

A Sociological Analysis of the Medicalization Process of Pregnancy and Child Birth in Bangladesh

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Abstract: Patriarchal and capitalistic ideologies and the domination of technology over nature have been transforming pregnancy and childbirth from a social to a medical issue that warrants more medical organisations and services for the safety of both mother and would-be-born child. This transformation is called medicalization of pregnancy and childbirth (MoP&C) in the medical and social science rhetoric. Exploring the extent to which the MoP&C is going on in Bangladesh was the main objective of the study. This study is of importance in that it helps to understand the effectiveness of the MoP&C in the reduction of high maternal mortality rate (MMR), resultantly achieving the 3rd Sustainable Development Goal (SDG)—ensuring better health for all ages of people by 2030—in Bangladesh. Different academic articles, newspapers and reports were consulted for developing arguments in this study. The main findings of the study suggest that there has been an increase in the availability of and accessibility to basic and comprehensive obstetric care. It draws a conclusion that the MoP&C has already been in Bangladesh though huge questions are raised about the efficacy of Western-based and medically proven interventions in the reduction of high MMR. As suggested, a robust national health policy and integrated health systems are the sustainable ways of improving maternal health.

Keywords: Medicalisation of pregnancy and childbirth, maternal health, ante-natal-care, Skilled birth attendance, Bangladesh

Introduction

Pregnancy along with childbirth has been transformed from a social to a medical event. Patriarchal and capitalistic ideologies and the supremacy of technology over nature have made major contributions to this transformation. This has resulted in providing the domination of obstetrics, mainly males, in the whole process of childbirth (Barker, 1998; Fox & Worts, 1999; Lewis & McCaffery, 2004; Rothman, 1989). Johanson, Newburn & Macfarlane (2002) claimed that the introduction of instruments, particularly forceps, by male barber-surgeons for safe baby delivery in the 17th or 18th centuries laid the foundation of an obstetric era. This instrumental mastery has changed the role and status of women in society. It has made not only pregnant women passive but also female midwives subordinate by not allowing them to use these

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instruments because of their feeble-mindedness, constructed by the so-called patriarchal ideology (Schnorrenberg, 2004). Later, this obstetric politics has begun to show pregnancy as a pathological matter that warrants certain interventions for successfully dealing with abnormal pregnancies (Henley-Einion, 2009; Johanson, Newburn & Macfarlane, 2002). Before that, the Cartesian principle¹ of dissection of mind and body and the development of chemistry and computer programming contributed a lot to the development of this idea (Rothman, 1989), the results of which are the already developed or developing different interventions. That means, medicalisation of pregnancy and childbirth (MoP&C) process has been going on since the 17th century.

This idea has also led political leaders and policy makers to propose different interventions at different national and international forums, particularly the International Conference on Safe Motherhood (held in 1987) and the UN Millennium Summit (held in 2000), to curb high maternal mortality rate (MMR) in developing countries though these were developed in western countries. These interventions include mainly ante-natal care (ANC), Caesarean section in place of vaginal delivery, the presence of skilled birth attendants (SBAs) at child delivery, basic and comprehensive essential obstetric care (B&CEO). As suggested by Henley-Einion (2009: 181), the care that the doctors suggest for giving to labouring women and the interventions used to ensuring normal safe delivery are based on western notions of time and scientific calculation and on economic aspects of minimising risks. Johanson, Newburn & Macfarlane (2002) also claimed that in the 19th and 20th centuries, MoP&C started to a larger extent with the development of certain medical interventions, such as analgesia, anaesthesia and safe blood transfusion.

The main objectives of the paper were to detail the historical developments of the MoP&C and explore the effectiveness of different interventions. Detailing the situation of Bangladesh in light of the expansion of different interventions—reflecting the medicalisation process going on in Bangladesh—was another objective. Different academic articles, newspapers and reports were the main sources of the study. Accordingly, the first part discusses the historical development of the MoP&C, western countries in particular, which is followed by the discussion of debates about different interventions. The next part highlights the development of these interventions in the context of Bangladesh. The penultimate part builds up arguments explaining main findings whereas the final part draws a conclusion.

