REPRODUCTIVE HEALTH BELIEFS AND THEIR CONSEQUENCES: A CASE STUDY ON RURAL INDIGENOUS WOMEN IN BANGLADESH

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ABSTRACT: This study investigated reproductive health beliefs among rural indigenous women in Kakon Haat village at Rajshahi district of Bangladesh. An explanation for the tendency of women in these communities to access traditional healers (THs) and spiritual healers (SHs) for reproductive health services was discovered. Data was collected by means of in-depth one-to-one interviews and focus group discussions with 22 participants using a snowball sampling technique. The use of THs and SHs for reproductive health services was attributed to three dominant themes: a strong belief in THs, influence of family members, and traditional belief. The study's findings suggest that that the key to improving rural indigenous women's health lies in freeing them from mythical beliefs and misconceptions; generally borne in rural areas of Bangladesh where poverty, education, access to medical facilities, and knowledge are great concerns.

KEY WORDS: Reproductive health, Traditional healer, Health beliefs, Perceptions, Santal.

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1. INTRODUCTION

Medical literature defines reproductive health as an organizational framework that incorporates maternal and child health programs, family planning, infertility, sexually transmitted diseases, post-natal infection and maternal and child health related concerns (Dudgeon and Inhorn, 2004). However, the present study adopts the World Health Organisation's (WHO) perspective that reproductive health refers to the rights of men and women to be informed and have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice and the rights of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth. In short, reproductive health addresses reproductive process, functions and systems at all stages of life (WHO, 2013). The World Bank's (WB) data shows that 31.5 percent of the total population in Bangladesh were living below the poverty line in 2010 (WB, 2014), and therefore, attaining effective, affordable, safe and acceptable reproductive health is a critical concern to this cohort of the population.

Asian cultures embrace traditional healers (THs) for various treatments that may vary between general colds-coughs and surgical operations. The rural women in Pakistan, for example, tend to access private informal health care services such as small hospitals, private nursing homes, and private clinics. In addition they get services from homeopaths, traditional physicians (hakeems), THs and spiritual healers (SHs), herbalists and other non-qualified care providers such as medical technicians and pharmacy dispensers (Gadit, 2003; Khowaja, 2009). THs are also found to play a vital role in the Malaysian healthcare services and in treating cancer patients (Merriam and Muhamad, 2012). Similarly, the rural women in Bangladesh go to THs and SHs for treatments like reproductive health and life threatening issues (Chowdhury *et al*., 2007; Sibley *et al*., 2009). These women have many social, cultural and religious beliefs predicated upon the strong role that

tradition plays in rural areas. These beliefs have significant influence on how individuals understand their own health related issues.

Although the adult literacy rate in Bangladesh has improved from 31 percent in 1991 (Bhola, 2009) to 79 percent in 2009 (Bangladesh Bureau of Statistics (BBS), 2010), rural people's basic abilities to read, write and sign a document do not necessarily equate with effective and basic health literacy. For example, a report by Caritas (2011) found that the 85 percent of Bangladeshi women who give birth at home and without the assistance of a trained birth attendant or midwives lack the knowledge needed to ensure protection of their own health and that of their children. The lack of health understanding has been further intensified by the fact that the rural women in Bangladesh often do not have an opportunity to access a specialist doctor. Although the use of semi-skilled birth attendants has improved this situation over the past fifteen years, it remained less than 20 percent as of 2007 and is especially low among poor, uneducated rural women (Koblinsky *et al*., 2008). In this context, a recent study, in particular, stated that "it is important to understand the perspectives of the women who receive maternity care, in particular those coming from groups among which disadvantage is more common" (Jomeen and Redshaw, 2013; 293).

The present study investigates the beliefs that are well entrenched among the rural indigenous women in Bangladesh and explains the reasons why they access THs and SHs for reproductive health care services. This research uncovers the insights of the participants in regard to the multiple realities of their lives and provides a better understanding about their reproductive health seeking behaviour.

