

## Health Care Seeking Behavior for Safe Motherhood: Findings from Rural Bangladesh

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**Abstract:** This study aims to explore women's health care seeking behavior for safe motherhood in rural Bangladesh. Using random sampling method, the study collects data from 118 married women aged between 15 and 45 years in three villages namely Attanda, Srifala, and Lokkhinathkathi in Keshabpur Upazila in the District of Jessore. Both qualitative and quantitative techniques were used to collect data. As a significant finding, the study reports that 69.39 percent women receive healthcare services from village doctors (*polli chikitschok*), followed by 21.43 percent from drugstore salespersons, and 5.10 percent from *kobiraj*. Another key finding of the study is that financial insolvency is the main reason for not receiving healthcare services from qualified providers during pregnancy. Based on the findings, the study recommends that the government take an integrated approach to increasing women's educational level, creating more income-generating opportunities for them, and providing basic healthcare facilities in rural areas of Bangladesh.

**Glossary:** *Kobiraj*: A practitioner of traditional medicine.

*Polli Chikitschok*: Medical practitioners who provide services to people in rural areas. They do not have higher education in medical science, and often lack government-issued licensure for providing medical services.

### Introduction

In rural areas of Bangladesh, people are in a vulnerable situation in terms of health care facilities. The situation is worse for women when it comes to their health care seeking behaviors and the services they receive during pregnancy and after childbirth. Health care seeking behavior is not an isolated event; rather, it is an integral part of a woman's status in her family and community. It is a result of an evolving mix of her personal, familial, social, religious, and economic factors. The process of seeking health care can be too complicated to be described in a straightforward term. A woman's decision to seek a particular health care service is the composite result of her personal needs, social forces, the availability and qualifications of the care providers, and the location of the services.

Some factors that might affect women's health care seeking behaviors for safe motherhood in rural areas of Bangladesh are age at marriage, age at childbirth, education level, work status, economic status, location of the residence, and husband's awareness and so on. Another serious problem in this regard is that there are many non-qualified health care providers in Bangladesh. A lack of government monitoring system makes this situation even more dangerous. In most cases, the people who provide services in rural areas do not have formal medical education and a government-issued license for providing medical services. Another serious problem in this regard is that many salespersons at drugstores provide services. It has been noticed that people go to drugstores, explain their illness to a salespersons, and seeks health care services from them. It is a common practice for

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the salespersons to sell medicine without a prescription from a doctor. Salespersons at drugstores and non-qualified providers make the health care sector very dangerous for the general people. Rahman (2000) found that in rural areas of Bangladesh 86 percent of women received health care services from non-qualified health-care providers.

The importance of safe motherhood to the overall development of a country has already been acknowledged at the highest levels. Without improving women's health care seeking behavior regarding safe motherhood, the overall development of the country will be hindered. This study, therefore, aims to explore health care seeking behavior of women regarding safe motherhood in rural areas of Bangladesh. Based on the findings of the study, the report also provides some recommendations which can be crucial to policy formulation and implementation to ensure safe motherhood in rural areas of Bangladesh.

### **Maternal Health Care in Bangladesh: An Overview**

Although significant development has been achieved in the area of maternal care over the past several years, the situation deserves further attention and action for improvement. Women are increasingly using antenatal care, and maternal mortality has evidently decreased. However, many women still face one or more life-threatening complications during pregnancy. Unfortunately, according to Koenig et al. (2007), only one in three women seeks treatment from a qualified provider. Poor nutrition, inadequate health care and large number of closely spaced pregnancies give the women high maternal mortality. Malnutrition is another common feature among the women in rural Bangladesh. Dietary practices are important indicators of pregnant women's care seeking behaviors for safe motherhood. After surveying pregnant mothers in a rural area of Bangladesh, Shannon et al. (2008) report that although most of the women have awareness of dietary requirements, half of the women in the survey report unchanged or reduced food intake during pregnancy. Many women practice various dietary taboos and food aversions. A large number of women receive last and significantly small shares of foods during mealtimes.