Medicalisation of pregnancy and childbirth: Historical backdrop

The MoP&C first started in the Western world in the 17th century with the development of biological knowledge. Before that, pregnancy was a normal physiological development in women's life cycle as is still the case in certain parts of developing countries. Historical documents suggest that childbirth in Britain, as

¹The philosophical and scientific traditions derived from the writings of the French philosopher Rene Descartes (1596–1650).

in other places, was considered as a social event which took place at home and in which lay midwives, friends and family members were the birth attendants till the 17th century (Anspach, 2010; Cahill, 2001; Fox & Worts, 1999; Henley-Einion, 2009; Johanson, Newburn & Macfarlane, 2002). Men handled complicated cases with lethal instruments and either baby or mother or both died before the introduction of forceps by Peter Chamberlen, a barber-surgeon, in the early 17th century (Cahill, 2001; Johanson, Newburn & Macfarlane, 2002).

The Chamberlen family kept it secret for three generations for consolidating their business interests. They only let people know that they had some preventive measures by which an impacted foetus could be extracted. Later, the barber-surgeon class was able to use it once their design was sold or became widely known. This established men's exclusive rights to forceps and excluded female midwives from using it (Rothman, 1991: 52). However, these small numbers of men-midwives who delivered live babies with the use of forceps began to challenge the traditional roles and functions of female midwives. As their services were costly, labouring mothers continued to be attended by midwives. By the next century (18th), medical practitioners were able to secure their influences and statuses in society by using the power of the church and state which began to demolish the reputation of local and non-licensed medical practitioners, such as midwives.

The antagonistic philosophy of medical practitioners against abortion and church against lay women healers (treated as witches) enabled licensed practitioners with their superior knowledge and competent skills to move away from orthodoxy and asserted their intellectual and moral superiority over midwives and pregnant women. This created an environment that supported their dominant position in society, demeaned midwives' significance as they came to be deprived of organisational support and regulations for further training and development and challenged the existing gender order: women were not allowed to go outside in the cold and that offered men-midwives the opportunity to assist in deliveries. Gradually, men-midwives began occupying the dominant position in childbirth practice. All these events suggest that scientific and factual knowledge is inherently male-dominated and males who subsequently claimed primacy over female intuitiveness, empathy and caring. Since then, medicine, religion and the state with its patriarchal ideology simultaneously devalued women's roles and traits and dissuaded them from playing important roles in society (Cahill, 2001; Henley-Einion, 2009; Lewis & McCaffery, 2004; Rothman, 1991).

Scientific advancements in physiology and anatomy attracted men to the midwifery profession. By using their knowledge as physicians and skills as surgeons (the newly-developed forceps proved handy), these male-midwives changed the nature and pattern of midwifery practice. They not only introduced a new

concept, that is, 'risk reduction or management'¹ in childbirth discourse by urging that their superior knowledge and scientific practice could help easily manage risky pregnancies (Henley-Einion, 2009) but also began to be known as 'obstetricians' after around 1828 (Lowis & McCaffery, 2004; Schnorrenberg, 2004). Their overriding position became a threat for women who had previously played dominant roles in pregnancy and childbirth (Henley-Einion, 2009).

The social structure in both the UK and USA also supported the supremacy of men over women in pregnancy and childbirth. Wealthier women had begun to show their preferences for doctors to midwives as birth attendants from the 18th century and this trend became more widespread in the next century. Midwife services were popular in the countryside and among lower class and black women which indicated their income level to have been less compared to doctors who discouraged women from becoming midwives (Lowis & McCaffery, 2004: 20-24). At first, men-midwives became popular among the upper classes who set the standard for the rest of society. This changed women's role in childbearing from active to passive and transformed the delivery place from home to hospital in the mid of the 18th century.

In the late 19th and early 20th century, childbirth began to be considered as a condition that warranted some kind of supervision. The introduction of X-rays between 1900 and 1910 complemented this idea (Henley-Einion, 2009). At the same time, the use of technologies successfully for toxemia² (the presence of albumin in urine) and eclampsia³ (increasing systolic blood pressure) during the ANC visits can make a pregnant woman an object and the physician a subject. The ability of a pregnant woman to know her own body through experience and exercising self-hygienic techniques to ensure her health is replaced by her new, primary patient status which necessitates technological monitoring, abstracts her body and creates an asymmetric power relationship between the patient and doctor (Barker, 1998; Rudolfstottir, 2000).

Rapid advancements in obstetric medicine, reproductive technology and pharmaceuticals in the 20th century not only provided women with reproductive freedom but also made them dependent on expert knowledge. The current trend of seeking expert opinion in complicated pregnancy provides obstetrics greater opportunity to exert their influence in pregnancy and childbirth (Henley-Einion, 2009). It is not true that all aspects of the MoP&C are negatives. Biomedicine has contributed to increasing the likelihood of survival of mothers and babies by using different interventions, such as foetal heart monitoring (FHM), more than others, including folk medicine. The use of antiseptic, aseptic and sulphonamides contributed or has contributed to the reduction of MMR (Henley-Einion, 2009; Johanson, Newburn & Macfarlane, 2002).

