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Health seeking behaviour of childless women in Bangladesh: An ethnographic exploration for the special issue on: Loss in child bearing

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ABSTRACT

This paper deals with the health seeking behaviour of childless rural poor and urban middle class women in Bangladesh. Data for this study were collected from a northern district of Bangladesh named Mymensing, using various qualitative methods including life histories, in-depth interviews, and key-informant interviews The study shows that social class and the geographical location of the childless women determine their health seeking behaviour. Local healers in the informal sector were found to be the most popular health service option among the rural childless women. The factors for utilising them included low costs, the gender of the provider (with same-sex providers being preferred), having a shared explanatory model with the healers, and easy availability. Unlike their rural counterparts, urban childless women predominantly seek expensive Assisted Reproductive Technologies (ART) treatment which is available only in the formal sector, in private services. However, despite their affiliation with modern treatment, urban childless women still believe, like their rural counterparts, that the remedy for childlessness ultimately depends on God. As a result, in addition to biomedical treatment, many return to or simultaneously pursue various traditional, spiritual or folk treatments. It was found in this study that in Bangladesh, where fertility control is the main focus of health policy, childless women are excluded from mainstream discussions on women's health. Consequently the childless women have to suffer in various ways as a result of their health seeking behaviour.

Introduction

Childlessness is the result of a complex interaction of biological and cultural factors, and has both social and emotional consequences. For women, it can result in role failure and social stigmatisation within the household and may lead to physical and psychological abuse. A recent review of existing population surveys on the prevalence of infertility shows that the 12 month prevalence rate ranged from 3.5% to 16.7% in more-developed nations and from 6.9% to 9.3% in less-developed nations, with an estimated overall median prevalence of 9% (Boivin, Bunting, Collins, & Nygren, 2007). However, there are debates about the prevalence rate of developing countries as very often childlessness is not formally reported, and there is a lack of reliable studies on infertility (Dyer, 2009; Ombelet, Cook, Dyer, Serour, & Devroey, 2008).

In the context of Bangladesh, the dominant health policy is to control fertility, and as a result infertility remains neglected as a state problem. There is no national data available on the prevalence or incidence of infertility in Bangladesh. I argue in this paper that infertility in Bangladesh deserves special attention, in the absence of a state level welfare system, children are necessary to secure parents' and families' survival. They also serve as a valuable power source. Moreover, in a context where 'motherhood' is the primary cultural identity available for women, the suffering due to childlessness is profound. As a result, childlessness is about much more than medically defined infertility, particularly for women in Bangladesh.

In many cultures and societies women are seen as the target population for fertility treatment and as the ones who are supposed to seek healthcare (Berer, 1999; Bhatti & Fariyal, 1999; Guntupalli & Chenchelgudem, 2004; Inhorn, 1994a, 1994b, 1996; Sundby, Mboge, & Sonkos, 1998; Unisa, 1999; Van Balen & Inhorn, 2002; Whiteford & Gonzalez, 1995).

In Western societies, the use of various Assisted Reproductive Technologies (ART) is common. The scenario is however different in non-Western developing countries. Here reproductive technologies are accessible only to a very limited number of rich people. From her experience of Egypt, Inhorn (1994a) described infertility treatment seeking as a never-ending story which she calls the 'quest for conception', shifting from one provider to the other.

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Furthermore, as a number of authors have argued, women's health seeking behaviour in terms of infertility also depends largely on the perceived causes of infertility, as well as on the availability and affordability of the different health services (Ebin, 1982; Foster & Anderson, 1978; Gerrits, 1997; Inhorn, 1994a, 1994b).

In recent years the ART industry has been booming in many low and middle-income countries, particularly in the Middle East (Inhorn, 2005) and in India (Gupta, 2005). Although access to reproductive technologies is limited in non-Western settings, Bharadwaj (2000) noticed that the media are attempting to create a demand for these technologies through advertisements. In India, for example, infertility and ARTs generally receive less attention from policy makers, health activists and feminists, yet medical practitioners offering infertility services mark infertility as a significant problem (Gupta, 2005).

Healthcare pluralism in general and treatment of infertility in particular is a prominent feature of Bangladesh health care sectors (Ahmed, Adams, Chowdhury, & Bhuiya, 2000; Helman, 2001; Nahar et al., 2000), following Kleinman (1980), discussed three healthcare sectors where people use treatment: the popular sector, the folk sector, and the professional sector. In Bangladesh these three sectors overlap to some extent and are inter-connected. The popular sector consists of self-treatment or home remedies. The professional sector consists of the legally sanctioned organised healing profession which generally includes only modern biomedicine. In the folk sector, healers are specialised healthcare providers who are not legalised. In this paper I will discuss the health seeking behaviour of infertile women from this background of medical pluralism in Bangladesh. I will refer to the professional sector as the 'formal' sector and to the popular and folk sectors as the 'informal' sectors.

