ORIGINAL ARTICLE

Access to Health Care Services of Rural Women in Dhamrai Upazilla of Bangladesh

KHAN S[1], KHAN S Z[2], CHOUDHURY S[3], AZIM E[4]

Abstract

Introduction: *Women constitute about 49.5% of the world's population. Besides, women are special in a way that their biology is different than that of the men and it has been seen that prevalence of women specific disease is getting high. Access to health care services is critical to good health yet rural residents face a variety of access barrier. Rural women health care services in Bangladesh are inadequate to say the least. The objective of this study was to find out the accessibility and obstacles to receive health care services of women in rural areas in Dhamrai Upazilla of Bangladesh.*

Methods: *A descriptive type of cross sectional study was done among 325 rural women aged 18 years and above in Dhamrai Upazilla of Bangladesh from January 2019 to March 2019, by face to face interviewing the rural women using pretested semi-structured questionnaire. The collected data were analyzed manually and by using MS Excel.*

Results: *According to this study, majority (35.4%) of the respondents were within age group of 18-27 years, 63.1% were Muslims and 67.7% of the respondents were married. About 36.9% of the respondents were educated up to primary level whereas 18.5% of them could sign only. Highest proportions of the respondents (83.4%) were home maker. More than half (56.6%) of the respondents lived in joint family and most (67.3%) of the respondents' monthly family income was within Tk.10,000 –Tk.20,000. Majority (96.6%) of the respondents felt the need of health care services. However, 41% could always afford to access the health care service and 32.2% of the respondents mentioned the most available health care facility was Community Clinic. Only 14.8% of the respondents received the required health care services very easily and about 12.2% women told not to attend health care centres due to lack of permission from family. It was found that 64.6% of the respondents received adequate information about the health care services and majority (29.6%) were informed this from their relatives and neighbors. More than three fourth of the respondent (79%) got treatment from the adjacent places and 16.3% of the respondent who did not attend the health care centers for illness and highest proportion (39%) gave the reasons as lack of financial support (39%). But About 36.9% of the respondents faced delay in making an appointment with a doctor and most of the respondents (87.7%) did not experience gender discrimination while receiving health care by health care providers.*

Conclusion: *To create awareness in terms of access of health care services it is recommended to encourage female literacy, provide employment opportunities for rural female and abolish cultural norms that stigmatize women related health problems.*

Key words: *Health care service, Accessibility of health care, Health of rural women*

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1. Dr. Sheela Khan, Associate Professor, Department of Community Medicine, Green Life Medical College, Dhaka, Bangladesh.
2. Dr. Sharmin Zaman Khan, Assistant Professor, Department of Community Medicine, Green Life Medical College, Dhaka, Bangladesh.
3. Dr. Shamima Choudhury, Assistant Professor, Department of Community Medicine, Green Life Medical College, Dhaka, Bangladesh.
4. Dr. Ehsamul Azim, Associate Professor & Head, Department of Community Medicine, Green Life Medical College, Dhaka, Bangladesh.

Address of Correspondence: Dr. Sheela Khan, Associate Professor, Department of Community Medicine, Green Life Medical College, Dhaka, Bangladesh, Email: sheela_khan07@yahoo.com

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Introduction:

Women's health is an example of population health. Because the health of the women determines the health of future generation. But the prevalence of women specific diseases is high. Many social, cultural and geographical factors as well as education level and poverty have been reported to play roles in the poor utilization of health services.[1,2,3] Access to healthcare has been highlighted as the major barrier towards the utilization of maternal health services in low-income countries, especially in sub-Saharan Africa (SSA).[4,5,6] Access to healthcare can be broadly defined based on availability, affordability, accessibility and acceptability[7] but is simply referred to

as the timely use of health services to achieve the desired health outcomes. Each ward now has at least one dispensary and/ or health center, each district has at least one hospital, while each division has at least one referral hospital. Despite agreement that access to healthcare must be universal and guaranteed for all on an equitable basis[8] women continue to face significant inequities in accessing and using healthcare particularly in low-income countries.[9] In relation to the problems experienced by women in accessing healthcare, the following four major problems have been addressed in previous studies: obtaining permission,[10,11] obtaining money,[12] distance to the health facility[13] and not wanting to go alone (lack of spouse or family member escort).[14, 15]

The problem of access to health care is particularly acute in Bangladesh. One crucial determinant of health seeking among rural women is the accessibility of medical care and barriers to care that may develop because of location, financial requirements, bureaucratic responses to the patient, social distance between client and provider, and the sex of providers.[16]

The main aim of this study was to find out accessibility and barriers that become hindrance to women's access to health care services which may provide data for planning, implementation and evaluation of health care programs that would enable them to lead a productive life and ultimately contribute in the development of the country.

