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Abstract

Homebirth is regarded as gold standard and the premier standard of birth possible. Community Skilled Birth Attendants (CSBA) received a six-month training in and out of class at skilled birth attendant (SBA) training institutes, approved by the Government of the peoples republic of Bangladesh. The trainees are involved in assisting the safe and clean delivery at home in rural Bangladesh. Many CSBA are engaged in Government and non-government organisations in relation to providing birth attendant services in rural Bangladesh. The intention of HNPP, BRAC is to increase the number of CSBA in order to achieve MDG 5. The study explored the process of social identification of CSBAs. The notion of social identity has delineated a comprehensive account of social relations in the theory of practice of Pierre Bourdieu. Moreover, social relations explained the process of social identification employing the concept of self-categorisation and social categorisation. The study employed qualitative methods to explore the mechanisms of internal and social categorisation of CSBAs. The findings reveal that CSBAs are known as BRAC health cadres in the community. They are struggling to establish their identity as trained midwives in the community. Despite some challenges of their professions, CSBAs are respected as '*dactar* or nurse *apa'* by the villages. Professional training on SBA enables them to generate income and social prestige. TBAs and village doctors create constraints to perform professional responsibilities of the CSBA in the community. On the other hand, the villagers are still bewildered about the terms as well as the roles and responsibilities of *Shasthya Shebika* (SS), Newborn Health Workers (NHWs), *Shasthya Kormi* (SK) and CSBA of HNPP, BRAC. They are confused whether health providers of BRAC are required paying for assisting homebirth. The villagers also perceive that assisting to homebirth is considered as social norm rather than professional duties. Moreover, the villagers hardly found the government service providers in this regard. Therefore, the study has outlined a number of recommendations for strengthening the profession of CSBAs of HNPP in BRAC.

Chapter 1.
Background and theoretical framework

1.1 Introduction

Maternal deaths across the world have been projected to be approximately 289,000 in 2013 (Islam *et al.* 2014). It is estimated that almost half a million women die of maternal causes annually and a number of initiatives changed in order to reduce the global maternal mortality rate. Moreover, approximately 10–15 million women suffer severe, debilitating health problems resulting from pregnancy and childbirth (UNFPA 2007). Rapid population growth has exacerbated to meet the challenges of the safe motherhood strategies. Many countries with highest fertility rates require involving larger number of skilled birth attendants (SBAs) (Dogba and Fournier, 2009). In countries, Cambodia, Thailand, Indonesia, Sri Lanka and Malaysia where SBAs trained and deployed for improving maternal healthcare. On the other hand, many countries where Governments have been unable to mobilise SBAs in rural areas, thus pregnant women are being deprived of receiving professional care from them (Rowen *et al.* 2011). Almost 34% of births worldwide still take place without assistance of SBAs (WHO, 2008).

Homebirth is regarded as gold standard, God's standard, the premier standard of Birth possible. Homebirth safety examples are the norm in countries such as the Netherlands, Canada and New Zealand, where homebirth is accepted as having good outcomes (Tritten, 2010). In Netherlands, most pregnant women are primarily considered as 'low risk' and in 2012, 85 % of them initially received antenatal care from an independently operating community midwife (Hermus *et al*. 2015). The increased demand to give birth outside hospital has increased the rate of homebirth. In the Netherlands, a third of women now have homebirths. In the UK, 3% of total births occur at home, while in the USA homebirth accounts for 1% of births or 25000 deliveries per year. Recent films, "The Business of Being Born" and "Orgasmic Birth", a major policy symposium organised by Childbirth Connection in Washington, DC. Ricki Lake contributed her endorsement of homebirth in documentary, 2008 "The Business of Being Born" (Armstrong 2010). The films promote practicing of homebirth.

Skilled Birth Attendants (SBAs) is strongly recommended in order to process childbirth properly at home (Gabrysch S and Campbell O 2009). SBAs are considered as the "single most important factor in preventing maternal deaths" (World Health Organization 1999). SBAs are also very important in preventing stillbirths and improving newborn survival (Gabrysch and Campbell 2009; Lawn, Cousens and Zupan 2005). SBAs are quite low in Bangladesh. About one in every five deliveries is attended by SBAs (Bangladesh Bureau of Statistics-UNICEF, 2007). Most deliveries in Bangladesh take place at home. It has observed that homebirth is universal practices in rural areas of Bangladesh (Chowdhury, Mahbub and Chowdhury 2003). Homebirths assisted mainly by traditional birth attendants (TBAs) is as high as 71% in Bangladesh. Government of Bangladesh introduced the community skilled birth attendant (CSBA) programme in 2003 with aiming to train 13,500 government field staff as CSBAs. Government focuses on the promotion of skilled care. The goal of the programme is to provide at least two CSBAs in each of the unions. About 7,000 CSBAs have been trained until 2012. As of June 2014, nearly 9,000 government CSBAs have been trained (Islam *et al.*2014).

BRAC introduced CSBAs in 2013, who has been selected from the existing community health workers (CHWs), known as *shasthya kormi* (SK) and they already have engaged

in providing family planning, maternity and child healthcare at the community. BRAC CSBA received a six months training, including theoretical class and clinical practices at SBA institutes approved by Government of Bangladesh. They are engaged to carry out safe and clean delivery at home in rural Bangladesh. CSBAs IMNCS project decided to increase the number of CSBAs to cover more people under skilled delivery care in order to ensure maternal and neonatal health outcomes. The current plan is to develop at least three CSBAs per union based on the workload. However, Bangladesh government has planned to train one CSBA for every 5,000 population in order to achieve MDG 5 target by employing the skilled birth attendance. Therefore, BRAC responded to complement government of Bangladesh in meeting the gaps by training more CSBAs. (Health Nutrition and Population Programme BRAC 2013). Many CSBAs are involved in government and non-government organisations in relation to conducting birth attendant services in rural Bangladesh.

1.2 Research objective and methods

The study explored the process of social identification of community skilled birth attendant (CSBA) of BRAC. Social identification of CSBA addressed employing the concepts of self-categorisation and social categorisation processes. Therefore, the subsidiary objectives were framed in order to capture the issue more exhaustively and explicitly.

1. How do the CSBAs categorise themselves in the community?

Methods: In-depth interview employed to understand the processes of self-identification of the CSBAs in the communities. Moreover, observation conducted in the public places where CSBAs and the villagers met each other. This endeavour provided immense information about the social relations between the CSBAs and the villagers.