2. LITERATURE REVIEW

Reproductive health-related beliefs may include influences from cultural and traditional practices adopted during the birthing process, early care of the newborns (UNICEF, 2008), and even during the pregnancy period. Such beliefs are more common in the remote rural areas, poorer geographic areas, and more prevalent among religiously observant segments (Siddiqi *et al.*, 2007). Cultural beliefs, for example, can deter young women from accessing reproductive health services because they are reluctant to show their pregnant bodies (Hira *et al*., 1990). In addition, they are less likely to seek care from a

doctor, nurse or midwife compared to urban women as they depend more on their husband's and in-law's decisions (Chowdhury *et al*., 2007). One particular study, in this context, finds that husbands are important factors influencing positively or negatively, directly or indirectly, the reproductive health outcomes for women (Dudgeon and Inhorn, 2004). This echoes Chowdhury *et al.*'s (2007) findings that women, whose husbands were not concerned about pregnancy complications, were one and a half times less likely to seek care from a health professional.

Rural and poor women often strongly hold cultural beliefs, and trust THs and SHs which, as demonstrated in the case of Pakistan, leads to a low rate of utilization of professional health services (Gadit, 2003). One study, in the Bangladesh context, found that about 46 percent of women giving birth did not seek any care for postnatal excessive bleeding soon after their delivery, and 21.8 percent went to a village doctor/*kabiraj* (a practitioner of herbal medicine that has spiritual knowledge) or other traditional sources, for the treatment of postnatal excessive bleeding soon after their delivery (Chakraborty *et al*., 2003).

Women in many developing countries suffer in silence due to particular health-related beliefs and their practices. In the rural Bangladesh context, for example, the mothers-in-law play a major role in decisions relating to childbirth and care related to pregnancies and they decide how the delivery will take place; whether it is by a traditional birth attendant or by a health facilitator (Piet-Pelon *et al*., 1999).

Health-belief also depends on cultural and religious norms such as *Purdah* restrictions that can prevent Bangladeshi women seeking health care from outside their home for themselves and their children (Rashid *et al*., 2001). The traditional expectation of a mother's gender-based role in child bearing, and the deeply rooted cultural beliefs about health care options, affect her health status resulting in rural mothers being often less empowered in the decision-making regarding fertility, child spacing and family planning aspects (Sathar *et al*., 1988; Jejeebhoy and Sathar, 2001).

Although there is a lack of health care services and professional health care personnel in rural Bangladesh, the pre-existent cultural beliefs in rural Bangladesh lead rural women to believe that it is mostly the spirits that cause complications during pre-natal and post-natal stages. However, the current literature does not adequately explain the extent, nature, scope, reason and consequence of these beliefs; nor is the current review adequate to explain

reproductive health related beliefs of specific Bangladeshi indigenous communities.

In particular, there is an inadequate understanding in the current literature as to (a) What are the beliefs and perceptions of Bangladeshi rural indigenous women towards reproductive health? (b) Why are these beliefs and perceptions so formative of behavior within their context? (c) How do these beliefs and perceptions shape rural women's understanding and their subsequent decisions about their reproductive health and the services that are available? In addition, there is still inadequate evidence as to whether a qualitative research approach is a good suit to explore these research questions.

The current study explores the answers to these questions with the Santali women of the Kakon-Haat village in Bangladesh; a community with a long and strong belief in traditional healing. The Santals or Shaotal community is separated from the main stream of society and often marginalized in various ways. According to Samad (2006)

> "the Santals are one of the most disadvantaged and vulnerable indigenous communities in Bangladesh. For hundreds of years, they have been facing serious violations of human rights….land-grabbing, threats, evictions and killings have marginalized them to such an extent that their existence in Bangladesh is currently at stake…they have become one of the poorest and the most vulnerable sections of the population" (p. 9).

3. RESEARCH METHODOLY

This study used a qualitative research inquiry as it yields data that provide depth and detail to create understanding of phenomena and lived experiences (Bowen, 2005; Bowen, 2008). The current study employed a case study research method that has a wider range of implications in the real life context (Desai and Potter, 2006). In particular, the reasons for applying a case study method are that: (a) this study deals with rural indigenous and vulnerable women who have hard core social, cultural and religious beliefs and have a tendency to avoid professional health care services; (b) this study is aiming to gather rich and high quality data explaining the phenomena, reasons and

contexts of their beliefs; and (c) this study contributes to the current knowledge by employing a case study research method.