Methods:

This was a cross-sectional study, which was a descriptive type of observational study. Study was conducted from January 2019 to March 2019. The study was carried out in the villages of Dhamrai Upazilla namely Barigaon, Keliya and Shuapur. Population was the women of 18 years and above in rural areas of Dhamrai Upazilla, Dhaka. Sample size was 325 women and sample technique was non-probability purposive type of sampling. Data were collected by face to face interviewing of women of 18 years and above using semi-structured questionnaire which was developed, pretested and finalized before data collection. Data were collected on socio-demographic details of the respondents and on health care service related information, availability and affordability of health care services and accessibility of health care services. After collection of data each questionnaire was checked for inconsistency. Then the data were analyzed manually and some portions by using computer based software- MS Excel.

Results:

About 35.4% women's' age was between 18 to 27 years, 67.7% were married , 23.4% were unmarried, 7.1% were widowed, 36.9% women had primary level education and 83.4% mothers were homemakers, about half (56.6%) of the respondents were from joint family and 67.3% women's monthly family income was 10001- 20000 taka. (Table- I)

Table- I

Distribution of respondents by socio-demographic characteristics

Socio-demographic characteristics	Frequency (n)	Percentage (%)
A. Age of respondents in year		
18- 27	115	35.4
28- 37	95	29.2
38- 47	55	16.9
48- 57	29	8.9
58-67	31	9.6
B. Marital status of respondents		
Unmarried	76	23.4
Married	220	67.7
Divorced	06	1.8
Widow	23	7.1
C. Educational status of respondents		
Primary level	120	36.9
No formal education	75	23.1
Can sign only	60	18.5
Up to SSC level	39	12.0
Up to HSC or above	31	9.5
D. Employment status of respondents		
Home maker	271	83.4
Student	13	4.00
Service holder	12	3.7
Business	25	7.7
Teacher	04	1.2
E. Type of family of respondents		
Joint family	184	56.6
Nuclear family	141	43.4
F. Monthly family income in taka		
10001- 20000	219	67.3
20001- 30000	52	16
0- 10000	29	8.9
>40000	25	7.8

About 96.6% women had opinion about necessity of the health care service, 82.5% had affordability of health care needs where about 91.1% women had knowledge of when to attend healthcare service facilities and 64.6% women had adequate available health care service information. (Table- II).

Table- II

Distribution of respondents according to health care service related information

Variables	Frequency (n)	Percentage (%)
A. Opinion about necessity of the health care service		
Yes	314	96.6
No	11	3.4
B. Bearing affordability of health care needs		
Yes	268	82.5
No	57	17.5
C. Knowledge about when to attend healthcare service facilities		
Yes	296	91.1
No	29	8.9
D. Adequacy of available health care service information		
Yes	210	64.6
No	73	22.5
Unsure	42	12.9

Highest proportion (29.6%) of the women got information about available health care services from relative. About 14.4%, 12.6%, 7.9% and 5.8% women got information about available health care services from school, hospital, health assistant and local pharmacy respectively. (Figure- 1)

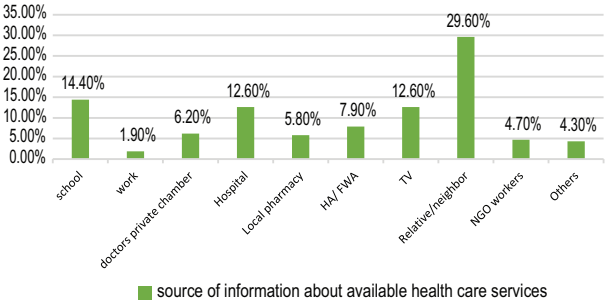

Figure-1: *Distribution of women according to source of information about available health care services*

About 52.3% women received needed health care service easily where 32.9% found it difficult. Here 6.1% never had financial affordability to access health care service. Highest proportion of the respondents (35.8%) told that health care facility available at community clinic for them. More than half (60.3%) had experience of financial difficulties for spending on health care sometimes, 64.5% women postponed health care visit because of cost. (Table-III).

