepted by the participants gladly and it became easy for me to build a good rapport with the participants in these three villages.

Once the rural community accepted me, I did not find it hard to get participants for this study. The news spread very quickly about me in these villages and the message that went across was that “there is a lady who is talking about health and giving incentives...” Giving motivational incentive as gifts was ethically approved by the University of Canberra, Australia (approved Project number 12-70), and eventually this worked in favour of the participants. For example, the Santal, one of the participant groups in this study, who are less paid in terms of their daily labour (80 Taka), which is equivalent to \$ 1.00, did not have to work for two days as I had given them 200 Taka (\$2.5) as cash incentive for being a participant in this study. It is not uncommon for researchers to provide such incentives to participants. For example, Afsana (2003) provided the following reasons for offering financial help to her participants while undertaking her study in Bangladesh.

“During my fieldwork I had to offer financial help to a few women, who I also interviewed. This may give rise to ethical concerns and risks threatening validity. From an ethical point of view, their economic situation was so miserable that my moral obligation was to help them. This is not an uncommon practice in a country like Bangladesh whose culture based on Buddhism, Islam and Hinduism, is developed through showing kindness and benevolence to

the poor. Even the medical doctors feel compelled to support their patients financially and set up funds for the poor from their monthly wages” (Afsana, 2003, P. 46).

On a similar note, Desai and Potter (2006) suggested that paying incentive or some sort of gift is helpful in a lower income community because people’s time is limited by income earning activities. Bangladeshi culture values customary giving and exchanging gifts. Giving gifts is also a sign of friendship that strengthens the bond of mutual understanding and also closes the gap between any hierarchal relations. As Frey and Fontana (1994) claim, gaining trust is important in otherwise hierarchal relations and eliminate suspicion or misapprehension. This trust was grown not through the process of formal interviewing but through exchange of views and the sharing of everyday life that made our relationship intimate and brought me close with all the participants of this research.

There is a tendency in rural Bangladesh that strangers attract a lot of public attention. Likewise, a group of children followed me wherever I went out of sheer curiosity about an outsider. Sometimes I felt good to have these children following me but often it was very difficult to concentrate as very rarely I had time alone with the participants to conduct the interviews in private. It was almost impossible to conduct the interviews in an isolated place without interference due to the crowds around me. On a similar note, Afsana (2003) conducted an ethnographic study on childbirth related issues in Bangladesh and revealed that privacy was difficult to obtain in the village for conducting interviews, due to people entering and exiting without notice or permission.

Another challenge of collecting data in a rural context is the use of multiple dialects. The three villages use two local dialects that vary enormously, especially, between the Santal and other groups. In particular, the Santali people use *Pali* as their first language and their second language is Bengali. In order to make the interview questions more viable, I rephrased and re-articulated the interview questions for this cohort of participants. While undertaking the interview, I followed the suggestion provided by Desai & Potter (2006) regarding conducting

comfortable, conversational and relaxing interview. I always kept in mind that an interview is not an interrogation and it should not be threatening to the interviewees. I also kept in mind that the data collection instruments (i.e., the questions) are very important to gather thick and rich descriptive data in the context of a qualitative research. In particular, developing the questions for this research and contextualising those by following the backgrounds of each individual respondent during data collection needed a lot of hard work and was a consideration during transcription. Before data collection, my visits and subsequent stay during day time with these communities have given me a good orientation about their culture and language. In this connection, I also followed the practice employed by similar studies (Geertz, 1973; Rashid, 2006).

Current research suggests reflecting on one's own experience then asks relevant follow up question to the respondents (Rashid, 2006). This helps respondents to open up their version of perceptions, especially, in one-to-one and/or focus group discussions. This also guides respondents to what sorts of information is requested from them, especially, when the respondents are relatively uneducated. I used to start the conversation by reflecting on my experience of attaining motherhood and childbirth, which made the participants of the study more comfortable to participate. I interviewed the participants near their houses and sitting on the grass. As I walked along the village road, sometimes women stopped us, started questioning and then shared their childbirth issues or pregnancy matters.

I always maintained the position of a good listener and never let my own ideas influence the participants. Most of the time, the discussion continued on a range of topics from reproductive health issues to everyday survival strategies. I never interrupted the flow of the discussion, but attempted to bring back discussion to reproductive health care issues, when participants have started long discussion about matters not relevant to this study.

In the beginning, the husbands of the participants were very suspicious of my visits. They thought that I was giving advice on birth control and negatively influence their sexual relationship. They used to stand beside me during the first

few visits that I made. Eventually, the husbands felt comfortable and stopped hanging around where the interview took place.

Establishing rapport with the participants is vital in order to gain their trust (Frey and Fontana 1994). In their study, Frey and Fontana (1994) stated that the advantage of knowing a local dialect for the purpose of data collection is that it helps one to have better communication with people. Interactions only with the participants did not always help in establishing a good relationship with the groups. The other family members might not appreciate the movement of outsiders in their house. Hence, in order to establish acceptability in the family, I continued to interact with the *Murubbis* (guardians/seniors) of the family along with the participants. There were times when I chatted for hours with the mother-in-law and with the sister-in-law simply to establish a trustworthy relationship. Building rapport with the family members also eased the process of interviewing the respondents of this study. At times we even exchanged food during data collection. I had also taken some food items from Australia, for example, assorted biscuits, chips and chocolates, and I shared those with the participants of this study. They were delighted on this exchange and also being shared with edibles from overseas. However, there was a group of men in Meherchondi who came to me while I was sharing biscuits to the participants and their children and in a threatening tone used derogating language stating that foreign biscuits would not suit them. It was quite dark by then and there was no electricity, I did not feel safe. My research assistants advised that we should leave the vicinity as soon as possible as Meherchondi is known as a crime zone due to abject poverty in the area. My assistants warned that there is a chance of being robbed as I was carrying a laptop, electronic camera, voice recorder, ipod and video camera; losing which could have serious consequences for my research. As it was a security concern, we (four of us; one was driver and two were research assistants) left the area very quickly. This incident enabled me to prepare carefully for the data collection in Bangladesh.

3.10.2 Fieldwork Dilemmas

My identity as a Bangladeshi living abroad helped me in some instances to get useful information as many of the participants felt more comfortable talking to an ‘outsider’ (Rashid, 2006). Researcher’s position in the fieldwork is a concerning issue because the researcher is the ‘outsider’ who is conducting the research on ‘others’ (Rashid, 2006). A similar experience is shared by Sultana (2009), who was also concerned about her personal background during her fieldwork as a feminist geographer, as her education and urban outlook placed her in a conflicting position of class and status difference. Doing research at ‘home’ (Rajshahi, Bangladesh) also brings different dimension, in terms of concerns of insider-outsider and the issue of representation in the fieldwork. According to Narayan (1997) an insider has an opportunity to speak about and even criticise the community that she is living in. In the current study perspective, I was not an ‘insider’ as I was not living in the area and rather was an ‘outsider’ as I am not living in Bangladesh any longer. People placed me in certain categories, ‘othered’ me and negotiated the relationship on a regular basis. Participants especially from Meherchondi were apprehensive of the idea that I have been living overseas for a long time and I might be ignorant and naïve of their life experiences. Having a couple of visits in the community and discussing my intention of what I was researching about created a friendly environment between myself and the participants. In addition, I possessed many commonalities—such as nationality, gender, ethnicity, attire and my ability to engage in regular conversation in the Bengali enabled me to close the gaps and become more accepted in the three communities that I have researched. As many people told me that I was after all a *deshi* (local) girl, and talking to a *deshi* girl (even if an outsider and from another city/country) was not generally perceived to be a problem in their local culture. It would be naïve to assume that I became an ‘insider’ or that the relationships were ever fully equal, but my own Bengali identity helped in forming the relationship of trust that is important in fieldwork.

Desai and Potter (2006) provide an in-depth description of their experience while undertaking fieldwork in Sierra Leone. Their study suggests the need to have good

logistics, remain reflexive in the field and have a good grasp of the location to make a well planned experience. Following this suggestion, I planned my visit each day, what electronics' devices to carry and how would I plan my time and approach the participants for data collection.

Each day of my fieldwork, I listened to the experiences of childbirth and mythical stories regarding post-delivery and also about malicious spirits. While conducting the interviews, I realised how little I knew about these communities and their reproductive health issues. For example, the relationships among the Santal community, the local traditional healers' and the abundant natural plants that surrounds them. I find that the Santali women depend on the medicines given by their traditional healers though they have no knowledge of what plants are used to prepare these medicines and the impact on their reproductive health. They informed me that they only receive a paste looking medicines. I find that the participants of Meherchondi and Khorkhori equally depend on traditional healers in regard to their reproductive and general health. I further look for evidence in current literature and find that Shahidullah et al.'s (2009) study took an ethno-botanical perspective and surveyed the Santals living in Rajshahi district, Bangladesh. This study obtained information on 26 medicinal plants. The Santali traditional healers are well known for their knowledge of medicinal plants that are used to treat ailments in both humans and cattle. Among these 26 medicinal plants, Shahidullah et al.'s (2009) study identified two especial plants, of which one plant named *Achyranthes Aspera* is used for stomach pain and excessive bleeding during menstruation; and the another plant named *Asiatica* is used for the lack of breast milk after childbirth. While medicines prepared from natural plants by the traditional healers are often found effective by the participants of this study, this study also sheds some lights on inequality in health services between scientific treatment that is available to communities in urban areas and traditional treatment that is available to rural and poor people in Bangladesh. This dilemma would be one of the major challenges to achieve the MDG 5 (health goal) by 2015 though Bangladesh has been achieving a relatively higher economic growth rate.

When I was in Meherchondi for data collection there was no electricity, it was raining and I was severely bitten by mosquitos while I trying to cover my feet from the mosquitos. A few of the women told me that “*apa* (elderly sister or respected sister) it is so difficult for you to remain in this place due to mosquito bites even for a few hours and we are living here with the mosquitos for so many years.” In my subsequent visits, I was better prepared and covered myself with long full sleeve dress to protect from mosquitos and heat, and carried mosquito repellent. I always tried to dress up and avoided wearing ornament usually tied my hair and covered it following the rural traditions in Bangladesh.

During my fieldwork, the issue of power, control of knowledge and my position were some of the important aspects that I found often very challenging. This is consistent with the similar studies conducted with rural women (Desai & Potter, 2006). The participants wanted to know my socio-economic status, despite my efforts to “fit in.”

Regularly, I transcribed the interviews from the digital recorder in Bengali and my research assistants helped me in the process of writing the Bengali version of the transcript. The dominant themes were recurring from the transcripts and often I re-checked the transcripts with the participants. The coding process of the transcriptions, of the interview facilitated categorising the themes were emerged that provided contribution to the findings of the study. The following discussion provides a detailed description of the interview findings.

3.11 Data collection

Data was collected following a two-step process: in-depth one-to-one interviews using semi-structured questions and focus group discussions. Both methods collected demographic and socio-economic data that ensured the credibility and validity of the collected data set (Bowen, 2005).

3.11.1 In-depth interview

In order to set an argument in the research, oral evidence is pertinent in establishing forms of inquiry and one of the vital techniques is using in-depth, semi-structure or unstructured interviews to collect raw data in the field (Rashid, 2006). In addition, in-depth one-to one interviews are suitable when researchers are researching on sensitive issues (Desai & Potter, 2006) such as HIV/AIDS, family planning, sexuality, domestic violence and on household income (Laws, Harper & Marcus, 2003).

A case study is illuminating when the in-depth study of a particular case is carried out (Merriam, 1998). In this case, in-depth interviews were conducted in one to one sessions with women who were not accessing reproductive health care services. In an in-depth interview, the interviewer is the informant and the interviewee is the respondent and the purpose of an in-depth interview is to gain “insights into certain occurrences and may use such propositions as the basis for further inquiry” (Yin, 2009, p. 107). The data for this research were collected using semi-structured conversational interviews on a one-to-one basis between the researcher and the participants. In one-to-one sessions, the participants of the study were able to share their views openly and they were encouraged in sharing their experiences about pregnancy and childbirth. Kuzel (1999) suggested that five to eight data sources or sampling units will often suffice for a homogeneous sample for in-depth interviews. Thus, the study had 30 in-depth interviews in three different villages of the Rajshahi district. Each in-depth interview took less than 2 hours, as I also had to keep in mind that the participants were also busy with their own lives and schedules and I should not place the participants in a “time-stressed situation” (Desai & Potter, 2006, p. 159).

While conducting the in-depth interview, I treated the participants as experts and I listened carefully. The interview questions were simplified and I avoided using medical terms attached to reproductive health. While undertaking my field study, I was very aware of what I wore and wanted to blend in as much as possible. I went for several days to the data collection sites to build a rapport with women and it

took a few days for the participants to share their experiences about their beliefs and attitudes towards pregnancy and childbirth issues. While doing my in-depth study, I did not show any bias towards medical health professionals nor against the traditional healers, spiritual healers, herbalists or traditional physcists. I kept my feelings to myself and asked questions, if I wanted more clarification. I believe my neutral position during my fieldwork paved the way for receiving acceptance from the participants, which contributed to the context of the study (Giri & Ufford, 2003). Each participant had different story to tell. Some were introverts and some were extroverts and their emotional states differed. Some described more about their experience of miscarriages, while others were reluctant or shy to share their story of early pregnancy.

In-depth interviews elicited individual experiences, opinions and feelings and uncovered and unveiled beliefs and attitudes towards reproductive healthcare services. Sometimes, sensitive (Kendall et al., 2007) subjects came up during the interview, such as knowledge about sexual relations prior to marriage. An in-depth interview is a useful method of obtaining an interpretive perspective because it is the common form of communication between people regarding events, beliefs and phenomena.

3.11.2 Focus Group Discussion

The focus group discussions are exploratory in nature and one of the aims of focus group discussion was to generate relevant themes (Sultan, 2011). Focus groups can be defined as in-depth qualitative interviews of organized discussions held with a small number of carefully selected individuals, brought together to discuss a particular topic, so that researchers can gain information about their views and experience of the topic of interest (Saha, 2006). Researchers differ over the optimum number of participants in a focus group discussion. For example, Gibbs (1997) recommends 6-10 participants for each of the focus group discussions, while Saha (2006) suggests 6-12 participants. Although there is no rule of thumb about the number of members in a focus group, one study suggested that “a group

consisting of 5–10 respondents is appropriate” (Krueger & Casey 2000, 10). The literature suggests that several (3–4) groups are convened depending on distinct population segments (Morgan 1988, Stewart, Shamdasani, & Rook 2007). The convenience sampling technique (Gatfield, Barker, & Graham 1999) and purposive sampling technique (Punch, 2005) are particularly useful for selection of focus group members.

