

Use of Modern Maternal Health Care by Mothers in Bangladesh: A Critical Analysis

Sanzida Akhter^a

^a *Assistant Professor, Department of Women and Gender Studies, Bangladesh*

Abstract

Socio-economic status has a great influence on how women in particular socio-economic group perceive childbirth and childbirth related health care ultimately shape their maternal health care seeking behaviour. Based on secondary literature this paper aims to understand that perception and views and how that constructs childbirth care seeking behaviour. The paper also highlights the differentials in maternal health care among the women from lower and upper socio-economic households. The differentials which is often evident in inequality, leads many mothers towards the risk of developing conditions that may result in long-term maternal morbidities. On the other hand, the mothers from upper socio-economic are often over using the services and thereby adding further to the maternal health inequality. Explanations of the poor-rich gap in maternal health care goes beyond the economic ability or inability of the mothers and households. Rather, it requires an understanding of childbirth, maternal health and health care seeking behaviour of mothers in any given socio-economic condition.

Keywords: Maternal health care, childbirth, Bangladesh, inequality in health care

Introduction

Improved maternal health is a longed for goal of Bangladesh- a signatory of MDG and SDG. In order to achieve this goal, over the last four decades, a number of initiatives have been taken globally and locally with a particular target to reduce maternal mortality and maternal morbidity. As a result, Bangladesh has made a remarkable progress in recent years in reducing its maternal mortality ratio (MMR). For example, Bangladesh Maternal Mortality and Health Care Survey (BMMS), 2010 shows that the MMR in Bangladesh has been reduced from 322 per 100,000 live births in 2001 to 194 per 100,000 live births in 2010, implying a 5.6% decline per year over the period 2001-2010 (NIPORT et al. 2012, p. xx).

However, reduction in maternal mortality ratio does not tell the whole story of maternal health of women in Bangladesh. While the overall MMR is reported to have been reducing, a new concern is growing about the rising poor-rich inequality in maternal health care in Bangladesh. The overall reduction in maternal mortality ratio does not necessarily ensure that mothers from all sectors and classes are receiving quality health care, neither does it say that the socio-economically advanced mothers are always in the advantageous position in terms of maternal health care. For example, in Dhaka, due to the intensity of poverty, particularly in slums, it is very likely that maternal morbidity will be very high (Uzma et al. 1999, p. 314). Even, in spite of the close proximity of health centres within Dhaka city, 82% of deliveries occurred at home and 76% of them were attended by untrained traditional birth attendants (Fronczak et al. (2005, p. 275). In contrast to the poorer sections of women, the better-off women receive high quality health care from the increasing number of private clinics, which provide maternal health care services at a very high cost. Moreover, an overuse of health services in private health clinics i.e., unnecessary clinical diagnosis and treatment during pregnancy and childbirth is now creating another concern among the better-off women, among health care providers and researchers. According to existing literature in Bangladesh, one example of this over-treatment of richer mothers during delivery is that of resorting to caesarean sections (or CS)* well above the limit of between 5 and 15% prescribed by the World Health Organization (WHO) in terms of emergency obstetric care (EmOC) (Wardlaw and Maine 1999, p 26). For the poorer section of the population, the CS rate remains far below the prescribed limit, indicating their inadequate access to EmOC. Thus, the poor-rich differentials in maternal health care is quite evident in Bangladesh and not only manifested in the less use of necessary maternal health care facilities by the poorer section, but also by the over use of the same by the richer section.