2. How do the different stakeholders of the community categorise CSBAs?

Methods: Informal discussion, in-depth interviews and focus group discussion employed to understand the processes of social categorisation of CSBAs. Informal interview and focus group discussion considered for the villagers and elders members of the community. On the other hand, in-depth interviews administrated for the service receivers, the local programme staffs of IMNCH project and the formal and non-formal healthcare providers in order to capture different social dimensions of CSBAs. Moreover, the traditional birth attendants (TBAs) considered for conducting in-depth interview to understand the relationships between CSBAs and TBAs in the same community. Social mapping and free listing exercises employed to comprehend the endeavours of CSBAs.

1.3 The study area (s)

BRAC CSBAs have been working in 47 districts of Bangladesh since the inception of the programme, 2013. Presently, a number of 1080 CSBAs are actively involved in assisting childbirth at home (Health Nutrition and Population Programme BRAC 2013). The study conducted in three unions from three districts. The study areas selected purposively *(Kishoregonj, Shalikha and Dhobaura).* The fieldwork was conducted between June, 2015 and July, 2015.

1.4 Theoretical framework

Social identity: Drury and Reicher (2000) elaborate the notion of social identity in terms of action and a set of social relations. Pierre Bourdieu (1977) has outlined a comprehensive account of social relations in his theory of practice. Bourdieu's the notion of social identity as intersubjective practice (Reicher 2004). In *Distinction* (1984) Bourdieu described intersubjective practice as everyday activities and choices, is constituted through the interaction of habitus, capital and field. A key concept for understanding identity in this world is the habitus. Habitus deals with the practice-generating and practice-unifying principle. Bourdieu describes the habitus as 'observable social condition' (Bourdieu 1984). Alternatively, the ways in which people know how to speak, walk and interact, that constitute their social identity. The habitus provides ways of being, seeing and doing which is the product of that social condition, it enables people to act in any particular domain of practice in ways that make sense to them and to others. Bourdieu explains the domains of everyday action as 'fields'. Capital is theorised to signify there sources to which people have access in different ways in social life. Fine (2000) says that Bourdieu uses capital as a metaphor for power, as the concept of capital includes not only economic resources, but also highlights the benefits of access to cultural, symbolic and social resources through lifestyle, education and social connections (Stephens 2007). The mechanisms of habitus, field and capital are offered to understand the process of the social identity of a particular group. Therefore, Bourdieu's theory of practice helps to conceptualise the social identity of CSBAs in terms of social actions in their everyday lives.

However, the concept of social identity is extremely vast and complex. Social identification is descriptive, prescriptive, and evaluative (Hogg *et al*. 1995). Prescriptive and descriptive describes and prescribes one's attributes as a member of that group while evaluative is strongly motivated to adopt behavioural strategies for achieving in-group/out-group comparisons that favour the in-group, and thus the self. Thus, social identification is the perception of oneness with or belonging to some human aggregate (Sammarra and Biggiero 2001). Social identification is a multilateral and dialectical process. Social interaction contributes to group identity in various ways in terms of internal and social categorisation or external categorisation. Social identification is not just a one-sided issue; it may be ascribed or prescribed by others. Social identification can be defined in two ways employing the concepts of self-categorisation and social categorisation.

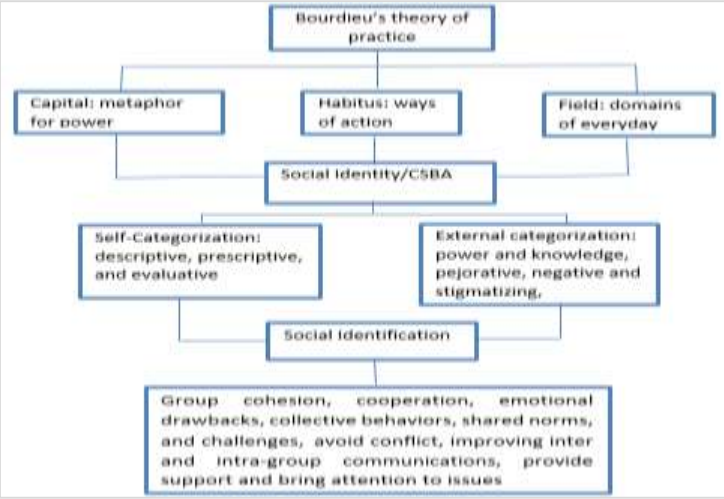
Self-categorisation: Self-categorisation (Turner *et al*. 1987) is the cognitive mechanism by which community people construct social categories through prototypes. A prototype is a subjective representation of the defining attributes of a social category that capture the context-dependent features of group membership, often in form of representation of exemplary members (Hogg *et al.* 1995). Therefore, self-categorisation is the process in which a person comes to realise what groups are significant to them, what attitudes concern them, and what kind of behaviour is appropriate for them. According to Reicher (2004), people's own actions shape their identity and these self-categories are projected.

Social categorisation: Social categorisation occurs outside or across the boundary through social interactions. This kind of identification process is called social categorisation or external categorisation. Thus social categorisation only takes place within active social relationships. The social categorisation might be produced by people who have the legitimate authority, knowledge and higher social status to categorise other groups according to their own styles or ways. However, social categorisation may

be produced by the exercise of power or physical force. Stigmatisation and violation may be deployed to identify a group. Under these circumstances, group categorisation may be pejorative, negative and stigmatising. Social categorisation might reshape the identity of the particular group through the use of physical force and threats, as well as the exercise of power and knowledge. Power and authority are embedded within social relationships and enable control over resources. Therefore, identity is produced and reproduced during social interaction, and interaction is always situated in the context of a social milieu (Jenkins 1997: 52-73).

However, the study applied the following theoretical models to gather information with a view to understanding the social identification of BRAC CSBAs. The theoretical model is sketched based on the concepts of theory of practice, self-categorisation and social categorisation processes.

Figure 1. Conceptualisation of theoretical framework



The CSBAs have distinct roles and responsibilities that shape their identity in the communities. Social identity of the CSBAs can be conceptualised through the theoretical concepts of capital, Habitus and field of Bourdieu's theory of practices. Subsequently, social identification of CSBAs has been explained by the theoretical concepts of self-categorisation and social categorisation of Turner (1987) and Jenkins (1997) respectively.

The first chapter outlines research background, objective, research methods and theoretical framework. The chapter also includes how professional identity of the CSBAs is constituted through the concepts of Bourdieu's theory of practices (1987). In the second chapter explores the process of self-categorisation of the CSBAs. The chapter also discusses different drawbacks of CSBAs in relation to performing their professional services. The chapter three illustrates the process of social categorisation employing theory of Jenkins (1997). Different people gave different views on the profession of CSBAs. Finally, chapter four addresses discussion and recommendations that will contribute in strengthening the endeavours of the programme.