¹ The concept of risk management was basically based on an industrial principle. By reviewing major industrial disasters, it discovered what factors had been responsible for these disasters and what should have been done instead. Within healthcare service industry, this reviewing started in western countries, particularly the USA, in response to litigation claims. This review began to discover a means by which 'adverse clinical events' were identified and how hospitals and other care providers complied with risk management was evaluated. In order to manage risks well, a standard care and guidelines, such as monitoring foetal rate, was developed.

² It was developed in 1843.

³ It was coined in 1894.

At present, normal labour means electoral monitoring of foetal heart rate, promoting epidurals and constant use of medical and surgical interventions to speed up the delivery process. It thus removes mothers from their normal surrounding and supportive agencies and warns that if they deviate from the given instructions they will face difficulties or risks. It is worth mentioning here that the obstetrics society sets the standard procedures of childbirth which ensures safe management of high risky pregnancies (Henley-Einion, 2009). This modern engineering obstetric practice has contributed to the re-conceptualisation of childbirth from a normal and attended event to an abnormal and managed risk or crisis that has put the domination of technology over nature and provided the ascendancy of medicine in childbirth rhetoric (Cahill, 2001; Fisher, Hauck & Fenwick, 2006). In Barker's (2010: 151) words, "Medicalisation is the process by which an ever-wider range of human experiences comes to be defined experienced, and treated as medical conditions." Henley-Einion (2009) claims that this re-conceptualisation has provided a biomedical or technocratic model (consider pregnancy a problematic and isolated event)¹ which replaced the natural or holistic model of childbirth (view pregnancy a personal experience and a natural biological act)². This technocratic model puts more emphasis on different interventions, as claimed in medical science discourse, are more effective for the survival of mother and children. These interventions include ANC, the presence of SBA and B&CEOC.

Debates surrounding different interventions

A debate about the effectiveness of the ANC has been emerging around the world. Although the medical rhetoric claims that ANC services help prevent, detect and investigate anaemia, pregnancy-related hypertension, pre-eclampsia, eclampsia and primary infection (Rooney, 1992 in Maclean, 2005), some studies (Maclean, 2005:288-89; Stanton *et al.*, 2006) reject this claim. Rather they show that the ANC services failed to routine measure of maternal height and weight and identify women's life threatening complications. Similarly, there has also been debates on the introduction of SBAs in place of traditional birth attendants (TBAs) who have been available during the baby delivering period in most of the developing countries. As SBAs come from city areas and have better educational background in comparison to TBAs, they can perform more efficiently than others (Blum, Sharmin & Ronsmans, 2006; Carlough & McCall, 2005), contributing to the reduction of high MMR (Cook, 2002). However, some problems arise when they are deployed in rural areas where the literacy rate is rather low. This restrains them from communicating with the local people. Their deployment increases program costs as they are provided with accommodations

¹ Body and mind, mother and foetus are seen as dyadic than as an integrated relation. Motherhood is seen as a job; the mother's work and her body are the resources from which babies are made, the final product is a baby produced by the labour of mothering and obstetricians are the forerunners or mechanics whose job starts when a pregnant mother comes to the clinic for ANC and finishes after her discharge from the maternity centre. It views the female body as a complex entity which warrants medical intervention to repair malfunctioning (Johnson, 2009; Miller *et al.* 2003; Rothman, 1989; Rothman, 1991; Rudolfsdottir, 2000).

² Being pregnant is seen as biologically determined by the 'feminine' qualities of women. The role of attendants like midwives or dai is to teach a pregnant mother how to give birth and to take care of a newborn baby (Clarke, 2010; Johnson, 2008; Meyers, 2001; Rothman, 1991; Rudolfsdottir, 2000; Van Teijlingen, 2005)

and incentives. Acceptability of their services depends on users' perceptions about their roles. Women often perceive them as rude, impersonal and arrogant as they undertake culturally sensitive practices like routine vaginal examination and lithotomic birthing position assessment. The waiting time, experience, age and gender of service providers appear to discourage women from accepting their services. They are treated, in most of the cases, as 'outsiders' in the areas they provide services because of their urban and higher educational backgrounds (Kruske & Barclay, 2004). This attitude dissuades people from accepting their services.

