

## **Women's Human Rights, Maternal Mortality, and The Role of the State: A Case of Bangladesh**

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It was late night. Anindita, a young girl was lying on a bed in an observation room attached to the labor room of a large hospital. Her left arm was tied to an intravenous saline, which was running slowly. She looked very restless and was moaning. An intern female doctor came close to Anindita and looked around for some assistance. She could not find anyone and opened Anindita's medical record. Her face became pale. She immediately measured her blood pressure and anxiously went out to call a senior doctor. Anindita gave birth in a rural sub-district level hospital and suddenly started to bleed. As there was no blood transfusion arrangement at those facilities, she was sent to a tertiary medical college hospital with an intravenous infusion. By the time, blood transfusion was started, many hours have passed and Anindita was gasping. Doctors were trying hard and decided to do surgery on her. Unfortunately, Anindita's little, malnourished body could not fight anymore and breathed her last breathing.

This is a typical incident, but tragic end occurs to many women in Bangladesh. Women in this country suffer a high burden of maternal deaths and diseases despite having success in reducing maternal mortality and fertility. Failure to provide accessible, affordable, quality services during pregnancy and childbirth is a violation of women's human rights. In this paper, I will present why and how women's access to health care is affected in Bangladesh.

Bangladesh located in the Southern part of Asia is a small country in terms of geographic dimension, but, the size of human resources position the country as the eighth largest country in the world and provides home to 150 million populations. With increasing per capita income of USD 750, life expectancy of 65.1 years and overall literacy rate of 56%, the country is slowly turning into a middle income country. Yet, on the other hand, in 2005, 40% of populations lived below poverty line, which has declined to 32% in 2010. It is reported that Gini coefficient was quite high increasing from .467 to .50 in rural areas during 2005-10 and maintained at .497 in urban areas suggesting a wide income inequality between rich and poor.

Here again, Bangladesh has made remarkable progress in maternal mortality and fertility. It is one of the few countries, which is on track for both millennium development goals (MDGs) 4 and 5. Between nineties and 2010, the maternal mortality ratio declined from 574 to 194 per 100,000 live births (BMMS 2010). Yet, health system is not adequately responding to the demand of the increasing populations in spite of the presence of enormous infrastructure all over Bangladesh. Even now, only 71 percent of pregnant women seek antenatal care, 23 percent of childbirths take place at hospital and 27 percent of all births are attended by skilled personnel. Yet, 40% of reduction in maternal mortality in 9 years was possible because of declining fertility, accessing services for complications, increasing women's education, improved awareness and better economic status.

Despite having stable economic growth and declining fertility and maternal mortality, the country suffers from diverse disparity across wealth quintiles, geographic terrain, territoriality and culture. Moreover, access to functional health facilities including quality of services, absenteeism of health care professionals and lack of skilled professionals and on the other hand, water, sanitation and hygiene situation, rapid urbanization and living condition in urban slum pose challenges to improve maternal health. Moreover, social norms, gendered roles, and women's status affect women's access to health care.

### **The State of Obstetric Care**

Childbirth is not a disease, but a normal event. In spite of having reasonable health infrastructure across the country, the current health care services neither provides adequate care nor meets rural, poor women's needs during pregnancy and childbirth. The country's policies and programmes bring modernity into health care and utilize its resources to transform the health system in its own image not recognizing the context of the country, socio-economic status and understanding and needs of users. Nearly all public facilities suffer from lack of skilled human resources, drugs, diagnostics, operating facilities and supply of blood transfusion amenities. Absenteeism of doctors, nurses and paramedics, lack of maintenance of official hours, behavior of health providers and corruption and malpractices in hospitals also make users reluctant to use facility services even in their life threatening, fatal situations.