Many women in Bangladesh experience life-threatening complications during pregnancy and childbirth. In most cases, they are not aware of the health-care services available for them. A very low rate of utilization of health-care services results in maternal morbidity, mortality, and other complications. Based on Andersen's health seeking behavior model, Haque (2009) investigates maternal health services utilization by married women in Bangladesh. The study reveals that education level is the most important determinant for utilization of antenatal care, choice of place of delivery, and types of assistance at delivery. Two other important factors are household wealth index and place of residence. In addition to utilization of health care services, the place of child delivery is an important factor in pregnant women's care seeking behavior. Studies show that a very small proportion of deliveries take place in hospitals where better services are available. Islam et al. (2006) find various complications such as maternal morbidity caused by the place of delivery. Most of the

deliveries take place at either woman's husband's house or at the parents' house. These deliveries are often assisted by untrained birth attendants or by elderly relatives.

Delay in seeking care is another crucial factor in women's maternal health. Killewo et al. (2006) show that delay in accessing obstetric care facilities is highly related to maternal mortality in rural areas of Bangladesh. Three main reasons for delay, identified in the study, are wait-time for results of informal treatment, inability to understand the seriousness of diseases, and a lack of monetary support. In addition to delay in care seeking, socio-culturally constructed gender roles place various expectations and constraints on women. Gender refers to socio-culturally constructed roles for men and women. It is different from sex, which denotes biological differences between men and women. Ahmed et al. (2000) argue that gender imposes certain reproductive roles on women, and thus results in early and excessive childbearing. Gender roles are also responsible for women's lack of power to make decisions about their reproductive behavior and to generate income to become self-dependent and independent decision maker. Thus, gender and socioeconomic inequalities in health-care facilities and services also affect women's care seeking behavior for safe motherhood. Therefore, it is essential to know about the actual health care seeking behavior of women for safe motherhood in rural Bangladesh.

Additionally, formulation of policies and their successful implementation have always been a challenge for both government and non-government organizations. One of the problems in this regard is a lack of correspondence between people's notions of care seeking behavior and the definitions used in maternal health programs. Moran et al. (2007) examined definitions of care seeking for maternal health complications used by families in rural Bangladesh, and concluded that families generally seek care for complications, but the ways they seek care do not correspond to the definitions used by various health programs. Therefore, it is recommended that local definitions be considered in designing interventions and providing services to people in need.

### **Methodology**

In this study, I used a mixed methods approach in which I combined qualitative and quantitative methods of data collection and analysis. I conducted two parts of the research sequentially, that is, qualitative part was followed by the quantitative. First, my interest in the studying phenomenon, i.e., rural women's health care seeking behavior, encouraged me to employ an exploratory inquiry. I started to make observations of the phenomenon. During my observations, I searched for patterns of women's care seeking behaviors. After gathering some preliminary ideas about the phenomenon, I conducted qualitative interviews with the participants. The main aim of these unstructured interviews was to hear from the participants about their care seeking behaviors. On the basis of the qualitative data gathered from my naturalistic observations and unstructured interviews, I developed a questionnaire that contained both closed and open-ended items. Thus, I started the second phase of my research, that is, the quantitative part of the study. The data gathered in the qualitative phase helped me explore ideas, words, categories, and concepts about the studying phenomenon through

the structured questionnaire. Together, the qualitative and quantitative approaches informed the comprehensive questionnaire that I administered to collect data from the participants.

I conducted the study in three villages namely Attanda, Srifala, and Lokkhinathkathi of Keshabpur Upazila in the District of Jessore in Bangladesh. The estimated population of the study was 1180 married women aged between 15 and 45 years who had at least one child at the study time. The population was selected according to the information obtained from the Upazila Family Planning Office of Kesahbpur. Respondents were selected by using random sampling method. The total sample size was 118, which was determined as 10 percent of the estimated population.

In the beginning of my study, I used naturalistic observation to collect preliminary data. Observation as a method provided me with an opportunity to watch the behavioral patterns and beliefs of the participants. The observations were naturalistic because I carried them out in a setting where the observable behaviors naturally occurred. I took an unstructured approach to observation because I wanted to gather data in a natural and open-ended way. I did not pre-determine and specify the types of data to be gathered. I observed the participant behaviors “as the stream of actions and events as they naturally unfold” (Punch, 1998, p. 185).