Moreover, a debate has been growing about the selection of birthing place and mode at both theoretical and practical levels. Various studies sorted out many reasons for selecting home as a birthing place. Some are lower level of mothers' education and occupation, lower yearly income (Wagle, Sabroe & Nielsen, 2004), very well-known attendants, home environment (Borghetti *et al.*, 2006), availability of TBAs everywhere (Suwal, 2008), easily made communication with TBAs, dependent on husband decision, family responsibility (Koblinsky *et al.*, 2009), no need to travel (Borghetti *et al.* 2006) and difficult to find transportation facility (Khan & Islam, 2006). The rest are long distance to maternity hospital with facilities for Caesarean section (Koblinsky *et al.*, 2009; Wagle, Sabroe & Nielsen, 2004), low cost, flexible payment systems of informal attendants (Borghetti *et al.*, 2006), direct and indirect costs related with facilities (Koblinsky *et al.*, 2009), young age at marriage, late age at menarche, multi-parity, having no ANC (Wagle, Sabroe & Nielsen, 2004), poor quality of healthcare services in the facility centres (Khan & Islam, 2006), fear of referrals to district level facilities and previous bad experience with the existing facilities (Koblinsky *et al.*, 2009).

On the other hand, it is sometimes urgent to select facility centre for the safety of both mother and would-be-born baby but Physicians appear to have greater influence on deciding on the mode of delivery. More often than not, they force pregnant mothers and their relatives to opt for Caesarean section in hospitals instead of vaginal delivery at home (Borghetti *et al.* 2006; D'Ambruso, Abbey & Hussein, 2005; Grisaru & Samueloff, 2004). In addition, some research raises doubts about safety and security of the Caesarean section (Alexander *et al.*, 2003; Grisaru & Samueloff, 2004; Harper *et al.*, 2003). However, this does not mean that vaginal delivery is always safer. Both mother (urinary and anal incontinence, pelvic floor dysfunctions) and baby (low birth weight) may face troubles for delivering baby vaginally in a repeated manner (Barbieri *et al.*, 2000; Bek & Laurberg, 1992; Connection, 2006; Sakala & Corry, 2005). Needless to say that the risks of spontaneous normal delivery for mother and child are low compared to other modes of delivery.

Current situation of these interventions in Bangladesh

Pregnancy in Bangladesh is not conceived as an illness but a natural event that generally requires no medical interventions, pregnant mothers only go for ANC services if they go through any bad experience during pregnancy (Pendzich, n.d: 2). However, pregnant mothers have begun to visit ANC centres of both

government and non-government organizations (NGOs) as a matter of routine (Afsana, 2005). The availability of and accessibility to ANC services has steadily been improving since the 1990s. For instance, the percentages of mothers in receipt of at least one ANC service increased by four between three years. The figure for 2004 was 56 percent, whilst it was 60 in 2007. Moreover, between 2004 and 2007, the coverage rate of qualified doctors in ANC services increased from 31.3 to 35.5 percent, whereas that of nurse/midwife/paramedic went down to 15.7 from 17.4 percent (NIPORT *et al.*, 2005; 2009). The latest data also indicates the same increasing trend. Eight in ten and six in ten mothers go for at least one ANC visit and receive ANC services provided by medically trained personnel respectively (NIPORT *et al.*, 2015). A number of reasons, such as confirming pregnancy condition (normal or complicated), position of the baby and the estimated date of delivery, lead pregnant mothers to seek ANC services (Koenig, Saha & Al-Sabir, 2003: 42). More or less the same reasons were found in Ghana (Mills & Bertrand, 2005: 55) and Maharashtra, India (Griffiths & Stephenson, 2001: 355). However, pregnant mothers sometimes feel discouraged to go to the health centre because of the failures of ANC services to identify complicated cases and to raise awareness about dangerous signs of pregnancy. It has been found in the case of Bangladesh that only 38 percent ANC service receivers were informed of dangerous signs of pregnancy, though weight (80.3%) and blood pressure (86.4%) were measured in most cases. Also, service providers gave iron tablets to 54.8 and took urine and blood samples from 54.2 and 36.8 percent mothers respectively (NIPORT *et al.*, 2009: 114). Pregnant mothers have been found to be nervous and pallid during their ANC visits being afraid of what the service providers would say about their pregnancies. They are also uncertain about certain procedures used there. One participant, for instance, said, "I feel scared because I don't know what she will be telling about me and my baby." Another participant added, "I don't like the way she touched my belly. She pressed so hard that I felt pain" (Afsana, 2005).