According to the 1991 census, there were 202 744 Santals in Bangladesh, 0.18 percent of the total Bangladesh population; and the majority live in the greater Rajshahi division (Samad, 2006). Data for the current study was collected from the Kakon Haat village, a small rural area to the north-west corner of Rajshahi district in Bangladesh, where 30 Santali families live. Pali is their first language and the second is Bengali.

A number of studies suggested a varied number of participants both for in-depth one-to-one interviews and focus group discussions (see, for example, Morgan, 1996; Kuzel, 1999; Krueger and Casey, 2000; Stewart *et al*., 2006; Sultan and Wong, 2012; Sultan and Wong, 2013). The current study found twenty-two Santali women, using purposive and snowball sampling techniques (Schuler *et al*., 2002; Desai and Potter, 2006), who were interested in participating in this study. The participants were homogeneous in terms of their ethnic, demographic and socio-economic characteristics (see Appendix 1).

Data were collected from this cohort of indigenous participants following a two-step procedure, in-depth one-to-one interviews and two focus group discussions (e.g. FDG1 and FDG2), in order to improve the rigor of this study (Patton, 1990; Morgan, 1996; Khan *et al*., 2002; Sarantakos, 2005). Each of the in-depth one-to-one interviews and focus group discussions were held at a neutral, safe and comfortable place (Powell and Single, 1996) of the participant's choice, such as, their home, yard or paddy field. This alleviated concern and enabled the participants to share their views without hesitation.

The data for this study were collected using semi-structured questions following the suggestions of Brenner (1985) and Frey and Fontana (1994). A pilot interview with three informants revealed that further explanation of the terms 'reproductive health', 'reproductive health belief' and 'reproductive health perception' were needed to help the participants of this study answer the questions effectively. The questions were in an order that maintained a coherent flow in the conversation (Mullins and Kiley, 2002). The following is a set of guiding and sample questions:

1) What reproductive health beliefs did you have after your marriage?

2) What reproductive health beliefs did you have when you were first pregnant?

3) What reproductive health beliefs did you have after becoming the mother of your child?

4) How did you receive the reproductive health beliefs?

5) Why do you trust the reproductive health beliefs?

6) What reproductive health beliefs do you currently hold?

7) From whom do you prefer to seek care for your reproductive health?

8) Why do you seek reproductive health care services from this person/centre?

The participants of this study worked both at home and elsewhere, and thus we avoided creating any 'time-stressed situation' (Desai and Potter, 2006). Each of the in-depth interviews and focus group discussions took less than two hours and about one and a half hours, respectively. Each interview was taped with an agreement of the interviewees, and then transcribed in Bengali. These were then transcribed into written English by a professional translator. The authors, having skills in qualitative research and in both languages, independently reviewed the transcriptions. This research received ethics approval from the University of Canberra, Australia (Reference No. 12-70).

A content analysis procedure was employed to analyse the qualitative data (Krippendorff, 2012). The first stage included identifying the recorded information that was important for developing themes and interrelationships following theoretical and conceptual suggestions (Neuendorf, 2002; Krippendorff, 2012). These were then coded by assigning key words suitable for a section of text, giving a particular meaning to or labelling a section of the material (Sarantakos, 2005). The coding process not only involved

categorising the chunks of text but also included memoing the data that is in short notes, backgrounds, ideas or thoughts about coding data (Sarantakos, 2005; Babbie, 2008). Finally, texts were categorised based on their respective coding. This was done in order to find the emerging themes for this study. The authors collaborated closely to identify emerging themes and sub-themes, and to verify their findings.

4. FINDINGS AND DISCUSSION

Demography of the Participants

Demography provides a context of the participants and their relevance to the findings of the study, and thus this strengthens the triangulation process (Patton, 1990). Approximately 14 percent of participants belonged to each of the 15-19, 25-29 and 40-44 age groups. In addition, 31.81 percent were aged 20-24 years, 18.18 percent were aged 30-34 years, and 9.09 percent of the participants were aged 35-39 years. Table 1 shows that most survey participants were Christian, with a few adhering to traditional religious practices. However, specific religious affiliation was not shown to be factor in the views expressed in this paper.

The participants of this study mainly work as daily labourers (twelve participants); however, seven participants were found to work at home (as a homemaker). One participant worked at a local indigenous primary school as a primary school teacher and the occupations of two participants were undisclosed. The monthly income of all of the participants varied between US$20 and US$120 per month.