Hadi (2001) suggests that a focus group discussion is considered the most suitable media to disseminate health knowledge amongst poor women as, most of the time, these rural women do not understand clearly most of the print media health messages due to their limited literacy skills. Focus groups allow a researcher to draw upon participants’ attitudes, feelings, beliefs, experiences and reactions (Saha, 2006). This study employed a total of three focus groups in three different villages of the Rajshahi district, encompassing around 5-10 members in each group. Cross-checking with the same people taking part in the focus group discussion and in the in-depth interviews provided a better triangulation of the study data (Morgan, 1988).

In the data collection procedure, I had to keep in mind that building a relationship with the participants would take some time, especially to build a rapport with the villagers. Choosing a site and creating access to the participants was also part of the research. As a researcher, I had to keep in mind that I had to choose a neutral site (Powell & Single, 1996) for taking interviews. Most of the time, I would set an open environment where my participants would feel comfortable.

During the field trip, I observed that there were many people in the village who lived in an extended family. Women did not feel comfortable in front of their in-laws, husbands or neighbours. Therefore, as a researcher, I had to make arrangements for conducting focus group discussions in a safe place, a type of open environment for my participants so that they could share their opinions about their reproductive health (Burgess, 1996). If the participants were not comfortable (Gibbs, 1997) about taking part in focus group discussion in their home, then I

would arrange an alternate space for them, such as beside the paddy field where they worked or in their home yards or back yards of where they lived.

During the focus group sessions, I worked as a facilitator and did not inhibit the discussion. The local community women in Khorkhori and Kakon Haat guided me in terms of who they had good relations with and who they were comfortable to discuss with in regard to their reproductive health issues. I also carried some snacks that I brought from Australia to share with the participants, this helped to open up and continue the discussion. Reciprocity in sharing and exchanging information about my life experiences made the participants comfortable in exchanging their experiences, as I had to keep in mind that they were the ones who were injecting knowledge into my research (Rashid, 2006; Corbin & Morse, 2003; Haraway 1991; Nagar & Raju, 2003; Sultana, 2007).

Primarily, participants were asked to introduce themselves and we all had a good laugh regarding what the participants were thinking about me (some thought I was a doctor and some thought I was from a charity mission or foreign donor agency like Caritas Australia or Save the Children and that eased the environment into an enjoyable discussion forum. We discussed some common topics such as motherhood and difficulties before, during and after pregnancy. Focus group discussion topics also evolved regarding giving birth at home with the assistance of a Traditional Birth Attendant. As a moderator or facilitator, I also noticed that the limitation of focus group discussion is that some people were more voluntarily participating, dominant in their expression and views while others were passive listeners and less voiced and this was unavoidable and inevitable in a focus group discussion (Desai & Potter, 2006).

3.11.3 Participant Recruitment

This section of the study discusses the women who were recruited as the participants of the study. The participants were aged between 18-56 years. The participants were selected to investigate their opinion, perception based on their

experiences and contexts regarding belief and attitude towards pregnancy, childbirth, abortion, miscarries and problems in conceiving a child.

In my fieldwork, I needed not only to collect accurate information on a variety of issues that were related to reproductive health care of rural women in Bangladesh, but also I had to feel and think like the women I was studying (Srinivas, Shah & Ramasamy, 1979). There was not any particular gatekeeper that I had to seek permission from while visiting the three research sites. The best possible sampling technique that this study used was snowballing sampling to recruit interviewees. Snowball sampling is another version of opportunistic sampling and requires researchers to initially select a few research participants and ask them if they know others who might meet the criteria of the research and who might be interested to participate (Liamputtong, 2006). The snowballing sampling has been widely preferred in qualitative research, especially when it is related to vulnerable or marginalised participants who are often difficult to access (Liamputtong, 2006) During the fieldwork period, it was usually one participant who suggested others and thus the list of potential participants increased (Desai & Potter, 2006). As I was using the snowballing technique, I had to keep in mind the importance of maximizing the diversity of the participants: therefore, I tried to reach as many contacts as possible in the villages. I contacted the elderly women of the community.

My research assistants⁴ also helped me to select the locations for data collection. The locations (Kakon Haat, Khorkhori, Meherchondi) of the study helped me decide the best suitable participants of the study. The locations of the study were rural in nature and each participant helped me to get the next participant. In Meherchondi, my research assistant took me to some of the houses as he knew more about the locality. In Kakon Haat, there were many enthusiastic Santali women who brought their friends to participate in the project who were working in the paddy field. Receiving approval from the community female elders (mostly

⁴ There were two research assistants who accompanied me to the field. Both of these gentlemen named Sirajul works as lab assistant andMohammed Rezaul is a peon (orderly) of the Biochemistry Department at Rajshahi University. My sister-in-law who studies English at Northern University, Rajshahi campus helped me transcribing the interviews.

mother in laws) (Kendall et al., 2007) ensured my position as a researcher in the fieldwork process.

Most of all, recruitment of the participants was only possible by engaging with people in the locality. This helped me to learn about their insights, experiences and reflections on what they understood and believed by the concept of reproductive health care services in the rural settings of Bangladesh (Scheyvens & Storey, 2003).

3.12 Data analysis

3.12.1 Recording the dataset

Spoken data that has been digitally recorded is then transcribed to convert into a written text (Sarantakos, 2005). By digitally recording the interviews and focus group discussions, I was able to concentrate on the development of the conversion. By having the interview digitally recorded, I could go back over an interview (or transcript of the interview) to discover the themes, categories and concepts of the data that were collected from the participants. The transcripts were later coded in the data analysis process.

Informed consent forms were obtained prior to the interview and assurance was given of confidentiality. During the data collection period, I kept a reflective journal and recorded my observations directly following each interview. Digital recording is only possible if the participants read and understand the consent form described in plain language in Bangla. During my fieldwork, I was conducting interviews, writing field notes and was working as an observer. On return from the fieldwork every day, I checked the short notes with the interview guidelines and also listened to the interviews. The process of transcribing the recorded dataset provided a better understanding of the insightful thoughts of my participants' viewpoints and discussion. Regularly, I transcribed the interviews from the digital recorder in Bangla and my research assistant helped me in the process of writing

the Bengla version of the transcript. The dominant themes were recurring from the transcripts and often I re-checked the transcripts with the participants.

After coming back from my fieldwork from Bangladesh, I started translating the interviews from Bangla to English. A similar study has also suggested that professional translators have been hired in other qualitative health research studies to provide better accuracy in reviewing translation from other languages to English, which eventually provides authenticity in the coding process of the data analysis (Hsin-Chun Tsai, Choe, Acorde, Chan, Taylor & Tu, 2004).

As I did the coding process of the transcriptions, which were drawn from the interview, the themes that emerged from the raw data contributed to the findings of the study. The data analysis process involved coding, categorizing and assembling all to a broader theme.

3.12.2 Data analysis

The content analysis procedure was followed in this study. Content analysis is often done in case studies and can cope with large volumes of qualitative data (Krippendorff, 2012). The method of analysis which was used involved a manual version of categorical analysis and coding process (Lankshear & Knobel, 2006). The raw data was drawn from excerpts of the interviews. The coding processes involved decontextualising the data from the interview excerpts. Categories of the coding process were engaged in the summarised version from the code level. Finally, the theme was the overarching issue from the category of the data. An example of the data analysis process is given in the following.

The demographic and socio-economic data was analysed using Microsoft Excel and detailed graphs in the findings chapter will present further details of the participants in terms of age, income status and ethnicity.

3.13 Summary of the method

The paradigmatic worldview facilitates the interpretation of multiple realities of different participants. To establish the credibility of the study in-depth interview, focus group discussion and demographic data were employed. All these parameters of data collection were explored after receiving the ethical clearance of the University of Canberra. Therefore, the methodology provided a better insight of the research by getting the real life experiences from the participants regarding their beliefs and attitudes towards reproductive health care services in rural Bangladesh.

Table 1: An Example of Qualitative Data Analysis

Overarching Theme: Belief and its reason

Self-care	Malevolent spirit	Traditional Healer (TH) as (Problem Solver)	Cultural Belief	Follow in-laws and elders	Self-realisation about medical treatment
<p>A.2. I had my first child after 3 years of marriage. When I was pregnant I used to drink lot of water. I did less physical work. I only did what I could do.</p>	<p>A.2. I stayed at home more often. I stayed because due to malevolent spirit and that is why I stayed in door</p>	<p>A.5. Tulu: I was told not to go outside and that is why I did not go.</p>	<p>A.6. When I was pregnant I had to follow the belief that was practice from the family and society. The elders told me that my child inside my stomach can be damaged or I can have any sort of problem. That is why I had to listen to my family and my society. If anything happens to my child or to myself then the blame will be upon me and the elders will say that because I did not listen to them that is why it had happened.</p>	<p>A.7. And I also feel that it is very important to see a doctor. I always want to see a doctor. I believe that I should see a doctor first. I have to make my in-laws understand that I have to see a doctor. Doctor can tell me that which side is my baby's position, how is the baby, or do I have water inside or not but a traditional healer can not say these. I have to see a doctor.</p>	<p>A11. However, I did not see a traditional healer and I did not take his medicine. I want to see a professional health specialist.</p>

Chapter 4: Findings and Discussion

4.1 Introduction

This chapter presents the findings based on the data collected from the field work. First, demography of the participants is provided to have a broader understanding of the localities that I have visited for data collection. Second, this chapter provides reflections on personal and socio-cultural aspects of the participants while conducting the interviews in the field. The later section, then, presents the findings from the interviews and focus group, which is followed by a discussion based on each of the themes and sub-themes, emerged from the field work in order to facilitate the findings. This chapter concludes with a thematic analysis of all the findings from the data. The following section provides a detailed demographic description of each of the participants who participated in the research.

4.2 Demography of the participants

Demography of the participants is important in qualitative analyses. This is because it provides a context of the participants and findings of the study, and strengthens the triangulation process (Patton, 2002). The participants in this study are rural indigenous Bangladeshi women, called ‘Santal,’ and Bangladeshi women of other ethnic groups. The participants were selected from three different villages, namely, Khorkhori, Kakon Haat and Meherchondi. The local indigenous community, the Santal community, lives in Kakon Haat village, whereas the other groups live in Khorkhori and Meherchondi villages.

The ages of the participants range between 18 and 57 years. Participants have various religious faiths including Christianity, Islam and Indigenous religion. Their monthly income varies between \$25 and \$120 per month. Table 2 illustrates the full demography of the participants including the number of children, family members, profession, education, household income, religion, frequency of accessing reproductive health care services, and frequency of accessing services to a homeopathy doctor or a traditional healer. The age group of the participants is illustrated in Figure 7. The highest representation was from the 23-27 years age

group and constituted 30% of the total participants. The second highest age group of participation was from 18-24 years of age and constituted 28% of the total participants.

Figure 5: Per cent of participants by age group

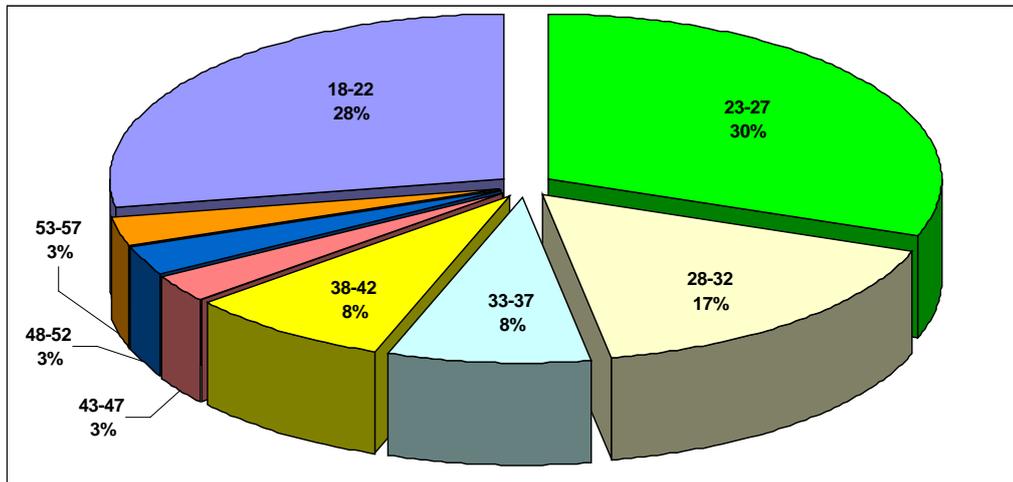
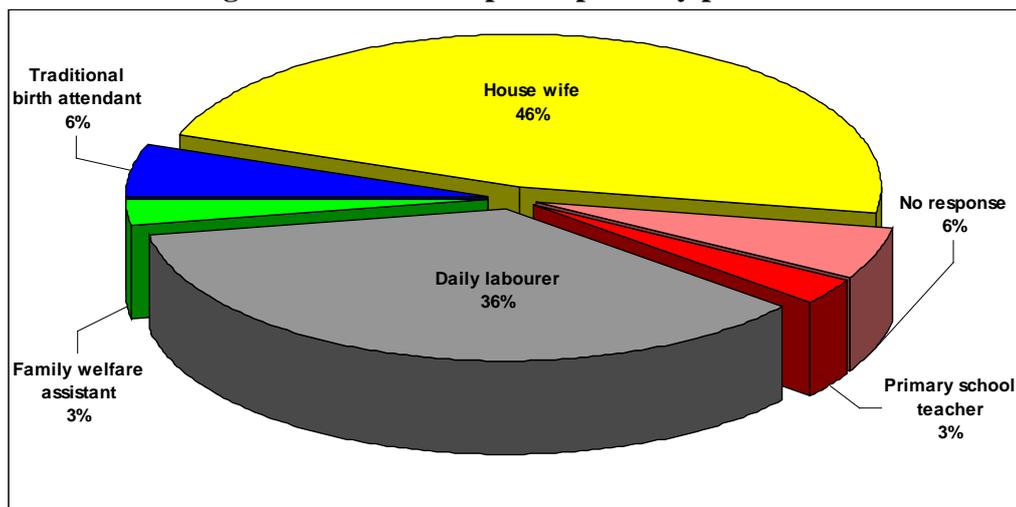


Figure 8 shows per cent of participants by profession, where 50 % of the participants of this study are home makers. The second highest percentage (38 %) of the participation was from daily labourers. Lastly, Traditional Birth Attendant, family welfare assistant 3 %, primary school teacher 3%, 2% and traditional birth attendant 6%, respectively.

