Comilla University Journal of Social Sciences
Volume 3 Number 1 December 2020
ISSN 2663-2659

Exploring Cultural Beliefs and Practices Associated with Maternal Health care: a Qualitative study of Salmanpur village in Cumilla city

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Abstract: *Maternal health issues have always been a key concern of any health care system. Though historically healthcare system of Bangladesh are mostly focused on mother and child health, but still this concern require more attention because of its connections with diverse socio-cultural affairs. Various cultural beliefs and practices may affect Antenatal Care (ANC), delivery, and Postnatal care (PNC) services. This study demonstrated an in-depth comprehension of people's cultural beliefs, attitudes, and practices towards pregnant women's association with maternal health care among middle-class Bengal families in a semi-urban area (Salmanpur in Cumilla city) of Bangladesh. Reviewing relevant articles and collecting primary data through nineteen (19) in-depth interviews with pregnant women and newborn mothers, their husbands, mothers-in-law, and community health workers, investigation on the concern issues were completed in the mentioned study area. Along with dietary restrictions, food taboos, movement and mobility restrictions, traditional approach to treatment, constraints of doing some other activities and, in-laws kin attitude, women shifting to parental from in-law's home were revealed as a customary practices. These beliefs and practices are proven as a bottleneck in receiving and continuing the comprehensive maternal health related services. Success of future pertinent interventions in ensuring maternal healthcare, further discovery of related cultural beliefs and practices's are important and their consideration are imperative.*

Keywords: *Maternal health, Belief, Practices, Customs, Barriers, healthcare.*

Introduction

The low and middle-income countries of the world struggle with their alarming number of mother and child deaths. The majority of these deaths take place at labor,

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delivery, and within the first 24-48 hours of the following birth (WHO, 2019). Bangladesh showed remarkable success in achieving Millennium Development Goals (MDG) 4 and 5 concerning reducing maternal mortality and infant mortality, but still, the circumstances need betterment. A few developing countries made notable platforms in reducing infant, mother, and child mortality in the last twenty years as it was a central element of the Millennium Development Goals and continues with a similar emphasis on Sustainable development Goals (SDGs) as well. Nonetheless, the progress in reducing levels of maternal mortality, and childbearing safer for women has been much behind than the target. An estimated 525,000 women mostly from developing countries die each year due to maternal complications (WHO, 2004).

The post-2015 maternal health strategy acknowledged overcoming two-thirds of preventable maternal mortality by 2030 from the 2010 baseline level of all countries (WHO, 2015). In the fourth Population and Health Program (1992), Bangladesh incorporated the maternal fatality levels declining and maternal health enhancement into fundamental policy and program intentions by the National Strategy for Maternal Health development (MOHFW, 2001). It signified the 'three stages' (antenatal care, care during delivery, and postnatal care service utilization and outcomes) framework of factors, also highlights the plan for emergency obstetric care (Thaddeus & Maine, 1994). However, the indirect factors of maternal mortality remain steady and data still unavailable in comparison to the primary or immediate determinants according to the Bangladesh Maternal Mortality Survey (BMMS) report 2001 and 2010. Immediate factors of maternal mortality have decreased progressively; nevertheless, about two-thirds of total maternal fatality happened throughout the postpartum stage (Roy & Shengelia, 2016). Based on reviewing relevant articles and grey literature and adopting qualitative tools of primary data collection (in-depth interview), this study demonstrated an in-depth comprehension of people's beliefs, attitudes, cultural reasons, patterns, and practices towards pregnant women associated with maternal health care among middle-class Bengal families in a semi-urban area of Bangladesh. These customary beliefs and practices are embedded with religion and culture. These are justified by practices of ancestors, and imperatives concerning maternal health care. Besides, the process of receiving 'three stages' care started residence's nearest healthcare (Chaudhuri & Mandal, 2020), thus, exploring relocation of pregnant women is significant in the continuation of ANC, delivery, and PNC services as well. Examining these traditional practices' concerns and connections with ensuring respective special health care services and their effect on maternal health is the expected outcome of this study.

