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Symbolic Violence and Gestational Anemia: The Invisible Power of the Husband in Therapeutic Adherence

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Abstract

This article investigates the non-compliance with medical recommendations for the prevention and treatment of gestational anemia among pregnant women followed at the Regional Hospital Center (CHR) of Séguéla, in relation to the exercise of marital authority. Relying on a qualitative approach based on semi-structured interviews, the study explores the social, cultural, and symbolic logics shaping prenatal health decisions—particularly in contexts where patriarchal norms continue to structure conjugal relations. Although some women exhibit a relatively high level of education or health awareness, the legitimacy of the husband as the head of the household and primary decision-maker remains a decisive factor. This authority manifests in the refusal or delegation of certain medical prescriptions, including iron supplementation, regular antenatal consultations, compliance with nutritional advice, and the completion of a Complete Blood Count (CBC) test, aimed at preventing anemia. By drawing on Bourdieu's theory of domination, the work of Sehi Bi Jamal on masculine legitimacy within the household, also Akindès work on the influence of beliefs on maternal nutritional practices despite a good understanding of anemia, and Coulibaly's research on food taboos, this article demonstrates that adherence to biomedical recommendations cannot be explained solely by individual, economic, or knowledge-based factors. Instead, it is rooted in deeply entrenched gendered power relations. The study underscores the urgent need to recalibrate maternal health policies to reflect these sociocultural realities, thereby enhancing the effectiveness of interventions aimed at combating gestational anemia and maternal mortality.

Keywords

Gestational Anemia, Non-Compliance, Medical Recommendations, Male

Domination, Gender, Séguéla

1. Introduction

Pregnancy is not merely a biological condition; beyond its physiological dimension, it constitutes a "total social fact" [1], involving multifaceted issues—bodily, economic, political, social, cultural, and symbolic—that give meaning to this state. The improvement of maternal health is a major public health concern across sub-Saharan Africa. Nevertheless, despite clearly established international guidelines, many pregnant women fail to comply with medical recommendations.

While existing literature commonly attributes this non-compliance to poverty, geographical inaccessibility, inadequate infrastructure, lack of information, or low educational attainment [2], sociological analysis remains underutilized. Yet it reveals powerful social norms that profoundly shape women's health decisions [2].

In Côte d'Ivoire, pregnancy management is embedded in social dynamics where marital legitimacy plays a central role. At the CHR of Séguéla, biomedical recommendations—such as regular antenatal consultations, adherence to nutritional guidelines, and completion of laboratory tests including the CBC—are often neglected by pregnant women. While economic and structural factors are frequently cited, sociological determinants remain largely underexplored.

Among these, marital power emerges as a structuring force that significantly influences pregnant women's autonomy and practices. Masculine domination persists within conjugal relationships, even when women possess some economic power, as demonstrated by [3]. Financial independence does not necessarily guarantee gender equality, particularly in relationships governed by hierarchical gender norms [4].

This study aims to demonstrate the influence of marital power on the observance of recommendations related to anemia among pregnant women followed at the CHR of Séguéla. It is anchored in a critical sociological framework inspired by the work of Pierre Bourdieu (1998) on masculine domination, where gendered habitus shape health practices that often diverge from modern medical prescriptions.

It also integrates the insights of Akmel Meless, who highlights that strong social norms—beyond poverty, education, and access to care—profoundly influence women's health decisions. The decision to seek care often depends on the opinion of the husband or mother-in-law, and some women believe that only "problematic" pregnancies require medical attention.

Additionally, the contribution of Akindès [5] reveals that women adopt health practices inherited from their mothers or communities, and their limited understanding of anemia should not merely be criticized but analyzed from a sociological standpoint. Even a good level of education does not guarantee compliance with nutritional advice. Cultural factors play a decisive role, as also illustrated by Herman C. [6], who shows how cultural taboos impact adherence to nutritional

guidelines in managing gestational anemia.

The working hypothesis of this study is that the non-compliance with medical recommendations by pregnant women at the CHR of Séguéla cannot be fully explained by the usual lenses of economic hardship or educational level, but rather by a system of internalized social norms legitimized through gender relations within the household and family.

2. Methodology

This research adopts a qualitative methodology underpinned by a comprehensive epistemological perspective [7], aiming to understand the meaning that social actors attribute to their actions.

Based on the assumption that social practices—in this case, the non-compliance with medical recommendations—are never neutral, but are embedded within systems of symbolic and relational constraints [8].