Chapter 2.
Internal categorisation

The section looks into the processes of self-categorise of CSBAs. They address many issues from their points of views that can be articulated as experiences. Moreover, the section explores the underlying challenges that they are being encountered in relation to performing their roles and responsibilities in the communities.

2.1 Self-identification of CSBA

The CSBAs are respected as *Dactar* (Doctor) or Nurse *Apa* (sister) as they use glove, scissor and musk during the processes of homebirth. CSBAs prefer to address themselves as trained midwives because they received profession training that enables them to facilitate childbirth at home as per procedure. Professional training on SBA accelerates their expertise knowledge to process homebirth. Moreover, the training makes a differences between the village doctors (unskilled doctor or quack doctor), TBAs and CSBAs in relation to processing homebirths. The training also enhances social status of CSBAs. To some extent, acceptability of CSBAs depends upon the quality of services, sense of humorous and rigorous techniques that they acquired from training sessions. CSBAs envisage that they are capable of saving the lives of the pregnant women as well. The CSBAs claim that professional engagement as trained midwives gives them immense pleasure to see the smiling faces of the service receivers. In addition, they perform a kind of social services require staying longer hours at the residences of the new born mothers. The patients feel psychologically relieved if the CSBA stays at the residence of the pregnant women. Psychological supports may develop their confidences in relation to giving birth to a baby at home. For this reason, many women prefers moving to the parental residences during childbirth because of getting extended cooperation and mental supports from their kinship networks. One of the CSBAs has estimated that almost 40% of women moved to their parental residences during childbirths.

However, most CSBAs feel proud to have been affiliated or worked with BRAC at some point of their career. Simultaneously, they perform dual roles in their profession according to job descriptions of the organisation namely SK and CSBA. Furthermore, CSBA training provides excellent carrier pathways that enable them to generate money through the endeavours. On the other hand, the pregnant women are being benefitted in terms of receiving professional services from them. In addition, the children of CSBAs are attending the schools and colleges because of their financial contribution to the households. Therefore, the profession contributes sustainable livelihoods of the CSBA as well as empowers them economically and socially in the family and community level. However, CSBA has confirmed that majority villagers are not familiar with terms of CSBA. The villagers address them as BRAC healthcare providers namely SS or BRAC *shasthya apa* (health sister), who takes care of maternal health. Sometimes social identification of CSBAs reflects with the previous occupation in which they were engaged. For example, a CSBA may be recognised as *masternee* (teacher) if she worked as school teacher in the community (annex-1).

2.2 Family and personal life

Family members are deprived of getting company from CSBAs because of the nature of their incessant services delivery towards the pregnant women. CSBAs envisage

additional pressures dealing responsibilities with SK and CSBA simultaneously. They are involved in assisting homebirths at day and night equally. They state that most homebirths take place at night. It is difficult to travel some locations of a village at night. But they respond quickly while they get informed related to the incidence of childbirths in the villages. The family members, especially male counterparts assist them to get the patient's residences at night. The female are not allowed moving outside alone at night on ground of social security. Arranging transportation in rural areas at night is difficult. But a few of them have opportunity to avail husband's motorcycle to reach the destination at night. Therefore, they are being encouraged by the families in relation to performing their roles and responsibilities, despite some difficulties. Without family approvals, they cannot be continued such profession in the villages.

Furthermore, family and social life of CSBAs become complexity when they stay at outside of residences for prolonged duration. They confirm that women are supposed to prepare meals for their families and this kind of household chores considers as 'routine works' of women of rural Bangladesh. But CSBAs cannot process meals regularly for families because of their ceaseless duties. Under the circumstances, the spouses of CSBAs take care of their offspring when CSBAs attend the patients' households with a view to assisting homebirth at the adjoining neighbourhoods. 'Normal delivery' at home requires longer hours to process. They also add that "only Allah knows when a mother can give birth to a baby at day or night". They have few hours to get relaxed at night. Therefore, they do not have scheduled or fixed working hours to complete their duties on regular basis. However, CSBAs have to spend additional money from their pockets in order to purchase delivery kits, including gloves and bled because the poor are not aware about kits that require to process homebirths. People become enthusiastic to find the delivery kits of CSBAs like musk and gloves that use to facilitate childbirth at home. Even, TBAs do not know how to use these kinds of delivery kits. Furthermore, CSBAs have to hold two bags on their shoulders that contain delivery kits and medication for the pregnant women. These bags are designed to perform two different professional duties separately, namely SK and CSBAs. It has been observed that they cannot move easily or comfortably from one place to another by carrying two bags together. Physical condition of the women during menstruation does not allow them travelling long distance in relation to conducting homebirths. However, they earn less income compared to their diligent and efficiency require to process homebirths. Though processing homebirths requires technical capacity, prolonged duration and physical labour, they receive lower remuneration. The average income of per homebirth processing is estimated between 100 BDT and 500 BDT (annex-1). Received remuneration is divided among the CSBA, NHW and SS, so that NHW and SS cannot process homebirths without CSBAs. Thus, CSBAs consider them as dedicated professional in terms of taking care of pregnant women routinely.

2.3 Communication and social position

CSBAs claim that they are involved in providing maternal health services in 'seven days of a week'. CSBAs quickly move to the patient house in responses to assist homebirths delivery. They generally attend the patients' residences on foot. Communication and transportation systems of the villages cannot be congenial during the rainy season. Even, they cannot travel at night without the assistance of male counterparts. Sometime CSBAs are received assistance from their husbands or adult male members of their families when they attend the patients' households, especially at night. However, they feel discomfort to ride bicycles in the villages considering social and physical conditions. The CSBAs have been residing in the husband's villages, but they are identified as "*Gramer Bou"* denotes the residents of husbands' villages. Though CSBAs have been

living in these villages for almost a decade, self-identification of the CSBAs reflects as dependent. This kind of social identification defers them to ride bicycles in the villages. To some extent, such identity limits to disclose individual exposures and capacities. Therefore, they do not feel free to ride bicycles in the villages due to having this kind of social identity. However, women may have gynecological problems that make constraints them to ride bicycles. Some of them states that they cannot ride bicycle during menstruation that causes abdominal pain and vomiting. In order to avoid these dilemma, they have desire to purchase motorbike. Moreover, ownership of a motorbike may enhance social status of CSBAs because a few villages can afford to maintain motorbikes. Motorbikes also help to travel distant locations in short time. Furthermore, they have to spend additional amount from their wallets in relation to attending the patients' households. Distances between the patients' households and CSBAs' households defer to respond quickly in terms of conducting homebirth delivery. It has revealed that most CSBAs are working outside of the programme areas. For instance, they visit the distant neighbourhoods for facilitating homebirths. Some CSBAs has already gained professional reputation through their tremendous efforts that enable them to visit neighbouring villages for assisting homebirths. Sometimes pregnant women become familiar with CSBAs through referral processes of service receivers. Service receivers refer CSBAs among other pregnant women due to their professional aptitudes.