The level of education among the participants was relatively low; with roughly half the participants who disclosed educational attainment having little or no education (please see Table 1). It was also found that participants from a wide range of social and economic backgrounds used rural health care (RHC) clinics and traditional healers (THs).

Table 1. Demographic and socio-economic information of the participants.

Code name	Age Interval	Number of children	Number of family members	Occupation	Accessing RHC	Accessing TH/Homeopathy	Education	Religion	Earning monthly (in US$)
R 25	18-19	1	3	Daily labourer	2	2	None	Christian	20.00
R 28	18-19	0	9	Daily labourer	2	2	Yr 5-10	Christian	25.00
R 37	18-19	0	--	--	0	--	Yr 5-10	Christian	--
R11	20-24	0	7	House wife	4	4	Yr 5-10	Christian	25.00
R12	20-24	1	7	House wife	4	4	Yr 5-10	Christian	25.00
R13	20-24	1	3	House wife	2	2	Yr 5-10	Christian	25.00
R14	20-24	1	3	Daily labourer	0	11	Yr 5-10	Christian	25.00
R21	20-24	1	3	Daily labourer	0	3	Yr 5-10	Christian	35.00
R 27	20-24	1	3	House wife	6	5	None	Christian	20.00
R 39	20-24	0	5	Daily labourer	0	2	Yr 5-10	Christian	25.00
R5	25-29	1	5	Daily labourer	0	10	None	Christian	25.00
R 36	25-29	1	5	Daily labourer	0	3	>Yr 5	Christian	25.00
R 41	25-29	3	5	Daily labourer	2	1	None	Indigenous	25.00
R4	30-34	1	3	Daily labourer	3	3	>Yr 5	Indigenous	25.00
R 33	30-34	4	5	Daily labourer	2	3	None	Christian	25.00
R 38	30-34	1	5	House wife	2	0	Yr 5-10	Indigenous	120.00
R 40	30-34	4	5	Daily labourer	2	3	None	Christian	25.00
R1	35-39	1	3	Primary school teacher	4	3	Yr 11-12	Christian	120.00
R6	35-39	2	5	House wife	2	0	Yr 5-10	Christian	25.00
R10	40-44	2	3	House wife	2	2	None	Christian	25.00
R 32	40-44	4	5	Daily labourer	0	2	None	Christian	25.00
R 35	40-44	-	-	-	-	-	-	Christian	-

Source: the Authors.

Beliefs of Rural Indigenous Women about their Reproductive Health

The findings are arranged according to the themes and sub-themes that emerged from the data analyses. This study identified three major 'belief themes', including, (i) a strong belief in THs, (ii) a strong influence of in-

laws and seniors/elders, and (iii) traditional beliefs, and their reasons. A number of sub-themes have also emerged for 'traditional belief' and these are also discussed in this section.

(i) A strong belief in Traditional Healers ('Kabiraaj')

The current study found that more than 80 percent of the participants have a firm belief in THs, and that they rely on TH's treatments for their ailments. THs are believed to drive away malevolent or malicious spirits and deities, determine the cause of a disease, and administer remedies based on their knowledge in holy verses. The participants of this study believed and confirmed that belief in THs is necessary in the healing process; otherwise the medicine won't work for them. The following quotes illustrate their beliefs:

> "I was able to conceive by the medicine of a traditional healer (Kabiraaj)" (R1).

> "I went to see a Kabiraaj when I was pregnant with my first child and again this time I am also seeing the same Kabiraaj…Kabiraaj understands…somehow in some way…they understand through magic or tricks" (R5).

The belief that they had been able to conceive by taking the medicines from TH was echoed by many participants of both FGD1 and FGD2, including educated, semi-educated and uneducated participants. These participants did not know the ingredients of the medicine; however, they all confirmed that the medicine usually comes in paste form. Thus, they had a firm belief that THs were capable of providing general and reproductive health treatments.

One of the participants (R5) stated that the major reason for consulting a traditional healer is that they are *easy to access* in a village like Kakon Haat; and often a TH visits these vulnerable women. A TH does not conduct a health check of a woman in terms of examining the body or putting their hands in the private parts of the female body during the birthing process, and thus *privacy* is maintained. In this connection, R5 stated that:

> "Because his medicine makes us recover faster and we feel good, we believe in him…the traditional healer 'does not check tummy' and only gives sanctified or holy water for medication" (R5).