Socio-economic status has great on how women in particular socio-economic group perceive childbirth. Thus, improved maternal goal in Bangladesh requires a deeper understanding on how the concept of childbirth is constructed among the mothers according to their socio-economic status. The beliefs, perception and practice related to childbirth events are highly embedded in the specific context of a society. The concepts of 'motherhood' and 'maternal illness' are also viewed and explained differently in different societies. Health care related to childbirth and associated morbidity is also shaped by the notion

* Caesarean section is one of the components of Emergency Obstetric Care (EmOC) and often considered as a proxy indicator of women's access to health care for complicated delivery (NIPORT et al. 2009, p. 118).

of motherhood and maternal illness embedded in the context of the socio-economic environment. In every society, the symptoms, pains and weakness considered as 'being sick' are shaped by cultural and moral values, experienced through interaction with members of one's immediate social circle and visits to health care professionals, and influenced by beliefs about health and illness (Lorber and Moore 2002, p. 2). Oakley (1984) described how the concepts of childbirth and motherhood have been viewed and defined differently in different societies, and argued that the "meaning of childbirth is interlocked with a society's attitudes towards women" (p. 10). Similarly, maternal health care is largely shaped by the notion of how childbirth is considered in relation to women's health.

Against this backdrop, this paper first discusses how socio-economic status, through its different components i.e. education, income, autonomy etc shapes maternal health care. Then the paper highlights the differentials in maternal health care among the women from lower and upper socio-economic households. Last, it analyses how childbirth care behaviour is constructed among the richer and poorer mothers in Dhaka.

Socio-economic status and women's health care

Women's socio-economic status has always been considered as one of the most influential factors in shaping the maternal health care seeking behaviour of mothers. In fact, this behaviour reflects the socio-economic status of women (Obermeyer 1993), for example whether they get to spend money on maternal health or whether they get to make informed decisions (WHO 1998). The most important indicators of the status of women which have the potential to improve health status are education and women's access to income earning (Obermeyer 1993; Chakraborty et al. 2003). Education, either directly or through a multiplicity of mechanisms, like changing marriage patterns, improving access to knowledge about illness and rights of women, operates to improve their health status (Obermeyer 1993, p. 362). Furuta and Salway (2006, p.7) found women's secondary education was strongly associated with greater use of health care. The second prior issue is women's participation in income earning activities, as women who are involved in gainful employment are more likely to use modern health care services to treat complications during pregnancy (Chakraborty et al. 2003, p. 333).

The discussion of women's socio-economic status is often accompanied by women's autonomy in shaping maternal health care seeking behaviour. The dimensions that are commonly used in understanding this are women's freedom of movement, discretion over earned income, decision making related to economic matters, freedom from violence or intimidation by husband, and decision making related to health care (Fotso, Ezeh and Essendi 2009, p. 3; Dharmalingam 1996). Fapohunda and Orobato (2013, p. 10) define women's autonomy as women's viability, visibility and worth, and is manifested in their ability to participate in decision making, owning property, being able to overcome inequality perpetuating tendencies and maintaining control over their own sexuality. Gabrysh and Campbell (2009, p. 8) included the women's position in the household, financial independence, mobility and decision making power regarding one's own health care as factors with associated women's autonomy. In their study in 31 developing countries of the world, Ahmed et al. (2010) introduced 3Es (economic, educational and environmental status) as components of women's autonomy, and found their

direct linkages to the uptake of the most basic maternal health services, like ante-natal care and skilled attendance at birth,

The general assumption about women's autonomy and maternal health care is that autonomy of women leads to improved health care seeking behaviour and, subsequently, improved health outcomes for mothers. A wide range of studies has been undertaken on various dimensions of women's autonomy and maternal health care behaviour, however, mostly in the rural and poorer households. Moreover, in those studies women's autonomy has been considered in creating demand for maternal health care from the mothers and their households' perspectives. Yet to be explored is whether and how women's autonomy impacts the health care experience of mothers while receiving care from health facilities. In addition, whether richer women being a part of rich and educated households can make autonomous decisions regarding their childbirth and related health care has not been fully investigated.

Maternal health care: poor-rich differentials

It has been mentioned earlier that one of the major worries in maternal health in Bangladesh is increasing inequality in maternal health care, which is evident in reception of ante natal care, child birth care and post natal care; in types of maternal morbidity and complication, in less and over treatment by the poorer and richer section respectively.