The study was conducted at the Regional Hospital Center of Séguéla. This town serves as the administrative capital of the Worodougou region in northwestern Côte d'Ivoire. According to the national health zoning, Séguéla and Kani constitute the two health districts of the Worodougou region, each with a CHR serving as an intermediate-level facility. The Ivorian health system operates as a pyramid, with Health and Social Promotion Centers (CSPS) at its base offering preventive and primary care, while CHRs like the one in Séguéla—established in 1998—provide a more comprehensive technical platform for managing intermediate-level cases and transferring severe cases to University Hospitals (CHUs) or national hospitals [9].

The CHR of Séguéla receives a diverse patient population from across the region and neighboring countries, thus offering a rich representation of the social realities in the Worodougou area.

The data collection took place between July and August 2022. A total of twenty-two participants were interviewed, including twenty pregnant women (comprising primiparous, pauciparous, and multiparous women, with a predominance of the second group), and two healthcare personnel from the antenatal consultation unit. All the women were of childbearing age, between 15 and 40 years old, and biologically active in terms of reproduction.

Participants were selected with the assistance of healthcare workers on duty during the data collection period. These professionals helped identify patient files that met the inclusion criteria for the study. The sample was constructed through purposive sampling and included only those pregnant women who had attended their first consultation but had not yet undergone the CBC test.

The final sample size was determined by the saturation of data—once the information became repetitive across interviews.

Semi-structured interviews were conducted in both French and Dioula. Where language posed a barrier, midwives, nursing aides, and even previously interviewed women were enlisted to translate the responses into French. Data pro-

cessing was carried out manually. Following a content analysis approach, data collected through handwritten notes, audio recordings, or videos were analyzed inductively—organized into meaning units, categorized, and synthesized to identify emerging patterns and relationships among facts [10].

The emerging themes were analyzed through the lens of Pierre Bourdieu's theory of domination, particularly using the concepts of symbolic violence and cultural habitus.

According to Bourdieu, "symbolic violence is a form of coercion that is exercised upon a social agent with their tacit complicity". It reflects the imposition of power relations that are not even perceived as such by the dominated. This form of domination operates with the unconscious consent of both the dominator and the dominated, as both internalize the system of domination.

As Bourdieu explains, "the dominated perceives the dominant through categories produced by the very structure of domination, which thereby serve the interests of the dominant". The analysis reveals two main outcomes related to the influence of marital domination on the compliance of pregnant women with medical recommendations for anemia care: symbolic violence and habitus. The habitus refers to the system of durable dispositions acquired by individuals over their lifetimes—unconscious principles of action, perception, and judgment—that shape behavior and are continuously influenced by new experiences [4].

3. Results

3.1. The Influence of Marital Domination on the Compliance with Recommendations among Pregnant Women at the CHR of Séguéla

3.1.1. Access to Health Information: Good Level of Health Awareness among Pregnant Women

To assess their level of knowledge about anemia, the pregnant women were questioned regarding their understanding of anemia. This knowledge encompasses their social representations of anemia, its symptoms, prevention methods, treatments, and associated risks.

1) Social Designations

From a social standpoint, the term used to designate anemia varies according to linguistic group, and is based on signs and symptoms. The following **Table 1** presents the social designations of anemia as expressed by the pregnant women interviewed. All of these designations refer, literally, to the common notion of "the blood is finished".

2) Knowledge of Symptoms

Regarding symptoms, 70% of the women interviewed stated that they recognized them, which is encouraging. However, 30% did not, which constitutes a risk. A lack of information may lead to delayed diagnosis and inadequate management.

3) Knowledge of Anemia Prevention Methods

A significant majority of pregnant women (65%) are aware of the means of preventing anemia and its associated risks. This indicates progress in education

Table 1. Social designations of anemia by the pregnant women (GES).

PREGNANT WOMAN (GES)	NATIONALITY	LINGUISTIC GROUP	SOCIAL DESIGNATION OF ANEMIA
GES 1	Ivorian	Dioula	Djerikodêssê
GES 2	Guinean	Dioula	Unknown
GES 3	Ivorian	Dioula	Bassiko
GES 4	Guinean	Peulh	Unknown
GES 5	Burkinabé	Sénoufo	Unknown
GES 6	Ivorian	Sénoufo	Unknown
GES 7	Guinean	Malinké	Djeritilô
GES 8	Ivorian	Baoulé	Unknown
GES 9	Malian	Maraka	Foretani
GES 10	Malian	Dioula	Bassité
GES 11	Nigerian	Bini	Sikla
GES 12	Malian	Malinké	Djeridêssê
GES 13	Ivorian	Baoulé	Unknown
GES 14	Guinean	Malinké	Bassité
GES 15	Guinean	Dioula	Djerisê
GES 16	Ivorian	Koyaka	Unknown
GES 17	Ivorian	Wôbbê	Wossénémonblé
GES 18	Ivorian	Dioula	Bassita
GES 19	Malian	Dioula	Bassiko
GES 20	Ivorian	Dioula	Bassité