After gaining understanding of the behaviors and actions of the rural women, I used qualitative interviewing to obtain information about their thoughts and beliefs about various care-seeking behaviors and actions. It allowed me “to enter into the inner world of another person and to gain an understanding of that person’s perspective” (Johnson & Christensen, 2008, p. 207). Interviewing as a research method is very important when a researcher is interested in the lived experience of other individuals and how they make meaning of their experience. Through understanding this experience, the researcher gains insights into crucial issues as reflected in the lives of those individuals. When the interviewees tell their stories, they provide the interviewer with access to their inner world, and thus a way of understanding their action. Therefore, interviewing can be a powerful method of inquiry when the researcher is concerned with making meaning through language (Seidman, 2006). In this study, I followed an informal conversational style for interview. Without any protocol, this unstructured interview helped me understand the participant’s behaviors and perceptions because the interview did not impose “any *a priori* categorization which might limit the field of inquiry” (Punch, 1998, p. 178). I took field-notes during and immediately after the interviews and used these notes as an important source of data.

In addition to observations and interviews, I used a questionnaire as a data-collection technique. My main aim was to understand the participants’ feelings, attitudes, and perceptions about the study topic, i.e., rural women’s care seeking behaviors for safe motherhood. I developed an interview schedule prior to the study and finalized it through pre-test. It contained both closed- and open-ended questions. The questions were written in English and translated into Bengali to the respondents for their better understanding. The interviews were completed orally in face-to-face interactions with the

participants. The field work involved going to the houses of the respondents and asking questions and opinions about their health care seeking behavior for safe motherhood. During the meetings with the participants, their responses were written on the printed copies of the interview schedule and questionnaire. Later, the data were processed and coded by using computer applications such as Excel and Statistical Package for Social Science (SPSS). After being processed, the data were analyzed by using both qualitative and quantitative methods.

I collected the data by using three different techniques—observation, interview, and questionnaire—so that I could triangulate them. Triangulation “is a process in which the data are looked at from a range of perspectives – usually at least three, if not more” (McNiff & Whitehead, 2010, p. 179). Researchers have different ideas about triangulation. Some believe that data should be gathered from three different sets of people. Others believe that data should be collected using at least three different techniques. Agreeing with the latter group, I utilized the triangulation process in my study as a means of achieving greater validity of the research data. The naturalistic observations helped me see the participants’ behaviors in a natural setting. The unstructured interviews were helpful for me to enter into the inner world of the participants. Finally, the questionnaires provided me with information about the participants’ experience of and beliefs about care seeking behaviors for safe motherhood.

I used the Miles and Huberman framework to analyze the data I gathered using three different methods. Miles and Huberman (1994) propose this framework which comprises of three main components: (1) data reduction, (2) data display, and (3) drawing and verifying conclusions. Data reduction happens in several stages. First, the researcher edits, segments, and summarizes the data. Then, the researcher uses coding and memoing to find out themes and patterns in ideas. In the final stages of data reduction, the researcher tries to develop understandings through conceptualizing and explaining. Data display, the second component of the Miles and Huberman framework, is very important because the collected data are usually voluminous and bulky and various display techniques such as charts, diagrams, concept-maps etc. can be very helpful in organizing, compressing, and assembling the gathered information. These two components of the framework happen concurrently and assist the researcher in drawing conclusions, that is, the third and final component of the framework. I found the Miles and Huberman framework very helpful in analyzing the qualitative and quantitative data in my research.

## Results

**Age of the Respondents:** Age is an important factor for safe motherhood because it is related to sexual desires and fertility. It is also related to various risk factors of pregnancy, which affect health care seeking behavior of women. Majority of the respondents in the sample belonged to the age group between 25 and 29 years which constituted 34.7 percent of the total. Among the participants, 1.7 percent women were found between the age 45 and 49 years, followed by 11.9 percent between

20 and 24 years, 16.9 percent between 30 and 34 years. Women aged between 35-39 years constituted 14.4 percent of the respondents.