According to the 2010 Bangladesh Maternal Mortality and Health Care Survey (NIPORT et al. 2012, p. 51), 31.2% of the women from the poorest wealth quintile receive ante-natal care from a medically trained provider,[†] compared with 81.9% of women from the richest wealth quintile. A distinct variation is apparent between the mothers of the poorer and richer wealth quintiles in terms of their experience of obstetric complications and treatment sought. Table 1 presents a comparative picture of seeking treatment of obstetric complication according to the wealth and education level of the mothers. It indicates that the richer and educated mothers seek treatment for complication at a much higher rate than their poorer and less educated counterparts.

[†] Medically trained provider includes qualified doctor, nurse, midwife, paramedic, family welfare assistance, Community Skilled Birth attendant (NIPORT et al., 2012, p. 51).

Table 1: Percentage of mothers with complications and seeking treatment for complications according to economic and educational background

Mothers	Poorest wealth quintile	Richest wealth quintile	No education	Secondary school +
Number of mothers who had complications [‡]	1,953	1,778	2,041	932
Percentage of mothers who sought treatment [§] for complications	60.5	76.5	59.2	81.9

Source: NIPORT et al. 2012, p. 85

Thus, it is apparent that those who are being monitored regularly during pregnancy will be able to readily identify any risk of maternal morbidity and take necessary precautions to treat or mitigate those risks. However, as mentioned before, the poorer mothers tend to suffer undiagnosed from long term maternal morbidity during and after child birth because of a combination of a lack of skilled birth and timely emergency obstetric care (EmOC).

Houweling et al. (2007, p. 746) showed that wealth and maternal health care are linked in the wealth hierarchy across many developing countries, with each progressively poorer group receiving progressively less care. Professional delivery care among the poor is below 30%, but it is 80% or more on average for the richest wealth quintiles. Similarly large gaps have been observed in Zambia, where 90% of the richest women receive medical assistance at birth, but only 20% of the poorest women receive such care (Kunst and Houweling 2000, p. 296). In Peru, this gap is six-fold between the richest and the poorest wealth quintiles (Filippi et al. 2006, p. 1,535).

The uptake of maternal health care varies even within the same socio-economic group. For example, in places where maternal health care is freely available in health facilities nearby, the poor mothers are more inclined to receive health care for children, family planning and also for ante-natal check-ups than mothers who have farther to travel to receive care. However, where childbirth is concerned, poorer mothers are largely found to be hesitant about receiving delivery care from health facilities. Kunst and Houweling (2000, p. 296) maintained that cultural dynamics, along with economic factors, may be more important determinants of the uptake of maternal health care than any other form of care.

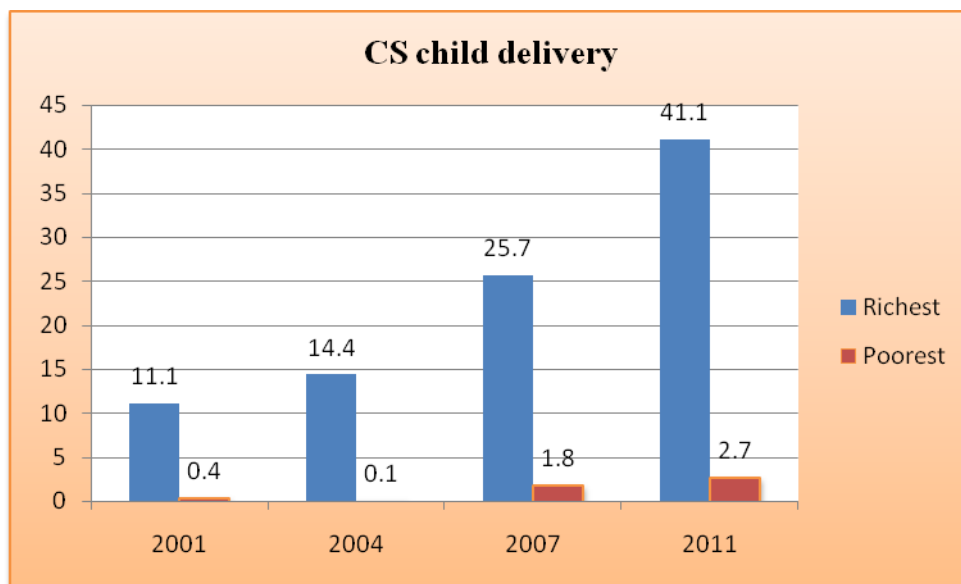
[‡]The complications that have been reported by the mothers participating in the BMMS survey are symptoms of preeclampsia, excessive bleeding, high fever with smelly discharge, convulsion/fits, obstructed/prolonged labour, retained placenta (NIPORT et al. 2012, p. 84).