Another aspect of consulting a TH is relevant to *limited financial capacity*. Unlike the professional doctor, a traditional healer charges a fee that is affordable by a family, which they generally offer him with a sense of gratitude. One participant, in this context, stated that:

> "We pay him (Kabiraaj) once in a year…and it is not fixed. It depends on the individual. If you want to pay more, you can; and if you pay him less that is also OK. If you want to pay 200 Taka [local currency equivalent to approximately US$2.70] in a year, he will accept this. It is also like whatever amount of Taka you offer him he will accept that" (R5).

R6 stated that she had not sought any advice from a TH though she had an understanding of getting *benefits* from THs. This participant stated that:

> "No, I did not see a traditional healer because I did not have a problem yet. If anyone has a problem then he or she sees a traditional healer. For example, if I were married for five–six years or ten–twelve years and still not pregnant, I would go and see a traditional healer" (R6).

During an interview with R11, it was found the she had been wearing an amulet around her neck. In response to a question, she stated that:

> "I used to have fever at night. I went to see a traditional healer. After taking the 'Tabeez' (amulet), I do not have fever at night" (R11).

Like R11, R6 and R5 indigenous women of this study believe that wearing amulets saves them from many illnesses and malicious spirits. For example,

R27 stated that wearing an amulet decreases the chances of her child suffering from 'dana-utha' (shoulder joint dislocation or displacement).

There was a consensus among the participants of FGD2 that THs have special skills, expertise and knowledge to heal sickness and predict the complications that may arise during their pregnancy, miscarriage and childbirth. In this connection, R26 stated that THs ease the childbirth process by pulling a tree that is in good condition from the soil and placing parts of it in amulets. This is symbolic of no struggle during the childbirth process.

The participants, in general, stated that if anyone is unable to conceive then one should take the medicine from the TH. In this context, one of the participants of FGD2 stated that *peer influence* is one of the key reasons for them to seek assistance from a TH. This participant stated that:

> "We will continue to believe in the traditional healer. We get influenced by peers, friends and the news gets across" (R36).

Peer influence is very pertinent in getting the message across regarding the issue of women's health in rural Bangladesh. Advice from a TH is sought when the labour pain during child birth is prolonged; and thus holy blow (i.e., reciting holy verses and blowing air from mouth on water, oil or pain area) or sanctified water/oil, herbal roots and amulets are commonly used during birthing to enhance the labour pain and to hasten the delivery process. On a similar note, research also found that difficulties in childbirth are eased by interventions such as bringing tidal water from the sea, which is believed to hasten the delivery process (Darmstadt *et al.*, 2006). The same belief of getting the tidal water for easing the process of the delivery was echoed among the participants of FGD1.

A number of studies conducted in rural Bangladeshi communities, other than the Santal, have found that the participants have deeply rooted beliefs in the natural plants and herbal medicines, holy water, and holy oil given by THs (Chakraborty *et al*., 2002; Chakraborty *et al*., 2003; Sibley *et al*., 2009). Our findings with the Santal community echo those studies and, in addition, reveal that the participants have a firm belief about THs like 'Kabiraaj' in their village. Our study advances the current literature and finds five factors that act to encourage rural women to seek advice from a TH. These factors are: easy access to a TH; limited financial capacity; reputation of healers to facilitate beneficial outcomes; peer influence; and privacy. This research

found that about 95 percent of the participants do not like consulting male doctors for fear of being touched by a male, which is against their socio-cultural values. They believe that the traditional way to deal with reproductive health is one of the best ways. Besides, they also understand that they have limited choices, and that a TH provides a one-stop solution to economically vulnerable rural indigenous women in terms of their reproductive health care services.

(ii) Influence of in-laws and seniors/elders

In rural indigenous communities, females were found to obey their in-laws and elderly ladies. It is very rare that they would question the cultural practices and family rules. Following their in-law's advice is also a sign of the respect and obedience of a daughter-in-law. Adhering to a mother-in-law's advice secures the position of a daughter-in-law in her family and establishes a good relationship between them. As stated by two participants:

> "They (in-laws) advise me to have more children. They say that children belong to the previous generations and encourage me to have as many children as possible" (R5).