2.4 Assisting homebirths by other stakeholders

Villagers identify to the village doctors and TBAs, who facilitate the homebirths mostly. To some extent, they have anchored better position in the community considering the length of experiences, empirical knowledge and old in aged dealing with homebirths. Thus, the village doctors and TBAs are still dominating stakeholders to process homebirth delivery in the remote areas. Village doctors work in collaboration with TBAs. TBAs report to the village doctors immediately when TBAs get informed regarding issues, so that they could process homebirths together. Village doctors prefer to administer saline and injection for inducing labour pains. Village doctors administer these procedures in consultation with TBAs. They obtain better results through the procedures and CSBAs feel insulated to find such practices during homebirth. Surprisingly, villagers asked CSBAs "you failed, but the village doctor succeeded through their mechanism". Even, family members of the pregnant women urge to complete homebirths by administering injection and saline. The villagers always call upon the local TBAs who reside closer to the patients' residences. TBAs are highly priority in these areas where they have been living for decade after decade. The relationship between village doctors and TBAs are profound in relation to conducting homebirths delivery. Moreover, they disseminate flawed information among the pregnant women and to their relatives that CSBAs cannot process homebirths properly because of lacking of empirical knowledge and experiences to deal relating issues. More specifically, village doctors and TBA propagate that the CSBAs are not aptitude to deal homebirth on ground of their age limits and shorter length of experiences. CSBAs who are young in aged consider as inexperienced persons to assist homebirths properly (Annex-1). Moreover, they also circulate that CSBAs are distributed medicine among the pregnant women that causes complexity during childbirth. TBAs usually expected cash or kinds like *Sari* or cloths, soap and oil as remuneration from their clients. Thus, they create constraints in terms of providing the antenatal and postnatal services that are supposed to be facilitated by the CSBAs. Under the circumstance, CSBAs cannot achieve the set targets of the programme in terms of processing homebirths each month. Thus, TBAs and village doctors create obstacle to perform professional responsibilities of the CSBA in the villages.

On the other hand, CSBAs resist village doctors and TBAs using the kinship networks of the pregnant women, so that they cannot involve in assisting homebirths. Moreover, CSBAs make an effort to establish rapport with the close kin of the pregnant women that can maximise social networking in relation to performing professional duties. CSBAs keep good relations with the educated women of the village, who can persuade village women regarding issues. Even, CSBAs build relationship with the rich family of the village because villagers prefer consulting with them prior to selecting health providers regarding issues. Incidence of conflict between CSBAs, TBAs and villager doctors is common. Therefore, there is common interest of conflict between CSBAs, TBAs and village doctors.

However, CSBAs cannot reach the distance locations of the villages on time. Sometimes, CSBAs are not capable of maintaining time scheduled due to poor transportation systems in the village. Under the circumstances, SS and NHWs take opportunities to conduct homebirth delivery without CSBAs. Even, they process homebirths without informing the CSBAs. Though CSBA, SS and NHW are supposed to conduct homebirths delivery together, SS and NHWs attend processing homebirth together for gaining financial or materials benefits. CSBAs cannot be achieved their professional feats without the assistances of the SS and NHWs. For this reason, CSBAs make an effort to keep good relations with the NHWs and SS, so that they cannot avoid the CSBAs in terms of processing homebirth delivery. Thus, incidence of conflict between CSBAS, SS and NHW cannot be denied. Some CSBAs has reported that they are ignored about the places where the majority pregnant women stay during childbirth. But CSBAs take care of arrival pregnant women who appear from another location at the time of childbirths.

2.5 Challenges and tensions

The poor are the major service receivers among others. They are confused whether CSBAs are paid or unpaid services providers. The villagers preferably give a kind of materials like *Sari*, oil and soap to TBAs in return of their services. The CSBAs always expect money from their clients, but they hardly receive preferred amount e.g. 500 taka for individual homebirth. On the other hand, the rich and the educated person consider the profession of CSBA as prestigious, but fewer among them can elaborate the meaning of CSBA. At the beginning, CSBAs were compared with the performances of TBAs. CSBAs had to struggle achieving their professional position in the community. However, they were scared to process a first couple of homebirths delivery when they embarked their professional duties in the villages. Professional reputation and acceptance were depended upon the first couple of months when CSBAs started to conduct homebirths delivery. At the begging, the villagers securitised closely how the CSBAs processed homebirths and they tried to demarcate a boundary between CSBAs and TBAs in this regard. Through the CSBAs were working as trained midwives for several years, they were not recognised yet as full-fledged professional midwives. Some CSBAs has asserted that they had lower trustworthiness in the community when they started their endeavours because villagers were reluctant to receive services from the new cadres. But committee members of MNCH, SS and NSWs introduced them to the community levels. They publicised that CSBA received specialised training on conducting homebirths delivery. These processes encouraged them to cope with the profession. These endeavours also strengthened their mental aptitude to conduct professional duties properly. Moreover, the CSBAs have emphasised the importance of the publicity of profession of CSBA. They believe that programme should be organised more meetings to publicise the expertness areas of the CSBAs in the community.

2.6 Expectation from CSBA training

The training package of CSBA did not instruct the methods of stitching of perineal tear. But one of the CSBAs knew how to stitch or repair the perineal tear, despite obtaining academic training. In the past, the CSBA worked at local nursing clinic from where she learned the technique. But the programme discourages and prohibits undertaking such action after processing the homebirths. Therefore, the CSBAs are not allowed to operate or repair the perineal tear according to the procedure of the programme. But perineal tear is common incidence to be found during childbirths. Under the condition, CSBAs refer the patient to Government hospital. For the reason, family members of the new born mothers blamed to the CSBA as they were not capable of repairing or stitching of the perineal tear. Even, CSBAs state that they cannot administer the injection and saline to the pregnant women requires during childbirth. Thus, some villagers have negative views on the professional skills of CSBAs due to the reasons. Under the circumstances, the villagers insulated to CSBAs, "what type of *dactari* you have learned"? And added another question "why did you come without receiving these training"? Therefore, the CSBAs urge to receive further training on the issue, so that they can perform their professional duties smoothly.