Figure 6: Per cent of participants by profession



There were 30 one-to-one interviews conducted in three different locations for this study. Their voices were heard only through the qualitative interviews that

interpreted multiple realities of the participants who took part in this study. It took several days for me to build rapport with the participants and there were many ups and downs while I was undertaking the field work for this research project. Next section is a reflection of my fieldwork experiences in all three villages.

4.3 Differences in reproductive health beliefs amongst various demographic variables

The following section, a comparison between the three research sites is discussed looking at demographic variables in detail. The demographic variables that are discussed in this section include income status, marital, education; profession and religion.

Table 2: Demography of the participants

No	Age	Number of children	Number of family members	Profession	Accessing RHC	Accessing TH/Homeopathy	Education	Religion	Cast	Earning monthly
R1	33-37	1	3	Primary school teacher	4	3	HSC	Christian	Santal	\$120.00
R2	23-27	2	3	House wife	4	1	Below Primary Level	Islam	Local Bangladeshi	\$50.00
R4	28-32	1	3	Daily labourer	3	3	Below Primary Level	Indigenous	Santal	\$25.00
R5	23-27	1	5	Daily labourer	0	10	No formal education	Christian	Santal	\$25.00
R6	33-37	2	5	House wife	2	0	Class 9 to secondary	Christian	Santal	\$25.00
R8	23-27	1	3	House wife	4	0	Class five to eight	Islam	Local Bangladeshi	A\$50.00
R9	18-22	0	1	House wife	2	0	SSC	Islam	Local Bangladeshi	\$50.00
R10	38-42	2	3	Housewife	2	2	No formal education	Christian	Santal	\$25.00
R11	23-27	0	7	Housewife	4	4	Class five to eight	Christian	Santal	\$25.00
R12	23-27	1	7	House wife	4	4	Class 5 to 8	Christian	Santal	\$25.00
R13	23-27	1	3	House wife	2	2	Class 9	Christian	Santal	\$25.00
R14	23-27	1	3	Daily Labourer	0	11	Class 9	Christian	Santal	\$25.00
R15	18-22	1	3	House wife	5	0	Class 5	Islam	Local Bangladeshi	\$30.00
R17	18-22	1	7	House wife	1	0	Below primary level	Islam	Local Bangladeshi	\$30.00
R19	43-47	0	3	House wife	0	1	No formal education	Islam	Local Bangladeshi	\$50.00
R20	28-32	2	4	House wife	1	1	No formal education	Islam	Local Bangladeshi	\$20.00

No	Age	Number of children	Number of family members	Profession	Accessing RHC	Accessing TH/Homeopathy	Education	Religion	Cast	Earning monthly
R21	18-22	1	3	Daily labourer	0	3	Class 9 to secondary school	Christian	Santals	\$35.00
R 22	53-57	3	3	Family welfare assistant	0	0	Higher secondary school certificate	Islam	Local Bangladeshi	\$150.00
R 26	18-22	0	7	Housewife	0	2	Class five to eight	Islam	Local Bangladeshi	\$40.00
R 27	18-22	1	3	House wife	6	5	No formal education	Christian	Santal	\$20.00
R 28	18-22	0	9	Daily Labourer	2	2	Class Five	Christian	Santal	\$25.00
R 29	48-52	6	3	Traditional Birth Attendant	0	0	No Formal education	Islam	Local Bangladeshi	\$50.00
R 30	18-22	1	3	House wife	0	2	Class five to eight	Islam	Local Bangladeshi	\$30.00
R 31	28-32	2	3	Traditional Birth Attendant and carer	0	2	Below Primary Level	Islam	Local Bangladeshi	\$40.00
R 32	38-42	4	5	Daily Labourer	0	2	No formal education	Christian	Santal	\$25.00
R 33	28-32	4	5	Daily Labourer	2	3	No formal education	Christian	Santal	\$25.00
R 34	28-32			N/R				Islam	Local Bangladeshi	
R 35	38-42			N/R				Christian	Santal	
R 36	23-27	1	5	Daily Labourer	0	3	Below primary level	Christian	Santal	\$25.00
R 38	33-37	1	5	House Wife	2	0	Class nine to secondary school certificate	Indigenous	Santal	\$120.00

4.3.1 Profession

A large percentage of participation was housewives 55 %, daily labourer 19 %, Traditional Birth Attendant 5 %, family Welfare assistant 2 %, and primary school teacher 2 %. Among the 22 Santali women 13 were day labourers. This study shows that Santali women in Kakon Haat have the higher proportion in the study sample, who works in formal labour sector. During the interview and FGD session the Santali participants revealed that they have no choice but to join the workforce in order to support the family from starvation and meeting other basic needs.

4.3.2 Income

The income earned by women in formal labour sector ranges between \$25 to \$120 (Australian Dollar). The overall average household income was \$25 monthly. Among 30 participants of the project, 12 participants' household income was \$25 monthly. The daily labourers constituted 29% of this study, and had a monthly income of \$25 and were more likely to seek advice from the Traditional Healer.

4.3.3 Education

Education plays a vital role in accessing reproductive health care services. Among 30 participants, 5 of them had below primary level of education and 7 of them had no formal education. This group had accessed a Traditional healer or a Homeopathy doctor up to 10 times in average, while those who had education from primary level to Higher Secondary Certificate had consulted a Traditional Healer on an average of three times. R14 who had education up to class nine had consulted a traditional healer eleven times. The findings are mixed and it is very difficult to justify the relationships between education and access to traditional healers or professional health care services as a complex picture emerges from local cultural and religious belief system, coupled with patriarchy and poverty.

4.3.4 Religions

Out of 30 participants of this study 13 of them were Muslims, 15 were Santali Christians (*Santali*) and 2 were Indigenous respectively. The Santali population depended mostly on the Traditional healer during pregnancy. The women group from Khorkhori have a regular access to a trained health professional. Women from Meherchondi depended on the traditional healer, similar to women from Kakon Haat. However, the Santali women consulted a traditional healer and a health professional.

4.4 Interview findings: the beliefs of rural women about their reproductive health

As the data were collected using in two different ways; in-depth one-to-one interviews and focus group discussions, findings from these two methods were compared and cross-validated and credibility was ensured. The following section discusses the findings from both sets of data, and the findings are arranged according to the themes and sub-themes which emerged from the data. This study identified three major ‘themes’: (1) a strong belief in traditional healers, (2) a firm belief of following in-laws and seniors/elders, and (3) superstitions and misconceptions. However, several recurrent themes that were also found through data analysis have been incorporated in each of these broad themes.

4.4.1 A strong belief in traditional healers (*‘Kabiraaj’*)

This study finds that the participants have deeply rooted beliefs in the natural plants and herbal medicine, holy water, holy blow⁵, and holy oil given by the traditional healers; and this is consistent with the current literature (Sibley et al., 2009; Chakrabarty et al., 2002, 2003). The traditional healers, herbalists, and homeopathic practitioners practice on a regular basis in the rural areas of

⁵ Reciting holy versus on water or oil makes holly water or holly oil

Bangladesh. The profession is adopted as a career, and their livelihood depends on it. Traditionally, local healers were not paid for consultations as it is believed that if they ask money for consultations, their skills will not be effective anymore. These practitioners depend on the voluntary payments offered by their patients which they accept with gratitude. The traditional healers treat patients with holy water or sanctified water (*Panipora*). There is a strong belief in R23 that holy blow, holy water and holy oil are effective remedies for sickness.

This study found that 80 per cent of the participants believe that traditional healer have enormous power to heal any sort of physical sickness through ‘holy blow’ (*Jhar fuk*⁶) and ‘sanctified water’ during pregnancy. The Santal community in Kakon Haat and the community in Meherchondi rely on the traditional healers’ treatment for their ailments. The traditional healer is known and believed to drives away malevolent spirits and deities, determines the cause of a disease, and administers remedies based on his considerable knowledge in holy verses (Shahidullah et al., 2009). The holy verses are blown on the oil or water that works as a remedy for various types of diseases. The participants of this study believed and confirmed that belief is necessary in the healing process that is sought from the traditional healer; otherwise the medicine would not work for them. The following quotes from various participants illustrate their beliefs:

“I was able to conceive by the medicine of the traditional healer (Kabiraaj)” (R1).

“Even a stomach ache can be solved by a traditional healer. There are many types of spiritual air around us. For example, there is one type that causes itchiness in eye. A Kabiraaj can fix this type of sickness with blowing spiritual air with oral air (*Jhar fuk*)” (R3).

⁶ Holy blow means reciting holy verses and blowing wind from mouth

“I went to see the Kabiraaj when I was pregnant with my first child and again this time I am also seeing the Kabiraaj...Kabiraaj understand... somehow...they understand through magic or tricks” (R5).

One of the participants of this study who had faith in the traditional healer during her birthing process mentioned that:

“Yes many *Kabiraaj* come here. For example if the pain rises for delivery or if the pain of the delivery is delayed then the *Kabiraaj* gives *Jhar fuk* or gives special type of medicine (name of the medicine is unknown to the participants) so that the pain speeds up, initiates and provides signal to the childbirth process” (R3).

It has been echoed in R1 and R14 and by other participants' comments that they were able to conceive by taking the medicine from the traditional healer. These participants did not know the ingredients of the medicine which usually comes in the form a paste. The current study also finds that both educated (R1) and semi-educated (R3 and R5) participants had a firm belief that traditional healers were capable of providing general and reproductive health treatment. There was a consensus among the participants about the traditional healer that he has special skills, expertise and knowledge to heal sickness and predict the complications that may arise during their pregnancy, childbirth and miscarriage. Participants from Kakon Haat also believed that if anyone is unable to conceive then one should take the medicine from the traditional healer. Participants (R14, R36, R37 and R38) of FGD3 informed me that peer influence is one of the key reasons for them to seek assistance from the traditional healer, as one participant stated:

“We will continue to believe in the traditional healer. We get influenced by peers, friends and the news gets across” (R36).

Peer influence is very pertinent in getting the message across regarding the issue of women's health in rural Bangladesh. Advice from traditional healers is sought when the labour pain during child birth is prolonged; and thus holy blow or sanctified water, herbal roots and amulets are commonly used during birthing to enhance the labour pain and to hasten the delivery process. Darmstadt et al. (2006), on a similar note, also find that difficulties in childbirth are eased by interventions such as bringing tidal water from the sea, which is believed to fasten the delivery process. The same idea of getting the tidal water for easing the process of the delivery echoed in the focus group discussions.

Another informant (R5) stated that one of the reasons for consulting a traditional healer is that they are easy to access; often traditional healers visit pregnant women and thus privacy is maintained. A traditional healer does not conduct the health check of a woman in terms of examining the body or putting their hands in the private parts of the body⁷ during the birthing process. In this connection R5 stated that

“Because his medicine makes us recovers faster and we feel good that's why we believe in him.....the traditional healer 'does not check tummy' and only gives sanctified or holly water as a medicine for medication” (R5).

One can conclude that the practice of a traditional healer is based upon the belief, culture and religion of the rural society, as 95 per cent of the participants of this study stated that they do not like to consult a male doctor due to the fear of being touched by a male, which is against their religious and cultural values.

Another aspect of consulting a tradition healer relates to financial resources. Unlike the professional doctor, a traditional healer charges a fee that is affordable

⁷ Private part of the body means vagina and words like vagina or breast are either used in code words or vaguely referred to (Khan et al., 2002). In Bangladesh, women do not utter the word vagina and there is no word for vagina in Bangla language. So it is mentioned as a private part, or a shameful part of the female body.

by the family, which they generally offer him with a sense of gratitude. One informant stated that

“We pay him (Kabiraaj) once in a year...and it is not fixed. It depends on individual. If you want to pay more, you can; and if you pay him less that is also ok. If you want to pay 200 taka in a year, he will accept this. It is also like whatever amount of Taka you offer him he will accept that” (R5).

One of the participants (R6) stated that she had not sought any advice from a traditional healer, though she had the knowledge of its benefits. This participant stated that

“No, I did not see any traditional healer because I did not have any problem. If anyone has a problem then he or she sees a traditional healer. For example, if I were married for 5-6 years or 10-12 years and still not pregnant, I would go and see a traditional healer” (R6).

While I was conducting an interview with R11, I saw her wearing an amulet around her neck and when I asked her the reason for wearing it. She stated that:

“I used to have fever at night. I went to see the traditional healer. After taking the *Tabeez* (amulet), I do not have fever at night” (R11).

R11 and many other rural women still believe that wearing amulets saves them from many illness and malevolent spirits. In regards to amulets, R27 stated that it decreases the chances of her child suffering from *dana-utha* (shoulder joint dislocation or displacement).

R21 believed that it is not appropriate to go to someone’s house when one dies, nor should one go to the graveyard due to the presence of spirits and fear of being possessed. I also came to know from R26 that a traditional healer eases the process

by pulling a tree that is in a good condition from the soil. This is symbolic of no struggle during the childbirth process.

The above discussion reveals that the participants of this study have firm beliefs about traditional healers like the ‘Kabiraj’ of their rural areas. They believe that the traditional way to deal with reproductive health is one of the best ways, and that they have plenty of evidences in their rural settings. However, they also understand that they have only a small number of choices available. Peer influence, seniors’ pressure, poverty, limited government services and poor infrastructure push them to these traditional healers as these healers provide a one-stop solution to vulnerable rural women in terms of their reproductive health care services.

4.4.2 Influence of in-laws and seniors/elders

Rural women who live with an extended family rely on the decisions of in-laws and elderly woman in the family (Rafiqul et al., 2007). Mother-in-laws play a vital role in decisions related to giving birth and the delivery process of the pregnant women (Piet-Pelone et al., 1999). There is a tendency, especially in rural Bangladesh for daughter-in-laws to be dominated by their mother-in-laws because mother-in-law holds an influential position in the family, which can create inequality. Inequality among less powerful and more powerful ones create imbalance in authority and power relationships, which can contribute to an indifferent hostile relationships (Edmonds et al., 2011). Inequality and power differences is mostly observed in the less developed countries (for example Bangladesh), where members are expected to live in a collective culture. This means that members behave according to social norms that are designed to maintain social harmony among members in a group (Hofstede, 2001). This study did not find any hostility towards in-laws from the daughter-in-law’s side or vice-versa. However, this study finds that daughter-in-laws feel obligated to remain obedient to their in-laws and seniors/elders, and it remains imbedded in a culture like Bangladesh.