Literature review

Despite the presence of effective health infrastructure in Bangladesh, the maternal health situation remained infirm, a substantial proportion of women deliver at home and report delivery-related complications (Fronczak, et al., 2005). Families often ignore very simple healthy practices as it is against tradition or common belief. Similarly, most people are not able to recognize when it is necessary to seek care for the mother or the baby (Haque et. al., 1997). The way of responding to sickness or seeking care varies by several factors that responsible for antenatal and postnatal care-seeking behavior (Uzma et.al., 1999). Poor socio-economic status of women, lack of physical accessibility, cultural beliefs and perceptions, the low literacy level of the mothers, large family size, and men's attitude towards women in a community determine their healthcare-seeking behavior (Ward et.al., 1997). These are also deep-rooted within the political, economic, cultural context, geographical, environmental, and organizational relationships (MacKian, 2003). Cultural beliefs and practices often lead to self-care, home remedies, seeking advice from elder women in the household, and consultation with traditional healers in rural communities (Nyamongo, 2002; Delgado et. al., 1994). These beliefs form an integral part of the oral traditions of rural Bangladeshi society in which elders pass down indigenous knowledge and beliefs through generations (Hossain & Chowdhury, 1987). Studies attained enormous traditional, cultural traits about food and diet in pregnancy such as confusing perceptions of hot and cold foods, and body habitus holds significance and importance to people (Nichter, 1987). In Bangladesh, giving birth to a child in a hospital or clinic considered as being "sick"; women with a defective body require hospital care (Afsana & Rashid, 2001). Though educated people are more cognizant, traditional and cultural practices and beliefs have a robust impact on the perinatal regularity formed under socio-environmental context (Kesterton & Cleland 2009). Studies asserted a large proportion of women don't believe in antenatal care benefits for themselves or their child that occurs a delay in seeking treatment for women and their children's illnesses (Choudhury & Ahmed 2011). The relation of socio-economic determinants is also significant; most families are unable to bear healthcare facilities for women and children, thus hiding their economic constraints with that belief and practice (Shahjahan et al., 2017). A requisite issue must be accorded that all traditional beliefs and practices in pregnancy and childbirth not always harmful, practicing those may not lead to major behavioral change (Raman, 2014). Only a few studies (Chaudhuri & Mandal, 2020; Gatrad et al., 2004; Rowther et al., 2020) focused on the importance of the place of residence of women for receiving PNC. They explained the socio-cultural aspects of shifting women to paternal home; nonetheless, no study assessed shifting maternal/paternal home along with diverse traditional belief and practices as a direct barrier of ANC, delivery or PNC.

Situation of maternal health care in Bangladesh

Amid developing settings, Southeastern Asia achieved striking improvement in twenty-five years, the rate of maternal mortality (MMR) declined to 66% (WHO, 2015). Importantly, the absence of qualified health caregivers is prevalent in 40% of childbirth in South-East Asia countries, which is a significant determinant for increasing MMR (WHO & World Bank, 2015; WHO, 2015). Hence, the community-level MMR data requires overt consideration in achieving the targeted rate of decreasing MMR. According to BDHS's recent report (2019), ANC receiving from health professionals increased from 64% to 82% since 2014, at least four times ANC visits during pregnancy increased from 31% to 47%, and the proposed coverage is 50% by 2022. The postnatal care receiving percentage is more than half from a medically trained provider within 2 days of delivery, but in the case of non-institutional deliveries, it is only 7%. Birth delivery at a health facility is 49%, which means 51% of women still beyond of accessing skilled birth delivery health facility (NIPORT & ICF, 2019).

However, pregnancy and childbirth-related health states still may cause a life-threatening situation, and more deaths and impediments than any other reproductive health problem in most developing countries (UNFPA, 1999). In Bangladesh, the utilization of health services is still far below any acceptable standard. Besides, the utilization of health services is a complex behavioral phenomenon (Chakraborty, et al., 2003), as the use of health services is related to the availability, quality, cost of services, social structure, health beliefs, and personal aspects of the users (Killeow, 2006). Studies reported only one in three women seeks treatment from a qualified provider (Koenig, 2007), although most of the women have awareness of dietary requirements, half of the women in a survey unchanged or reduced food intake during pregnancy (Shannon, et al., 2008). Many women practice various dietary taboos and food aversions. In most cases, clinical assistance requires only after appearing complications, childbirth is often considered as a test of endurance, and seeking care in pregnancy is assumed as instability of a woman. Many women are unable to receive adequate ANC while pregnancy is viewed as confidential (Walton, et al., 2013).

