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CULTURAL BARRIERS TO MATERNAL HEALTH CARE IN RURAL BANGLADESH

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Abstract

Bangladesh is a country with over one third of the population living in poverty and another one third living just above poverty level. The World Health Organization (2010) indicates that Bangladesh has poor prenatal and postpartum care, nutritional deficiencies, high incidence of non-skilled birth attendant utilization, and the second highest maternal mortality and morbidity rates next to sub-Saharan Africa. Women living in Bangladesh are at high risk for maternal mortality and morbidity in the postpartum period. Malnourishment, anemia, poverty, lack of skilled birth attendants, and limited prenatal and postpartum care are some of the issues facing women living in rural Bangladesh. There remains a need for providers with expertise in obstetrics and gynecology, women's health physical therapists, and other maternal health providers to provide postpartum education regarding prenatal and postpartum care to women and their skilled birth attendants living in the more vulnerable rural regions.

Keywords: Postpartum, Maternal Health, Morbidity, Mortality, Bangladesh

Introduction

Bangladesh is a country with over one third of the population living in poverty and another one third living just above the poverty level (World Bank Report 2010). The World Health Organization indicates that Bangladesh has poor prenatal and postpartum care, nutritional deficiencies, high incidence of non-skilled birth attendant utilization and the second highest maternal mortality and morbidity rates next to sub-Saharan Africa (WHO, 2011). There are eight United Nations Millennium Development Goals (MDG) signed by all UN members in September 2000 for action to be taken to address poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women by 2015 (WHO, 2010). Millennial Development Goal 5 (MDG5) focuses on improving the maternal health of women in developing countries, including Bangladesh. This includes improving access to prenatal and postpartum programs that effectively reduce the morbidities associated with postpartum maternal health. However, there is currently no information on the specific religious, cultural and socio-economic barriers experienced by women living in Bangladesh that may limit access to these programs. If religious, cultural and socio-economic barriers are not considered, Bangladeshi women may be at an even higher risk for postpartum problems.

Gender-equity theories propose that empowerment for women should begin with access to social, health and nutrition services and economic opportunities (Gill, Pande, & Malhotra, 2007). In Bangladesh, social, health, nutrition, and economic opportunities are inaccessible to many women. Yet, to effectively address the specific needs of women, it is important to understand the medical needs, local practices, and perceptions of pregnancy, birth, and the postpartum period and how they are affected by culture and religious beliefs. However, this knowledge is essential for effective strategies to be developed by governmental and non-

governmental organizations, and implemented by physicians, physical therapists, and other health care practitioners in Bangladesh for the success of future maternal health program development. Therefore, the purpose of this paper is to delineate the cultural risk factors that compound postpartum morbidities of Bangladeshi women.

Malnutrition & Risky Birth Practices

Bangladeshi women are already at high risk for postpartum disorders such as infection, hemorrhage, urologic dysfunction and pelvic pain. The body mass index (BMI) norm range is 19-25 and is a widely used indicator of overall health. The national average BMI of Bangladeshi women is < 18.5, which is considered considerably underweight and in the category of malnourished. Malnutrition potentially compounds the problems that previously existed during the prenatal and postpartum period (NIPORT, 2001). A survey of 26, 424 pregnant women living in Bangladesh found that 35-38% of pregnant women had a body mass index less than 18.5, weighted 48-49 kg and over 50% were suffering from severe iron deficiency anemia (Faruque, Ahmed, & Ahmed, 2008). Being underweight makes Bangladeshi women more vulnerable to postpartum complications such as eclampsia and anemia compared with women who have adequate nutrition.

Nutritional deficiencies such as Vitamin D, B12, iron and folate have been linked to higher maternal and infant mortality. This is especially so for women living in the rural areas of Bangladesh and also women living in the slum areas of Dhaka (Christian, 2002; Seshadri, 2001). Over 2,000 women who were given calcium supplementation during pregnancy showed a 60-70% decrease in preeclampsia and hypertension, two of the most common morbidities leading to maternal death for women living in the subcontinent (Bucher, Guyatt, & Cook, 1996). However, no significant reduction in preeclampsia or hypertension was found when over 4,000 non-

calcium deficient women living in the United States were given calcium supplementation (Levine, Hauth, & Curet, 1997). This dichotomy in research findings may suggest a special and specific role that calcium supplementation has for women living in poorer regions of the world, where many are considered underweight.