**Education of the Respondents:** Education is an important issue in a woman's life because it helps her lead a better life. Through education, she can also acquire knowledge regarding health care seeking behavior for safe motherhood. The sample was not homogenous with respect to educational attainment. The literacy rate was good which marked about 12 percent as illiterate and 88 percent as literate. Findings show that 34.7 percent of the respondents were educated between grades I to V, 33.9 percent of the respondents were in grades VI to X, 11.9 percent women passed SSC examination, and only 2.5 percent women were college graduates.

**Age at Marriage:** Age at marriage is a key factor in women's health and safe motherhood. Although the government prohibits marriage of girls who are below the age of 18, it is reported that many girls in rural areas are married off before the age of 18. In the study population, 55.1 percent of the respondents were married between the age of 10 and 14. Among the participants, 30.5 percent of the women were married between the age of 15 and 19. A total of 8.5 percent of the respondents married when their age was between 20 and 24, and 3.4 percent of the women married when they were between 25 - 29 years of age. Only 2.5 percent of the women got married when they were between 30 - 34 years old.

**Time between Marriage and Conception of First Child:** A long interval between marriage and conception of first child can be helpful for those girls who get married at an early age. Among the respondents, 15.3 percent of the respondents conceived their first child 1 month after their marriage, 12.7 percent of the women after 2 months of marriage, 11 percent after 3 months of marriage, 1.7 percent after 11 months of marriage, 43.2 percent after 1 year of marriage, 9.3 percent after 2 years of marriage, and 4.2 percent after 3 years of their marriage. Only 2.5 percent of the women conceived their first child 4 years after their marriage.

**Consent for Childbearing:** Women's consent for childbearing is an important factor in the physiological and emotional wellbeing of both mother and child. According to the study, not all women gave consent for childbearing. It was found that 36.4 percent of the women gave consent for childbearing. However, 63.6 percent of the respondents did not give consent to conceive a child at that time. Among the respondents who did not consent for childbearing, 86.67 percent mentioned that their husbands decided for their childbearing, followed by 5.33 percent where decision was made by parents, and 8 percent by their in-laws.

**Medical Check-up During Pregnancy:** Medical check-up during pregnancy is one of the most important needs of expecting mothers. This can detect any threats to mother and the unborn baby. While medical check-up during pregnancy is commonly observed among the middle and upper class women in urban settings, the situation can be different in rural areas. The study finds that most of the rural women did not have regular medical check-up during their pregnancy, which constituted 88.1

percent of the total. Only 11.9 percent women did have medical check-up during pregnancy. So, it may be said that regular medical check-up during pregnancy is not a common phenomenon for women in rural areas.

**Sexual Intercourse during Pregnancy:** Sexual intercourse during pregnancy can be an important factor for the health of mothers and their unborn babies. Sometimes, women may be forced to sexual intercourse which can hurt their physical and mental health. Almost all the respondents had sexual intercourse during their pregnancy. The data indicate that 6.8 percent of the respondents continued having sexual intercourse up to the 5<sup>th</sup> month of pregnancy followed by 8.5 percent until the 6<sup>th</sup> month of pregnancy, 16.1 percent until the 7<sup>th</sup> month of pregnancy, and 68.6 percent of women until the 8<sup>th</sup> month of pregnancy.

**Physical Work during Pregnancy:** Due to poverty and agro-based economy, many women in rural areas are engaged in manual work. In addition, most of the women live in extended families and they have to prepare meals for other family members. Traditionally, it is a housewife's job to cook for all other members of the family. All the respondents were engaged in physical work during their pregnancy. This can be detrimental to their health and damaging for the unborn babies. The data show that most of the women were engaged in household chores which constituted 91.5 percent of the total respondents. In addition, 5.1 percent respondents were involved in agricultural work in farms, in addition to household chores. The data also show that 3.4 percent women had outside job, in addition to household chores.

**Being Extra Careful during Solar or Lunar Eclipse:** Many people believe that solar and lunar eclipses result in bad effects on their lives. It may have effects on their health, financial status, education etc. Many people believe that pregnant women should stay indoors during solar eclipse to prevent the baby from developing birth defects. From the study, it was known that all respondents took special measures during the solar and lunar eclipse. The data show that 16.9 percent of the respondents did not take meal during the eclipse, followed by almost 12 percent who did not sleep during the eclipse, 65.3 percent who did not cut anything, and almost 6 percent who did very limited physical movement.