Pregnant mothers usually need assistance from anyone trained, untrained or skilled during delivery, because certain changes occur in their physical and biological system at that time. Delivery without any assistance is highly risky for mothers; oftentimes it can prove fatal (Trevanthen 1987 in Afsana & Rashid, 2000: 25). The training of the TBAs, started in the 1980s, stalled one decade later this was blamed on the fact that trained TBAs were inefficient in containing the high MMR, although no robust data corroborates this claim and the Bangladesh Government (BG) trained 24,000 TBAs in two phases (first, 1979-80, and second, 1980-81) (Hossain, Huq & Alam, 1989: 8). A new strategy, therefore, was adopted — encouraging the presence of SBAs — doctors, midwives and nurses (Mannan, 2008) — at delivery time. The percentage of mothers delivering baby with the assistance of medically trained birth attendants increased from 32 in 2011 to 42 in 2014 (NIPORT *et al.*, 2015). Further, there has been an increasing trend of urban women with better education using professional services compared to rural mothers having less education (Koenig, Saha & Al-Sabir, 2003; NIPORT *et al.*, 2005; NIPORT *et al.*, 2009).

Different factors, such as mother's age and education, parity¹ and costs associated with attendance seem to influence people's decisions about their selections of birth attendants. For instance, the cost of a *dai* is Taka 180 (equivalent to 2.5 US\$) and a piece of cloth, while the cost of a nurse, as an SBA, is 1200 Taka. The cost of getting a doctor's assistance in hospital in complicated cases is exorbitant though the amount varies depending on the nature of the complication (Caldwell, 2002: 14).

However, the BG started to create a new cadre namely, 'community-based skilled birth attendants' (CSBAs) in 2000 who are assigned to conduct normal home deliveries and refer complicated cases to facility centres at the appropriate time (BRAC & UoA, 2001: 24; Haider, 2007: 1). On paper, SBAs are supposed to perform different activities, such as managing normal labour and delivery, identifying the onset of complications, performing essential interventions, starting treatment and supervising referral cases, etc (Graham, Bell & Bullough, 2001: 99). One study revealed that 83 percent of ANC and 42 percent of delivery care services were provided by CSBAs, reflecting high coverage of services by trained and skilled hands. Their acquired knowledge and skills were also considered satisfactory by the majority of clients (Haider, 2007: 20). Similarly, another study found that more than half (52%) CSBAs performed ANC check-ups, followed by post-natal check-ups (44%) and attended home deliveries (29%). A large percentage of service users (91% of 288) were fairly or fully satisfied with their services. Among researched women (49%) with the expectation of having another child, 60 percent expressed that they would select CSBAs as attendants for their next delivery (Ahmed & Jakaria, 2009: 48).

Most SBAs are young, urban-centred and provide services in communities with which they are not familiar. Consequently, their services are not well accepted at the community level. In addition, retaining them in rural areas may require higher salaries, housing, special allowances and work prospects for their spouses and educational opportunities for their children. Even if they fail to communicate with rural mothers due to lack of understanding of local dialects and fail to respect their belief and practices relating to birthing, a small number of women are naturally willing to receive their services (Prata *et al.* 2011: 87; Walraven & Weeks, 1999: 527). So their workload is always low compared to other community-based health workers, particularly TBAs. The comment of one CSBA reflects the picture at the field level:

I performed only one normal delivery after receiving SBA training. I have visited many pregnant mothers and tried to convince them to seek my support for delivery but they do not feel confident about me because I am newly trained and young. They feel that the local TBA is more skilled, close to them, can give motherly affection and can attend any time of the day and night. Also they are not aware of the benefit of performing delivery by a skilled birth attendant (SIDA-Bangladesh, 2010: 63).

Other studies reported that the CSBAs had low job satisfaction because of the lack of an enabling working environment, resultantly low acceptability of their services at the community level (Adegoke & Broek, 2009; Turkmani & Gohar, 2015). Both studies indicate that the demand for CSBA services is not increasing. Like

¹ The order of pregnancy.

the CSBA, Rozario (1998) found the failure of professionals in rural Bangladesh in recognising the perspectives and actual situations of the villagers, including women giving births, their families and *dais*. Another study on Bangladesh found organisational (lack of transportation, environment and supplies of equipment and drugs), cultural (not accepted their service patterns) and personal (insecurity on the way) difficulties that SBAs faced carrying out deliveries at home (Blum, Sharmin & Ronsmans, 2006).