about healthy eating and sanitary practices, although efforts remain insufficient to ensure optimal protection. Key preventive measures include a diet rich in iron (red meat, green vegetables, lentils, fortified cereals), iron and folic acid supplementation, vitamin C intake to enhance iron absorption, and regular medical check-ups to detect early deficiencies.

As for the perceived risks, the women link them directly to their representation of anemia as a potentially fatal condition for themselves and their unborn child. For them, life equates to blood—to lack blood is to die: anemia is "*djeriko dessê*" as expressed by Gestante 13, which literally means "the blood is finished".

The results show that most pregnant women have an understanding of this condition. They remain aware of the risks it poses to both themselves and their unborn babies.

As an old African proverb says, "He who has once been bitten by a snake fears even a vine". This wisdom suggests that the notion of "awareness" is closely associated with "caution", and that "health consciousness" relates to the preservation

of life. Indeed, the individual who is aware of the danger of a snake (through experience or hearsay) does not behave in the same way as someone who knows nothing about it: the well-informed individual takes fewer risks, while the less-informed one is more exposed—living dangerously out of ignorance. In other words, awareness protects and saves, while its opposite—ignorance—exposes and kills.

Without delving into semantic, philosophical, or psychological considerations, let us simply note that "consciousness is coextensive with life" (Bergson), and it is not unrelated to the order of human values. It is eminently ethical: "the conscious being, insofar as he disposes of his lived experience in accordance with what he ought to be, is essentially a logical and ethical being—a 'rational being' who aligns his feelings, desires, and knowledge with the various possibilities open to him" [11].

3.1.2. Non-Compliant Attitude of Pregnant Women toward Biomedical Standards: Non-Adherence to the Complete Blood Count (CBC)

In the management and monitoring of gestational anemia, several recommendations and tests are advised for pregnant women, including the CBC test (Complete Blood Count). In this study, compliance is assessed primarily through the completion of the CBC test.

1) Non-compliance Highlighted by Health Personnel

Interviews with healthcare staff revealed, among various difficulties encountered with patients, a recurring issue: non-compliance with medical recommendations, particularly the failure to carry out the CBC test. This test is frequently noted in prenatal consultation records as "not done", "to be repeated", or highlighted in large print.

This non-compliance was also clearly perceived in the interviews conducted with the pregnant women.

2) Evident Non-compliance Revealed in the Discourse of Pregnant Women

To gather information on whether the CBC test had been conducted, we asked the following question: *What tests have you undergone, and when?* The responses clearly illustrated this non-compliance, as evidenced by the following verbatim quotes:

- *"None, I haven't done any…"*
- *"No test, I'm going to do the ultrasound today."*
- *"Ultrasound yes, but no blood test."*

Among the 20 pregnant women interviewed, 95% had not undergone the CBC test, while only 5% had. Alarmingly, some women at full term—with a gestational age of 9 months—had not completed the CBC test. This is a concerning situation. Failure to perform this test may lead to health risks for both mother and child, such as late detection of anaemia, incomplete prenatal care, and potential neonatal complications. It is essential to perform the CBC test to ensure appropriate care and reduce pregnancy-related risks.

Unfortunately, despite a relatively high level of health awareness concerning

anaemia, the CBC test completion rate remains very low. Pregnant women implicitly prioritize certain tests over others—notably favouring the more expensive ultrasound (costing around 8000 CFA francs) over the CBC (which costs no more than 3000 CFA francs), allocating more than half the cost of the CBC to the ultrasound instead.

Thus, we observe a glaring non-compliance with the CBC test among pregnant women.

3.2. When Love Decides Care: Marital Symbolic Domination Amplified by Cultural Habitus

> "I didn't do anything because my husband said to pay only for the medicine."

This statement illustrates total dependence on the husband's decisions, despite the fact that the woman is at full term (9 months and 1 week of pregnancy). Analysing this situation through Pierre Bourdieu's theoretical framework—particularly the concepts of symbolic violence, cultural habitus, and social capital—allows for a deeper understanding of how maternal healthcare management is shaped by gendered power dynamics.