Materials and methods

Both primary and secondary data are considered in this study, and semi-structured in-depth interviews are adopted for collecting elemental data. A literature review on maternal and neonatal health-relevant beliefs and practices concerning safe motherhood has been explored in the study. PubMed, AnthroSource, and Science Direct electronic databases were used for searching relevant literature. A set of keywords [(*Traditional beliefs and practices) AND ("Pregnancy" OR "Anti-natal care" OR "delivery" OR "post-delivery*")] was used to search relevant literature

from databases along with advanced search to manage the large scale literature from databases. Therefore, from PubMed (360 articles), AnthroSource (578 articles), and Science Direct (681 articles) a total of 1619 articles were found. The selection process and inclusion criteria were determined by years (1990-2021), review articles, research articles, Anthropology, and Social science subject area, open-access type, and English language; eventually 25 articles are selected after forming inclusion criteria of articles. Scientific studies were selected going through the title and reading abstract and findings, directly and indirectly, connected with traditional beliefs and practices and their impact on pregnant women and newborn mothers' health care. Few articles and gray literature were collected before publishing 1990 due to the presence of relevant data for the study.

Primary data were collected from the semi-urban study village Salmanpur, ward no 24, situated in Cumilla City Corporation, Bangladesh. According to Bangladesh demographic and health survey 2017–18, only 47% of rural clusters get a government facility within their village, and NGO health facility is eight times higher in the urban area than a rural area. 22% of urban people have an access to a private facility within their village, in opposition; rural people get 3% of services (NIPORT & ICF, 2019). One of the research objectives of the study was analyzing attitude and practice regarding maternal health facility utilization. Studies found very similar practices among the poor rural women or women from the urban slums due to the dominance of the strong influence of culture and tradition in the area (Chowdhury, et, al., 2003; Uzma, et, al., 1999). Thus, the study selected a semi-urban area to examine if determinants of beliefs and practices of maternal health differ in a semi-urban area rather than in an urban or a rural area.

For this study, three financial status groups of the participants were defined as operational. Up to 15000 BDT household incomes category is poor, up to 40000 is middle, and 40000 up is rich. The educational attainment of participants assigned three grades; educated criteria admitted the education level from class five to ten and grade eleven+. Class One to four is classified in uneducated criteria. A total of 19 in-depth interviews were conducted with 4 pregnant women, 4 mothers of the newborn, 2 husbands of pregnant women, 2 husbands of newborn mothers, 4 mothers-in-law, and 3 community health workers (Family Welfare Assistant, Health Assistant, and Family Welfare Visitors). The study participants were selected purposively from the study population of pregnant women, newborn mothers, husbands of both the pregnant women and newborn's mother, and their respective in-laws. Selected respondents covered all the variations of the study population and were often involved and accountable to the related family decision.

Table 1. Demographic profile of respondents

Respondent	Age	Education	Occupation		Household Income (BDT) (Monthly)
			Wife	Husband	
Mothers of Newborn Babies	25	HSC	Housewife	Businessman	35000
	19	HSC	Student	Primary School Teacher	20000
	22	SSC	Housewife	Service Holder	15000
	26	BA (Hons.)	Primary School Teacher	Grocery Store Owner	25000
Pregnant women	21	HSC	Housewife	Businessman	30000
	28	Class 10	Housewife	Immigrant	50000
	20	SSC	Housewife	Van driver	12000
	25	Class 4	Tailor	Salesman	10000
Husband of Pregnant Women	27	HSC	Housewife	Immigrant	50000
	31	Class 10	Housewife	Carpenter	6000
Husband of the Mother of Newborn	27	Class 9	Housewife	Auto riksha driver	12000
	34	SSC	Housewife	Van driver	10,000
Mother-in-law of Pregnant Women	48	Class 3	Housewife		15000
	57	Class 3	Housewife		25000
Mother-in-law of a mother of Newborn	52	SSC	Housewife		40000
	49	SSC	Housewife		23000
Health Service Providers	24	SSC	FWV		16000
	32	Diploma	HA		12000
	28	SSC	FWA		12000