Zinc may also play an important role in reducing the risk of severe problems during labor and delivery such as premature rupture of membranes, placental abruption, prolonged labor and severe lacerations, although this has not been studied for Bangladeshi women (Viteri, 2011; Lagiou, Mucci, & Tamimi, 2005). Nutritional deficiencies, including Vitamin D, B12, A, iron and folate play a substantial role in the maternal health and in minimizing complications during the prenatal and postpartum period, as well as during delivery. Therefore, nutritional deficiencies in women living in Bangladesh should be considered when addressing the quality of life of these women during the postpartum period. This will provide a comprehensive understanding of all the underlying factors that influence maternal health and quality of life.

Economic Opportunities

Literacy and Language Barriers

Economic opportunities and the development of programs that care for the health of women are limited because of literacy and language barriers. The WHO recommends prenatal and postpartum programs that address commonly associated morbidities as one of several methods to improve Bangladesh maternal health care. However, the literacy rate is extremely low among women living in Bangladesh with only 13.4% of women in the poorest quintile and 54.8% of women in the wealthiest quintile who are literate (Khan, Kramer, & Khandoker, 2011). This can clearly be a challenge when providing written educational materials about women's health programs or conducting research on this population. Some have taken an "anti-colonial"

approach to illiteracy by claiming the focus on illiteracy has been "ethnocentric" and devalues the Bangladeshi oral tradition, which should also be respected when developing and providing health programs to women living in Bangladesh (Mayuzumi, 2004).

Education, literacy and maternal mortality and morbidity correlate highly with one another. A study of 80 Bangladeshi women in two different districts, performed by Kalim et al (2009), found a significant relationship between maternal years of education, literacy rates, and the utilization of skilled birth attendants and maternal mortality rates. Having a skilled birth attendant present at delivery is one method used to improve maternal health care and is directly correlated to maternal health. This study found that the community with higher literacy rates and education had corresponding higher utilization of skilled birth attendants (over 20%) and reported significantly less maternal deaths (351/100,000). Conversely, women in the community of Syhlet (471/100,000) with lower literacy rates used skilled attendants less often (less than 10%), which contributed to higher maternal mortality rates.

Social and Health Services

Religion-based Cultural Practices

Cultural homogeneity is considered a stronger influence on the behaviors of the Bangladeshi people than religion, with religion usually reinforcing deeper, regional-specific cultural values. Bangladesh is primarily Islamic, with estimates from Pew Research and Bangladeshi Population Census reporting 83-90% of the population as Muslim, 8-9% Hindu, and a small Christian population less than 1-2% (Pew Research Center, 2008). Hinduism and Islamic cultures strongly influence health beliefs, attitudes and perceptions of maternal health in Bangladesh. Therefore, to be considered by Bangladeshi women, maternal health care information must be presented in a culturally and linguistically regionally-appropriate format

that may be useful to patients, health care providers, and other stakeholders. Based on a study conducted in the United Kingdom, the major barriers to maternal health care for immigrant Muslim women were: (1) lack of material in linguistically appropriate format, (2) lack of understanding of religious practice and cultural habits, (3) and social isolation (Reitmanova and Gustafson, 2008).

Shared Cultural Similarities Across Different Religious Faiths

"Although established religion has facilitated inter linkages throughout India, regional variations or diversities have occurred over time, whereby persons subscribing to different religious faiths in the same region share cultural similarities, which persons of the same faith from other parts of the country do not enjoy" (Sathymurthy, 1996). This suggests a similarity between religious groups from different areas across the subcontinent, but also similarities of the local culture that may be more deeply rooted and shared by both Muslims and Hindus and any other religious group living in the local region.

For example, the majorities of women living in rural areas of Bangladesh are Muslim and adhere to Islamic Law (Sharia), and the proscribed cultural and religious edicts for living. These are an integral part of the medical advice provided to women in both the prenatal and postpartum periods (Feldman, 2011). Although some research in India suggests that the majority of Muslim women there utilize some form of birth control despite the "maulanas" (religious leaders) preaching against their utilization. In addition, the majority of Muslim women living in India compared to Hindu women were married to older men, got married at younger ages (between 13-20 years of age), were younger at first pregnancy and delivery, had more children than women living in the same culture, and suffered from greater maternal mortality rates than their Hindu counterparts living in the same region (Hussain, 2001).