**Place of First Childbirth:** Place of childbirth is another important indicator of women's care-seeking behavior. It was found that 74.6 percent of the respondents gave birth to their first child at their parents' house, followed by 18.6 percent at their in-law's house, only 0.8 percent at government hospital, and almost 6 percent at private clinics.

**Birth Attendant in First Child Delivery:** Birth attendants play very crucial roles in child delivery. In general, there is a lack of trained birth attendants in rural Bangladesh. The data show that 5.1 percent of the respondents were assisted by trained birth attendants, followed by 88.1 percent by untrained

birth attendant, 0.8 percent by either a doctor or a nurse at a government hospital, and almost 6 percent by doctors and nurse at private clinics.

**Physical Problems after First Childbirth:** Many women experience health problems during the first year after childbirth. Common postpartum problems are fatigue, bowel problems, lack of sleep, postpartum depression, urinary incontinence, back pain, and pelvic pain. These common physical and mental health problems can lead to both short- and long-term sickness. According to the study, 100 percent respondents experienced physical problems after their first childbirth. The data show that 35.6 percent respondents suffered from physical weakness after their first child's birth, 26.3 percent women had vaginal infection, and 21.2 percent suffered from excessive bleeding. The women who felt pain in their belly made up 6.8 percent of the total population, and 10.2 percent of the respondents reported to have uterus infection after their first childbirth.

**Consulting Providers for Physical Problems:** It is important for mothers to receive healthcare services from qualified providers for the illness they suffer from after their childbirth. As the data show, 74.6 percent of the respondents consulted providers for the health problems they experienced after their first childbirth. However, 25.4 percent of the respondents did not see a provider. Choosing an appropriate service provider is a crucial decision for mothers because a wrong choice may result in detrimental effect on the health of both mother and child. Among the mothers who consulted providers, 55.68 percent visited village doctors for their illness. Only 4.55 percent of the women sought health care services from qualified doctors with MBBS degrees, 6.82 percent consulted homeopathic doctors, and 32.95 percent of them consulted *kobiraj* for their illness after first childbirth.

**Breastfeeding after First Childbirth:** Breastfeeding not only provides maximum emotional satisfaction to both the mother and the child creating a bond between the two, it is also a wholesome food with protein, sugar, fat and vitamins that the baby needs. The study shows that 96.6 percent of the respondents breastfed their child immediately after the child was born, while 3.4 percent shows the reverse result. Many women believe that breastfeeding has negative impact on mother's health. As the data show, 94.1 percent respondents said that breastfeeding had negative impact on their health, and only about 6 percent reported no impact of breastfeeding on their health. Respondents specify two main impacts of breastfeeding on their health. A total of 82.88 percent reported that the main impact of breastfeeding was physical weakness of a mother, and 17.12 percent mentioned mother's weight loss as an effect of breastfeeding. Another significant finding was that almost 80 percent women believed that breastfeeding might decrease the beauty of women's breasts.

**Opinion about Supplemental Food for Mothers:** Pregnancy and childbearing pose a number of physiological and emotional challenges to mothers. During this period, women need additional food to cope with the changes their body and mind go through. According to the study, all respondents said that a new mother should take supplemental food. They mentioned two main reasons for this opinion.



A total of 86.4 percent mothers believed that mothers should take supplemental food because it is good for their child's health, while 13.6 percent believed that it is good for the mother's health.

**Total Number of Childbirths:** The total number of children a woman gives birth to is a key factor in her physical and emotional health. A woman's care-seeking behavior may also be affected by the number of childbirths that she goes through. According to the findings of this study, 9.3 percent of the respondents had only 1 child at the time of the field survey, 34.7 percent had 2 children, and 29.7 percent had 3 children. Another group of women who constituted 6.8 percent of the sample had 4 children, 16.1 percent had 5 children, and 3.4 percent had 6 children. With regard to the number of dead children, the study showed that 58.5 percent of the respondents had no dead children at the time of interview while 23.7 percent of the women had 1 dead child, 7.6 percent had 2 dead children, 7.6 percent had 3 dead children, and 2.5 percent of the women had 4 dead children.