Maternal age and education, parity (Afsana & Rashid, 2000), perception of labour and healthcare quality (Afsana & Rashid, 2000; Caldwell, 2002; Griffiths & Stephenson, 2001), socio-economic condition (Afsana & Rashid, 2000; Basu, 1990), availability of healthcare services (Griffiths & Stephenson, 2001; Stephenson & Tsui, 2002), child delivery procedure (Afsana & Rashid, 2000) and costs of services (Caldwell, 2002; Griffiths & Stephenson, 2001) appear to influence people's choice of birth place, be it home or hospital/clinic. One Bangladesh study revealed shyness in asking anyone for help and permitting outsiders, particularly male practitioners, to examine their genital condition, apprehension that facility centres would invariably carry out surgery even if for minimal 'complications', and the traditional giving of a higher value to birthing at home are important factors that encourage pregnant mothers to prefer having babies at home (Parkhurst & Rahman, 2007: 394). However, there has been a decrease in delivering baby at home. It has been estimated at 63 percent delivery at home in 2014 whereas the figure for 2011 was 71 (NIPORT *et al.*, 2015). It has also been claimed that younger educated women with middle class backgrounds prefer delivering babies in hospitals (Afsana & Rashid, 2000; Barbhuiya *et al.* 2001; Caldwell, 2002; Kunst & Houweling, 2001; Stephenson & Tsui, 2002).

Mothers usually prefer home delivery unless an emergency situation occurs for which institutional arrangements are required. For instance, 86.3 percent of 1,825 slum households in Dhaka (Bangladesh) mentioned that they did not feel the necessity for institutional delivery (Caldwell, 2002: 11). In another study, almost all births were reported to have occurred at home (Barkat *et al.*, 2006). If labour is perceived to be normal, rural women in Bangladesh choose to remain at home (Griffith & Stephenson, 2001: 349). Other factors for selecting home include unfriendly and uncomfortable atmosphere in hospitals, male birth attendants and uneasy birthing procedures (Afsana & Rashid, 2000; Caldwell, 2002; Sultana & Islam, 2007).

It is not always true that doctors have total influence over pregnant mothers' choice of Caesarean delivery. The latter sometimes request health personnel for conducting Caesarean delivery. There are many reasons, such as avoiding negligence claims, earning more money within a limited time frame, ease of decision making and exerting power in the medical, specially obstetric, field for which doctors generally prefer Caesarean to normal delivery (Bhuiya, 2009; Leone, Padmadas & Matthews, 2008; Sultana & Islam, 2007; Wagner, 2000). On the other hand, doctors use many phrases—"Caesarean is safe", "Upcoming baby can face difficulties if baby is normally delivered", and "Pelvic is not opening"—in true or false senses to persuade their patients to opt for Caesarean delivery (Sultana & Islam, 2007). Sometimes doctors even

criticise women for not going for Caesarean and tease them as 'selfish', that is, mothers only think of their own health rather than the future of the upcoming baby (Wagner, 2000).

Bangladesh has the highest institutional Caesarean delivery rate compared to other countries (such as Colombia, Dominican Republic, Egypt, Morocco and Vietnam). The current trend is that one in four pregnant women goes for Caesarean section baby delivery (NIPORT *et al.*, 2015). One of the main reasons for this situation is that physicians, especially private ones, prefer to perform Caesarean delivery in private hospitals. They earn more money if they serve in private hospitals, which also provide them with other forms of financial incentives (Chong & kwek, 2010; Leone, Padmadas & Matthews, 2008: 1239). For instance, one specialist doctor in Bangladesh said that he received a maximum 5,000 Taka for normal delivery which took either eight to nine hours or more, while he can earn 8,000 Taka or more for Caesarean delivery which takes not more than an hour. Specialist doctors prefer Caesarean because they can easily maintain their routine in their preferred way. In normal deliveries, they have to spend more time to observe the progress of the labour pain and keep close supervision for a longer period (Sultana & Islam, 2007). Wagner (2000: 1678) claims that the Caesarean takes 20 minutes and normal delivery takes ten hours or more of the doctor's time. Doctors and hospitals always earn more money from Caesarean than normal delivery.