2.7 Future plan and aspiration of CSBAs

Most CSBAs gave different views on how they could accelerate their professional achievements. Some CSBA have desire to open dispensaries for providing services among the pregnant women. A few of them wants to open delivery centre at the premises of their residences. Some CSBA wants to involve in Government or private clinics for better income. But they have identified a few issues that require strengthening their profession at some points. For instance, they need rigorous training on CSBA modules, so that they can learn more gynecological issues in terms of performing better services. Moreover, they need financial supports or grants to set up delivery centre at the premises of their residences. They think about government approval or license prior to set up a clinic in the village. Therefore, they are expected to receive financial support from BRAC in order to inaugurate new endeavours amid their profession. CSBAs envisage that they have already acquired substantial knowledge and empirical experiences dealing with homebirths. But they want to learn more on gynecological and obstetrics issues, so that they can deal complex issues at the delivery centres independently. They also added that BRAC can provide them an ambulance in relation to conducting their professional responsibilities smoothly and prestigiously. The ambulance services can be symbolised them as 'expert and trained midwives' in the community.

Chapter 3.

Social categorisation

The community response towards CSBAs is significant. Social categorisation is constituted through social interactions between different stakeholders, professionals or groups. CSBAs are categorised based on knowledge, profession and social position of the villagers. The section discusses the processes of social categorisation of CSBAs. These outside constructions of group identities are important to understand how CSBAs are evaluated in the community. The section includes the perceived knowledge of the villagers, formal and non-formal healthcare providers, the elder villagers, UP members, the local programme staff of IMNCH, the pregnant mothers and service receivers towards CSBAs. They categorised CSBA in many ways from their points of views. They categorised the CSBAs positively or negatively considering different circumstances. The perception of the rich, poor, and middle categorised CSBAs based on their land possessions, resources, social position and income.

3.1 Processes of social identification of CSBAs

Majority villagers claim that they are not familiar with CSBAs yet. Some villagers confirmed that they heard the name of CSBAs at the first time when the interview session took place at the villages. Even, they are also unaware about the roles and responsibilities of the CSBAs. On the other hand, CSBAs are classified as TBAs. A few villages recognise CSBAs because they have already received services from them. Some villagers acknowledged that CSBAs have received training on ‘nursing issues’ that held in the different districts. But they do not know the exact training what they received from districts level. Moreover, they cannot know the literal meaning of CSBAs in terms of their specialisation. CSBAs are known as SS or SK because they have been working as above-mentioned designations in these villages for several years. Some villagers have identified CSBAs as BRAC health works.

However, few male of the community envisages that BRAC health workers cannot process homebirth delivery properly and they make more mistakes dealing with homebirths. Even, they refer the patient to the Government hospital after processing of normal delivery. Conversely, the male also states that BRAC health workers merely discuss with female when they visit the pregnant women. They should integrate male members of the household to make it meaningful discussion. Some villagers claim that CSBAs may have good relations with government hospitals and the private clinics. For this reason, they refer the patient to the hospitals. In this connection, some villagers called them as ‘the agents’ of the hospital and clinics. Furthermore, CSBAs are not considered as professional cadre yet because of referral system of their profession. According to the guidelines of the programme, CSBAs refer the pregnant women to Government hospital in order to avoid the risk factors of homebirths. But some villagers perceive that CSBAs seem to be untrained professional as they take prolonged duration to process homebirths. Thus, they state that physical condition of the pregnant women can be deteriorated under the reason.

However, the villagers assert that the poor receive financial benefits from BRAC authority when the pregnant women are hospitalised at government hospitals. BRAC also helps to the pregnant women by providing vehicle in case of emergency, so that they could easily arrive to the hospitals. Some villagers mentioned that the poor usually prefer such services that can be received without spending money. The villagers

recommend that CSBAs should have special dress pattern, bag, umbrella, which can symbolise their professional identity in the community.

3.2 The perception of payment for homebirth

The villagers prefer homebirth delivery because of avoiding expenses of transports and medication. Moreover, pregnant women require extended helps or assistances from the relatives while they hospitalise at government or private clinics. Women prefer to receive services from the experienced persons who have been working as TBAs or *Dhai* for many years. The villagers perceive that homebirths does not require money. Assisting to homebirth is considered as social and cultural norms mean to receive help from experienced women without spending money. They also perceive that it is integral social responsibility to be expected assistance from experienced persons to process homebirths. Only women have access to assist homebirth delivery. Thus, it has become social norms to get assistance from the midwives, TBAs, etc. without money. However, villagers are habituated to offer material items including a *Sari*, soap and hair oil to the *Dhatri or Dhai* for their services. A few villagers offered money to the *Dha*i in return of their services. The villagers think that it is not mandatory to pay cash to CSABs or related stakeholders for their services. Therefore, paying remuneration to SS, CSBAs or midwives or *Dhai* depends on willingness of individual or financial condition of the service recipients. Some villagers state that BRAC healthcare providers do not charge fee for processing homebirths.

3.3 Views of the pregnant women

Pregnant woman become demoralised if she finds consecutive pregnancy as daughter because parents in laws and husbands might be annoyed under the reasons. The pregnant mothers assert that they feel anxious and social pressures if they give birth to two daughters consecutively. Under the circumstance, the relationship between husbands and wives may be worsened. Therefore, the pregnant women need mental support to overcome such stresses. On the other hand, the pregnant women expect to get spare or relaxed time during pregnancy, but the parents in laws and their husband perceive that pregnant women do not need relaxed period. In this connection, they report that giving birth to a baby is natural phenomenon of a woman. Sometimes pregnant women are not allowed to visit their parental residences that result hampering 'the routine works of households'. The elderly women say "we gave birth to children while we were doing our jobs at homes". The pregnant women also claim that mother in laws may not be supportive in terms of caring of them during pregnancy. But the pregnant women prefer staying at the parental residences during childbirth in order to receive emotional supports from their relatives. The pregnant women require psychological supports during childbirth at home. Complex issues can be normalised with aid of psychological counseling to involve different stakeholders of the society. Giving birth to a baby is not only involved with physical stress of a woman, but it also associated with the mental anxiety. The pregnant women depend upon the doctor or trained midwives and supportive persons, who could take care of their physical and social circumstances. They need caring and emotional support to overcome complicated issues that appear during pregnancy.