Data analysis and interpreting conclusions attended the thematic analysis procedure. Respective primary data notes and reviewed findings formulated several initial themes and sub-themes. Interviews were facilitated in the Bangla language, primary data were audio-recorded, and resulted in the transcribed verbatim. Transcriptions were translated in English by the trained graduated interviewer and for ensuring the essence of the meaning; translations were rechecked by the core research team members. Translation followed coding initially and through a cross-coder check, initial code lists were finalized from primary data. The process is

followed by open codes, axial codes, and finalized with selective codes. From these selective codes, a few themes and sub-themes have emerged which were cross-checked with review and followed by finalizing a finding structure's skeleton development. Data were compiled under those developed themes and sub-themes, and through few drafts, findings were finalized.

Health belief model (HBM) as a theoretical framework of exploring traditional belief and practices and their correlations with ensuring relevant health care

Considering the significant intersection between socialization and behavior/ practice (Lewin, 1951), this study acknowledged the health belief model theory (HBM) originated from theories in Cognitive Psychology to determine the relevance and significance of this research. The correlation between health beliefs and health-related behavior patterns indicates the influence of such behaviors on healthcare. The aspect of health and health behavior representation of individuals specified by two key beliefs: threat perception (awareness of health problems, and expected severity of the illness outcome) and behavioral evaluation. The HBM model centered on these two aspects and intended that, if appropriate beliefs are grasped, cues to action can activate health behavior. Personal understandings of symptoms, social influence, or health education operations might act as 'cues'. The model emphasized an individual's general health motivation or his/her concern regarding health issues and specified six more distinguished forms of health beliefs and practices (Sheeran & Abraham, 1996).

Individual's preventive health behavior signifies health-promoting (e.g. diet, exercise, and rest) and health risk behaviors; sick role behaviors particularly indicate adherence to prescribed medical regimens and clinic use refers to physician visits for a variety of reasons (Sheeran, & Abraham, 1996). As HBM is applied generally to predict health behaviors in a specific population, this study endeavored to search for individual's preventive health behavior, sick role behavior, and clinic use to learn traditional beliefs, practices, and connections with respective health care services and their effect on maternal health.

The framework helps to understand individual diversity in health behavior patterns and determined behavior change interventions. The study examined four major constructs: susceptibility, severity, benefits, and barriers; and estimated cues to action (health motivation-related) findings. Then the study examined the themes of combining maternal health care beliefs, and subsequently, explored how the maternal health care beliefs played role in negotiating the effects of socio-structural variables and past behavior.