Other reasons for the increasing Caesarean rate include doctors' fear of normal delivery, lack of confidence of doctors in taking decisions and the politics of obstetricians. One reason for promoting Caesarean, according to Wagner (2000: 1679), is to ensure the domination of obstetricians who always try to keep midwives as their subordinates. A midwife considers a breech delivery¹ as a variation of normal delivery, whereas doctors, particularly obstetricians, consider this condition as pathological. A study found that the trainee doctors in Bangladesh conducted most of the deliveries be they normal or Caesarean (43.6%), followed by medical officers (25.7%). These trainee doctors assisted deliveries more (54.4%) than interns (19.0%) and nurses (15.8%). It claimed that Caesarean delivery rate has been increasing. As the trainee doctors performed more deliveries, they are more than willing to take decisions quickly for Caesarean delivery rather than waiting for a normal delivery (Bhuiya, 2009).

Rich and highly educated pregnant mothers sometimes request doctors for Caesarean delivery or 'elective Caesarean', due to the changing role and status of women in society, lack of physical fitness, avoiding tension and labour pain, high 'value' of the baby due to infrequent or no previous conception, and increasing access to ANC services hinting the development of congenial interactions between pregnant mothers and service providers (Leone, Padmadas & Matthews, 2008; Pittrof, Campbell & Filippi, 2002; Sultana & Islam, 2007). For instance, Sultana and Islam (2000: 32) reported that, in Bangladesh, eight out of 10 middle class

¹ Delivery of a foetus with the buttocks or feet appearing first.

respondents aged between 24 and 38 had Caesarean delivery experience. As reported by Leone, Padmadas & Matthews (2008: 1237), talking to peer groups and family members about reproductive health issues, including pregnancy and its outcome, may have an impact on demand for a Caesarean delivery. For instance, women having good interaction with family members and peer groups during pregnancy are less likely to prefer Caesarean delivery. Two studies (NIPORT *et al.*, 2005: 144; NIPORT *et al.* 2009: 119) also reported that in Bangladesh economically solvent urban women with better education are more likely to go through Caesarean delivery.

The possible effects of Caesarean, be it elective or emergency, are anaesthesia accidents, damage to blood vessels, accidental extension of the uterine incision, damage to urinary bladder and other organs (Lumbiganon *et al.* 2010: 495; Parkhurst & Rahman, 2007: 399; Wagner, 2000: 1677). Both immediate and late complications were reported to be considerably more in Caesarean than in normal delivery cases (Begum *et al.* 2009). On the bad consequence of Caesarean delivery, Wagner (2000: 1677) commented, "If a Caesarean section is done, the woman and her baby take the risks while if the Caesarean section is not done, the doctor takes the risk". All these facts indicate, in most Caesarean cases, pregnant mothers are not informed by doctors about the side effects of Caesarean.

High costs and deaths associated with the Caesarean mode of delivery appear to have had a negative impact on pregnant mothers' choice of Caesarean. For these reasons and others, there has been growing mistrust in doctors' recommendation for Caesarean delivery and a developing perception that doctors conduct medically not-justified Caesarean deliveries for their own interests (Collin, Anwar & Ronsmans, 2007; Koehlmoos *et al.* 2011: 75; Parkhurst & Rahman, 2007: 392; Penn-Kekana, McPake & Parkhurst, 2007: 34). Avoiding this situation arising from the greed of medical personnel, the International Federation of Gynaecology and Obstetrics (FIGO) (2007 in Leone, Padmadas & Matthews, 2008: 1254) correctly advised, "women should not be denied access to Caesarean delivery when needed, for want of funds or infrastructure; neither should they be placed under pressure to have a Caesarean birth because of a lack of professional care to support a normal labour and delivery."

Main discussion

The BG formulated a population policy in 1976 and attempted to deliver family planning (FP)-related healthcare services for addressing the high population growth. The concept of Primary Health Care started receiving more attention after the 'Alma Ata Conference' held in 1978 which led the BG to plan the setting up of rural centres for providing basic healthcare services to all. Meanwhile, the International Conference on Population and Development (ICPD, Mexico, 1984), the Safe Motherhood Initiative (SMI, Nairobi, 1987) and ICPD+10 (Cairo, 1994), the 4th World Conference on Women (Beijing, 1995) and Cairo+5 (Cairo, 1999), the UN Millennium Development Summit (2000) and the UN Post-MDG Summit sought to create pressure on the government for ensuring the safety of both mothers and newborns. As a signature country of all

international initiatives, Bangladesh has been formulating its policy to set up more medical centres where medically qualified personnel and internationally acclaimed and medically proven intervention-related services (ANC and B&CEOC) are available.