Table- III

Distribution of respondents according to availability and affordability of health care service

Variables	Frequency (n)	Percentage (%)
A. Receiving the necessary health care services within 12 months		
Easy	170	52.3
Difficult	107	32.9
Very easy	48	14.8
B. Financial affordability to access health care services		
Sometimes	172	52.9
Always	133	41
Never	20	6.1
C. Places where health care facility are available for the respondent		
Community clinic	116	35.8
Upazilla health complex	104	32
Hospital	105	32.3
D. Experience of financial difficulties for spending on health care		
Sometimes	196	60.3
Never	129	39.6
E. Postpone health care visits because of cost(n=322)*missing data present		
Never	209	64.5
More than two times	116	35.5

Highest proportion (51.1%) of the women suffered from fever, 16.3% and 9.2% were suffered from hypertension and gynecological problems respectively. During illness 83.7% women attended at health care centre, 35.5% faced delay in availing necessary medicines, 36.9% faced delay in accessing appointment with doctor and 21.9% faced delay in accessing treatment intervention.(Table- IV)

Table- IV

Distribution of respondents according to accessibility of health care service

Variables	Frequency (n)	Percentage (%)
A. Types of illness suffered in last 12 months (n=392) *Multiple responses		
Fever	166	51.1
No morbidity	143	44
Hypertension	53	16.3
Gynecological	30	9.2
B. Attending health care centre during morbidity (n=270)* Missing data		
Yes	272	83.7
No	53	16.3
C. Delay in availing the necessary medicines		
Yes	115	35.5
No	210	64.5
D. Delay in accessing appointment with a doctor		
Yes	120	36.9
No	205	63.1
E. Delay in accessing a treatment intervention		
Yes	71	21.9
No	254	78.1

Highest proportion (39%) of the women did not attend health care center due to lack of financial support, 12.2 % due to not getting permission from family, 8.1% due to transportation problem and about 6.1% due to distant from home. (Figure- 2)

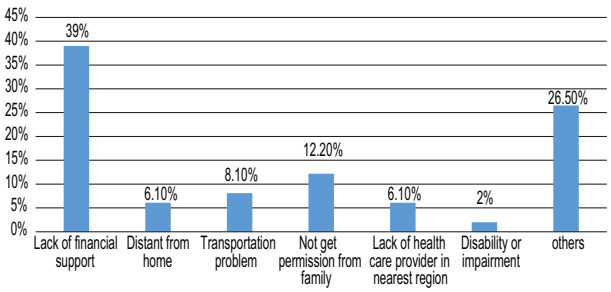

Figure-2: *Distribution of women according to reason for not attending health care centres*

About 18% of the women's care seeking place was another city and 3% was another region. (Figure- 3)

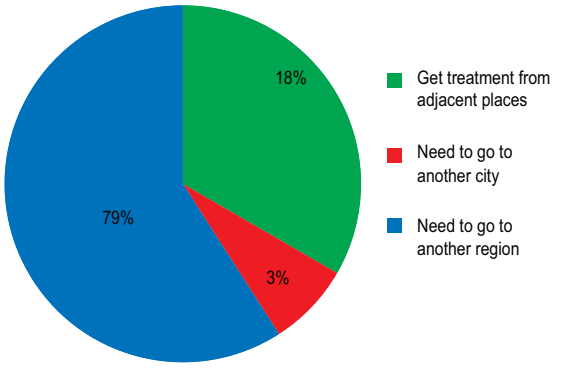

Figure-3: *Distribution of women by their care seeking places*

Discussion:

In this study the major proportion of the respondents were within the age group of 18 –27 years (35.4%). Most of them (63.1%) were Muslim and 36.4% were Hindu. The marital status of the respondents showed that 23.4% were unmarried, 67.7% were married, 1.8% were divorcee and 7.1% were widowed. About 83.4% were home maker and only 3.7% were service holder. In comparison to the study 'Brutal neglect: Australian rural women's access to health services', majority of the respondents that is 33% were within the age group of 45 – 54 years. Most of them (80%) were married and 4% were divorced, 5% were widowed, 3% separated and 8% were single. About 79% of the respondents were earning.[17] Among the respondents who believed that the information is adequate 14.4% got the information from school, 1.9% from work, 6.2% from doctor's private chamber, 12.6% from the hospital, 5.8% from the local pharmacies, 7.9% from health assistant or family welfare assistant, 12.2% from television, 29.6% from relatives or neighbors, 4.7% from NGO workers and 4.3% from others. As compared to the study conducted in America, 85% had TV, 54% had relatives and neighbors, 51% had newspaper while only 38% had health professionals as their source of health related information.[18] According to the Health Bulletin 2016, about 63.2% did not have enough information about health care services and did not know where to go.[19] Present study illustrates that accessibility to the needed health care services within past 12 months was easy for 52.3%, very easy for 14.8% and difficult for 32.9%. Also, 41% can always afford to access the health care services, 52.9% can sometimes afford and 6.1% can never afford to access the health care services. Financial difficulties as a result of spending on health care was experienced by 60.3% sometimes and 39.6% never experienced any problems.

According to the respondents, majority (35.8%) of the respondents sought the health care facility from Community clinics, 32% from UHC, 32.3% from Hospital. On the other hand, in the study "The Disease Pattern and Utilization of Health Care Services in Pakistan", majority (57%) of the respondents sought health care services from private doctors/clinics, 26% from government hospitals and 13.7% from hakeem/ homeopaths. Only a very small proportion (3.3%) of the respondents has reported visiting community health workers/lady health visitors and faith healers.[20]

As per our study, over the last 12 months, 44% had no morbidity, 51.1% had fever, 16.3% had Hypertension, 9.2% had Gynecological Problem. In contrast to the survey in the article 'Disease pattern and Health Seeking Behavior in Rural Bangladesh', 33.2% suffered from fever, 24.9% from gastrointestinal diseases and 17.8% from respiratory diseases.[21] Of the respondents, 83.7% attended health care center for their illness while 16.3% did not receive any health care services because of various reasons like lack of financial support (39%), not getting permission from family (12.2%), transportation problem (8.1%), distant from home (6.1%) and lack of health care providers in nearest health centers (6.1%). In contrast, a survey conducted by BDHS described that 80% of rural women live in hard to reach areas of our country with no nearby health facilitates, 54% mentioned a lack of confidence in the health care services, 71.4% faced financial constraints, 44% inability to get family permission; 49.2% difficulty to get someone to accompany them due to security and cultural norms.[19] When asked about any delay in health related services, 36.9% had delay in making an appointment with a primary care doctor , 21.9% had delay in accessing a treatment intervention and only 35.5% had delay in taking required medicine, which is quite high as compared to the scenario of America reported in 'Health disparities in rural women' published by The American College of Obstetricians and Gynecologists.[20] Seventy nine percent of the respondents preferred to receive treatment from the adjacent places. Only 21% had to travel far to get themselves treated, which if compared to the report 'Health disparities in rural women' is less which is about 10%. [22]

Conclusion:

To find out the access and obstacles to receive health care services of women of Dhamrai Upazilla, Bangladesh, this cross-sectional study was carried out. The study found that majority of the respondents were within the age group of 18-27 years, married, Muslim, housewives and were educated up to primary level. Of the women, who did not attend the health care services, cited various reasons responsible for it. These include lack of financial support, not getting permission from family, transportation problem, distant from home and some of them even mentioned their disability as a reason. About nine out of ten women knew when to attend the health care services and most of the respondents believed the information is adequate. According to the study, almost all the respondents had health care services available to them. The main hindrance in accessing the health care services as cited by the respondents was financial problem with significant number of people reducing the expenditure on primary essential needs.

Access of health care services to rural women can be improved by increasing income generating activities of the family, improving services of community clinic, overcoming all social and family obstacle and finally arranging of health education programs periodically for the rural family.

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