In rural Bangladesh, women tend to obey their in-laws and elderly women. It is very rare that they would question the cultural practices and family rules. Following in-laws advice is also a sign of respect and obedience of the daughter-in-laws. In most cases, the daughter-in-law in rural and urban Bangladesh follows the advice of the mother-in-law. Adhering to the mother-in-law's advice secures the position of the daughter-in-law in the family and establishes a good relationship. As stated by the participants:

“When I become pregnant, I try to follow the beliefs that were practiced by my mother, elders and my mother-in-law” (R7).

“My family member say that it is not proper to go out in mid day time...everyone say that... they will definitely say it” (R3).

“...we have to take advice from our in-laws. When I was pregnant, I had to follow the familial beliefs. For example, I did not go out at night. Whatever my in-laws says, I follow this otherwise bad things will happen to me. So, I follow this” (R2).

“They (in-laws) advise me to take more children. They say that children belong to the previous generations so they encourage me to take as many children as possible” (R5).

Mother-in-laws roles play a vital role during the daughter-in-law's birthing process. This study finds that mother-in-laws often are ignorant, indecisive or unaware about their daughter-in-law's reproductive health and pregnancy related complications. As a result, mother-in-laws cannot comprehend the need for medical emergency and related services. For example, R2 had a miscarriage and her mother-in-law had no understanding of it, but blamed the malicious spirit. Similar evidence is found from R6's statements where she had nothing to do but to accept the advice from her elders. The specific quotes are as follows:

“They have a special place. They are spiritual friends of my mother-in-law and they told that my child is no more. My mother-in-law did not tell me that my baby died inside me, and I did not know whether she knew about it or not” (R2).

“When I was pregnant, I had to follow the belief that was a practice from my family and society. The elders told me that my child inside my stomach can be damaged and I can have any sort of problem. That is why I had to listen to my family and my society. If anything happens to my child or to me, blame will be upon me. The elders would say that I did not listen to them and as a result it happened with me” (R6).

Hossain et al. (2011) states that women who are living with large family members have less control over their reproductive health related matters. Raising concern before, during and after pregnancy and consulting a medical professional is not encouraged in a rural society like Bangladesh as mentioned by R6 and R11. The relationship between mother-in-law and daughter-in-law remains tense, which is common in other cultures.

The findings reveal that participants were negatively affected by following social and familial beliefs that are channelled through elders, in-laws and traditional healers. It is a common cultural practice that elderly women enjoy power over younger women, though it is up to the couples to make decisions regarding the size of the family. It is the woman’s reproductive rights to make decision regarding child bearing. Reproductive rights means when a women express a sense of entitlement or self-determination in everyday decisions about childbearing, work, marriage, fertility control and sexual relations. It considers the strategies that women employ in their negotiations with parents, husbands or partners, health providers, and the larger community over reproductive and sexual matters; and the roles that economic constraints, religion, tradition, motherhood, and group participation play in shaping their decisions (Petchesky & Judd, 1998).

This is also evident in rural society. As a result, advice from in-laws and seniors is taken under duress and has negative connotations; though in some instances women expressed it with a positive note. R18 stated that the elders in her family tell her not to go out in the dawn, dusk or at mid-day to respect the horoscope and evil spirits. R18 also revealed that elders like her mother-in-law remind her not to go under a big tree. R18 follows her elders' advice out of respect as their life experience spans over the years.

4.4.3 Superstitions

Rural Bangladeshis believe in many superstitions that are related to reproductive and maternity health, mainly because of lack of education. Poor social and familial infrastructures along with poverty preserve rural participants to firmly hold onto these superstitious beliefs. This study uncovered some of these aspects through data analyses.

4.4.3.1 In-door stays during post-natal period

Edmunds et al. (2011) explored a qualitative study with 25 women regarding the type, content and source of women's perceived social support during pregnancy in rural Bangladesh. This study found that elders suggest decreased movement during pregnancy as a precautionary intervention aiming at preventing spirits. During pregnancy period, elders also suggest pregnant women to seek remedies from and wear amulets given by the traditional healers; mainly to get protection from malevolent spirits during and after pregnancy. Edmunds et al.'s (2011) study finds a common view that 40 days post-natal in-door stay as an incentive for the new mother to get some rest from her domestic workload as this has been a traditional practice in rural Bangladesh. Restriction of movement is a common practice followed by woman in the antenatal and post-natal period of pregnancy across culture. Elderly women insist on following the rules of staying in-door for the 40 days after child birth. Mostly, rural women do not have any clear idea of the rationale behind this cultural practice. These young mothers are doing it because

they are told by their mother-in-laws or elders in the family. As stated by the participants:

“I did not go out for 40 days... you see everyone says to do this so I do this and I follow what everyone says...I am just doing it, I am following someone and some one will follow me... it goes like this...” (R5).

“Yes there are many restrictions from home. Family members say that do not go out during evening times, mid times...so I follow these” (R3).

“After having the first child, I did not go out for 40 days. The previous generation says I should not go out for 40 days” (R8).

The findings reveal that this culture specific or traditional advice regarding constraint on movement after birth makes a woman vulnerable because it is believed that the malicious spirits are the reason for excessive, forceful and continuous bleeding and bleeding with clots (Sibley et al., 2009). The participants of this study mentioned that they never questioned this practice and they were simply following the rules. There is no logic behind restricting the birthing women’s movement. However, the participants were just following these cultural practices for several generations. Following the elders and mother-in-law’s instruction is also like a cultural practice or belief that still remains in rural and urban families in Bangladesh. These participants have a firm belief that during the pre-natal, ante-natal and post-natal period, a woman is vulnerable to the evils of the spiritual world and thus the elders restrict her movement. As stated by one of the participants:

“The elders say that do not go outside in the noon time. They also say that do not go in the evening time and do not keep hair

open.⁸ The elders say that tie a knot in the end of the *sari* or shawl so that the malevolent spirit do not affect us” (R9).

Following the elders without questioning the rationale of their advice is very common when it comes to pregnancy and after child birth. This is how mother in laws, seniors or elders hierarchical position in the family is acknowledged and respected by a daughter-in-law. As one participant reveals:

“My mother told me not to go out for 40 days after child birth. My mother asked me not to do any household work like pressing the tube well. My mother said she and other elders will do all the household work for me. I just looked after my own baby. My mother told me not to go out in the evening time. If I had to go to the toilet to urinate then there was a big bowl given in the room. I used to urinate in that bowl. In the morning I used to throw it. I did all these so that we have no problem” (R19).

Following elder’s instructions is common among many of the participants of this study as one participant, R30 is restricted in her thinking and unable to avail modern medical facilities due to various barriers such as dependency on elder’s advice, a lack of formal education and knowledge in reproductive health care.

After giving birth, women are not allowed to cook unless there is nobody to do it for her and they are secluded from the rest of the members of the family. In general, women perform very light household works for the first 40 days of giving birth as it is believed that the new mother must remain inside the house all the time to regain strength and avoid evil spirits (Darmstadt et al., 2006). One of the participants (R32) from FGD2 shared the same experience that she was unable to come out of the house as her in-laws told her not to go out and she was only able to

⁸ In rural Bangladesh, it is often encouraged from the elderly women that keeping the hair open will initiate the malevolent spirit to possess. Tying a knot at the end of the shawl is believed to prevent a malicious spirit from possessing a woman.

step out after 40 days of indoor stay. She (R32) also stated that heavy menstruation after giving birth is considered unclean, and she had to remain indoors for 40 days after giving birth to each of her four children. There is a cultural belief that women, after giving birth, purify only after 40 days and only then she is able to perform regular household activities, prayers and observe religious practices. Seclusion after giving birth is observed due to the new born's mother's post-partum bleeding (Darmstadt et al., 2006). The Post-partum stage is linked with heavy menstruation and women feel "polluted, impure and stinky" (Blanchet, 1984 & 1991). Due to the seclusion during the post-partum period from the rest of the family, women suffer from severe malnutrition, which is created for not eating nutrients foods (Darmstadt et al., 2006).

Mothers of newly born children stay in a room most of the time separated from the rest of the house and this separated room is called '*atur ghor*.' I was told by R20 that she had to stay in-door as it was told by the elders due to being '*napak*', which means unclean. R20 believed that staying in '*atur ghor*' would prevent '*Chora Chunni*' (evil spirits) to take her child away. R20 informed me that Diphtheria and Pneumonia is another version of '*Chora Chunni*' that takes the baby away. Later, I confirmed their version of the meaning of '*Chora Chunni*' through the FGD1. The participants also shared similar information regarding '*Chora Chunni*', Diphtheria and Pneumonia.

One of the participants (R31) of FGD1 states that elders suggested throwing away their first breast milk as it is believed to be impure. Darmstadt et al.'s (2006) study discussed the reasons for not giving the initial breast milk to newly born babies in rural Bangladesh, and found that initial breast milk (called Colostrum) is not given to newly born babies in rural areas because of its thickness, and it is termed as '*dirty milk*,' which is believed to have an association with some evil spirits. In this connection, R20 stated that she had received this message that if she came out of the house, her breast milk could dry out, and as a result she remained inside the room.

This study found that 40 days post-natal in-door stay among rural women is a common practice. There have been many mythical/oral stories that have been rooted amongst new mothers by their elders, poverty, for the sake of the new born mother's health. The mythical stories and hierarchical social order are so deeply rooted that the new born mothers (participants) seldom question a reason for their 40 days in-door stay after giving birth.

4.4.3.2 Malicious spirit

Malicious spirits are believed to be active at mid-day and at dusk, as stated by one participant:

“For malevolent spirit, a pregnant woman can not go outside. For example, malevolent spirit can harm an in-born child and even an in-born child can be aborted for it. That is why our neighbours say that do not go outside and stay at home. Especially, it is not proper to go outside during mid day or evening time. In addition, my neighbours say that do not go beside a pond during mid day, do not go to a toilet at night, and do not wake at night. This is all about pregnancy” (R 3).

It is found from the discussion with R2, R16, R17 and R23 that there are some specific places for the malicious spirits and that these spirits do not roam around everywhere. These sprits have their own destination to look for whom they can possess, such as a pond area, under the banyan, tamarind tree and other big trees. The current literature in the context of Bangladesh holds a similar notion. In particular, Blanchet's (1984 & 1991) studies have discussed that pregnant mothers and the mothers of newly born children are strictly forbidden to go outside in the dark, in the afternoon, in a storm, after cooking, near a tube well, with their hair down or with their *saree* (traditional dress) touching the ground—all due to fear of attracting evil spirits.

During and after pregnancy, mothers are usually advised by the elderly women about the effects of malevolent, and roaming evil spirits on pregnant women. These evil spirits are believed to possess a pregnant woman who travels alone outside her residence, especially during noon and dusk time (Edmunds et al., 2011). It was believed by R23 that very early morning is the prime time for the malevolent spirit to possess a pregnant woman. A case control study on 24 cases by Mercer et al. (2006) indicated that women in rural Bangladesh believed in malevolent spirits that cause excessive, forceful and continuous heavy bleeding and as a result they seek help from traditional healers. As commented by three participants:

“My mother-in-law has two spiritual companies (Alga) and I had no idea of it. I fell down on the ground...the baby died inside me and I did not understand.the malevolent spirit also told my mother-in-law that...the baby died inside me.... As I fell on the ground... then after 3-4 days I went to a professional clinic and the doctor told me that do not cry... the baby is no more...” (R2).

“A pregnant woman can not go outside for malevolent spirit. For example, malevolent spirit can harm an in-born child and even the in-born child can be aborted for it. That is why our neighbor tells me not to go outside and stay at home” (R3).

“When I was pregnant with the 5th child I started taking special amulets from the traditional healers. I also went to the hospital. But the traditional healer told me to put on amulets. I told the tradition healer that I am having so much of bad dreams. Because I have had so many miscarriages, I used to be afraid of my dead children. So when I was pregnant with the 5th child I met the traditional healer and got this amulet. I also had to get

services from the traditional healer to save my house from the evil spirit. I have to get good spirit around my house” (R10).

These statements imply that due to malicious sprits, the rural pregnant women do not go out. There is a strong belief among the participants (R2, R3, and R10) that a malicious spirit can cause damage to the un-born child, therefore, any miscarriages are blamed on their presence. Traditional healers are the ones who are sought to get rid of the malevolent spirits.

One of the compelling reasons for rural women in Bangladesh to believe in the malicious spirits includes distance to health care services and cultural beliefs, and how to respond to emergency medical care (Chakraborty et al., 2002). Believing in malevolent spirits is more like a culture-specific domain that reflects the persistence of traditional practices surrounding the issue of pregnancy and post-natal period (Edmunds et al., 2011). The current study also finds that lack of education and financial opportunities have created a gap between the rural women and professional medical service centres. As a result, this gap is currently being filled by local traditional healers backed by various mythical stories and beliefs. An inability to interpret the severity of the critical stage in pregnancy can be life threatening for the mother and their child, and blaming the evil spirit for this would simply be harmful to mothers and their children.

4.4.3.3 Food taboos

Food choices are restricted for the newly born’s mother in Bangladesh rural setting, and food taboos are maintained to ease the healing process during the delivery time (Goodburn, Gazi & Chowdhury, 1995). Restriction in food consumption among the pregnant women is imposed mostly by the in-laws, elder/senior men and/or women in the family because there is usually more than one decision-maker per household in Bangladesh who could be father, mother-in-law or other relatives depending on the circumstances (Ahmed, Sobhan, & Islam, 2001). One participant, in this context, stated that:

“Family members say that I should not eat everything. I should restrict my food choices“(R3).

Prohibition of food can create malnutrition among the pregnant women. In their study, Shafique et al. (2007) found that the pattern of malnutrition among Bangladeshi women was dominated by under nutrition especially among the rural women.