3.4 Place preferences

The villagers prefer homebirths because it requires minimal money. For instance, some kinds of cosmetic or cloth are offered to the TBAs. Moreover, the pregnant mothers need nominal assistance from their relatives during postnatal period if the delivery takes

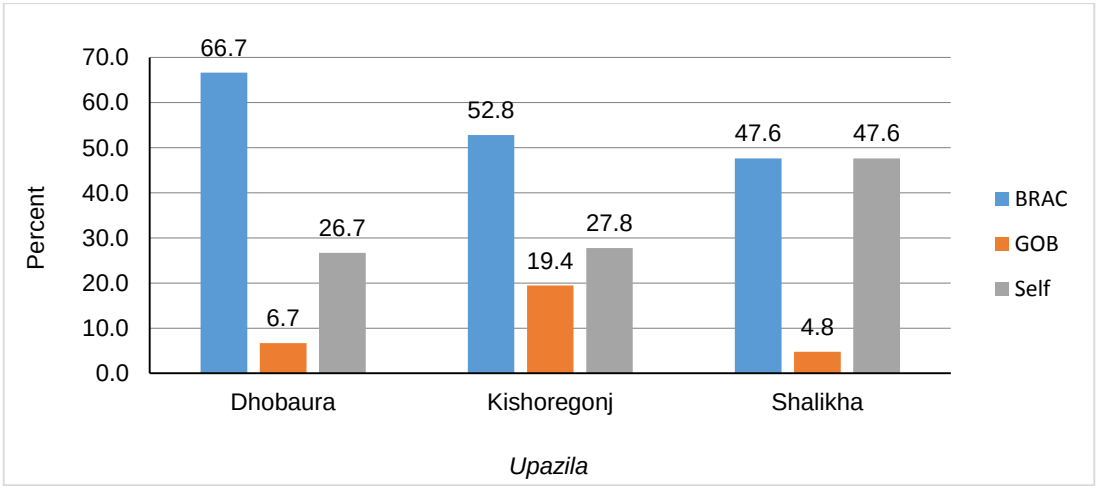
place at home. The villages envisage that hospitalisation is complex procedure in terms of managing a seat in the hospital and there is poor communication system between the hospital and patients' house. However, the preferences of birthing places are determined based on socioeconomic position of the pregnant women. The rich are likely to attend the private clinic while poor people prefer government hospital for processing childbirth. The villagers always expect to receive better quality of services with minimal costs. Sometimes the poor households attempt to avoid government hospital because of presence of poor healthcare systems. Even, money is required to process normal delivery at the hospital. In remote areas, the villagers have to pay additional amount to attend the hospital. The transport expenses consider as additional financial burden regarding households. But they have no alternative rather than to hospitalise the pregnant women to Government hospital considering their financial condition.

However, most villagers feel embarrassed to attend the hospital where the male doctors are taking care of delivery section. Women are reluctant to meet the male doctors for delivery purposes because the *purdah* or modesty of a woman may be damaged due to the reason. Moreover, some villagers are familiar with the ambiance of the hospital where gathering is common phenomena that defer to receive better quality of services. Most villagers are aware about the unhygienic condition of government hospital causes infection among new born mothers. The villages confess that BRAC healthcare providers refer the pregnant women to government hospital. The pregnant women are hospitalised when CSBAs fail to process homebirth delivery.

3.5 Availability of stakeholders in the villages

In order to understand the availability of service delivery for maternal healthcare, we arranged a number of 14 focus group discussions in the three different study locations. The participants prepared a free listing chart in which they identified different stakeholders who can deal with homebirths. One point of the sessions, we asked how many services providers are practicing in the villagers and they identified BRAC healthcare providers as major stakeholder followed by the self-practitioner dealing with homebirths. Most villagers were familiar with BRAC healthcare providers, including SS, SK, NHW and CSBAS (figure-1).

Figure 2. Availability of different service providers during pregnancy by *Upazila*



n=112 based on number of focus group discussion (14×8 persons in each focus group discussion)

The Table-1 demonstrates different healthcare providers who assisted homebirths delivery. The villagers scored against each healthcare provider based on their performances in terms of processing homebirths delivery. They scored ranging from 0 to 10. BRAC healthcare providers including SS, SK, NHW and CSBAs were received higher mean scores depending on their performances in terms of dealing homebirths delivery. Moreover, it has revealed that TBAs are proactive in the study areas, received lower scores compared to BRAC and government healthcare providers relating to maternal health services.

Table 1. Ranking of health providers regarding pregnancy care based on respondent's views

Service Provider	Dhobaura	Kishoregonj	Shalikha	Over all
BRAC	7.3	8.3	9.3	8.3
GoB	7.0	6.3	9.0	6.7
Self	5.8	6.6	6.6	6.5
Total	6.9	7.4	8.0	7.5

n=112 based on number of focus group discussion (14×8 persons in each focus group discussion)

Table 2 shows that villagers were confused about the trained person who can process homebirths delivery properly. They scored against individual stakeholders including CSBA, SK, SS, etc. ranging from 0-10. The table provides striking information that the villagers are not familiar with the trained midwives in the study areas. The villagers scored based on their experiences and quality of services that they received from different stakeholders. They categorised these stakeholders without understanding of individual's knowledge and skills related to processing homebirths. It seems to be claimed that the villagers do not have adequate knowledge about CSBAs in these localities.

Table 2. Ranking of the individual service provider in the study areas

Service Worker	Score
CSBA	7.9
SK	7.9
SS	8.8
NHW	8.1
GOVT. (FWA/FWV/CSBA/Nurse)	6.5
TBA	7.0
Village Doctor	6.1
Total	7.5

n=112 based on number of focus group discussion (14×8 persons in each focus group discussion)

Chapter 4.

Discussion and recommendations

According to Bourdieu's theory of practice (1987), social identity constitutes of intersubjective practice in terms of habitus, capital and field that discussed elaborately in the theoretical framework. Bourdieu's theory of practice allows us to conceptualise social identity of CSBAs. The study has identified that CSBAs do not have inadequate 'power' means limited access to culture, symbolic form and social resources in light of theory of practice. CSBAs are struggling to establish their identity in the community because of their limited 'power'. Social and cultural norms prevent growing up professional identity of CSBAs as trained midwife. CSBAs have identified some constraints in terms of limited access to culture and social resources are constant reality of their professional circumstances. Moreover, CSBAs have addressed some social and cultural issues that defer to develop their professional identity. On the other hand, majority villagers recognised them as stereotyped TBAs.