**Mothers' Experience of Stillbirths:** A stillbirth is defined as the death of a fetus after the 20th week of pregnancy up to birth. Stillbirths may occur during pregnancy and at the time of delivery. The data show that 51.7 percent of the participants gave birth to stillborn baby. However, 48.3 percent respondents never experienced stillbirths. Among 61 respondents who experienced stillbirths, 81.97 percent of mothers gave birth to 1 stillborn child, and 18.03 percent mothers gave birth to 2 stillborn babies. Among the women who experienced stillbirths, 45.90 percent respondents believed that the reason for their stillbirths was fear while 34.43 percent women reported hard physical work as the main cause of stillbirth. Additionally, 19.67 percent women believed that excessive sexual intercourse during pregnancy was the main cause of their stillbirths.

**Mothers' Experience of Abortion:** Abortion means the termination of a pregnancy by the removal or expulsion of a fetus or embryo from the uterus, resulting in or caused by its death. An abortion can occur spontaneously due to complications during pregnancy or can be induced. The study shows that 73.7 percent of the respondents went through abortion. Among the respondents who experienced abortion, 54.03 percent of mothers underwent abortion once until the time of data collection, 31.03 percent of the respondents had two abortions, and 12.64 percent of the women underwent three abortions. Among the women who experienced abortions, 88.50 percent of them said that their husbands played the main role in their abortion while 4.60 percent women said that their parents played the main role in their abortion. For 6.90 percent of the respondents, it was their in-laws who made decisions regarding abortion.

**Physical Illness after Abortion:** Women often suffer from physical illness after abortion. This illness can lead to a state of maternal morbidity and even maternal mortality. The study shows that 100% women who went through abortions suffered from illness and complications. Among them, 80.46 percent suffered from weakness, 14.94 percent had excessive bleeding, and 4.60 percent suffered from uterus infection after their abortion. The study also shows that 48.28 percent of the women consulted providers for their illness after the abortion. Among the women who sought health care

services after their abortion, none of them consulted a qualified doctor who had an MBBS degree, 30.95 percent women consulted village doctors, 21.43 percent of them consulted homeopathic doctors, and 47.62 percent of them consulted *kobiraj* for their illness and other complications.

**Mothers' Knowledge about Maternal Morbidity:** Knowledge about maternal morbidity is very important for women's physical and mental health. As the study shows, 83.1 percent of the respondents said that they had knowledge about maternal morbidity. However, 16.9 percent women did not have any knowledge about maternal morbidity. Among the respondents who claimed to have knowledge about maternal morbidity, 56.12 percent of them believed that it meant physical weakness, 11.23 percent thought it was related to low blood pressure, 7.15 percent thought it was asthma, 9.18 percent thought it meant heart diseases, and 16.32 percent thought it was gastric.

**Mothers' Knowledge about Maternal Mortality:** Knowledge about maternal mortality plays important roles in women's care-seeking behavior. A total of 90.7 percent of the respondents said that they had knowledge about maternal mortality. Among these respondents, 64.49 percent believed that a lack of medical treatment was the main reason for maternal mortality. For 9.65 percent of the women, the main reason was excessive sexual intercourse, for 12.15 percent of the women it was hard work during pregnancy, and for 14.01 percent of the respondents it was excessive frequency of pregnancy.

**Mothers' Knowledge about Safe Motherhood:** Safe motherhood means that no woman should die or be harmed by pregnancy or childbirth. It is a state of well-being in which a woman approaches childbirth with confidence in her abilities to give birth to and nurture her newborn. Knowledge about safe motherhood is important for an expecting mother's physical and emotional health. According to the study, 8.5 percent of the respondents said that they had knowledge about safe motherhood. Among these women, 30 percent of them thought that safe motherhood meant good health of mother, 20 percent women thought it meant giving birth to healthy babies, and 50 percent of mothers believed that it meant safe mother and safe child. The study further shows that among the respondents who did not know about safe motherhood, 14.82 percent of them believed that the main reason for not knowing about it was illiteracy, and for 85.18 percent of the women the main reason for not knowing about safe motherhood was a lack of facilities.

