Promoting maternal health: gender equity in Bangladesh

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Gender roles and relations, that is, the social constructions of what it means to be female or male and the multiple and complex power relationships between females and males affects women's experiences of maternal health and maternal health outcomes. In the Bangladeshi context, the social construction of gender means that the sexuality and reproductive capacity of women is seen as belonging to husband, family or community.

Gender roles and relations operate at the household and community level to shape women's reproductive experiences and maternal health-seeking behaviour. Women do not always get the support they need to fulfil their reproductive intentions and sometimes fear reprisals from disapproving husbands or in-laws. A recent study on urban adolescent women in slums in Dhaka found that, of 153 young women, 128 felt pressured to have children because of social and cultural expectations of fertility (Rashid, 2006). Access to resources, gender division of labour, gender norms and values and gender-based violence intersect to affect women's ability and autonomy to be able to access maternal health care where and when they need it.

Gender norms and values also operate within health systems. There is evidence that within provider–client interactions some providers show judgmental, negative and uncaring attitudes towards women, especially towards more vulnerable groups of service users, such as poor, uneducated or illiterate women. For example, lack of privacy, mistreatment, long waiting hours and insensitivity by providers for women requesting family planning methods and delivering in a hospital have been documented in Bangladesh (Schuler and Hossain, 1997; Afsana, 2004; Pitchforth et al, 2006). A recent study on counselling and care at both government and non-governmental organization (NGO) facilities for women seeking menstrual regulation services found discriminatory attitudes towards clients that built on negative gender stereotypes (Grant, unpublished observations, 2007). Socio-cultural and economic costs and lack of accountability of facilities are a major barrier to accessing appropriate care. A study on poor women seeking obstetric care in rural areas found that poor families ended up paying on average Taka 13000 (US $260) for delivery (caesarean), drugs, laboratory tests, blood transfusions and in some instances had to bribe staff to obtain services (Afsana, 2004).

If maternal health strategies are to be effective and equitable there is an urgent need to promote gender equity in programmes at the community level, within health systems and in policy. This is BRAC's approach. BRAC, established in 1972, is one of the largest non-governmental organizations in the world. It undertakes programmes in health, education and micro-credit which reach out to over 100 million people in Bangladesh.

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At the community level BRAC programme staff organize advocacy workshops and health forums to create awareness of current best practices on maternal health and the consequences of delayed referrals. Advocacy and forums in the community speak on how gender, poverty and culture interweave to impact on women and their maternal health experiences. Posters, leaflets and dramas are arranged in the communities to highlight violence against women, the importance of male involvement in reproductive and maternal health issues as well as how to encourage saving funds for an obstetric emergency. Given that maternal health is mediated by gender relations at the household and community level the target group for these activities is not just women but local elites, political and religious leaders, other NGO and government health professionals.

At the health service delivery level, BRAC works to bring gender sensitive and pro-poor services close to communities. BRAC has engaged more than 70000 female community health workers called Shasthya Shebikas throughout the country. They work as the front-line service providers of the health programme. As well as technical skills, privacy, dignity and information for birthing women, especially the poor, are emphasized.

BRAC is in the process of establishing birthing huts in urban slums and monitoring their value as a way of improving delivery situations and quality of care. These are run by urban birth attendants and aim to offer privacy and clean delivery to birthing women and quick referral for quality services to health facilities in case of emergencies. An initial piloting led to the setting-up of birthing huts in all urban slums of Bangladesh reaching 8 million populations. BRAC aims to support poor women and families in rural and urban contexts: any poor family who requires emergency obstetric care can approach BRAC to pay for costs.

As the Bangladesh experience demonstrates, gender roles and relations intersect with poverty at both community and health systems levels to affect women's ability to access quality maternal health services. This means that to be both effective and equitable, maternal health programmes and strategies need to promote gender equity at multiple levels. This comment has outlined some of BRAC's approaches to this challenge and the intention is to further dialogue in this important area. **BJM**

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