On the other hand, villagers emphasise on branding issues of CSBAs are required to consider. To some extent, they cannot draw boundaries between the CSBAs and other stakeholders, who are involved in dealing with homebirths delivery. Moreover, process of social categorisation has demonstrated that community people have inadequate knowledge about the role and responsibilities of CSBAs. Thus, the study has articulated that CSBAs have limited professional identity in the community. This means "identity crisis of the CSBAs". Therefore, concerned authority need to take due initiative in relation to promoting homebirth by SBA, mass awareness need to be considered in this regard (Islam *et al*. 2014). Violence against women causes maternal mortality that need to be taken into consideration (Bangladesh Maternal Health Services and Maternal Mortality Survey 2001)**.** Lack of skilled healthcare providers is major constraint to ensure better quality of maternal health services. Furthermore, villagers did not find referral services as simply accessible or available (UNICEF 2009).

However, the study has outlined a numbers of recommendations which can be enhanced professional identity of CSBAs. The programme can initiate the following mechanisms through which professional identity of CSBAs will be strengthened. Thus, CSBAs will be branded as professional midwives in the community. The respondents also provided some suggestion in strengthening the profession of CSBAs. Recommendations are discussed sequentially.

- CSBA need financial opportunity to set up labour centres at the premises of their residence.
- The programme can set up delivery centre in the union level, so that they can provide services through the centres.
- The programme can arrange meeting invariably to introduce the CSBAs among the villagers.
- The programme can arrange full packages of training session for CSBAs, so that they can process homebirth without referring to the hospital in case of perineal tear.
- The programme should hang signboard at the local bazaar or markets or avenues of village road, so that villagers can easily identity the location of CSBAs. More announcements in form of stickers, posturing are required to be publicised the cadre of CSBAs more effectively.

- Programme can redefined the workload of CSBA and SK because CSBAs are called while they conduct routine works of SK.
- Programme can help CSBA financially, so that they can purchase motorcycle for communication purposes.
- Programme can screen movie or theatre in relation to publicising the expertise areas of CSBAs.
- Programme can disseminate information of the CSBA through the Family Welfare Centre (FWC) where many people frequently visit for different purposes.
- Programme can disseminate the messages through parents meetings of the schools and colleges.
- Programme needs to be enhanced the quality of SS because they are frontline healthcare providers of the community.
- Programme can provide delivery services through the Community Clinic of Government.
- Programme can arrange meeting with the local influential and political leaders to convey the message about CSBAs
- Villagers recommend special dress pattern for the CSBAs, so that they can be recognised easily.
- Programme needs to introduce special hand bags designing with distinctive symbols for CSBAs, so that villagers could recognise them easily in the village.
- Programme can introduce transport services in the village for delivery purposes. Availability of transport services in the villages can reduce the maternal mortality rate.
- BRAC should organise the yard meeting with male and female respectively with a view to enhance the popularity of CSBAs.
- SS, SK and other health service providers only discuss with the female, but they need to discuss with the male persons in the village by organising yard meeting.
- CSBA need to maintain good relations with SS and NHW, so that they cannot interrupt CSBAs work. Sometime it is impossible to continue work without the assistance of NHW and SS.
- The programme needs to discuss with parents in laws and male members of the family, so that they can cooperate to facilitate the delivery processes either at home or hospital.
- Higher official of the programme should visit the villages repeatedly, so that villagers can realise the importance of CSBAs.
- Referral systems should be reconsidered for the exceptional cases because many people have mixed experiences while they attend the government hospital for different purposes.
- Counseling team can be formed in order to reduce the mental pressures of the pregnant mothers.
- A study can be undertaken to understand the trend of birthing practices in a village of Bangladesh.
- The programme can recruit the parapsychologist, so that they can organise counseling sessions with the family members of pregnant women. The process will reduce the mental stress of the pregnant women. Moreover, family members will be aware about issues related to violence against women.
- The programme can consider the salary structure of CSBAs and programme can offer traveling allowances if they attend processing homebirth delivery at distant locations.