**Safe Motherhood:** Many respondents in this study did not have knowledge about safe motherhood. However, all of them thought that it was an important factor in maternal health. The study shows that 100 percent of the respondents believed that safe motherhood should be ensured for all mothers. With this regard, 79.7 percent of the respondents believed that government should take effective initiatives, and 20.3 percent of the women believed that both government and non-government organizations should take initiatives to ensure safe motherhood. The data further show that 21.2 percent of the respondents believed that creating awareness should be prioritized for ensuring safe motherhood, 50.8 percent of the respondents suggested that more hospitals be established in rural

areas, and 28.0 percent of the respondents believed that free treatment should be provided to every pregnant woman.

### **Discussion**

The most important key finding of this study is that the socio-economic status of women in rural Bangladesh is a major factor in their health care seeking behavior for safe motherhood. In families with low income level, pregnant women cannot afford to consult qualified doctors for their physical problems and illness. Often they end up visiting village doctors or *kobiraj* who can jeopardize their maternal health. Visiting village doctors and *kobiraj* also pose a threat to the health and well-being of the unborn child. Most of the women in the study sample seek health care services from unqualified providers such as village doctors (*polli chikitshok*) and drugstore salespersons. About 69 percent women receive healthcare services from village doctors, 21.43 percent women from drugstore salespersons, and 5.10 percent women from *kobiraj*.

Age of childbearing is another crucial factor because childbearing at an early age can pose serious health and psychological risks to young girls. A significant finding of the study is that majority of the women gave birth to their first child before the age of 17. It is alarming that 11 percent respondents bore their first child by the age of 14. In addition to age, the place of childbirth is an indicator of mothers' care seeking behavior for safe motherhood. Almost 75 percent respondents were at their parents' house for their first childbirth. Another indicator of their care seeking behavior is the person who assisted them in their child delivery. Almost 88 percent of the participants had untrained birth attendants to assist in the child delivery process.

Doing physical work during pregnancy is another important indicator of women's health and wellbeing. The study finds that 100 percent of the respondents were engaged in physical work during their pregnancy. All the respondents were extra careful at the time of solar or lunar eclipse. Almost 17 percent women did not take meal at the time of eclipse. Almost 12 percent women did not sleep, and 65 percent women did not cut anything at the time of eclipse.

Eating appropriate type and amount of food during pregnancy is an indicator of women's awareness of health and wellbeing. It is a key finding of the study that 100 percent of the respondents said that a new mother should take supplemental food. However, due to poverty, many women could not increase their food intake during pregnancy. In addition, women's consent for childbearing is an important factor in the physiological and emotional wellbeing of both mother and child. The study finds that not all women gave consent for childbearing. Only 36 percent women had consent for their first childbearing. Women who did not give consent for childbearing were imposed the decision by their husbands, parents, or in-laws.

Almost 74 percent women had experience of abortion. The total number of abortion mothers underwent varies from 1 to 4. All of these mothers suffered from illness and physical problems after

they had gone through the abortion. The illnesses included weakness, bleeding, and uterus infection. Not all of them, however, sought services from qualified providers. Most of them received services from unqualified providers such as village doctors and *kobiraj*.

Another significant finding is that almost 83 percent respondents claimed to have knowledge about maternal morbidity. They thought maternal morbidity means weakness, low pressure, asthma, heart disease, and gastric. The reasons for these problems, according to them, are a lack of medical treatment, a lack of consciousness, excessive sexual intercourse during pregnancy, and malnutrition. They also have similar beliefs about maternal mortality. However, almost 92 percent respondents did not have knowledge about safe motherhood. Respondents who claimed to know about safe motherhood thought that it was related to the good health of mothers and children. They mentioned two main reasons for not knowing about safe motherhood: illiteracy and a lack of facilities. However, all the respondents believed that safe motherhood should be ensured through government and non-government initiatives. The suggestions they provided were creating awareness, establishing hospitals in rural areas, and providing free treatment to all pregnant women.

### **Recommendations**

The present study finds that women's socio-economic status heavily affects their healthcare seeking behavior for safe motherhood. It is often a lack of financial solvency which prevents them from receiving healthcare services from qualified providers. If women are financially solvent, it is expected that they will be able to make decisions regarding their healthcare services. The number of total pregnancies is also an important factor in women's reproductive wellbeing. In this regard, education and awareness were found to have positive impacts on the motivation for fertility control and healthcare seeking behavior. Therefore, an increased awareness of physical and emotional health during pregnancy and after childbirth is required for safe motherhood.