> "When I was pregnant, I had to follow the belief that was a practice from my family and society. The elders told me that my child inside my stomach can be damaged and I can have any sort of problem. That is why I had to listen to my family and my society. If anything happens to my child or to me, they will blame me. The elders would say that I did not listen to them and as a result it happened with me" (R6).

Inequality and power differences are observed in less developed countries, like Bangladesh, where members are expected to live in a collective culture and social harmony enforced through strong social norms. This study finds that daughters-in-law have a sense of being obedient to their in-laws and seniors/elders, and that is embedded in Santali culture. Rural women who live with an extended family rely on the decisions of in-laws and elderly woman in the family (Chowdhury *et al*., 2007) and have less control over

their reproductive health related matters (Hossain *et al*., 2011). Thus, mothers-in-law play a vital role in decisions related to giving birth and the delivery process of the pregnant women in Bangladesh (Piet-Pelon *et al*., 1999).

According to Petchesky and Judd (1998), reproductive rights require that women express a sense of entitlement or self-determination in everyday decisions about childbearing, work, marriage, fertility control and sexual relations. It considers the strategies that women employ in their negotiations with parents, husbands or partners, health providers, and the larger community over reproductive and sexual matters; and the roles that economic constraints, religion, tradition, motherhood, and group participation play in shaping their decisions. The findings of this study also reveal that participants were affected in many ways by following social and familial beliefs that are channelled through elders, in-laws and THs. Often this causes life threatening consequences both for rural pregnant mothers and their un-born children with a concomitant neglect for their reproductive rights. Thus, women's reproductive rights are inconsistent with the tradition of other family members advising on how many children to bear.

(iii) Traditional beliefs

Rural Bangladesh has many traditional beliefs and misconceptions that are related to reproductive health issues, mainly because of lack of education. Poor social and familial infrastructure along with poverty has reinforced rural participants desire to hold firmly to these traditional beliefs, which can be classified under the following themes.

Malicious Spirits

Restriction of movement is a common practice followed by woman in the antenatal and post-natal period of pregnancy. Elderly women insist on applying the traditional rule of *staying in-doors for forty days* after child birth. During one's pregnancy period, elders also suggest pregnant women to seek remedies from, and wear amulets given by, THs. This is mainly to get protection from malicious spirits during and after pregnancy. Staying in-doors for forty days for a woman after giving birth is an advice that is often received from seniors such as mothers-in-law. This study found that rural

women, in most instances, do not have any clear idea of the rationale behind this practice. As stated by the participants:

> "I did not go out for forty days… you see everyone says to do this so I did this and I follow what everyone says…I am just doing it, I am following someone and someone will follow me… it goes like this…" (R4).

> "After having the first child, I did not go out for forty days. The previous generation says I should not go out for forty days" (R10).

One of the participants (R32) of FGD2 shared the same experience that she was unable to come out of the house as her in-laws told her not to go out and she was only able to step out after forty days of indoor stay. She (R32) also stated that heavy menstruation after giving birth is considered unclean, and as a result, she had to remain indoors for forty days after giving birth to each of her four children. In this connection, the participants of FGD1 stated that their new born child will be taken away by 'Chora Chunni' (mythical malicious spirits) if they do not stay in-door for forty days. There is also a cultural belief that women, after giving birth, become totally purified only after forty days and only then they are able to perform regular household activities, prayers and observe religious practices. They are secluded from the rest of the family members after giving birth and are not allowed to cook unless there is nobody to do it for her.

Seclusion

After giving birth, seclusion is observed due to the new born's mother's post-partum bleeding (Darmstadt *et al*., 2006). The post-partum stage is linked with heavy menstruation and women feel polluted, impure and stinky (Blanchet, 1991). It is believed in a rural context of Bangladesh that the malicious spirits are the reasons for excessive, forceful and continuous bleeding and bleeding with clots (Sibley *et al*., 2009), and they should perform very light household works for the first forty days of giving birth and must remain inside the house all the time to avoid evil spirits (Darmstadt *et*

al., 2006; Edmonds *et al*., 2011). Although forty days post-natal in-door stay is a kind of incentive for a new mother to get some rest from her domestic workload (Edmonds *et al*., 2011), these mothers often suffer from severe malnutrition as a result of not eating poultry foods and due to the seclusion during the post-partum period from the rest of the family (Darmstadt *et al*., 2006).