[§]Includes those who brought medicine to treat the complication.(NIPORT et al. 2012, p. 85).

A large inequality in maternal health care between the rich and the poor in Bangladesh has been reported in a number of studies. Matthews et al. (2010, p. 2) have shown that urban inequality in the use of health care services has increased in Bangladesh since 1993. While by 2007, rural people started to benefit from increased access to health services, there has been hardly any progress in minimizing the poor-rich gap in cities with many slum settlements. However, it is pleasing to see that the percentage of births attended by skilled birth attendants, which is considered as the “gold standard for diagnosis of maternal morbidity” (Koblinsky et al. 2012, p. 126), has been increasing in Bangladesh (NIPORT et al. 2013, p. 132).

Along with the increasing rate of skilled birth attendants, inequality in the rate of caesarean section (CS) for childbirth is also greatly increasing in Bangladesh. Anwar et al. (2004, p. 131) stated that among all the segments of maternal health care, inequality in CS is particularly high. As said before, the recommended population based rate for CS should lie between 5 to 15% of all births (Wardlaw and Maine 1993, p. 260; Anwar et al. 2004, p. 131). Anything below 5% indicates that a substantial proportion of women do not have access to potentially life-saving surgical obstetric care. Although the overall CS rate in Bangladesh is 12.2% per year, the rate vary according to the type of facilities as well as the socio-economic context, a mother belongs to. The Figure 1 presents such variation in CS between the richer and the poorer women in Bangladesh.

Figure 1: Poor-rich gap in CS in Bangladesh, 2001-2011



Source: NIPORT et al. 2003, NIPORT et al. 2005, 2009, 2013

Figure 1 shows that in 2011, while the rate of CS delivery for the mothers from the richest wealth quintile is 41.1% that for the mothers from the lowest wealth quintile is still far below the minimum of 5% recommended. Over the years, the rate of use of CS for childbirth has increased, however, at the same

time the gap between the rich and the poor in utilizing CS has also increased. As stated by Naznin et al. (2014, p. 104), over the last decade, 60% of the population that makes up the lowest three wealth quintiles in Bangladesh had a CS rate which is far below the minimum recommended rate of 5%. If the highest CS rate recommended by the WHO is 15%, then the CS rate of 41% among the mothers belonging to the highest wealth quintiles implies that among 26% of these mothers, CS has been resorted to for reasons other than emergency obstetric care (EmOC). This raises concerns that CS has been used not as an emergency life-saving measure for mothers and their babies.

Similar significant poor-rich inequalities in skilled birth attendance and CS exist in some other countries as well. In Cambodia and Nepal, a rate of childbirth with skilled attendants of over 80% for the urban rich co-exists with rates of around 20% for women in the poorest wealth quintile (Matthews et al. 2010, p. 2). A significant poor-rich difference in use of maternal health care is even found where health care services are provided free (Anwar et al. 2004, p. 130). The possible reasons for this could be practical, like transportation difficulties, lack of knowledge, reference etc., as well as cultural preference for home based childbirth, and perceived low quality of health facilities that tend to affect poorer sections of the community more than the better-off.

Thus, a large inequality in maternal health care is evident in many developing countries of the world. This inequality leads mothers to be deprived of appropriate maternal health care during pregnancy, childbirth and the post-partum period, to be more at risk of developing conditions that lead to long-term maternal morbidities. Explanations of the poor-rich gap in maternal health care goes beyond the economic ability or inability of the mothers and households. Rather, it requires an understanding of maternal health and health care seeking behaviour of mothers in any given socio-economic condition.