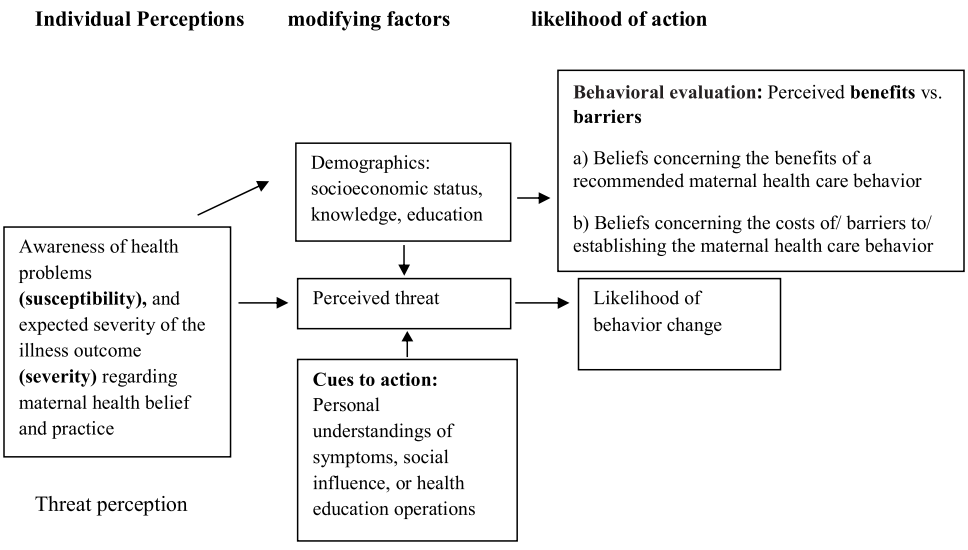

Diagram 1: Health belief model regarding maternal health beliefs and practices

Findings

According to UNICEF, as many as 27 different types of superstitions have been identified in Bangladesh that are harmful to achieving healthy and safe motherhood and contribute to the development of postpartum morbidity. Mostly these practices involved restriction of mobility, consumption of adequate food, and growth of the fetus (Rahman, et al. 2003). By examining existing literature and cross-checking through primary findings this study scrutinized 5 specific contextual base themes: (a) movement and mobility restriction during pregnancy b) Individual's preventive health behavior (dietary beliefs and practices) (c) sick role behavior (adherence to prescribed medical regimens) d) Shifting to the parental home for maternal care, e) susceptibility, and expected severity of the illness outcome regarding maternal health belief and practice

a) Movement and mobility restriction during pregnancy

The study findings ascertained that participants have a profound belief in supernatural phenomena as the reason for complications during pregnancy. Few socio-cultural beliefs, norms, and expectations against supernatural phenomena may have satisfying influences on delivery, the senior member of the family and in-law family members also support these views, practices, and involve monitoring pregnant woman's mobility.

Beliefs and practices	Ground/base of beliefs	Verbatim
Prohibition on going outside at night or in the afternoon, going outside without covering hair, avoiding the end of sari to trail on the ground, avoid walking through graveyards	wicked spirits are more aggressive in the evening, at noon, and night	*"Kharap batash (evil spirits) could cause a miscarriage of the fetus, I did not go outside in the evening, bod nojor (evil gaze) contracts the baby and the mother at that time"* (IDI, a lactating mother)
Carrying a piece matches and iron which would ensure protection	staying away from the evil gaze of the spirits and ensuring protection	--
Staying inside the home, restriction on eating, cooking, cutting, and twist anything, not laying down on the bed during eclipses	The child may suffer from a cleft palate or born with deformed features	"*Baby could undergo crack lips, ears, or fingers if we do cut anything at eclipses*" (IDI, a pregnant women)

b) Individual's preventive health behavior: dietary beliefs and practices

Numerous traditional beliefs, prohibitions, and prejudices during the pregnancy, early postpartum period, and in the postpartum period have been found which makes certain patterns of food consumption. Food taboos are also termed food trends and fallacies and vary with caste and creed. Due to the improper and unscientific beliefs, several foods were defined as excluded from the list of food items by respondents. As a result, pregnant mothers avoided highly nutritious food items, such as fish and lentils, as part of local practice and custom.

Beliefs and practices	Ground of beliefs
a pregnant mother should eat less Shouldn't drink water at the time of delivery of a baby	to maintain the growth of baby minimum for easy delivery
Newborn babies should not be given colostrum	the thick substance of milk may irritate the baby's stomach

Pregnant and lactating mothers should not consume eggs, pineapples, papaya, coconuts, banana, and prawn/ shrimp	duck eggs cause asthma to a child, pineapples, and papaya responsible for abortion, coconuts make a child's eye white or blind, banana causes tetanus in children, prawn or shrimp causes reduction of milk secretion
'hot' foods should be avoided in pregnancy 'cold' food during the postpartum period	Causes the delay delivery period may generate an inconsistency in postpartum
Children shouldn't drink cow or buffalo milk	baby could behave like an animal and would be less capable and dumbstruck
Having pair of joined banana	Women may give birth to twins
Women shouldn't eat cucumber and chicken	The baby may be born with ichthyosis, may have hairy skins, and may suffer from pneumonia.
Green herbs, pumpkins, and apples are dangerous	A 2-3 months old child may suffer from diarrhea if the mother consumes these foods.

c) Sick role behavior (adherence to prescribed medical regimens)

The study found the number of antenatal visits and postnatal care to the provider was low. The median time of the first visit was at six months of pregnancy, only one in few cases did women initiate antenatal care during the first trimester. While women are advised at the ANC sessions of the importance of fish and lentils food items, many avoided this food consistently due to food taboos. Several respondents and their families have beliefs in prescribed herbs and amulets by quacks, natural remedies, traditional food consumption as a medicine, and self-care. Still, people have stigmatization in terms of utilizing maternal healthcare from health clinics and hospitals. Child care and maternal issues are considered a natural process as well.