Food taboos are also practiced among traditional birth attendants. For example, R29 is a Traditional Birth Attendant and a participant of this study. She confirmed that she ate limited variety of food during her pregnancies and accordingly she instructs pregnant women not eat meat, chicken and fish during their pregnancy and after giving birth. The belief behind this is that consuming poultry items during the antenatal period can cause skin diseases and foetal death; and thus, food restrictions are placed on the mothers (Darmstadt et al., 2006). There is a strong belief among the participants of this study that these food items will make un-born babies sick. For example, the FGD1 participants stated that they were told by their respective elders not to eat *Hilsha* fish, Palm and Palm cake, as these could potentially bring evil spirits or ghosts.

This study also identified another taboo that was linked to food consumption. Pregnant women are not allowed to see the sun’s eclipse as the baby may turn into an evil being. During the eclipse, a pregnant woman has to eat meals in the day before evening, and she is allowed to have water and food once the eclipse is over. As stated by one participant

“Elders say not to cut fish when it is sun eclipse. I obey this belief. If my mother-in-law understands anything from the darkness at night then she will tell me not to eat rice. She will tell me not to cut fish at night because the child may have a lip cut. Sometimes she will ask me to take the dinner early. I believe all these...” (R8).

It was also found that pregnant women are not allowed to cut fish at night and are not allowed to eat during the eclipse because there is a belief that the un-born baby could have some sort of deformation such as lip cut. Pregnant women often become vulnerable due to various beliefs and superstitions in rural Bangladesh. These discourses influence women to abide by certain specific social customs passed from generation after generation without having any proper knowledge and reason behind it. As a result, the costs of personal health and costs to the society are enormous.

Malnutrition in rural Bangladesh, especially amongst pregnant women, in-born child and children are strongly evident. One reason for this is the food taboos that are often imposed by in-laws and seniors/elders because of having various superstitions. Often restrictions on food choices are maintained in order not to avoid obesity during pregnancy as women are shy to show their pregnant bodies in Bangladesh culture. In this connection, one study stated that young teen-aged mothers in Bangladesh often feel shy to reveal their pregnant bodies; in addition, the village elders often embarrass a pregnant woman for having a big belly (Blanchet, 1999 & McConville, 1988) and thus they are very reluctant to seek reproductive health care services (Hira et al. 1990; Rafiqul et al. 2007).

4.4.3.4 Privacy in birthing

This study found that maintaining privacy during childbirth is very important for the birthing women. While undertaking this fieldwork, I was informed by one of the participants (R9) of this study that giving birth is a silent, private and secret matter. In particular, she stated that

“Women from previous generation had their deliveries at home. They believe that if people know that anyone is pregnant then the baby will die (R9).

I was also told that it does not bring any good if the whole village knows about the pain of a birthing woman. The concept of giving birth in privacy illustrates the

secret matter in the social context of the participants of this study. There is a belief that delay in delivery usually occurs if people are informed ahead about the pregnancy and delivery. Thus, pregnant women in rural Bangladesh do not like to talk about pregnancy or show their pregnant body to the people who they are not familiar with. They are reluctant to take any precautionary measurement regarding pregnancy related complications (Darmstadt et al., 2006). Therefore, they believe that the process of giving birth has to be a silent process and a birthing mother should not express the pain that she goes through unless it is unbearable.

4.4.4 Beliefs about Infertility

The rural population in Bangladesh are poor in general, and have little or no education with very limited access to economic resources and modern health care facilities. Their belief and value systems, in general, are dominated by tradition, myths and mystery (Nahar et al., 2000). One of such myths is related to the women with no child. Women who do not have children have to face a lot of humiliation from their family, friends and community. As a result, infertile women suffer from anxiety, frustration, grief, fear, and lack of self-esteem and a sense of powerlessness. Van Balen and Bos (2009) have highlighted the sufferings of childless women such as anxiety, frustration, grief, fear, lack of self-esteem, and a sense of powerlessness in resource-poor country like Bangladesh because it is overpopulated, patriarchal and class-biased. Generally, childless women are blamed and stigmatised for their failure to give birth (Nahar & Richter, 2011) as stated by R13 and R14:

“If anyone is late in conceiving a child then she has to go through lots of public humiliation. People will say that it has been so long and still why I am not pregnant?” (R13)

“People used to give me *khota* (cutting remark, hints at a fault, and makes cutting remarks or insinuations). But what

should I do. If God does not give me any child what shall I do”? (R14)

A childless woman feels vulnerable and becomes fearful of eventually being abandoned by the husband due to society’s response to her as a childless woman, and the consequences are polygamous husband, divorce, or abusive behaviour of the husband in these circumstances that creates fear of abandonment amongst women who do not conceive a child soon after marriage (Nahar & Richter, 2011). In their study, Nahar & Richter (2011) find that some childless women are beaten by their husbands. As husbands and in-laws try to find fault in everything about them and torture them mentally and sometimes physically.

From the FGD2, this was also revealed that barren women have to bear humiliation and accept social isolation. This creates a lot of psychological pressure on the women who are being blamed for not conceiving (R13 and R14), and are without proper knowledge about reproductive health. The FGD2 findings reveal that a woman is also blamed for not giving birth to a male child. In particular, R32 and R33 were blamed for not being able to give birth to a male child, respectively. These participants have no idea that they are not responsible for the determination of the sex of the child (Irving, Bitting, Peverall, Murch & Matson, 1999). In rural Bangladesh preference for a male child is observed by Hossain and Glass (1988). A male child is seen as the one who would potentially make an economic contribution and a female child is seen as a burden to the family due to the custom of dowry. I was asked by participants of this cohort (i.e. FGD2) whether there was any injection available to the doctors that can ensure a male child. As stated by R32 and R33:

Me: When did you first have your child after marriage?

R32: After 5 years of my marriage. My neighbours blame me as I have 4 daughters. I feel I should have a son. My husband blames as I could not give birth to a son.

R33: Is there any injection available to the doctor that can assure it is injected then I or ladies like me can have male child.

Participants like R32 and R33 believe that a male child will be the main source of income and the decision maker in the family. Not all participants believed in social customs or beliefs and there was a degree of variation in their beliefs. For example, women of Khorkhori had access to a trained health professional provided by BRAC who meets rural women once a month and checks their health. Participants in Khorkhori were more aware of looking after their health, as one of the participants revealed:

“My husband and my mother give me encouragement to look after my health. If I do not look after myself then I am the one who is going to suffer. The BRAC *Apa* comes and checks our blood pressure” (R15).

Women (R15, R16, R17 and R18) in Khorkhori are regularly visited by a trained health professional from BRAC. BRAC selects women from villages and gives them training in reproductive health such as the checking blood pressure, stomach and eyes of the pregnant women of rural areas in Bangladesh.

In summary, the findings from the study suggest that traditional healer plays a major role in terms of providing the rural women's reproductive health care. Due to financial limitations rural women are unable to avail themselves to doctors and are pushed by circumstances to see a traditional healer for getting medical assistance. Similarly, cultural limitations on their movement for forty days after childbirth have traditionally imposed on women in rural Bangladesh. During the entire pregnancy, a pregnant woman in rural Bangladesh relies on the decisions of her in-laws and extended family members. Following the instruction of the in-laws demonstrates respect from the daughter-in-law.

4.5 Reasons for beliefs

There are themes that emerged from the analysis of the participants' interviews regarding their beliefs on reproductive health. The dominant sub-themes that were obvious from the interviews were poverty; or financial limitations; lack of awareness; education, and availability and access distance to health care services. The following section will discuss each sub-theme in more detail.

4.5.1 Poverty

Poverty is interlinked with various stages of functioning and well-being of a human being (Sen, 1999). Poverty limits access to commodities; participation in social life, access to medical services and the ability to make informed choices regarding health, nutrition, accessing and valuing education (Sen, 1999). Poverty thus limits a person's choice to live a better life. Poverty probably is the single most reason for accessing traditional healers in rural Bangladesh. Figure 5 shows the belief–poverty framework, where access to traditional healer or professional health services depends on the extent of poverty and socio–cultural context of belief structure.

Figure 7: Belief—Poverty Framework

Extent of Poverty	<p>Traditional Healer Extent of poverty strongly exists SCCBS is low/weak</p>	<p>Traditional Healer Extent of poverty strongly exists SCCBS strongly exists</p>
	<p>Professional Health Centres Extent of poverty is weak/low SCCBS is low/weak</p>	<p>Traditional Healer Extent of poverty is weak/low SCCBS strongly exists</p>

Socio—cultural context of belief structure (SCCBS)

Source: Tarafder, Rashid, Sultan (2012)

The belief-poverty framework explains that access to traditional healer or professional health service depends on the extent of poverty and socio-cultural context of belief structure. In particular, the framework states that rural vulnerable women are more likely to go to a traditional healer if the socio-cultural context of beliefs' structure (SCCBS) and/or poverty are prevalent in a society, in this instance, Khorkhori, Meherchondi and Kakon Haat, were the research sites, where the current study was conducted. However, they are more likely to go to a professional health practitioner if SCCBS and the extent of poverty are low in a society.

Poverty limits rural women's choice and their right to access reproductive health care services. The findings of the study revealed that poverty is one of the main reasons for not seeing a professional doctor and consulting a traditional healer. A traditional healer takes consultation fees based on the family's financial situation.

“If I knew about reproductive health care then I would not take risk... if I do not work who will feed me? ... I know I have to look after myself as I am pregnant but I cannot do so” (R5).

“If I see a doctor he or she will take 200 Taka (\$1.20) for the consultation fees. We do not have money in our pocket. ... We do not have money to see a doctor. So why we should go to a doctor... where shall we get...fish to eat? We can not buy fish...” (R3).

“I think that if I had money now I could have seen the doctor for my health check ups... the doctor could tell whether it is boy or a girl” (R5).

The focus group participants have indicated that their health care comes after meeting their basic needs in life. Schuler et al.'s (2002) study suggests that people who are from a low income background prefer to seek free treatment, or at the lowest possible cost or nominally priced health care service. Financial limitation

was also echoed by R5 who informed that she should have taken 2-3 years of gap between her first child who is eight months old and another expecting. Due to poverty she has to work in the paddy field to support the family. She thinks she is depriving herself and her children from getting nutritional food. R5 had eight months old child and at the time of the interview for this study and she was pregnant again. R5 mentioned that due to financial constraints she is unable to see a doctor. She, along with her in-laws, regrets that due to financial constraint she is unable to seek care from the doctor.

A daily labourer who earns only 2000 Taka (\$25.00) a month can not afford private medical services. The government services, in this context, are often found to be difficult to access, mainly because of distance, availability of professional skilled health professionals and medicines, and cost of accessing the service. Findings of this research confirm Schuler et al.'s (2002) study suggesting that poor people are often prejudiced against the richer because of their better access to health care facilities. Participants of this study showed resentment and frustration for being denied government health care services. There is a sense of anger in the participants (R21 and R23) as they blame the government and the society for the vicious cycle of poverty that they are living in. As one participant stated:

“He who has no money does not get any special care from anyone” (R3).

R21 has the knowledge that doctors provide good advice and give proper medicine; however, due to financial limitations R21 can not afford to consult a doctor when in need of care. R21 does not have the financial capability to access the medical services (Sen, 1999). In addition, poverty has an impact on a person from being resourceful, intelligent and functional in day to day activities (Yunus, 2003). It has been stated by Yunus, the Bangladeshi Nobel Laureate that:

“Poverty and the human species just do not go together. But in reality it has happened because we created wrong mindsets which did not allow poor people to know how much potential they have. All we

have to do is to remove the heavy crust that keeps their abilities unknown to them” (Yunus, 2003, p. 10).

Not having access to better medical facility makes one incapable of functioning a normal life (Sen, 1999). Having the knowledge of medical facilities and the ability to access them, thus, puts any disadvantaged person into an advantaged position, which ensures the capability of a person (Sen, 1999). Professor Sen states that poverty is interlinked with the stages of functioning or doing, and well-being of a human being. Poverty puts a limit on accessing commodities, activity levels in daily social life, access to medical services, one’s ability to participate in economic activity and have education and nutritional knowledge. Thus, poverty and capability has an inverse relationship. This study explored rural women’s beliefs about their reproductive health and explores the degree of freedom of the participants for availing reproductive health care services. The application of the ‘capability approach’ to explore rural women’s reproductive health beliefs is an appropriate approach as this study embarked upon well-being, development and poverty, and freedom and functioning.

4.5.2 Unawareness and lack of education

In this study, education has been discussed from two perspectives, in terms of formal schooling and also in terms of gaining knowledge and awareness in reproductive health, legal rights and other health issues. Lack of individual initiative and awareness of what might constitute a medical emergency is related to rural women being not exposed to proper education and awareness. Comprehending the medical emergency and responding to it is an important action of individual initiative. R10, for example, has never taken any decision regarding her health related issues. She had no idea about the medical emergency that she needed in her early marriage life. Similarly R7 also informed me that she does not have sufficient knowledge of health concern around puberty and reproductive health, indicating that:

“I do not have sufficient knowledge. I do not know about puberty, reproductive health and other health issues” (R7).

“...I did not follow any birth control method. I did not take any pill. I just did not have any children. I did not get pregnant because of hard labour. During my 4th pregnancy, I had a miscarriage while I was urinating. I don't know why...” (R10).

Inability to respond to medical needs and a delay in seeking medical care for reproductive matters are connected to the participants' incapability to interpret their health conditions. This study found that the Santali women in Kakon Haat and women in Meherchondi do not have proper education at least to interpret their health related needs including reproductive care. In particular, one respondent stated that

“I do not have sufficient knowledge about my health and my child's health. I do not have much knowledge about women health, for example, first period age and puberty and reproductive health” (R25).

R25 was 18 years old during data collection period, and had only a vague idea about the basics of reproductive health. Khan et al.'s (2002) study found that the rural girls who were married before the age of 16 years rarely had any idea of how children are conceived and the mechanism of contraception. The discussion of contraceptive usage was introduced to them on the day of their marriage or two days before the event. In their study, Hossain et al. (2011) stated that Bangladesh has one of the highest rates of child marriages in the world and nearly two in five girls aged 15-17 are married before 18, despite 18 being the legal age of marriage. Early marriage leads to unwanted pregnancy (Khan et al., 2002). A high fertility in younger age and a low birth weight of child cause poor physical and mental development both for mother and child, respectively. In consequence, this limits the progress of human development as they both lack physical and cognitive abilities. In this connection, Jejeebhoy and Sathar (2001) found that delayed

marriage among in South Asian women resulted in more independence, autonomy and self-confidence than married at an earlier stage in their life.