Use and overuse of maternal health care services

So far, we have seen that poorer mothers in some countries, including Bangladesh, are less inclined to seek obstetric care from health facilities for various reasons. This may put them at risk of developing a lifelong illness or condition. In comparison, a large number of rich women across the world welcome surgical interventions in childbirth even if it is not strictly necessary. Many study findings suggest that for the poor, illiterate mothers, treatment for maternal complication and maternal morbidity is often an unknown, fearful and difficult to access world. However, in many instances for the urban well-off women some obstetric treatments, particularly caesarean section (CS), are a matter of responding to the modern delivery practice trend or that of avoiding delivery pain (Akhter 2015). This section will discuss these two opposite tendencies, among the poorer and richer mothers, particularly in the context of performing CS childbirth.

Anwar et al. found that in Matlab, indicators of CS seemed to be more socio-economic rather than medical, as most CS operations took place in private sector facilities and were used mainly by well-off families (2008, p. 257). On the other hand, the fear of treatment for complication, particularly CS, exists among many rural women. For example, one particular study (Parkhurst and Rahman 2007, p. 396) found

that women in rural Bangladesh fear going to facilities because doctors ask for CS when they are not needed. However, this fear is grounded by the cultural perception of childbirth, high cost involved in health facilities and often by some true stories of unnecessary CS performed by the medical practitioners. Moreover, CS is regarded as a reproductive defeat in many societies (Parkhurst and Rahman 2007, p. 393). Due to these various reasons, the poorer mothers tend to not use the maternal health care that may require making the childbirth safe for mothers and baby.

On the other hand, overuse of maternal health care is more common among the urban middle or upper class women in Bangladesh. CS is done for treating some obstetric complication. As richer women do routine ANC, it is more likely that their problems are diagnosed, avoided or treated by doing CS. However, in many cases CS is not related with dealing with complication, rather it is more likely to be related to avoiding labour pain or profit for the provider, sometimes at the cost of further deterioration of women's health. A study by Liu et al. (2007, p. 457) found that the overall incidence of severe maternal morbidity is 27.3 per 1,000 women who had a planned caesarean delivery, compared with 9 per 1,000 women who had a planned vaginal delivery. As argued by Deneux-Tharaux (2006, p. 541) "[I]t seems likely that the range of indications for caesarean delivery has broadened considerably, and that more caesarean deliveries are performed with few or no medical indications". The author further argued that some professionals have gone so far as to propose elective caesarean delivery as an acceptable first-choice method of delivery for women with a normal pregnancy. Modern women consider elective caesarean section as an opportunity to avoid the natural labour pain. According to NIPORT et al. (2012, p. 7), among women who reported no complications, 9.4% had a CS, presumably for the convenience of the mother or the provider. In both rich and poor countries, caesarean rates are raising exponentially without a concomitant improvement in maternal and foetal health outcomes (Althabe et al, 2006; Wagner, 2001). The higher rate of CS among the higher socio-economic as well as their leaning towards a bio-medical process of childbirth have often been criticized as over dependence on limited medical resources for childbirth (Turner, et al. 2006; Rothman 2000; Lupton 2000) and as further enhancing inequality in maternal health care (Christilaw 2006, p. 234). Too much dependence of mothers on medicalized childbirth processes has also been criticized as undermining women's autonomy over childbirth (Oakley 1981; Kent 2000).

An overuse of medical technology by richer mothers and underuse of the same by the poorer mother is evident world-wide (including developing countries). The disparity of access and utilization of maternal health care, which is considered as a basic human right, has led to widespread concern and debate in literature from different perspectives. Particularly, the overuse of medical intervention in childbirth had been contested by feminist and medical sociologists, writers in regards to women's autonomy (Oakley 1984; Rothman 1982; Davis-Floyd and Cheney 2009).