There is a strong belief that a malicious spirit can cause damage to an unborn child and to a pregnant woman. Thus, any miscarriage is blamed on the presence of malicious spirits. A number of studies (e.g. Blanchet, 1984; 1991) have observed that pregnant mothers and the mothers of newly born children are strictly forbidden to go outside in the dark, in the afternoon, in a storm, after cooking, near a tube-well with their hair down or with their *saree* (traditional dress) touching the ground—all due to fear of attracting evil spirits. In this connection, one of the participants (R10) stated that:

> "When I was pregnant with the fifth child, I started taking special amulets from a traditional healer. I also went to the hospital. But the traditional healer told me to put on amulets. I told the tradition healer that I am having so many bad dreams. Because I have had so many miscarriages, I used to be afraid of my dead children. So when I was pregnant with the fifth child I met the traditional healer and got this amulet. I also had to get services from a traditional healer to save my house from the evil spirits. I have to get good spirits around my house" (R10).

The participants believed that THs are able to get rid of the malicious spirits. It was also found in FGD1 (R21) that it is not appropriate for a pregnant woman to go to a house where one dies, nor should one go to a graveyard due to presence of spirits and fear of being possessed. Malicious spirits are believed to be predominant at mid-day and at dusk. One of the participants (R37) of FGD2 stated that elders had suggested *throwing away their first breast milk* as it is believed to not be pure. This is similar to the findings of the current studies that find that initial breast milk (colostrum) is not given to newly born babies in rural areas because of its thickness, and it is termed 'as dirty milk,' which is believed to have an association with some evil spirits (Darmstadt *et al*., 2006). In this connection, R39 stated that she

was told that her breast milk could dry out if she comes out of her house before forty days, and subsequently, she remained inside the room.

The findings reveal that there are several culture specific and traditional beliefs such as the forty days seclusion and discarding of colostrum. The participants of this study observed these practices due to their belief in malicious spirits, and protected themselves by wearing amulets and taking holy blow from a TH.

Childbearing

Generally, childless women in rural Bangladesh are blamed and accused for their failure to give birth. As stated by R13 and R14:

> "If anyone is late in conceiving a child then she has to go through lots of public humiliation. People will say that it has been so long and still why am I not pregnant?" (R13).

> "People used to give me *khota* (cutting remark, hints at a fault, and makes cutting remarks or insinuations). But what should I do. If God does not give me any child what shall I do"? (R14).

The demography of the participants shows that both R13 and R14 have one child each. However, R13 accessed rural health clinics and a TH, each on two occasions, during her pregnancy period. By contrast, R14 went only to a TH eleven times for pregnancy related matters.

A childless woman feels vulnerable and uncertain, and becomes fearful of eventually being neglected due to society's response to her as a childless woman. The consequences might be getting a divorce, remarriage, or accepting the unruly or irresponsible behaviour of a husband. In addition, it was revealed in FGD2 that a barren woman has to bear humiliation and accept social isolation. This concurs with one study which found that some childless rural women are beaten by their husbands, and that this circumstance creates a fear of abandonment amongst women who do not conceive soon after their marriage (Nahar and Richters, 2011). This creates a lot of psychological pressure on the women who are being blamed for not

conceiving; mainly due to a *lack of proper knowledge* about reproductive health in a society.

The FGD2 findings reveal that a woman is also blamed for not giving birth to a male child. In rural Bangladesh, preference is given to a male child over a female child (Hossain and Glass, 1988). This is because a male child is seen as the one who potentially will make an economic contribution, while a female child is seen as a burden to the family due to the custom of dowry. In particular, both R32 and R33 were blamed for not being able to give birth to a male child. These participants and their family members have no idea that they are not responsible for the determination of the sex of a child (Irving *et al*., 1999). Participants like R32 and R33 believe that a male child will be the main source of income and the eventual decision maker in the family. These two participants of FGD2 asked the interviewer if there is any injection that is available from a doctor that can ensure a male child. As stated by R32 and R33:

> "I became a mother after five years of my marriage. I have four daughters; my neighbours blame me for having 4 daughters and no son. My husband also blames me for this. I wish if I could give a birth to a son" (R32).