Especially in the rural areas, both Hindu and Muslims have strong expectations of women's behaviors outside of the household that may influence a female's ability to seek prenatal and postpartum care. According to a prospective study of 300 women in Varanasi, India, Muslim women demonstrated closer relationships to "natal kin" than other religions. These relationships positively influenced "mobility patterns" and were linked to greater utilization of prenatal care. However, in rural Bangladesh, perhaps because of the distance from kin and young age of marriage (average age is 13.5 years old), there remains a restriction on autonomous motility for most women and this prevents them from seeking care outside the home (Brugha and Pritze-Aliassime, 2003).

Gender Role Expectations in a Patriarchal Society

Gender role expectations in Bangladesh are primarily male dominated and limit the autonomous decision making of women when it comes to prenatal and postpartum care, nutrition, and daily activities. These expectations may further increase the risk of problems during childbirth or in the postpartum period. Tradition dictates that Bangladeshi women rely heavily upon their husband and mother-in-law for direction regarding nutrition, healthcare, finances, and daily activities (Bloom, 2001). Tradition also dictates that women should: (1) be inactive during pregnancy (2) observe a 40-day waiting period for physical and sexual activity in the postpartum period, and (3) rely on traditional medicines and spiritual healers (Bloom, 2001).

In the Islamic culture, it is expected that the mother is the primary caretaker of the husband and children as reported in a study where over 76% of the women studied were housewives with no outside work. It is expected that a woman first take care of her home and family before making any commitment to work outside of the home. However, it is also expected that a Muslim woman who is nursing a child will not take part in any household work

during the period of lactation (Ott, 2003). Lactation past two to three years is a common practice among Muslim women and has been directly linked to nutritional deficiencies in the postpartum period in one cross-sectional study of 791 lactating rural Bangladeshi women between the ages of 18-40 (Sarker, Islam, Saha, 2001). The Islamic culture also requires that certain hot foods rather than cold foods are eaten during the postpartum period and the assistance of extended family members is required during the postpartum period (Dennis, Fung, and Grigoriadis, 2007).

The mother-in-law or the husband of a Bangladeshi woman decides whether the woman will travel, which is required for prenatal or postpartum care. Additionally, in rural areas, there is a lack of proper transportation that further prohibits a woman from seeking care in a clinic or hospital at a distance. There is also a reluctance to seek modern medical advice, and women are often referred by their husband or husband's mother to a spiritual healer or pharmacist for obstetrical care and during the postpartum period (Sibley, Blum, and Kalim, 2007).

Other practices, such as non-exclusive breastfeeding and extending the time that mothers spend breastfeeding over the normal 24 month recommended period further complicates the risk of postpartum morbidities. The median time a mother spends breastfeeding a child or in non-exclusive breastfeeding of more than one child in Bangladesh is 30 months. This practice increases the mortality rates in women who prolong breastfeeding and who practice non-exclusive breastfeeding of more than one child (Pena and Barcallao, 2002).

Traditional Medicines and Spiritual Healers (Pir)

The reliance on traditional medicines may also present a barrier to the postpartum care of women living in Bangladesh. Traditional medicine approaches are deeply valued among the females of this society and are deeply rooted within the female Bangladeshi culture. Male household members are often the ones to bring modern medical suggestions to the household

because they are better educated and are expected to provide this advice in the context of a patriarchal society. In order to empower women, the health information that they receive should show respect for and incorporate folk medicine, rather than sole reliance upon western health programs that ignore the local culture, religious and spiritual beliefs, folk medicine, and the oral traditions of the people of Bangladesh.

Conclusion

Women living in Bangladesh are at high risk for maternal mortality and morbidity in the postpartum period. Malnourishment, anemia, poverty, lack of skilled birth attendants and limited prenatal and postpartum care are some of the issues facing women living in rural Bangladesh (Dennis, Fung, and Grigoriadis, 2007). Cultural and religious practices also may influence maternal healthcare in Bangladesh and need to be considered when determining future maternal health program development. Therefore, maternity health care information must be presented in a culturally and linguistically regionally-appropriate format that is useful to patients, healthcare providers, and other stakeholders in order to be efficient and effective.

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