Beliefs and practices	**Ground/base of beliefs**	**Verbatim**
Health care from a hospital is not necessary	Only pregnant women with a defective body go for health care in hospital	*"Senior members of my in-law family advise me to keep myself in pardha and maintain all restrictions during pregnancy. My mother-in-law said I don't need any healthcare from clinic. I collected some tabiz (amulets) and herbs from the village kabiraj (quack), those will protect me and my child"* (IDI, a lactating mother)
Clinics and hospitals are only to treat patients and diseases	Giving birth to a child in a health facility represents the "sickness"	
If needed, home remedies, self-care, and traditional healer's advice are enough and prioritized in pregnancy	These are better than modern medicines. only complicated pregnancies can be treated in health clinic	
Supernatural aspects induce complexities during pregnancy	Doctors are not worthy to recover the evil gaze of bad spirits	

d) Shifting to the paternal home for maternal care

Pregnant women and lactating mothers in the study usually receive the 'three stages' care from the nearest healthcare of her residence. Most of the respondents live with their in-law family, mother-in-law or traditional birth attendants conducted their childbirth process. A common birth custom is women were shifted to their parent's house before giving birth or after. Therefore, a woman's place of residence is an influential factor for getting 'three stages' care. In semi-urban areas, female family members were provided support during pregnancy, delivery, and in mother and newborn care after birth; married women usually, relied heavily on their paternal kin for support. Most of the respondents shifted from in-law family to paternal family due to receiving proper care than in-law, some of them reported about in-law family member's attitude. However, a gap in receiving ANC and PNC has been observed, maintaining the schedule of receiving ANC from health service providers is discontinued due to shifting. It also happened again during PNC when they shift from their paternal home to in-law family after child delivery.

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Beliefs and practices	Ground/base of beliefs	Verbatim
Pregnant women prefer to stay in their paternal home than in-law home for more comfort and services.	During pregnancy in eight-ten months, pregnant women feel more unrest and ill than earlier, at that time they need extra care and rest.	"*I gave birth and I am not supposed to cook for 40 days. Because I am having regular bleeding after the delivery, my body is polluted. Cooking or touching utensils are not good for a 'poaati ma' (newly lactating mother) even. Other family members of my family give me food and services in my room.*" (IDI, Newly delivered mother)
women are considered to be impure after gave birth, They shouldn't touch and prepare any meals	Women bleed at least for forty days after their child's birth. They need paternal kin's assistance during this time.	
Routine prenatal and postnatal checkup is not required for healthy woman and child	Child delivery is a natural phenomenon	"*If the child is born without any difficulties, medical healthcare is not needed further. Delivery is a natural process; seeking care without reason should be avoided*." (IDI, mother of a pregnant woman)

e) Susceptibility, and expected severity of the illness outcome regarding maternal health belief and practice

The study respondents described a few more beliefs and practices regarding awareness of health problems and expected severity of the illness outcomes. Bad symptoms defined for health disorder mostly related to evil spirit drive or a consequence of food consumption. Among other beliefs, food and nutrition-related creeds are more imperative than other beliefs. The terrain of these beliefs and practices received from the older generation and mostly rooted in the everyday occurrences of people.