3.2.1. Symbolic Violence: A Silent Control Over Medical Decisions

Bourdieu defines symbolic violence as a form of domination that is unconsciously accepted, where individuals internalize and legitimize their own subordination without questioning it [8].

In this instance, the pregnant woman complies without resistance with her husband's opinion. She does not request additional tests or prenatal consultations, instead considering her husband's decision as a legitimate social norm. Her statement—"because my husband said"—clearly shows that the decision to seek medical care is not her own, but rather stems from the authority of her spouse, who imposes a framework of action that she does not challenge.

This tacit acceptance of the man's role as the sole decision-maker in health matters exemplifies symbolic violence. The woman does not perceive her own effacement as coercive but rather as part of a normalized social structure.

The husband thus becomes the main manager of medical care, while the woman adopts a passive, waiting posture.

Health decisions are often limited to the expenses the husband deems acceptable, rather than based on a comprehensive medical assessment of the pregnant woman's needs.

3.2.2. Cultural Habitus: Reproduction of Traditional Patterns in Medical Decision-Making

According to Bourdieu, habitus refers to the set of dispositions acquired by an individual through their sociocultural environment, which unconsciously shapes behaviours and perceptions.

In this case, the pregnant woman evolves within a social environment where

medical decisions are reserved for the man, while the woman follows his directives without intervening. This dynamic follows a social pattern where:

The husband acts as the primary manager of medical care;

The woman adopts a passive role;

Health decisions are determined more by the husband's definition of necessary expenses than by an objective medical evaluation of the woman's needs;

Pregnant women reproduce this model without questioning it, thereby reinforcing its cultural entrenchment across generations.

This social habitus prevents the pregnant woman from making autonomous decisions, as she does not perceive her role as active in managing her own health.

4. Discussion

This article has highlighted the influence of marital power on the non-compliance with medical recommendations among pregnant women. Two major aspects have been emphasized: the insufficient economic and educational levels as explanatory logics of non-compliance, and marital symbolic power as a mechanism of domination amplified by cultural habitus.

4.1. Insufficient Economic and Educational Levels as Explanatory Logics for Non-Compliance

It is not uncommon for pregnant women to deviate from medical recommendations, and such behaviour should not be immediately construed as negligence. Rather, it reflects a complex interplay of structural, cultural, and psychological factors. Limited access to health information, entrenched cultural norms, familial expectations, and anxieties surrounding the experience of pregnancy all contribute to this phenomenon

Most existing literature on health identifies poverty, low educational attainment, and lack of knowledge as key factors in the non-adherence to medical recommendations.

However, having a good level of education or health awareness does not automatically lead to adherence to medical recommendations among pregnant women.

As Akindes demonstrates in his article Anemia in Côte d'Ivoire: The Importance of a Sociological Approach, women engage in practices inherited from their mothers and social environment, and their limited knowledge of anemia should not simply be blamed. Rather, these behaviors must be understood through a sociological lens. Often, even educated women submit to the decision-making authority of their husbands, in-laws, or extended family.

In our study, most women had a good understanding of anemia and a solid awareness of health issues, despite not being formally educated. Nevertheless, they did not follow health workers' recommendations out of deference to their husbands' decisions. Our field data even include cases where women with a secondary school education (BEPC level) said they would wait for their husband's approval

before undergoing a CBC—the primary medical recommendation for the management of gestational anemia.

This finding demonstrates that knowledge and education alone are not sufficient to ensure women's autonomy in the structural dynamics of the household.

From an economic standpoint, having financial power does not guarantee that a woman will be autonomous in making decisions about her health. As Jamal Sehibi shows in his dissertation "Women's Financial Autonomy and Marital Dependence: The Illusion of Emancipation in Patriarchal Societies", even when a woman is financially independent, her decision-making power remains impacted by her husband's authority and his role as head of the household.

This was clearly observed in our study through the discourse of women who were not housewives and had independent income but were still subject to their husband's approval.

Let us illustrate this with the words of a respondent, who held a BEPC-level education and was financially independent. Despite her husband being away on a trip, she came to her prenatal consultation without having done the recommended tests, stating:

> "My husband is not here, he is traveling—I'm waiting for him."

This quote demonstrates that despite her financial independence, the woman is not autonomous in making decisions regarding her health. Financial autonomy does not automatically lead to decision-making autonomy.