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Annexes

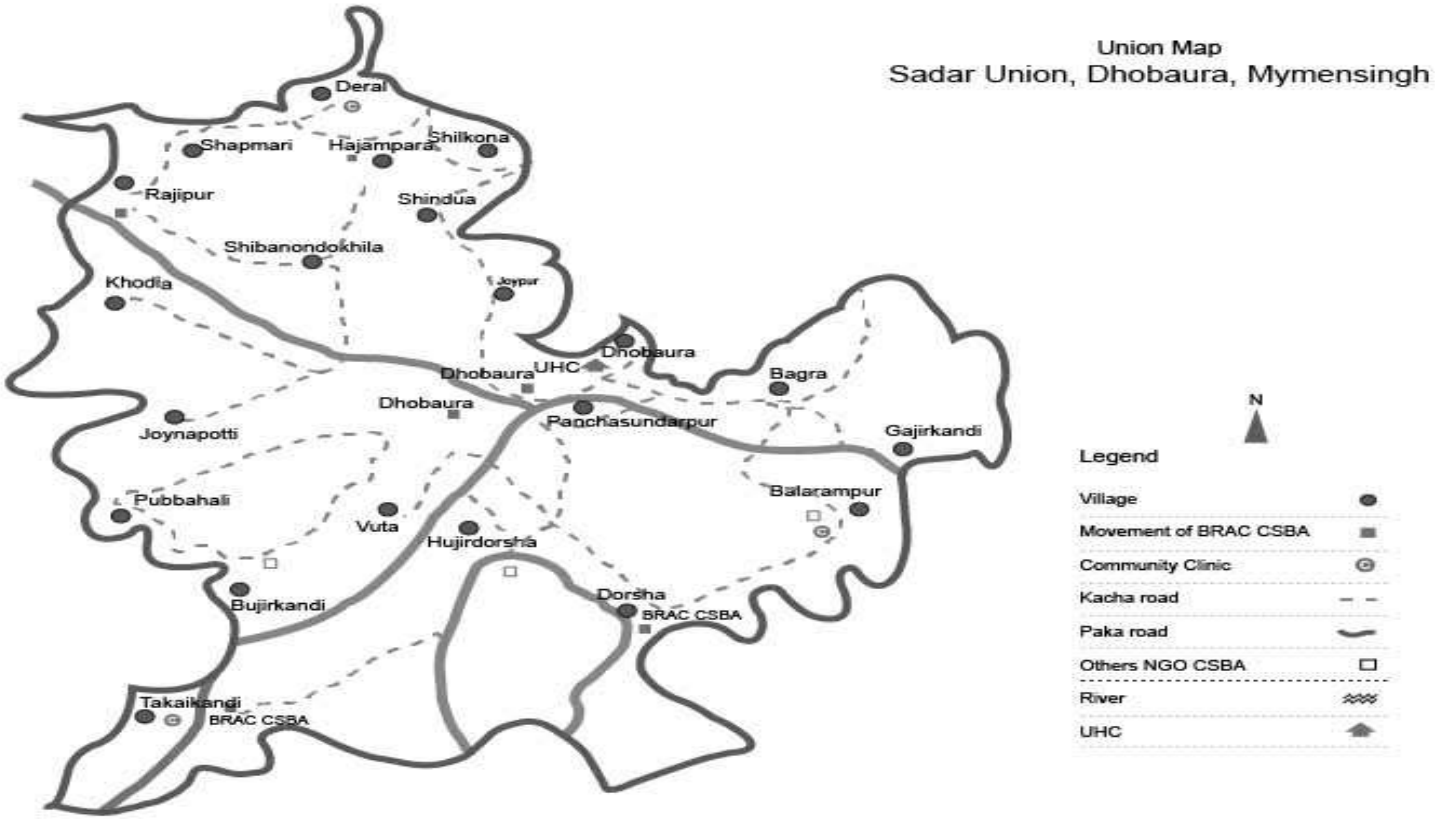
Annex-1

Profile of CSBAs in study area (s)

Upazila Name (s)	CSBA in a Union	Education	Age	Marital status	Affiliation with BRAC in year (s)	Previous profession status	Professional experiences in year (s)	Previous experience in conducting homebirth	Number of processing home delivery in the last three months	Number of references in the last month	Last month income
Kishoregonj	A	HSC	32	Married	9	School Teacher, BRAC	1	No	22	19	6000
	B	SSC	36	Married	8	Paralegal volunteer, RDRS	4	No	23	35	7025
	C	SSC	38		5	School teacher, BRAC	4	No	8, 3	5	6025
Shalikha	D	SSC	28	Married	5	No	2	No	11	7	5325
	E	SSC	24	Married	6	Nurse, private clinic	5	2 years	13	5	5325
	F	HSC	28	Married	6	School teacher, Local NGO	5	No	6	1	7000
Dhobura	G	SSC	32	Married	7	School teacher, BRAC	5	No	11	2	4550
	H	HSC	30	Married	7	-	4	No	14	2	5100

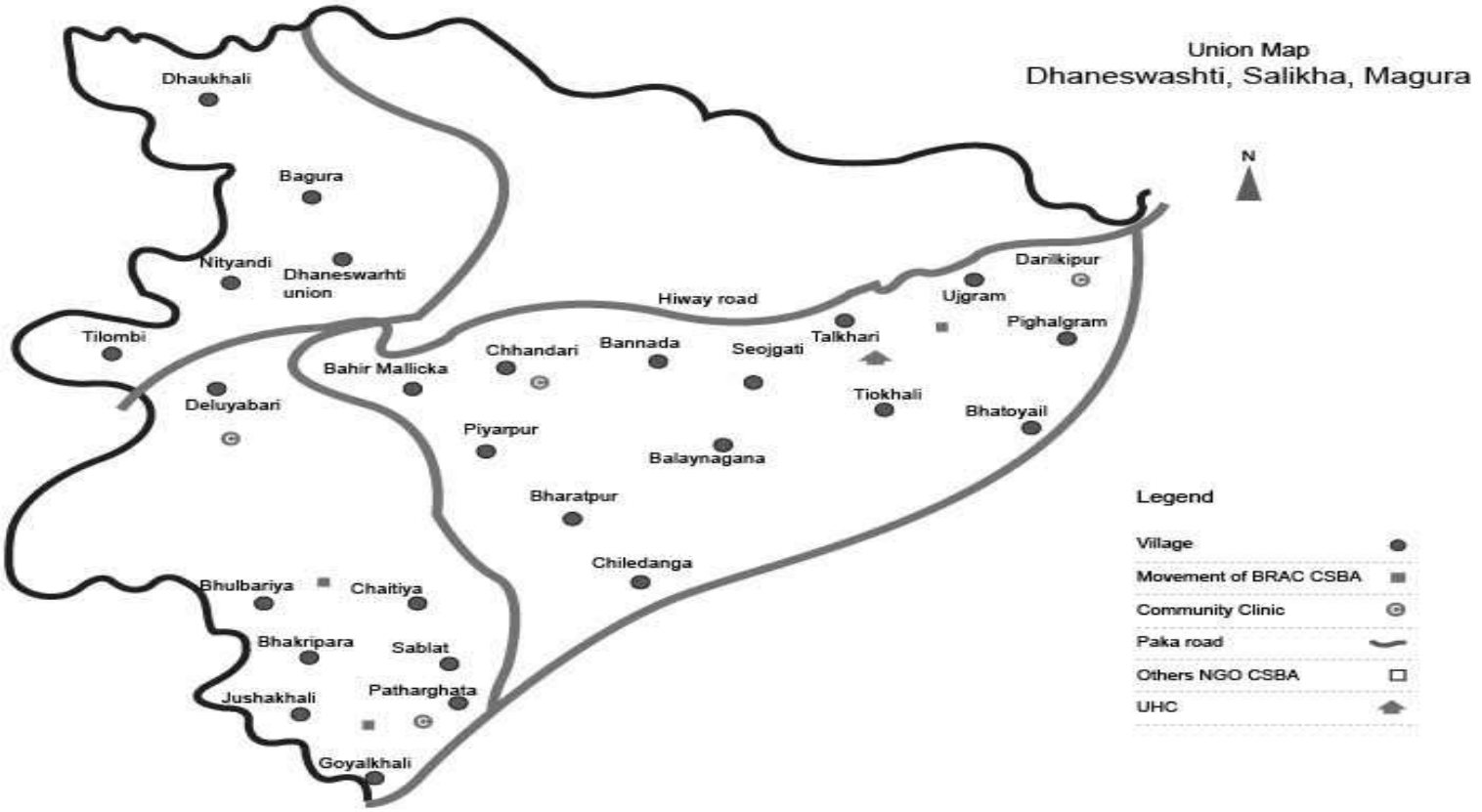
Annex-2

Social map of the study area where CSBAs are working



Annex-3

Social map of the study area where CSBAs are worki



Annex-4

Social map of the study area where CSBAs are working