Regarding overuse of maternal health care, Davis-Floyd and Cheney (2009, pp. 10-11) state that:

[m]uch of our knowledge of unmedicated birth has been lost. Physicians have been deskilled and often no longer know how to attend normal deliveries patiently. After all, why learn how to attend a vaginal breech birth when a caesarean is so much easier (for the physician), and often

more lucrative, to perform? As birth became more medicalized around the world, in most places, midwives lost their prestige as the guardians and guides at normal deliveries, becoming subordinated to physicians and trained out of traditional practices toward more industrial and technocrat approaches to birth.

This statement suggests that the authoritative and hegemonic attitude of medical knowledge is more likely to overshadow other existing and traditional knowledge of childbirth (e.g. knowledge of midwives, traditional guides to normal deliveries) and be a triumph of industrial and technocratic approaches to childbirth. Calling medicalization the “colonialization of birth by medicine”, Oakley (1984, p. 15) says, “[i]t is a thread in the fabric of cultural dependence on professional health care”. Giving importance to the social aspect of childbirth, Oakley further argues that “birth is a biological episode only to hospital administration and official statistics. The women, who give birth, have a past and a future. So it is in this biographical context that childbirth has a social meaning” (1984, p. 23). Malacrida and Boulton argue that the modern birthing experience is “consumer driven” (2013, pp. 2-3) and state that “the increase in CSRs (Caesarean Section Rates) reflects the escalating medicalization of childbirth and how medical authority over birth takes away women’s natural capacity of childbirth”. This can be manifested by communication between the health providers and mothers, information and counselling provided to the care-receiving mothers, and cultural sensitivity of the health providers.

Quite a broad range of studies have discussed the issues that disempower mothers from the birthing process and make them merely a passive receiver of medical technology in childbirth. Kabakian-Khasholian et al. (2000, p. 112) mentioned that health systems often ignore the emotional process women undergo during labour and delivery by totally medicalizing all the features of childbirth, and suggest “to view childbirth with a holistic approach and render the care more suitable to the multidimensional aspects of the childbirth experience”. A similar argument is reflected in Oakley’s (1984) statement:

The quality of medical care depends on the extent to which interventions of proven effectiveness are properly applied to those who can benefit from them. It also depends on allowing women choices, in giving them back the power to decide not only whether they have children but when, where and how they may do it. It means counting the costs and appreciating the benefits, it means seeing childbirth as a momentous time in a woman’s life, an act of significance in terms of her own particular life and identity.

In spite of all these criticisms, the medical conquest of childbirth seems to be largely welcomed by the richer women (Fox and Worts 1999, p. 328), as it provides them with the opportunity of labour-free, hassle-free birth, and at the same time ensures better health care and health outcomes for mothers and newborns. However, the thing that is not being highlighted in this realm of modern treatment is the fact that the health hazards of a CS can also trigger new health hazards for both mothers and infants (Malacrida and Boulton 2013, p. 43). Another important concern is that in the developing countries where resources (both human and infrastructural) are limited, and where people have to pay from their own pocket for every visit to doctors, overuse of medical maternal health is promoting a capitalistic profit oriented approach in maternal health, instead of an essential human right.

Construction of motherhood, illness and maternal health care

Afsana and Rashid (2009, pp. 124-125) argue that the construction of childbirth has created disparities and inequities for women in accessing obstetric care. For example, the authors maintained that the silent endurance of labour pain has been valued in Bangladeshi culture for a long time, and this silence brings a self-pride to mothers (Afsana and Rashid 2009, pp. 124-125). However, the irony is that in rural areas and in the poor households this silence may keep the mothers from divulging any issues, which means they are not privy to health care information that they might need to save their life. In addition to that, existing poverty and lack of scientific knowledge in society provides for misinterpretation of illnesses and misguided blame on the mother herself for maternal morbidity.

Conversely for the urban based richer women, childbirth is commonly construed as an illness episode that is expected to be treated under medical supervision. These women are more likely to link childbirth with something uncontrollable and unpredictable (Wijma, Wijma and Zar 1998), for which they prefer to follow bio-medical process of childbirth. Bio-medical processes of childbirth emphasize pathology that is diagnosed and treated, as argued by Hunter (2006, p. 120) under the Cartesian Principle in which mind and body are considered separately. This principle also views the body as a machine that is fixed by medical intervention if broken. There is hardly any space for emotive language and contextual information in this principle.