4.2. Marital Symbolic Power as a Mechanism of Domination Amplified by Cultural Habitus

Empirical data show that in most couples, health-related decisions fall under the authority of the husband, who is recognized as the head of the household—the hierarchical figure within the family.

According to Pierre Bourdieu [8], women experience domination from their spouses as heads of the household. This form of marital symbolic violence is expressed through the symbolic role of "head", which cultural norms bestow upon the husband. These values and norms are typical of patriarchal societies.

This domination is not solely external but also internalized and perpetuated by women themselves. They adopt gender norms that define their place as subordinate. This internal domination corresponds to the cultural habitus described by Bourdieu—the transmission of social rules and norms from one generation to the next.

This form of domination directly impacts the adherence of pregnant women to medical recommendations.

Our study confirms this. Decisions regarding pregnant women's health are contingent on the husband's approval. This is clearly illustrated in the following quote:

> The refusal to undergo a CBC test stems from the husband's decision-mak-

ing authority—an authority socially legitimized by norms and cultural rules that are amplified and perpetuated by the cultural habitus well described by Bourdieu.

These habitus explain the non-compliance of pregnant women through the legitimized authority of men as the hierarchical guarantors of the household.

5. Conclusions

This article on non-compliance with medical recommendations concerning anemia among pregnant women at the CHR of Séguéla has highlighted the influence of marital symbolic domination, amplified by cultural habitus, on women's health decisions. Neither educational attainment, health awareness, parity, access to care, nor even financial power can sufficiently explain these non-compliant behaviours. Only a sociological approach to gender power dynamics can reveal their underlying logic.

-Raising Awareness Among Men About Maternal Health

Engaging men in maternal health is a critical yet often overlooked dimension of public health strategies. Traditional gender roles and sociocultural norms frequently position maternal care as a women's concern, thereby excluding men from discussions and decisions that profoundly affect family well-being. Promoting male involvement requires targeted education campaigns, community outreach, and policy initiatives that challenge stereotypes and emphasize shared responsibility. When men are informed and emotionally invested, they are more likely to support prenatal care, accompany partners to medical visits, and contribute to healthier maternal outcomes.

-Involving Couples in Healthcare Journeys

Promoting the active participation of couples in maternal healthcare pathways strengthens both emotional and clinical outcomes. Beyond the individual experience of the pregnant woman, healthcare decisions are often influenced by dynamics within the couple. When partners engage together—from prenatal consultations to childbirth preparation, they foster shared understanding, reduce anxiety, and build mutual support.

-Training Healthcare Workers on Gender Relations and Cultural Norms

Integrating gender-based education into the curricula of health professionals is essential for developing inclusive and respectful care practices. Training must address social constructions of gender, patterns of conjugal domination, and prevailing cultural norms that shape patients' experiences, particularly among women.

-Strengthening Pregnant Women's Autonomy through Dialogue-Based Support

Fostering the autonomy of expectant mothers requires more than medical guidance—it calls for the creation of safe spaces where their voices and choices are genuinely heard. Establishing support groups focused on conjugal negotiation enables women to reflect on power dynamics within their relationships, share expe-

riences, and gain tools to assert their needs.

-Strengthening Collaboration with Community and Religious

Building alliances with community and religious leaders is pivotal in reshaping social norms and advancing reproductive health. These figures hold moral authority and cultural influence that can be leveraged to promote gender equity, challenge stigmas, and foster more inclusive health practices.

-Leaders & Integrating Conjugal Power Dynamics into Reproductive Health Policies

Incorporating analyses of gender relations and conjugal power into national health programs ensures that reproductive policies are grounded in social realities. Recognizing how marital dynamics affect women's autonomy and access to care allows for the development of interventions that are culturally sensitive, rights-based, and socially transformative. Bridging these dimensions enhances the effectiveness of public health efforts by rooting them in both structural change and communal engagement.

-Revising Health Policies to Include Indicators of Informed and Voluntary Male Participation

To build more equitable and inclusive reproductive health systems, it is crucial to reframe male involvement not as a top-down directive, but as a process grounded in informed consent and relational responsibility. Policies should include measurable indicators that reflect men's voluntary engagement—such as participation in prenatal visits, shared decision-making, and support during postnatal care—without reinforcing patriarchal oversight or coercive dynamics. This calls for a paradigm shift where male presence in maternal health is encouraged as a supportive act, not an act of control. Institutionalizing such indicators helps track progress while ensuring that gender equity remains at the core of public health programming.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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