> "Is there any injection available to a doctor that can ensure a male child for a woman like me?" (R33).

This study finds that child bearing has two main aspects–barren women and preference toward a male child, and in both aspects women are thought to be responsible. Both barren women and women with no male-child, in a rural Bangladesh setting, have to face a lot of humiliation from their family, and this may cause anxiety, frustration, grief, fear, lack of self-esteem, and powerlessness in their community (Van Balen and Bos, 2009).

Overall, the findings of the study suggest three key beliefs and the reasons for these beliefs. First, the Santal community has a strong belief in THs who play a major role in providing reproductive health care services to them. They are motivated by easy access to THs, limited financial capacity (poverty), seeking privacy, peer influence and the perceived beneficial outcomes. These motives are themselves shaped by local culture, social, familial and religious practices. The second theme of this study is related to

the influence of in-laws and seniors/elders in the Santali's socio-cultural context. The mothers-in-law and seniors/elders in their family and community possess an authority, and they hold beliefs regarding reproductive health and instruct accordingly to their daughter-in-laws, daughters, and pregnant indigenous women in their community. These beliefs and instructions are often backed by fear factors that have negative connotations. This research found that gossip, word-of-mouth and discussion are the most effective ways to disseminate these beliefs and mythical stories in a rural setting like Kakon-Haat. The final theme of this study is traditional beliefs. As found in this study, traditional belief has two major aspects: malicious spirits and childbearing. The current research finds that mothers-in-law and elderly women instruct both pregnant women and new born mothers to stay in-doors (seclusion) due to malicious spirits and they often seek remedies from THs to get rid of malicious spirits. They also instruct them to throwaway their first breast milk as this is believed to be associated with malicious spirits. In regard to childbearing, the findings of this study suggest that barren women and women with no male-child face tremendous psychological pressure and often physical assault primarily from their family and community.

5. CONCLUSION, IMPLICATIONS, LIMITATIONS AND FUTURE RESEARCH

The participants of this study stated that this had been the first opportunity for them to speak to someone outside of their community about their pregnancy related beliefs. They felt that they had been listened to and that they also had a voice and story to tell. They felt they were important as human beings and 'included' in a greater society. The current study explored the Santal's beliefs about their reproductive health and explains the reasons for availing reproductive health care services from THs and SHs. The findings of this study suggest that the key to improving rural indigenous women's health lies in freeing them from mythical beliefs and misconceptions; generally borne in rural areas, where poverty, education, access to medical facilities, and knowledge are great concerns.

The findings of this study are an indication, only. This study could be a useful framework for future policies and strategies, and a point of departure

for developing programmes for this vulnerable cohort living in Kakon Haat, Bangladesh. Information provided by this research has the potential to broaden the understanding of reproductive health care services in people of rural Bangladesh and improve the outreach of services in rural communities. As a result, Non-Government Organisations can reform their practices and advocate for changes to government policies on reproductive health care issues in Bangladesh.

There are several limitations involved with this study. This study took a sample size of twenty-two participants, and they were interviewed twice: in-depth one-to-one and focus group discussions. While this may be a methodological contribution, the findings that came through focus groups are not dissimilar to what this research found through in-depth one-to-one interviews; suggesting the consistencies of the findings. However, some of the participants were found to be reluctant in focus group discussions; may be due to peer influence and/or possessing less than adequate knowledge. In contrast, some participants of this study were more voluntarily participating and dominant in their expression and views while others were passive listeners and less voiced. This was unavoidable and inevitable in a focus group discussion (Desai and Potter, 2006). With such a small number of participants and one village, this study does not afford to generalise its findings.

Future studies should have broader samples that will enable generalisation of their findings using statistical modelling techniques. While collecting data in the field for this work, many participants stated that their fertility rate is low and they do not know why. Future study should explore this further. Future study should also examine how religious affiliation could affect one's beliefs and perceptions about reproductive health. Finally, participants' personal details, such as, address, name, age at marriage and age at first child remained anonymous due to the approved conditions of the human research ethics approval.

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