The construction of childbirth in this way, as argued by Fisher et al. (2006, p. 66), “provides an intervention point for medical professionals and medical technology that supposedly transforms the uncontrollable natural process of birth into a relatively predictable and controllable technological phenomena”. This view is also associated with the behaviour and skills of the professional providers of health facilities who may not be tolerant of the specific cultural beliefs and practices of childbirth. In contrast, richer, often better-educated women and their families may have a more modern world view, greater identification with the modern health care system, greater confidence in dealing with officials, and greater ability and willingness to travel outside the community, all of which may facilitate use of professional maternity care (Houweling et al. 2007, p. 750). On the contrary, poor women see childbirth as a ‘non-illness’ event, and as they associate health facilities with treating illness, they may prefer TBAs or family members for childbirth.

Even the understanding of quality of health care varies among the care receiving mothers in terms of their socio-economic status. The quality of care provided in the health facilities and the experience a mother gets largely influence her subsequent visits to health facilities, regardless of the socio-economic context. Bruce (1990, p. 64) developed a framework of quality in health care, which included six elements: choice of methods; information given to clients; technical competence; interpersonal relations; follow up mechanism and appropriate collection of services. Bruce argued that all six elements of quality of care impact upon the knowledge, satisfaction and health of the care receiver. Although Bruce developed this framework in the context of family planning health care, the elements could be equally applicable to the

other segments of health care, particularly related to maternal and reproductive health. In different studies, the quality of maternal health care and women's perception of it also tend to reflect these six elements. Poor quality hospital service is one of the factors that are strongly related to a poor maternal health outcome (Goodburn et al 2003, p. 26; Acharya and Cleland 2000, p. 228). There are some other important things that can be raised as quality concerns in health facilities, including social and hierarchical distance, way of communicating between women and health personnel, perception of care providers to women in general and the mother's illness in particular, and the official and unofficial costs involved in health care.

Mothers receiving care perceive quality of health facilities in many different ways, partly influenced by their respective socio-economic position. In studies, women are found to report dissatisfaction with rude, negligent behaviour of staff in health facilities, thus preferring the care of a TBA or relative (Gabrysch and Campbell 2009, p. 9). In some cases, quality is perceived as hygiene with regard to health facilities, availability of drugs and equipment (Acharya and Cleland 2000, p. 225), and to some people, waiting time (Griffiths and Stephenson 2001, p. 349). WHO (2007, p. 28) reported that it would often appear that being poor and a woman can be the reason for receiving poor services in health facilities and poorly explained reasons for procedures, compounded by the view sometimes held by health workers that women are ignorant. Thaddeus and Maine (1994) showed in their three delay framework how perceived quality of care like long waiting time, availability of supplies, consistency with local belief, and maintenance of privacy impact on the decision associated with seeking health care for childbirth and associated complications.

Depending on the view towards childbirth and related socio-economic conditions mothers experience quality in different ways. For example, for the poorer women in a developing country, apart from the distance and cost factor, unofficial user fees (Afsana 2004), disregard by the medical professionals to traditional childbirth practice (Afsana 2005), social distance between the professional and themselves, and complicated institutional procedures are all found to be matters of concern. Afsana (2004, pp. 177-178) showed how cost (both official and unofficial) incurred at every step of facility-based obstetric care makes mothers and households even poorer, resulting in them refusing to access facility based obstetric care. Parkhurst and Rahman (2007, p. 397) in their study on the perception of CS child delivery in Bangladesh, showed that

Having a CS almost always involved paying to be a 'private' patient in a doctor's private clinic, with high fees charged. Yet nurses and midwives in public hospitals often received tips or small payments from women who delivered in the labour wards. In some cases, pregnant women who attend services could be caught in a struggle between midwives and doctors who may both be looking to supplement their income.