As mentioned earlier, infertility is a neglected topic in Bangladesh, and as a result it is almost absent from the health care discourse. In this situation hardly anything is known about the experience of infertile people in general and their health seeking behaviour in particular. Based on a larger ethnographic study that I have done to explore the life experiences of infertile women in both rural and urban areas of Bangladesh, this particular paper aims to document the health seeking behaviour from experiences of those women (Nahar, 2007). The findings have important implications for the health policy makers of Bangladesh.

Methodology

This study was conducted using an ethnographic approach. Kleinman and Kleinman (1998) suggest that a central orienting question in ethnography should be to find out what is at stake for individual participants in a specific situation, and they further argue that an 'experience-near approach' offers the most valid understanding of the research subject. An ethnographic approach was considered to be suitable for this study as hardly anything is known about the experience of infertile women in Bangladesh. I have collected personal life experiences of rural poor and urban middle class childless women, and tried to place their experiences of infertility in the broader cultural, social and political context of Bangladesh.

To gain insights into individual experience, life-history interviews were conducted with twenty rural poor and eleven urban middle class childless women. Attig (1993: 146) stated, "A life-history is a personalized account (a 'life-story') of an individual's life experiences including the thoughts and events which permeate them". Life-history interviews, through accurately portraying the infertile women's feelings, opinions, and choices, also provided a holistic picture of their lives. Twenty four Key-Informant interviews were carried out with national and international key people in the field of reproductive health. These people included government and non-government policy makers and programme implementers, researchers, and representatives of donor agencies. All the names used in this paper are fictitious.

For urban middle class respondents, the study site was the capital city of Bangladesh, Dhaka. Rural poor respondents were selected from a village in the Mymensing district, about 150 km north of Dhaka. The sites were selected for convenience, as I was based in Dhaka and I have contacts in Mymensing. Respondents from both the urban and the rural settings were selected through snowball sampling methods. My field research was undertaken over the period of one year, from June 2003 to June 2004. Since none of the rural poor participants' infertility had been medically diagnosed, I have used the term 'childless' instead of 'infertile' to refer to them.

For data analysis I followed the stages described by Silverman (1993) and Patton (2002), beginning with basic description, then organising the data into clear categories which helped to order it conceptually, and finally theorising by making logical and systematic connections between the concepts. I used the computer software ATLAS-TI for organising the narrative data. The research has undergone ethical review and achieved ethical clearance from Monash University, Melbourne, Australia.

In the following part I will present the findings of my research in three sections, including health care seeking for rural poor childless women, health care seeking for urban middle class childless women and infertility services in the formal sector of Bangladesh. Finally I will offer some concluding remarks about infertility services in Bangladesh and their impact on the lives of childless women in rural and urban setting.

Findings

Health care seeking of rural poor childless women

The results suggest that rural childless women rely mainly on the informal sector, and more precisely the folk sector. The main folk sector providers include: Kabiraj (herbalists), Fakir (magic/religious healers), Baidda (gypsy, snake charmers), Hujur and Emam (both are religious leaders), Moajjin (people who call for prayer in the mosque), Majar (holy shrines), Pir (Muslim spiritual healers), Shadhu (Hindu healers), Ojha (magic healers, experts in possession and snake bites), street canvassers, and medicine shop-keepers. It was found that women are more popular providers of folk medicine than men. For the rural women the reasons for childlessness lie usually in the magical, spiritual or personal sphere. Thusit is believed that the treatment is beyond the scope of biomedicine. It is widely believed by the rural women that infertility is mainly caused by an indigenous creature called joha-juhi. Briefly, it is an imagined pair of creatures believed to be residing inside a woman's womb caused by an evil spirit. The creature eats the embryo whenever women become pregnant, thus causing infertility. There are various perceived reasons for a woman to get a joha-juhi including committing a sin. It is strongly believed that the herbalists can get rid of joha-juhi. As God's will is often also cited as a reason for infertility, remedies are also provided by a spiritual healer. Respondents said that some women do undergo ultrasonography, not for biomedical reasons but to check whether they have joha-juhi inside their womb. I only met one woman who claimed that she had seen *joha-juhi* during her ultrasonography and the attendee technician had confirmed to her its existence. As the technician could not be located, it was not possible to explore what exactly the technician told the woman. However, the respondent claimed that she had removed the *joha-juhi* with the help of a traditional healer (during my interview she was a new mother).