After marriage, women in rural Bangladesh from low income backgrounds have less control over their lives in terms of fertility control, contraceptive usage and access to health care (R7). In this regard, Khan et al. 's (2002) study explored the issue of sexual behaviour of married women and found that out of his 54 female participants 24 (44 per cent) had no idea about sexual relationship before marriage. The study found that girls who were married before the age of 16 years rarely had any information on sex and the idea of contraceptive was unclear to them.

During the interview session, R27 mentioned that she had very little knowledge of reproductive health, marriage and legal rights. However, she informed me that doctors understand more about health as they can predict the health condition by using the ultrasound and other modern techniques. When asked how she would look after herself when she is pregnant, R7 replied that she would not upset the elders and would follow their advice and customary beliefs. Participants from FGD2 (R21, R35 and R32) depended heavily on the decision of their husbands. Among the FGD2, one of the participants, who is not a Santali woman, raised her voice against this dependency by saying that

“These women do not go anywhere. If I tell them to go then these Santal women will say I have not finished my work yet. There are many NGO that provides training on child birth related matters. I go there no matter how much work I have. I listen to the training provider regarding child birth issues. I may not know how to explain it but I have good understanding in the concept of pregnancy and child related matters. I do not agree with these women. These women will listen to whatever husband will say. But I should also have my understanding. Why should I jump in to the dark hole by listening to my husband? I believe I am a human-being and my husband can

not rule my life as he does not have that right to do so. This is my life. We live in a family and we have to respect to each other. My husband cannot bully me. I also have rights” (R34).

I was encouraged by the openness of participant in sharing their thoughts and arguing about their rights for accessing reproductive health care. R35 who is an elderly woman in the community told that it is not good to argue with husband as she shared her opinion with others:

“How can I argue with my husband? Whatever my husband will say I have to follow otherwise my family will be broken..... If my husband says why should I see a doctor and why am I going and still if I am adamant that I will go then is that good? I don't think so. How can I go if my husband does not want?”

R 34: “You have to make your husband understand the importance of looking after your health.....You see it is true that you cannot argue with your husband but you can make your husband understand about the importance of seeing a doctor. The husbands who have some sort of knowledge or their hearts are have listened they will not forbid me of seeing a doctor a trained health professional. He will rather encourage and say that by gaining some training on child birth related issue will enhance my knowledge of reproductive health and both I and the baby will be benefited.”

R35 stated that as her husband does not like seeing a doctor, therefore, she should not disrespect his opinion. In this connection, Schuler et al. (2002) explored the issue of cost related to paying reproductive health services with 500 respondents and their qualitative findings suggest that gender inequality was observed among women as husbands did not like their wives to see a doctor and did not want to

spend money on their wives for any sort of health issue. In another study, Uddin (2009) found that the Santali family structure is patriarchal in nature and the family authority is assigned to the elder male members. Due to living in a patriarchal family structure, R35 believes that sharing and exchanging information with the husband can lead to arguments which can be catastrophic for the family. During the FGD2, R34 tries to make the other participants understand the necessity of sharing information on reproductive health issues with husband and she is very confident that husbands will be able to understand these concerns.

Comprehending the medical emergency and responding to it is an important individual initiative. Participants like R2 have never taken any decision regarding health, or any other personal issues. She is also not aware of medical emergencies that need immediate attention. Due to a lack of individual initiative, both R2 and R10 remain unaware of what might constitute a medical emergency. As stated by one participant:

“No I did not follow any birth control method. I did not take any pill. I just did not have any children. I did not get pregnant because of hard labour. During my 4th pregnancy I had a miscarriage. I asked someone to bring medicine. I told that person that I don't know why I my water broke? I took the medicine. I had to go to the toilet as I had to urinate. But while I was urinating then I had the miscarriage” (R10).

Lack of individual initiative and awareness regarding medical emergency is related to rural women being not exposed to education and modern health facilities. Inability to respond to medical emergencies or a delay in seeking medical care for reproductive matters is connected to women's incapability to interpret and enforce individual rights in terms of education, better health and access to health care services.

4.5.3 Access to health care services

One of the aspects that affected the belief structure of rural women remains access to reproductive health care services. Participants in Kakon Haat and Meherchondi have mentioned that distance to the health clinic is one of the main reasons for not accessing health care centres. The Santali community have informed me that the distance of the health clinic from their house remains a concern. As stated by one participant:

“It takes 1 hour by foot to go to the health clinic. It is far away”

(R1).

It takes one hour by foot and it takes 45 minutes by rickshaw van to go to the health clinic for R1 and the 22 participants in Kakon Haat. Rickshaw puller carries usually 6-8 people on a rickshaw van. For a pregnant woman to walk under the extreme heat to see the health professional is a struggle. For the disadvantaged ones, the quality or existence of a health service is meaningless if they have not access and this is where NGOs play a major role by providing home visits to cater their needs (Schuler et al., 2002). The necessity to have a NGO provided service in the vicinity of Kakon Haat was also highlighted by R27, as she said that “the BRAC people don’t come here. That’s why we don’t know anything.” The findings also suggest that these participants seek services from traditional healers as they come to their homes. The participants of the study highlighted the need of investment in infrastructure such as health and roads. As they said:

“I would like to tell this to the government that we need a medical hospital here” (R1).

“There are couples of things that we need. We do not have proper roads. We do not have access to drinkable water. We drink only tap water which is full of germs. We do not have medical hospital here. We do not have a Masjid here. It is so far away” (R2).

“Yes everybody needs help. Those who are helpless needs more care. We need money. We need a clinic in our village” (R8).

During the field study, I also came to know that women like R29 had to deliver their own children due to the lack of medical facilities and resources in the village. I was astounded to know that R29 had also cut the umbilical cord by herself as there was no doctor or traditional birth attendant at the time of her pregnancy.

The need for health clinic in the area of Kakon Haat was echoed in all the conversation with participants from Santali women. They have been deprived in terms of health, education, accessing proper road and transport facilities. Most importantly, they do not have clean water to drink. R20 expressed her anger by saying that they do not have access to an ambulance when emergency demands. A need for paramedical clinic for the community was suggested by R22 that would facilitate birthing women. Lack of proper roads remains an obstacle to access health services by pregnant women in rural Bangladesh.

This study finds that poverty plays a critical role for a belief system in the sampled areas. This study argues that poverty is the main reason for holding onto cultural beliefs among rural and indigenous women. Findings from the participants of Khorkhori gave a positive impression that they are encouraged to look after their reproductive health and BRAC is working in the area to provide regular health check-ups for all women including pregnant women. Women in Khorkhori are more aware in terms of responding to medical emergencies than women of Kakon Haat and Meherchondi.

4.6 Balancing Traditions and Health Needs

This study finds that rural and indigenous women are obliged to follow family rules and regulations, where the mother-in-law dominates decisions regarding childbirth and access to health care services. For example, R11 has a mixed feeling regarding seeing a doctor and a traditional healer. In one instance, she informed:

“Every month I have pain during the time of period. I went to see the doctor. Doctor has given me medicine. I also have seen a traditional healer. But the medicine of the traditional healer does not work. But still I belief in Traditional healer. It is doctor who gives better treatment....There is a change. I am going to see the doctor. Whatever family says, I have to listen. Whatever my in laws says I have to listen. I have to listen to the family members. I have to see the doctor as well. I have to maintain both. I go and see a doctor and also belief in traditional healer” (R 11).

On a similar note, R2 has realized that by not seeking immediate care while she was pregnant led to a miscarriage. R2 also informed me that her mother-in-law did not suggest seeing a doctor, though she fell on the ground while she was pregnant and the consequently lost her child. She also understood that she already had a miscarriage, and she has to make her mother-in-law understand the urgency of accessing health practitioner. Despite the realization of the need to see a health professional, she feels that she has to confirm and not disrespect her family tradition. It is evident that there are other factors or barriers such as lack of initiative, dependency on in-laws and elders and she feels that she has to confirm and not belief in spiritual entities that hinder her (R2) access to health care professionals. All of these cultural and traditional beliefs are directly or indirectly linked with a vicious cycle of poverty and dis-empowerment leading to such conforming behaviour. A similar realisation of the phenomena has been evident amongst other participants. For example:

“Rural women in Bangladesh should not have two children so quickly because I am not getting proper food and my children are also not getting proper nutrition” (R5).

“Pregnant women should look after themselves and pregnant women should eat good food as well” (R1).

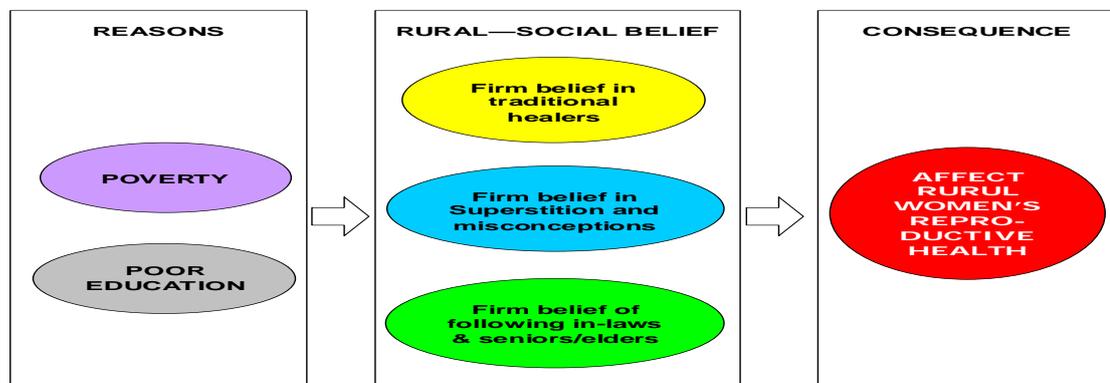
Self-realisation in regard to seeing a doctor was also echoed by R6. She understands the fact that it is important to see a doctor, however, she has to make her in-laws understand of its urgency. She has a high regard for her family traditions but at the same time values the examination by a qualified health professional of the doctor who has the knowledge to examine the baby’s position when the mother is pregnant. She (R6) stated that:

“And I also feel that it is very important to see a doctor. I always want to see a doctor. I believe that I should see a doctor first. I have to make my in-laws understand that I have to see a doctor. Doctor can tell me that which side is my baby’s position, how is the baby, or do I have water inside or not but a traditional healer cannot say these. I have to see a doctor” (R6).

Similarly, R15 also believes that it is always better to seek advice from the doctor as they have the required knowledge. Like other participants, R10 believed that there has to be a balance between meeting the personal health care needs, respecting elders and tradition and understanding health needs through education at school and from the media.

The findings suggest that there is a sense of realisation of having a balance between myth, tradition and understanding and responding to the need of individual health especially when emergencies arise.

Figure 8: Reasons and consequences of belief



4.7 Summary of the research findings and discussion

The aim of this study was to explore the reproductive health beliefs and the reasons for holding such beliefs among rural women in Bangladesh. Traditional healers hold a respectable position due to their special skills, experience and knowledge to heal sickness and predicting complications, which may arise during the pregnancy. There is also a strong belief that the holy or sanctified water, herbal roots and amulets given by the traditional healer can make a woman pregnant who has failed to conceive long after getting married. A rural woman prefers a traditional healer because he does not physically examine the body of a woman and seeing a traditional healer is cheaper than a doctor. It is believed that a traditional healer has spiritual power that protects the birthing woman from malevolent spirits.

The findings of this study suggest that superstition remains a key reason for the participants of the study for not accessing reproductive health care services. Poverty, including financial limitations and being unable to pay the doctor's fees, has been the major reason for not getting medical treatment. The poor public health facilities, services and the high price for seeing a specialist doctor in a private clinics keeps the poor people far away from accessing health care services, especially in Kakon Haat and Meherchondi. The findings also provide an overview of the differences in reproductive health beliefs amongst various demographic in terms of age, profession, income, education and ethnicity. Rural women in these areas turn to traditional healers or spiritual leaders to get medical treatment. This study also finds that there are participants who realize the importance of seeing a doctor due to their knowledge and experience, however, family members, in-laws and elders may not have the knowledge to interpret the medical needs required for someone who is pregnant and this can potentially be life threatening.

Chapter 5: Conclusion

5.1 Introduction

The chapter, first, summarises all the previous chapters; it then discusses the contributions to knowledge; the thesis's contribution to research methodology and the practical contribution of this study. Limitations of this study are addressed and discussed in section 5.6. Finally, a discussion about future research and concluding comments are placed in section 5.7 and section 5.8, respectively.

5.2 Summary of the chapters

This research provided insights to the questions, which were answered in the findings and discussion chapter. The first chapter, introduction, discussed an overall understanding of the notion of reproductive health, its definition and function to men and women. It provided a general introduction to Bangladesh describing the political and geographical scenario of the country. It provides a snapshot of reproductive health care services in Bangladesh that are found inadequate and beliefs that are marred by rural traditional values, religious and culture. In addition, the reason for undertaking this study was discussed in the background section of the study, where I have gathered my personal reasons for adhering into this issue of reproductive health care. It discussed the research issues briefly and addressed the aim of the research. The significance of the study and a brief description of research methods were also discussed. Finally, the introduction chapter addressed the thesis outline that leads as a framework.

The second chapter, literature review, explores the existing body of knowledge, which is based on the discussion of women's beliefs and attitudes towards reproductive health care services in Bangladesh. It developed an array of discussion from the current studies on the role of culture, health-related beliefs and attitudes, barriers to accessing reproductive health care services and reproductive health awareness. The literature found that the current studies were mainly based

on mixed-method using a cross-sectional survey, where multiple-regression analyses were often used. However, there is still an inadequate understanding of the beliefs and attitudes towards reproductive health care services in Bangladesh using a qualitative research approach, demonstrating the need for an in-depth investigation of rural women's rich insights into their experiences of belief and attitudes towards reproductive health.

The third chapter, research methodology attempted to explore two research questions of the study and embarked upon beliefs and attitudes of reproductive health care services in the context of rural areas in Bangladesh. Firstly, a detailed description of each of the sample areas was provided to have a broader understanding of the nature of the rural setting, surroundings and people. This study used two tiered qualitative research methodology by employing in-depth one-to-one interviews and focus group discussions using semi-structured questions; in order to confirm and validate the data collected from three villages in Rajshahi, Bangladesh. During the fieldwork, thirty interviews and three focus group discussions were conducted using snowball sampling technique that ensured the data triangulation of this study. The demographic and socio-economic data had established the credibility and validity of the dataset by bringing together the contributing factors that influence rural women's beliefs and attitude towards reproductive health care services.