It has been mentioned before that the urban richer mother considers childbirth more of a medical event and follows the advice or direction of the medical professional. The health care service provided to them might be viewed and considered differently than that of poor mothers. This could also be because, due to the monetary affluence, the richer mothers are treated better in the health facilities than the poorer

mothers. Houweling et al. (2007, p. 750) state, in this regard, that professional providers in health facilities treat poor women with less consideration than they do the richer, more educated women. This difference in treatment is likely to dissuade one group of mothers (poorer mothers) to seek care from health facilities for childbirth and post-partum issues, whilst persuading other groups (richer women) to access these services.

The social and authoritative distance between the healthcare providers and doctors is another big quality concern that contributes to shaping health care seeking behaviour. Especially, when it is a matter of childbirth, women need extra support both mentally and physically, not only at home but also when they are in health facilities. At a health facility, there is more likely to be some clash in terms of beliefs, rituals and practices that a mother holds regarding childbirth, with those associated with the medicalized process of childbirth (Afsana 2005), as the bio-medical process of childbirth tends to reject traditional ideas and practices and sets a specific medical standard which holds a dominant position in most societies (Afsana and Rashid 2000, p. 74). Thus, it is obvious that some distance between the health care receiver and providers will exist apparently as well as inherently. While richer and more educated mothers can adapt to this distance faster, for the poorer, less educated mothers it becomes a challenge to adapt it. Afsana and Rashid (2000, p. 75) stated “the knowledge of bio medicine, however, stands in apposition of cultural authority and plays a dominant role”. This dominant role that “makes the care receiving mothers feel powerless and disengaged from the birth process, however, is taken for granted” (Afsana and Rashid 2000, p. 75). The authors also claimed that in many cases women were not provided with enough explanation and information about what was being done to their body. All of this results in a wide gap in the relationship between health providers and birthing women. However, as argued by Houweling et al. (2007, p. 750), “poorer women tend to stop using traditional maternity care in contexts where medically trained, accessible, affordable and good-quality professional care becomes available, though they may be slower to adopt such care than rich women”.

Thus, the concept of childbirth as well as maternal health care is constructed differently for the poorer and the richer mothers in their respective socio-economic context. The health care associated with childbirth also takes shape along the line of how childbirth is constructed. Understanding health care seeking behaviour in a comparative context (for example, lower and upper socio-economic), requires understanding the different contextualisation of childbirth.

Conclusion

This paper drew attention on the differences on how mothers from different socio-economic status view childbirth and maternal health care. It is important for the policy makers and maternal health workers to understand that different views for the policy makers and maternal health workers because type, quality and utilization of maternal health care service largely depend on how mothers and respective households perceive MHC. This perception is developed based on the socio-economic context in which a mother lives in. Like, Stating that motherhood is an ‘institution’, Oakley argued that “the institution of motherhood is the way women become mothers in industrialized society today” (1992, p.11).

One of the main aspects of this paper is that it has brought the point that inequality should not only be understood by the inadequate use of maternal health care services but also by the rate of excessive use of the same by the richer people. The later has been emphasised in this paper because excessive use of biomedical service for childbirth inspires more commercialization of maternal health care, a human right for all women. Moreover, overuse of maternal health care service can also be a concern related to women's informed choice and control on own body and child birth process which is likely to be threatened not only by the impact of poverty but also by the increasing commercialization of maternal health care. Although it is very expected that mothers from higher socio-economic status will receive high quality bio-medicalised service of childbirth, sometimes overuse of so may put them in a new health threat including post caesarean and long term health complication. Moreover, due to the insidious nature of bio medical model of childbirth, women's control on own body and informed choice might also threatened in the childbirth process. On the other hand, poorer mothers, due to their socio-economic condition, fall behind the standard use of maternal health care services for pregnancy and childbirth. While Bangladesh has almost reached the target of millennium development goal 5 of improving maternal health and moving towards Sustainable Development Goals (SDGs), addressing maternal health inequality through the understanding the view of mothers to childbirth and maternal health care is needed for better and overall improvement of maternal health.

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