The State has given full autonomy to medical professionals by providing opportunities for their practice. In Bangladesh, there is no control or supervision of medical practices by the State. Illich's (1977) argument about the role of medical professions in modern State seems

appropriate. In this context, he claims, “They turn the modern State into a holding corporation of enterprises which facilitates the operation of their self-certified competencies” (p.16). This control is reflected in hospitals of Bangladesh where the monopoly of the medical professionals is so dominant that their technological, economic and social activities are never questioned or scrutinized by the State. It is the power of biomedical knowledge that makes all the events natural and acceptable by the State as well as by the people. This continuation of the process eventually affects the poor, rural women whose visions and versions are already silenced in power struggles with the authoritative knowledge of biomedical professionals.

The medical profession is established in the context of the social, economic and political forces developed in the modern State. In discussing the power of the modern State, Chatterjee (1993) argues, from the Foucauldian perspective, that it is the advance of a ‘modern’ regime of power that facilitates and produces more power of the colonial legacy in postcolonial India. His argument is that the postcolonial State shaped and patterned by the precise rules and techniques left by the colonizers are the power of modernity manipulated in the modern State. It is this power of the modern State that influences modern obstetric practices in postcolonial Bangladesh. That espousal of the modern State renders the medical profession a powerful, professional group not only by delegating full authority to possess knowledge of the body and to control the health of the population, but also by creating space for medical education and practices (Foucault, 1980b). In fact, this concentrated, elitist knowledge makes the profession dominant because of its overriding monopoly that precludes other forms of knowledge (Illich, 1977). At the same time, modern capitalism adds monetary value to the medical profession conferring on it a higher societal status. As a result, in Bangladesh, the policy and planning concerning childbirth issues are accorded with the ideas of medical profession that facilitates modern, obstetric practices in hospitals and creates a speciality no matter how useful it is for childbearing women. The recent policy of Safe Motherhood Initiatives supported by WHO is geared to increase skilled, birth attendance in which people with proficient midwifery skills such as doctors, nurses and midwives are accountable to manage normal deliveries and refer complications (World Health Organisation, 1999). This influences the State to initiate the training of new generations of literate midwives who will soon be introduced into the community (Ministry of Health and Family Welfare, 1998a). The WHO approach, in fact, supports modern biomedicine. It is in this context, I can argue that the State and the WHO influenced by modernity patronize cosmopolitan obstetrics, and attempt to eliminate the already marginalised *dainis* condemned as dirty, ignorant and failed by facilitating this modern approach which

Wagner (1995) terms as “global witch-hunt” (p. 1020). The WHO has lost its philosophy developed on primary health care when it was born in 1946 and reaffirmed by the Alma Ata declaration in 1978.

The most important issue addressed in health policy and planning with regard to childbirth is the reduction of maternal deaths and diseases. Here, we can observe that the State policy is geared towards modern obstetric care allocating the total budgetary resources by organising different programs in health care hierarchies. Yet, the resources used for obstetric care are not at all adequate for the women for whom it is intended. In Bangladesh, 77 percent of births occur at home. Although, the public facilities are supposed to provide free care to all, in reality, costs for normal deliveries and c-section are quite high compared to economic status of rural populations. The under resourcing of hospitals occurs not just because of the “lack of resources” in the country “but who has control over these resources” (Navarro, 2000, p. 673). This is reflected in the maldistribution of resources at a national level where health budget (5%) is not geared to poor populations (Ministry of Finance, 2002). In this context, Navarro (1981, 2000) argues that this situation occurs to meet the self-interests of lumpen-bourgeois who themselves participate in maintaining the power of the State. Moreover, maldistribution in health care hierarchies arises from facilitating the urban-centric, medical practices that benefit the upper class societies as well as medical professions (Phillips, 1990). Poor resources in annual hospital budget for patient care give rise to poor, quality, hospital services with a lack of supplies and facilities that not only impede patient care, but also result in an unclean hospital environment encouraging infections and cross-infections. Even if women survive, their impoverished bodies are worsened by fiscal violence and incapacitated by hospital morbidities.