Bangladeshi pregnant women started to accept ANC services though cultural practices and inter-generational beliefs create hindrances. However, the effectiveness of ANC in preventing high MMR is questionable; there is no robust data claiming the ability of it to reduce MMR. Sometimes, it fails to predict the possible outcomes of the pregnancy. TBA services are still more preferable to Bangladeshi women due to their high local connection and minimum level of service charge. However, the necessity of SBA services has been realising. As a result, the number of childbirth attended by the SBA has been increasing. As SBAs have urban and higher educational backgrounds, their services have not easily been accepted in rural areas. Home delivery is still more acceptable than institutional delivery. Unfriendly hospital environment, higher costs associated with institutional delivery and perceived rude behaviour of formal health personnel are potential barriers to increasing institutional, particularly hospital, deliveries.

The current trend does not support this argument. Mothers and their families now prefer for institutional delivery to home delivery in order to keep alive of both mother and children. In some cases, mothers are forcibly sent to hospitals for delivery when complications develop. With an increase in the facility-centre-based baby delivery, the Caesarean-section baby delivery rate has also been rising. An associational relation of education and wealth with the use of ANC, SBA and facility-centre-based services found here. Rising economic condition, building aware of dangerous signs of pregnancy and deleterious effects of delivering baby at home through different media, increasing literacy rate, particularly female, and tremendous development of communication systems are seemingly main reasons for this associational relation (Kabir & Khan, 2013; Killewo *et al.* 2006; Nahar, Banu & Nasreen, 2011; Paul & Rumsey, 2002; Rahman & Anwar, 2013; Simkhada *et al.* 2008; Syed *et al.* 2006; Uddin & Choudhury, 2008).

Following lessons from other developing countries¹, Bangladesh with a dearth of medically trained qualified health workers can provide trainings local level health workers with or without medical background on administering 'Misoprostol' during the post-partum haemorrhage, anaesthesia, surgery, identifying blood loss using local instrument and referring complicated cases at the right time. These trainings help Bangladesh reduce high MMR within a short period. However, these should not be treated a panacea. No interventions can replace the need for strong basic health care systems that ensure safe delivery and supply essential drugs and equipment in emergencies. Rather, these strategies should be considered as interim solutions among many, albeit ones that can meet basic needs for MHC in resource poor countries,

¹ Fleming, 1994; Hussein *et al.* 2010; Koehlmoos *et al.* 2011; Kruger, 2009; Maine, 2007; Mavalankar & Sriram, 2009; Nyamtema *et al.* 2011; Prata *et al.* 2011; Ray & Salihu, 2004; Rodgers, Little & Nelson, 2004; Sibley & Sipe, 2006; Sibley *et al.* 2007; Thaddeus, Nangalia, & Vivio, 2004.

particularly rural areas in Bangladesh. For this reason, Prata *et al.* (2011: 90) state that countries with less than half of births attended by SBAs should make attempts to introduce short-term interventions with a specific objective of improving maternal health (MH). It may take longer to bring a positive result if long-term strategies are taken. Moreover, Maine (2007: 1382) claims that Malaysia and Sri Lanka following a horizontal approach are able to cut high MMR by half every 7-10 years. Therefore, unless a strong integrated basic healthcare system through single delivery mechanism¹ is developed, a robust national health policy (NHP)—giving a future guideline about how to improve different sectors, including MH, through proper coordination, supervision and monitoring—is adopted and a behavioural change communication (BCC) program at community level is introduced, it will not be possible to reduce high MMR.

Conclusion

Capitalistic, patriarchal, religious and technological ideologies have made significant contributions to the establishment of domination of men-midwives over females and of the pre-eminence of technology over nature in pregnancy and childbirth which are the founding stones of MoP&C. This process produces a bio-medical model which ultimately replaces the social model of childbirth. Later, global politics has led this process to advance and moved pregnancy and childbirth from being social to being medical events.

All pregnancy and childbirth-related interventions, such as ANC, SBAs, Caesarean section, and B&CEO, are the results of this process. Bangladesh is not an exception to this process. There has been an increase in the availability of and accessibility to ANC, SBA, B&CEO and facility-centre-based services, indicating that Bangladesh has already been in the MoP&C. The efficiency and effectiveness of this MoP&C in reducing high MMR is still not out of doubt.

However, the experience of other liking countries asserts that these interventions vis-a-vis the MoP&C can be the short-run solutions to the existing high MMR. It thus suggests that formulating a robust NHP and developing integrated health systems are the actual means to improve public health that ultimately improves MH.

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¹ The two wings of the Ministry of Health should be made single for avoiding duplication and internal competition or rivalry.

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