It is imperative to note that many women conceive and give birth to children without their consent. While becoming mother is a pleasant experience for most women, a forced conception without their consent can have a negative effect on their physical and emotional health. According to the findings of this study, 81 percent respondents conceived a child without their consent at some point in their reproductive life. This can have a long-term effect on mothers. For safe motherhood, it has to be ensured that every woman is ready for childbearing and enjoys the freedom to decide when she will bear a child. Additionally, early marriage has been identified as another major threat to women's reproductive wellbeing. It has been found that a large number of girls in rural areas of Bangladesh are married before the age of eighteen.

Another important factor in women's care seeking behavior is abortion. A large number of women in the study went through abortion. Sometimes they wished to have an abortion, but at other times they were forced to abort their babies. A forced abortion can have a very detrimental effect on their physical and emotional health. Therefore, creating awareness about abortion and ensuring post-

abortion health care facilities is an important measure for improving care seeking behavior of women in rural Bangladesh.

When it comes to providing the expecting mothers with nutritious supplemental food, family members need to have more awareness. Many respondents believe that taking supplemental food is beneficial for their health. However, no significant increase of nutritious food intake during pregnancy was observed in the study. Therefore, greater awareness about the importance of supplemental food during pregnancy needs to be created among the rural men and women.

Based on the findings of the study, three key recommendations for enhancing women's health care seeking behavior are women's education, employment opportunities, and basic healthcare services. It is also important to know what kind of education, employment, and health care facilities can have the greatest impact on the status of women and their perception of health care seeking behaviors. Because of the interrelatedness of these components, an integrated approach to solving the problem will have a greater impact on care seeking behaviors.

A rigorous effort to improve women's health care seeking behavior through education, work opportunities, and health care within an integrated framework can have positive impacts on the improvement of rural women's health care seeking behavior for safe motherhood. Therefore, this study recommends the following three important measures:

- *Education*: education for all rural women needs to be ensured for increased knowledge and awareness of pregnancy and childbirth;
- *Income-Generating Opportunity*: income-generating work opportunities need to be created for women so that they can be financially independent to make decisions and to seek better health care services; and
- *Health-Care Facility*: basic healthcare facilities need to be available in rural areas of Bangladesh so that women do not have to depend on non-qualified providers such as *kobiraj* and drugstore salespersons.

Finally, women's care seeking behavior is such a complex issue that it cannot be improved overnight. In this regard, an increase of people's awareness is a must. Moreover, an integrated approach to improving women's education, creating income-generating opportunities, and providing healthcare facilities in rural areas should be taken by the government and non-government organizations in order to avoid what Moran et al. (2007) call a narrow approach to care seeking for safe motherhood.

### **Limitation of the Study**

A limitation of this study is that it collected data from 118 women of three villages in Keshabpur Upazila of the District of Jessore in Bangladesh. Therefore, it is difficult to generalize the findings to all women in all rural areas of Bangladesh. Women's care seeking behavior may be different in another rural region of Bangladesh. Moreover, the socio-economic condition and availability of health care facilities are not similar across all rural areas in the country. Hence, the generalization of the findings

is a potential limitation of this study. Nevertheless, naturalistic generalization might be used to ensure the validity of the findings. Naturalistic generalization refers to the notion that “the more similar the people and circumstances in a particular research study are to the ones that you want to generalize to, the more defensible your generalization will be and the more readily you should make such a generalization” (Johnson & Christensen, 2008, p. 281). Therefore, I hope that the findings can be generalized to other sets of people in similar socio-economic contexts. Additionally, the study provides important insights into our understanding of health care seeking behavior of women in rural areas. Since there are many similarities of socio-cultural and economic conditions among various regions of Bangladesh, the findings of this study can provide us with valuable information regarding women’s health care seeking behaviors for safe motherhood. Moreover, this study can be replicated in other rural regions of Bangladesh to achieve greater generalization of the findings.

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