Childbirth is medicalised, turned into a commodity in modern, capitalist society. It is the State that facilitates modern, obstetric practices because the whole medical system has become a business enterprise. In this business enterprise, medical professions, pharmaceutical companies, technological factories, laboratories, hospitals and clinics all are involved (Sanders & Carver, 1985). These elites monopolise this business throughout the world and at the same time, facilitate funding to the international NGOs as well as the projects in the developing countries. The globalised, market economy enhances the flourishing of medical professions and modern obstetrics for their own benefits, and the State, in this context, plays an intermediary role to facilitate the process (Doyal, 1979, 1995). Thus, like many developing countries, whatever resources are allocated for the improvement of maternal health in Bangladesh used to

serve the interests of capitalist, market economy in which modern obstetric practices are intertwined.

**Women's Silence in childbirth** Women's silence was evident in all aspects of the childbirth experience: when they conceived, when they gave birth at home and when they were delivered in hospital. It is reported that the news of being pregnant was kept silent and secret, birth events were observed secretly and labor pain was endured silently. This unexpressed expression of silence is a socially obligated burden, which rural women carry for years by adopting gendered characteristics - *sharam* (modesty and shyness), patience and tolerance imposed by traditional societal values. Weedon's (1987) argument, developed from Foucauldian perspectives, supports the gendered constitution of silence locating its origin in patriarchal subjection of power. Chatterjee (1993) claims that the feminine quality maintained in the inner world - 'home' is the result of traditional Indian patriarchy. Bordo (1999), on the other hand, argues that in modern Western society, normative feminine practices produced and reproduced in cultural demands give rise to docility and obedience in female body. It is this docility and subservience to normative feminine practices that account for rural women's silence in pregnancy and birth. The maintenance of feminine qualities is described as subjectivity, which is referred to as, "conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world" (Weedon, 1987, p.32). In the rural context, the constitution of women's subjectivity produced within the discursive practices of Indian traditional patriarchy makes women docile and thus, silent, tolerant and modest. The feminine qualities of powerful Indian Goddesses are essentially intended for the emancipation not for the repression of women. But, in cultural practices, these qualities now serve to keep rural women's sufferings in silence.

In hospital birth, women remained quiet in labor room for fear of hospital environment and behavior of doctors, nurses and other hospital staff and new experience of birth event. I would argue that women are made silent by the disciplining power of authoritative hospital obstetrics where the female body becomes the place of contestations of bio-power. Silence is expressed in resistance that includes non-cooperation, denial of treatment and ultimately, refusal of hospital care. This silence consequentially enhances maternal sufferings and risks their lives, no matter where birth takes place.

Giving birth in a hospital reduces women to patient status (Rothman, 1982). In *The Oxford Illustrated Dictionary* (Coulson, Carr, Hutchison & Eagle, 1962), the word 'patient' means one having patience or a person under medical treatment, especially with reference to his doctor. In a medical establishment, women are transformed into patients through multiple rituals of medicalised treatment (Martin, 1989; Oakley 1980; Rothman 1982). Yet, the very meaning of the word, 'patience' that carries a sense of being quiet and acquiescent is applicable to rural women when they undergo hospital birth in Bangladesh. Biomedical models of treatment based on scientific and rationalistic, modern, Western patriarchy (Good, 1997) create male-centric management in Bangladeshi hospital obstetric facilities even with the preponderance of female health providers. Under these circumstances, the medicalised experience of birth and unusual experiences in the hospital reinforce rural women's patience and silence.

Women's silence is expressed in their disciplining and conformity to medical authority. The disciplining of patients is caused by "bio-power" in which numerous and diverse techniques are employed "for achieving the subjugation of bodies and the control of populations" (Foucault, 1978, p. 140). The body becomes the place of contestations of power to make patients disciplined and self-regulating – "docile" bodies (Foucault, 1978). As a consequence, rural women silently conform to the authority of doctors and nurses. Bartky (1986, as cited in Sawicki, 1991) argues, from Foucauldian perspectives that the silencing and powerlessness result from disciplining of the feminine body. This silencing and powerlessness cause rural women to suffer physically as well as emotionally. As Foucault (1978) reasons, where there is power, there is resistance. Women's silence does not indicate agreement with everything rather it is expressed as resistance against the medicalised experiences, the authority of biomedical professionals and unfamiliar situation in the hospital. Women are made silent by the disciplining power of cosmopolitan obstetrics, but they remain silent by manipulating resistance in the form of non-cooperation and denial to accept their care. Within women's silence, both power and resistance are displayed. Silence is, therefore, approved as a mark of discipline, but resentment is expressed within silence. Rural, poor women simultaneously conform to and deny the authority of cosmopolitan obstetrics.