Beliefs and practices	Ground/base of beliefs	Verbatim
Pregnant women are prohibited to tie anything around her belly	The child might in danger due to binding the umbilical cord around its neck	"*My sis-in-law informed me about some household chores that should be avoided during pregnancy. Later my mother-in-law also advised me not to touch firewood or make a fire stove. I heard from my mother that cooking 'teller pitha' in pregnancy is a cause of having large ears of the baby"* (IDI, a newly delivered mother)
A pregnant woman must avoid touching firewood	The child might have pustules in the skin	
A pregnant woman must not make new fire stove	Baby may born with birthmark	
All kind of 'Teler pitha' (flapjack or patty) should not make during pregnancy	The child may carry large ears	
Buying new clothes	Could bring bad luck for the child	
Drinking kerosene oil or onion juice	Makes an urge to vomit, which will force to expel the placenta	

Respondent's socio-economic status and education are significant factors concerning the benefits and the barriers to establishing a recommended maternal health care behavior. Educated respondents of the study are more informed; still, their socio-cultural circumstances are reshaped by traditional and cultural maternal practices and beliefs. Most respondents are in the study sample from low-income families and unable to afford to consult qualified doctors. They seek health care services from unqualified providers such as village doctors, drugstore salespersons, and 'kobiraj' that may create a threat to the health and well-being of the unborn child.

Discussion

The majority of participants of the study carried beliefs surrounding dietary taboos, food aversions, movement and mobility restriction, and awareness of health problem preferences. Several strong and deep-rooted socio-cultural beliefs are grasped by respondents, their understandings of illness symptoms, threat perception (susceptibility, severity), and media of social influences assigned by elders. Subsequently, this situation activated their preventive health behavior such as diet or rest, health-seeking, and health risk behaviors. The findings of the study present evidence that due to personal beliefs and understandings of illness symptoms, many of the health problems remain untreated; even though services are available at the doorstep. Besides, existing studies also supported that cultural and religious practices regarding dietary behaviors are likely responsible for a child's lower average birth weight (Withers et al., 2018; Gatrad et al., 2004).

This study revealed that most respondent's maternal health problem awareness (susceptibility) and the expected hardness of the illness outcome (severity) are controlled by traditional health beliefs and practices; because these behaviors are deep-rooted within the political, economic, and cultural context as well as specific social relations. In terms of seeking initial guidance regarding three stages of care, most participants adopted the beliefs and practices of older women in the household. These factors are common amongst women, which result in a delay in seeking treatment for them. Indigenous belief systems formulate local causation modalities and explanatory models related to health and disease. Thus, before antenatal care and nutrition education contact, women already have developed detailed perceptions and belief systems related to pregnancy and childbirth. Therefore, medical health and nutrition education often is received and understood by local traditions and explanatory models (Gatrad et al., 2004) that hamper the ANC, delivery, and PNC service continuation.

The study findings showed that several families undergo lower wages and do not get an opportunity to learning; supporting healthcare facilities for women and children is hard for them, sometimes they hide their economic hardship with traditional beliefs and practices (Shahjahan et al., 2017). The study didn't find any significant distinction of belief and practices of maternal health in a semi-urban area in comparison to an urban or a rural area. The study found conflicts between local explanatory models and biomedicine knowledge in terms of food intake, healthcare, and medication adherence of pregnant women. The study result showed receiving three stages of care is challenged by few sturdy blocks. Most of the pregnant women shift from their in-law's families to their paternal families for child delivery. A gap raised in receiving recommended a minimum of four antenatal care visits from the registered healthcare center due to these shifts of placement. This study has few

shortcomings. Findings only represent the semi-urban area in Bangladesh. The study participants are self-reported, and data is not cross-checked.

Conclusion

Cultural beliefs and norms have a strong influence on maternal care practices among semi-urban households and override the success along with the beneficial effects of healthcare support intervention. Bangladesh's health system is historically focused on mother and child health care services, especially its primary health care level. Despite the presence of an impressive establishment of health infrastructure in the country, numerous maternal health practices are often compromised by various taboos and beliefs. Identifying and highlighting relevant cultural beliefs and practices during pregnancy, improvement in the care of obstetrical emergencies, influential health care system, and improved coverage of skilled attendance at birth require long-term planning to reduce the mortality and morbidity challenges. Initiating susceptibility of considering conventional beliefs and practices as barriers through the decision-makers and policy planners might ensure women ensuring proper ANC, delivery, and PNC services along with other nutritious dietary practices.

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