The fourth chapter is based on the findings and discussion emerging from field data. A demographic table has been presented that includes various demographic variables such as education, income, and ethnicity, number of children, family members, and frequency of contacting homeopathy doctor or traditional healer. A detailed fieldwork experience illustrates the rapport building processes with the participants and the dilemmas faced during the data collection processes. The findings reveal three critical themes regarding rural women's beliefs and attitudes toward reproductive health. These are: a strong belief in traditional healers; a firm belief of following in-laws and seniors/elders, and superstitions regarding fertility, pregnancy and child-birth. The third theme, in particular, led to further discuss on

five sub-themes, including in-door stay during post-natal period, malicious spirit, food taboos, and secrecy in birthing and sexual related issues.

Finally, this chapter provides a summary of the research findings, and their contributions to knowledge, research method and practice. The findings suggest that the participants of this study rely on traditional healers being cost efficient and accessible unlike professional health care service. Moreover, superstitions and adherence to elders' decisions hinder the participant from accessing trained health professionals. The findings and discussion is supported by the two figures that have been derived from the findings of this study. The first one is the belief-poverty framework, where access to traditional healer or professional health services relies on the extent of poverty and socio-cultural context of belief structure. The second framework, however, demonstrates the two major reasons namely poverty and poor education that aggravate and helps sustaining rural-social beliefs across generations, and consequently affects rural women's reproductive health.

5.3 The Methodological Strength

This study has several methodological strengths. First, the research design followed the methodological triangulation (using more than one technique) approach through in-depth interviews, focus group discussions and demography of the participants following the suggestions of the current literature (Laws, Harper, Marcus, 2003; Denzin, 1989). This study had thirty in-depth interviews from three different villages of the Rajshahi district in order to have more rigorous dataset. The focus group discussions have been very useful because women could share their personal issues like pregnancy and childbirth. Hadi (2001), in this context, suggested that a focus group discussion is considered the most suitable media to disseminate health knowledge amongst poor rural women as, most of the time; these rural women do not understand most of the print media health messages due to literary context.

The present study carried out an explorative research and addressed two research questions regarding an understanding the beliefs and attitudes of rural Bangladeshi women towards reproductive health and how these beliefs and attitudes shape rural women's understanding and their subsequent decisions about their reproductive health and the services that are available. There are many aspects that shape rural women's beliefs and attitudes toward reproductive health in rural Bangladesh. These aspects are based on age, professions, income, education and ethnicity. In the study sample, 23-27 year age group has the highest frequency to access trained health professionals. Participants belonged to various groups such as house wives and day labourers.

The housewives from Khorkhori had regular communication with the NGO health workers regarding their pre-natal, antenatal and post-natal care. They do not consult the traditional healer, whereas the Santali women from Kakon Haat had a tendency to seek advice from the traditional healers for their health needs at times. In addition, the Santali women from Kakon Haat also sought health advice from a professional health specialist to get the appropriate health services for their reproductive matter. On the other hand, women from Meherchondi had no contact with the professional doctor; they relied heavily on the traditional healer. It establishes that access to health care services have an impact for rural women in availing reproductive care.

Income is another influential factor on the decisions made by the participants of this study to access and chooses health professionals. The demographic analysis reveals that the average income of Santali household is \$25 per month, keeping them below the poverty line. It has been determined from the findings and discussion chapter that due to financial limitation, women from Kakon Haat and Meherchondi are availing to traditional healer, when it is required. Therefore, low income is one of the barriers for the participants of this study not to access professional health care services.

This study illustrated the cultural beliefs that moulded the understanding, perspective and perception of the rural women's belief and attitude towards reproductive health. This study investigated how these beliefs and attitudes play a role in making decisions to access a particular reproductive health service. The findings suggest that mother-in-law plays a key role in deciding the daughter-in-law's childbirth. Participants, especially from Kakon Haat live in an extended household with their in-laws. Mother-in-law has a hierarchal position in the family due to her position and age. This study shows that woman who lives in extended households are reluctant to responding to medical needs due to lack of initiative and dependency on in-laws and elders.

The focus group discussion elaborated that participants from Kakon Haat had a sense of self-realisation and seek a balance between meeting the expectation of the elders and understanding one's own needs by responding to medical emergencies. A contributing factor is their education level and access to the media leading to their knowledge about health needs. Awareness about health especially reproductive health can prevent the rural women from miscarriages, abortion and other life threatening complications during pregnancy and after child birth.

Overall, this study did not aim to project any pre-determined side for the health professional or against the traditional healers. The main objective of this study was to explore and identify the beliefs and attitude that shaped the understanding of reproductive health of rural women in Bangladesh. The unfolded experiences of the participants about their reproductive health care contribute in broadening our understanding of reproductive health care services in rural Bangladesh. There is a growing body of literature that illustrates how reproductive health can be accessible for rural women in the developing and under developed countries, who are generally marginalised due to cultural and religious belief and for poverty. These findings contribute to the current discussion on achieving the targets of MDG 5 'safe motherhood' programme that ensures better maternal health for all women. The following section discusses the contribution to current knowledge of the study.

5.4 Contributions to current knowledge and practice

This study contributes and extends existing understanding of belief, attitude, perception and perspectives of reproductive health care services. It contributes to similar findings through the research works of Sibley et al. (2009). Several studies (Field & Ambrus, 2008; Anwar et al. 2008; Chakraborty et al., 2003; Hadi, 2001; Amin et al., 2010; Saito et al., 1997; Rafiqul et al., 2007; Gayen & Raeside, 2010; Strobach & Zaumseil, 2007) considered researching on the issue and aspect of maternal health education and reproductive health care services following a demographic study and using a quantitative research method. This research concludes that there is inadequate knowledge regarding the perceptions and perspectives of rural Bangladeshi women's beliefs and attitudes about their reproductive health provides new insights into the experiences of rural women who had been in their pre-natal, antenatal and post-natal stages; and unfolded their experiences with social, religious and rural beliefs. The two research questions investigated and evaluated rural women's capacity to access reproductive health care services and the degree of freedom in terms of mental and physical state that enhances or decreases her choice for accessing health care services. In order to evaluate rural women's capacity for accessing reproductive health care Amartya Sen's 'capability approach' is employed to find out well-being, development, poverty, freedom and functioning of the participants of this study.

Sen's (1997, 1999) capability approach to well-being and development evaluates people's access to clean water, well-nourished food, knowledge on health issues, and access to medical facilities. Many of the participants of this study had no knowledge about pre-natal, antenatal and post-natal care. The evidence from this research suggested that participants of the study felt that they need nutritious food for them and for their un-born child but due to extreme poverty they are unable to meet these needs. This study also suggested that poverty, lack of awareness and limited support during the pre-natal and post-natal stage can have a huge negative impact on the well being of the mother and the child.

In addition, the in-depth interviews and focus group discussion reiterated that their husband and in-laws did not like the idea of seeking professional help and advice. The study also concludes that financial limitations remain one of the major causes for not seeking professional advice. This study explored how belief and attitude towards reproductive health care services affected the well-being of the participants from rural Bangladeshi communities. The capability approach covers the full terrain of human well-being and development. The capability approach enquires whether the participants of this study avail the services of medical health professionals for their reproductive health care. The notion of capability also explores whether the participants of the study are willing to avail to medial services. The most important part of applying the concept of capability approach was to explore the degree of freedom, well-being and development of the participants for availing reproductive health care services. Well-being and doing is discussed in this study for rural women who are not availing reproductive health care services and the opportunities they can undertake to improve the health of mothers and children. The study found that the participants of this study cannot avail professional reproductive health care services mainly due to poverty, illiteracy, and being influenced by various cultural, traditional, religious and familial beliefs.

There are several contributions of this study. One of the key contributions of this study is that it explored the key aspects that determines or confirms rural women's beliefs and attitudes to reproductive health care in the context of Bangladesh. The findings of this study are an indication, only, of the current state of achieving one of the millennium development goals (MDGs) of Bangladesh, 'improve maternal health' (Goal 5), by 2015. This study could be a useful framework for vulnerable cohort of rural women in Bangladesh, as through raising awareness and promoting skilled attendants at the time of birth and profession health practitioners may reduce the incidence of adverse pregnancy outcomes. This may be achieved through improving awareness levels and natal care seeking practices of women, as well as, making skilled attendants more accessible to women from a social,

geographical, economic and health system related contexts. The findings of this study are based on a small group of participants residing in three villages in Rajshahi district. The findings of this study will contribute to various on going projects for reducing maternal and child mortality rates by providing training to midwives and traditional birth attendants. This study has practical usage for Non-Governmental Organizations (NGOs) as it can potentially broaden their understanding of reproductive health care services and its scope and necessity to the rural Bangladeshi women and contribute to improve the outreach of services in rural communities.

Improving women's social status through promotion of health education, participation in paid work force to improve economic status and enhancing independence to visit healthcare providers may improve mother's reproductive health and child's neo-natal health. These can be achieved through joint and community based approaches by government departments of health, education, women development, social welfare and religious affairs to address these demographic and social inadequacies in the status and health of women in rural Bangladesh. Thus, this study contributes further to achieve MDG 5 and seeks attention from the stakeholders to improve facilities, provide support and supply of medical assistances adequately to the rural women in Bangladesh.

5.5 Limitations of the Study

Although this study makes several contributions in terms of knowledge and practice, its limitations should be noted. First, this study was confined to three villages in Rajshahi district of Bangladesh, thus, the findings of the present study are confined to three villages and a small sample size. This study used a qualitative method with in-depth face to face interviews and three focus group discussions. This study does not attempt to generalise its findings as the sample size is fairly small. One of the greatest challenges for qualitative research is regarding generalising the findings that are based on a small sample. However, by gathering

rich data with in-depth description provides knowledge that aligns existing knowledge with community needs and insights.

5.6 Future Research

Future study could have broader samples that can lead to generalise its findings which can have a broader impact on the rural women in Bangladesh. While collecting data in the field, Santali women have informed me that their fertility rate is low which needs further investigation and research to critically analyse the situation. This study suggests exploration of these concerns through a longitudinal research in the area, on an indigenous Santali community that is in the danger of being extinct (Mannan, 1997).

This study makes a number of observations regarding the reproductive health services available to the rural women in Bangladesh. This implies that there is a scope of further research in broader perspectives including women's beliefs and attitudes towards reproductive health in the context of urban Bangladesh, and examining their differences with a larger sample of rural women. It would be interesting to compare and contrast similarities and differences of these beliefs and attitudes of reproductive health care in rural and urban Bangladesh. Finally, an ethnographic study could provide a greater understanding of the lives of the indigenous women, especially their beliefs that influence their reproductive health.

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Appendices

Please see the attached documents detailing:

Appendix A (Ethics Approval)

11/05/12 **HUMAN RESEARCH ETHICS COMMITTEE**

APPROVED - Project number 12-70

Ms. Tarafder Tasmiha

Faculty of Arts and Design

University of Canberra

BRUCE ACT 2617

Dear Tarafder,

The Committee for Ethics in Human Research has considered your application to conduct research with human subjects for the project entitled **Reproductive Health care services in Bangladesh: A Case Study of Belief and Attitude of Rural Women in Bangladesh. Approval is granted until 30/06/13 the anticipated completion date stated in the application.** The following general conditions apply to your approval. These requirements are determined by University policy and the *National Statement on Ethical Conduct in Research Involving Humans* (National Health and Medical Research Council, 2007).

Monitoring: You, in conjunction with your supervisor, must assist the Committee to monitor the conduct of approved research by completing and promptly returning project review forms, which will be sent to you at the end of your project and, in the case of extended research, at least annually during the approval period.

Discontinuation of research:

You, in conjunction with your supervisor, must inform the Committee, giving reasons, if the research is not conducted or is discontinued before the expected date of completion.

Extension of approval:

If your project will not be complete by the expiry date stated above, you must apply in writing for extension of approval. Application should be made before current approval expires; should specify a new completion date; should include reasons for your request.

Retention and storage of data:

University policy states that all research data must be stored securely, on University premises, for a minimum of five years. You and your supervisor must ensure that all records are transferred to the University when the project is complete.

Contact details and notification of changes:

All email contact should use the UC email address. You should advise the Committee of any change of address during or soon after the approval period including, if appropriate, email address(es).

Please add the Contact Complaints form (attached) for distribution with your project.

Yours sincerely

Human Research Ethics Committee

Charnel Slater

Ethics & Compliance Officer

Research Services Office

T (02) 6201 5870 F (02) 6201 5466

E-mail: Charnel.Slater@canberra.edu.au

Appendix B

(Participants' informed sheet in English and Bengali)



Information and Consent Sheet

What is this research all about?

I am undertaking Master by Research in University of Canberra, Australia. My name is Tahmiha Tarafder (Tina). For your convenience you can call me Tina. The title of my research is about “Reproductive Health Care Services in Bangladesh: A Case Study of Belief and Attitude of Rural Women.” Before we start our discussion on reproductive health care, I would like to give you an understanding of what does it mean? Reproductive health care in this study relates to the care that a woman need before becoming mother, while being pregnant and after her pregnancy.

Who is participating in this research?

I have already informed you I will be investigating the belief and attitude of rural women in Bangladesh, therefore, rural women who are married, going to be mother, have recently become mother can participate in this research. Belief, attitude, experiences and multiple realities will be explored in this research.

What incentives you will get from this research?

Your valuable participation in this research is very appreciable and welcoming. Your insightful discussion and experiences can make this research very successful. Those of you who will be participating in this research for a successful interview and focus group discussion will get an incentive of 200 Bangladesh Taka. Moreover, I will again come to cross-check the data gathered from the interview and discussion will get an amount of 100 Bangladesh Taka.

What are your rights for participating in this research?

Participation in the research is completely voluntary and participants can withdraw from the interview session at any time. The interview will not take more than two hour and it will only be recorded after getting the permission from the participants. The researcher respects the rights of the participants not to participate in the project. There is no risk or any harm to the participants, which relate to privacy and confidentiality. Please be assured that all the data collection from the participants

will be stored securely and only accessed by the researcher. Great care will be taken to ensure that any reports of the data do not identify any individual or their circumstances. Participation in the focus group discussion and in the one-to-one interview session with the researcher will be at a time that is convenient.

How will the research maintain your privacy, confidentiality and anonymity?