Women's silence in birth causes sufferings, no matter where the birth occurs. At home, rural women are subjected to silence by their intrinsic feminine qualities. On the other hand, in hospital, the imposed patient role objectifies women to remain silent through disciplining of the body. Yet their resistance intensifies this silence. As Das (1997) states, "Tradition is what

diminishes women and permits a subtle everyday violence to be perpetrated upon them” (p. 75). In this context, rural women’s sufferings in silence are tantamount to violence perpetrated by the traditional value system. This exposition of violence goes beyond tradition when she observes violence in modernity, as it is reflected in women’s silence and sufferings in hospital birth. Standing on the brink of modern society, traditional, rural women suffer as victim of both traditional values and modern technological system.

### **Women’s Human Rights and Maternal Health**

While the causes of maternal mortality and morbidity are debated, the significance of socio-economic contexts is ignored with little effort undertaken to address those issues in Bangladesh. Maternal mortality is reduced not simply due to better access to obstetric care, but to better education, better nutrition, improvements in housing and working conditions, and wider availability of effective, birth control (Doyal, 1995; Mckeown, 1989). In Bangladesh, poor women are deprived of those social facilities that enhance their socio-economic conditions. Moreover, the impoverishment of the postcolonial State still carries the trait of exploitation from the colonial period due to the drain of wealth, the destruction of productive systems and the creation of a backward economy (Chatterjee, 1993). Later, in the postcolonial period, as experienced by all developing countries, this State becomes the victim of the neo-colonial invasion of modern, capitalist, market economy. It is the modern State, regardless of its economic status, facilitates the upper class economy eventually giving rise to increasing social inequalities (Navarro & Shi, 2001). It is reflected in the current situation of Bangladesh where the level of consumption expenditure inequality is increasing between rich and poor in both urban and rural areas (Ministry of Finance, 2010). When the poor become poorer, there is less scope for improving maternal health only by reorganizing obstetric care in hospitals.

Bangladesh is a modern State. It is the power of modernity that shapes ideas and practices of the State influencing the health policy and planning. The *techne* of the State denoted as “bio-power” (Foucault, 1978), is intended to improve maternal health, but, the power struggles of different discursive practices occurring in the social, economic and political contexts give rise to a situation where poor, rural women agonize. Foucault (1991b), in fact, condemns the present situation of modernity as the “governmentalisation of the State” (p. 103), where the problems of governmentality and the techniques of government turn into political issues and the space for political struggles. He argues that the tactics of governmentality define and redefine the survival and limits of the State, which are internal and external to the State. It is in this context, the

health policy and planning for the reduction of maternal mortality and morbidity become the space for political struggles and contestations of different groups, individuals and institutions due to the problems of governmentality occurring within and outside the control of the State. Within power struggles, this modern State acknowledges and strengthens modern, obstetric care. This eventually results in a situation where the State's approaches to reducing maternal mortality and morbidity turn into a charade for rural, poor women for whom it is intended.

In Bangladesh, women are dying and suffering from unnecessary, preventable causes. Breaking women's silence during childbirth by addressing values of both traditional systems and modern, technological systems will improve their health care practices. On the other hand, making health facilities more accessible and affordable recognizing needs of rural, poor women is critical to improve use of service facilities when it is needed. More importantly, women's socio-economic empowerment is a necessity. Without tapping the basic rights, women's human rights cannot be established. Thus, to improve maternal health in Bangladesh, women's rights to social and economic emancipation and access to health care are crucial for rural, poor women who undergo the miseries of life.