Only the researcher will have access to the individual information provided by the participants. Privacy and confidentiality will be assured at all times. The research outcomes will be provided in the final thesis and in the research publications. However, in all these research outcomes, the privacy and confidentiality will be protected. By no means will the research contain any information that can identify any individual and all information will be kept in the strictest confidence and code will be used to mention name in this research.

Whom to Contact for further communication?

Firstly, you all can communicate with me. My address in Bangladesh is: House name: "Sarnalee," Talaimari, Rajshahi, 6204. You can also contact with me in the following address as well: Tasmih Tarafder, Masters Student by Research, Higher Research Degree (Student Study Centre), Building 20, room no: 18B, University of Canberra, Bruce, 2601, ACT, Canberra. Australia.

What is expected from you?

Please take enough time to answer the questions that I am going to ask you and you all. You can discuss with others. I will listen to what you say and I will only record the interview or discussion if you agree upon it.

তথ্যপত্র

এই গবেষণাটি কি বিষয়ে?

আমি একজন স্নাতকোত্তর পর্যায়ের গবেষক। বর্তমানে আমি ক্যানবেরা বিশ্ববিদ্যালয়, অস্ট্রেলিয়াতে গবেষণা করছি। আমার নাম তাসমিহা তরফদার (টিনা)। আমার গবেষণার বিষয় বস্তু হচ্ছে: "বাংলাদেশের প্রজনন স্বাস্থ্য সেবা: গ্রামীণ মহিলাদের বিশ্বাস ও ভাবমূর্তি"। আমাদের আলোচনা শুরুর আগে আমি আপনাদেরকে সংক্ষেপে প্রজনন স্বাস্থ্য সেবা সম্পর্কে আমি কি বুঝি সে সম্পর্কে ধারণা দিতে চাই। প্রজনন স্বাস্থ্য সেবা হলো মা হবার পূর্বে, মা হওয়াকালীন সময় এবং মা হওয়ার পর আমাদের মহিলাদের যে ধরনের স্বাস্থ্য সেবার প্রয়োজন দেখা দেয়। এই গবেষণা ক্যানবেরা বিশ্ববিদ্যালয়, অস্ট্রেলিয়া কর্তৃক অনুমোদিত, যার সূত্র নাম্বার হচ্ছে HREC 12-70.

এই গবেষণাতে কে অংশগ্রহণ করতে পারবেন?

এই গবেষণাটি প্রজনন স্বাস্থ্য সেবায় গ্রামীণ মহিলাদের বিশ্বাস এবং ভাবমূর্তি বিষয়ে, কাজেই, গ্রাম-বাংলার সাধারণ মহিলাগণ বিশেষ করে যারা বিবাহিত, মা হতে যাচ্ছেন, এবং কিছুকাল পূর্বেই মা হয়েছেন, তারা এই গবেষণায় অংশ নিতে পারবেন। এই গবেষণায় প্রজনন স্বাস্থ্য সেবা সম্পর্কে তাদের বিশ্বাস, চিন্তা-চেতনা, কর্ম এবং ভাবমূর্তি সম্পর্কে জানতে চাওয়া হবে।

এই গবেষণায় অংশগ্রহণে আপনার প্রনোদনা গুলো কি কি?

আপনার অংশগ্রহণ এই গবেষণায় একান্ত কাম্য। আপনার অভিজ্ঞতা ও আলোচনা এই গবেষণাকে সফলতা দিতে পারে। আপনাদের মধ্যে যারা এই সাক্ষাতকারে সফল ভাবে অংশগ্রহণ করবেন ও শেষ করবেন, তাদের প্রত্যেকের জন্য রয়েছে ১০০ টাকা, এছাড়াও আমি আবার যাদের কাছে আলোচনার জন্য অন্য কোন দিন ফিরে আসব, তাদের প্রত্যেকের জন্যও রয়েছে ২০০ টাকা।

এই গবেষণায় অংশগ্রহণে আপনার অধিকার গুলো কি কি?

এই সাক্ষাতকারে অংশগ্রহণ আপনার ইচ্ছার উপর নির্ভরশীল। এই সাক্ষাতকার সর্বোচ্চ দুই ঘন্টা স্থায়ী হতে পারে। এই সাক্ষাতকার চলাকালে আপনি যদি শারীরিক কিংবা মানসিক ভাবে অসুস্থ বোধ করেন, আপনি আমাদের কে বলে চলে যেতে পারেন। এই সাক্ষাতকারে আপনি অংশগ্রহণ করলে, আমি বুঝব যে এতে অংশগ্রহণে আপনার মতামত আছে।

এই গবেষণা কি ভাবে আপনার গোপনীয়তা রক্ষা করবে?

এই সাক্ষাতকার শুধুমাত্র গবেষণার কাজে ব্যবহার করা হবে। আপনার ব্যক্তিগত তথ্যসমূহ যেমন: আপনার নাম, গ্রাম ও ঠিকানা কোনো ভাবেই প্রকাশিত হবে না।

আপনি অতিরিক্ত তথ্যের জন্য কার সাথে যোগাযোগ করবেন?

প্রথমত: আপনি আমার সাথে যোগাযোগ করতে পারেন। আমার ঠিকানা হলো: তাসমিহা তরফদার (টিনা), "স্বর্ণালী", তালাইমারী, কাজলা, রাজশাহী ৬২০৪। এছাড়াও আপনি নিম্নোক্ত ঠিকানায় যোগাযোগ করতে পারেন। যোগাযোগের ঠিকানা:

Tasmiha Tarafder, Masters Student by Research, Higher Research Degree (Student Study Centre), Building 20, room no: 18B, University of Canberra, Bruce, 2601, ACT, Canberra. Australia.

আপনাদেরকে কি করতে হবে?

আপনাকে/আপনাদের কে আমি কতকগুলো প্রশ্ন করবো। আপনি/আপনারা সময় নিয়ে এই প্রশ্ন গুলো নিজেদের মধ্যে আলাপ-আলোচনা করবেন। আমি আপনাদের কথাগুলো শুনবো, লিখবো এবং রেকর্ড করবো। সেই সাথে আমি মাঝে-মাঝে আপনাকে/আপনাদের কে সংক্ষিপ্ত প্রশ্ন করবো।

Appendix C
(Consent form in English and Bengali)



Consent Form

Project Title: *Reproductive Health Care Services in Bangladesh: A Case Study of Beliefs and Attitudes of Rural women*

Consent Statement

I have read and understood the information about the research. I am not aware of any condition that would prevent my participation, and I agree to participate in this project. I have had the opportunity to ask questions about my participation in the research. All questions I have asked have been answered to my satisfaction.

Please indicate whether you agree to participate in each of the following parts of the research (please indicate which parts you agree to by putting a cross in the relevant box):

- Provide detail information about, age, income and number of family members to the researcher.
- Participate in focus group discussion with the researcher.
- Participate in an interview with the researcher.

Name.....

Signature.....

Date

A summary of the research report can be forwarded to you when published. If you would like to receive a copy of the report, please include your mailing (or email) address below.

Name.....

Address.....

গবেষণার বিষয়:

"বাংলাদেশের প্রজনন স্বাস্থ্য সেবা: গ্রামীণ মহিলাদের বিশ্বাস ও ভাবমূর্তি"

সম্মতি পত্র

আমি এই গবেষণার বিষয়বস্তু সম্পর্কে অবগত আছি I আমার অংশগ্রহণে বাধা সৃষ্টি করতে পারে এমন কোনো অবস্থা সম্পর্কে আমার জানা নাই, এবং আমি এই গবেষণায় অংশগ্রহণে সম্মতি প্রদান করছি I এই গবেষণায় অংশগ্রহণে আমার প্রশ্ন করার সুযোগ ছিল I আমার সমস্ত প্রশ্নের সন্তোষজনক উত্তর আমি পেয়েছি I

এই গবেষণার নিম্নোক্ত প্রতিটি ধাপে অংশগ্রহণ করতে ইচ্ছুক কিনা এই মর্মে আমাদেরকে নির্দেশনা দিন (আপনি যে সমস্ত ধাপে অংশগ্রহণে ইচ্ছুক, দয়া করে সে সমস্ত ধাপের বক্সে 'x' চিহ্ন দিন) I

- আমার ও আমার পরিবারের বয়স, আয়, সদস্যসংখ্যা সম্পর্কে গবেষককে তথ্য প্রদান করব
- গবেষকের সাথে দলীয় আলোচনায় অংশগ্রহণ করব
- গবেষকের সাথে একক আলোচনায় অংশগ্রহণ করব

নাম: _____

স্বাক্ষর: _____

তারিখ: _____

এই গবেষণা প্রকাশিত হবার পর, এর সারাংশ আপনাকে দেয়া যেতে পারে I আপনি যদি এই গবেষণার সারাংশ পেতে চান তাহলে নিম্নে আপনার নাম, ঠিকানা (অথবা ই-মেইল) উল্লেখ করুন I

নাম: _____

ঠিকানা: _____

ই-মেইল: _____

Appendix D

Interview Questions in Bengali and English

তথ্যপত্র

যে প্রশ্নগুলো দিয়ে আমরা আলোচনা শুরু করবো তা হলো:

১. আপনার/আপনাদের নাম, বয়স, বিবাহিত-নাকি-অবিবাহিত, পরিবার কি করে, কাজ করেন কিনা, কতজন ছেলে-মেয়ে, পরিবারে স্বামী-ছেলে-মেয়ে ছাড়া আর কেউ থাকে কিনা, এবং গ্রামের নাম বলবেন কি?
২. প্রজনন স্বাস্থ্য সেবা সম্পর্কে আপনার/আপনাদের ধারণা কি?
৩. আপনার/আপনাদের কি ধরনের প্রজনন স্বাস্থ্য সেবার প্রয়োজন হয়েছিল?
৪. শেষ কবে আপনি/আপনারা প্রজনন স্বাস্থ্য সেবা নিতে গেছেন?
৫. আমাদের দেশে অনেক রকমের সামাজিক/পারিবারিক বিশ্বাস থাকে, তাইনা। যেমন, আমি যখন মা হলাম তখনআমার পরিবার থেকে বলা হলো যে "তুমি ৪০ দিন বাইরে যেতে পারবে না"আপনার/আপনাদের ক্ষেত্রেও কি এমনটা হয়েছিল/হয়ে থাকে? এ রকম আর কি কি সামাজিক/পারিবারিক বিশ্বাসের মুখোমুখি আপনি/আপনারা হয়েছেন? একটু বিস্তারিত বলবেন কি?
৬. মা হবার পূর্বে, মা হওয়া কালীন সময় এবং মা হওয়ার পর -
এই তিন অবস্থায় একজন মহিলা কে কি ধরনের সামাজিক/পারিবারিক বিশ্বাসের মুখোমুখি হতে হয়? আপনার/আপনাদের নিজের জীবনের কোনো অভিজ্ঞতা থেকে কিছু বলুন?
৭. কোন সময় গুলোতে/কখন আপনি/আপনারা প্রজনন স্বাস্থ্যের সামাজিক/পারিবারিক বিশ্বাস মেনে থাকেন?
৮. কোন অবস্থাতে প্রজনন স্বাস্থ্য সম্পর্কে সামাজিক/পারিবারিক বিশ্বাস কে আপনার/আপনাদের কাছে বড় মনে হয়?
৯. আপনি/আপনারা কি বিশ্বাস করেন যে, সামাজিক/পারিবারিক বিশ্বাস অনেক সময় আপনার/আপনাদের চিন্তা-চেতনা, কর্ম ও ভাবমূর্তি কে প্রভাবিত করে? একটু ব্যাখ্যা ও উদাহরণ দিয়ে বুঝিয়ে বলবেন কি?

১০. প্রজনন স্বাস্থ্য সেবা সম্পর্কে আপনার/আপনাদের সামাজিক/পারিবারিক বিশ্বাস এর কি কোনো পরিবর্তন হয়েছে?
১১. আপনি/আপনারা কি আপনার/আপনাদের পরিবার থেকে প্রজনন স্বাস্থ্যের যত্ন নিতে উত্সাহ পান?
১২. আপনি/আপনারা কার কাছে প্রজনন স্বাস্থ্য সেবা নিতে আগ্রহ বোধ করেন? এবং কেন?
১৩. আপনি/আপনারা কি মনে করেন যে, একজন প্রশিক্ষণ প্রাপ্ত ডাক্তার বা সেবিকার কাছে প্রজনন স্বাস্থ্য সেবার জন্য যাওয়া উচিত? কেন এমনটা মনে করেন?
১৪. আপনার/আপনাদের বাসা থেকে সরকারী/বেসরকারী প্রজনন স্বাস্থ্য কেন্দ্র কত দূরে? আপনি/আপনারা কি ভাবে যাতায়াত করেন ও যেতে কতক্ষণ সময় প্রয়োজন?
১৫. আপনার/আপনাদের মতে প্রজনন স্বাস্থ্য সেবা সম্পর্কে গ্রামের মহিলাদের সচেতন করার জন্য কি কি করা যেতে পারে?

Interview questions in English

- 1) Could you please tell me your age, whether you are married or unmarried, do you work, how many children do you have, are there any other extra member in the family and what is the name of your village?
- 2) What is your understanding of the concept of reproductive health care?
- 3) What sort of care did you need to avail for reproductive health services?
- 4) When is the last time that you avail to reproductive health care services?
- 5) In our country we have many sorts of superstitions, cultural beliefs and family beliefs. Is not it? When I become a mother I was told from my family that I should not go outside for 40 days. Did you have same experience like me? Did you face any sort of this type of cultural practices after becoming mother? Could you please explain it?
- 6) Do you think that a woman has to face any sort of social or familial belief before becoming mother, while being pregnant and after becoming mother? Could you please relate with your experience?
- 7) Is there any particular time that you had to accept the social or familial belief of reproductive health care?
- 8) In which situation you think cultural belief and attitude played a major role in your reproductive health care?
- 9) Do you think that family tradition and cultural belief can have an impact on your thoughts, work and attitude? Could you please explain and give example?
- 10) Is there any change of reproductive health care in your social and family life?
- 11) Do you get encouragement from yourself and your family regarding reproductive health care services?
- 12) Whom do you prefer to seek care for your reproductive health? And why?
- 13) Do you think that it is better to seek advice from a trained health professional or from a trained birth attendant regarding reproductive health care? Why do you think that?
- 14) How far is the government or non-government reproductive health care service? How do you travel and how long does it take?
- 15) What is your suggestion for improving awareness for rural women's reproductive health care services?