Vol. 02, No. 01, Jan 2004

ORIGINAL ARTICLE

Under–Utilization Of Health Care Services By Rural Community Of Bangladesh

Farhana Dewan[1], Zaman Ara[2], Anowara Begum[3], Mstm. Rashida Begum[4]

Abstract

The study was carried out on Hundred women of reproductive age and twenty one village leaders in Rupgonj thana of Narayangonj district. Rupgonj is about 34 kilometers north – east of Dhaka across the river Shetalakhya. About 99% women said that they were aware about the existence of the health center; all of them admitted that they were aware of the fact that should go to the hospital during illness. Although 99% of the women were aware of the service delivery system in the THC, only 56% showed their interest to go there. The remaining 44% were not interested to go even during sickness. Sixty five percent of women said that they had gone to a center in the past. Forty eight women reported that they were satisfied with the treatment which they had received in the center. All women who had some formal education knew about the existence of THC. There was no significant association between education & willingness to attend THC but willingness was more among illiterate women. The low-income group went to the hospital more then the high-income group. All the men knew about the health center. Eleven men responded by saying that they wanted to go to the health center when need arose.

Introduction

Health for all by the year 2000 is a resolution promulgated by World Health Organization (WHO), which has been accepted by most nations as a worth while goal. The central theme of "HFA/ 2000" is universal access to health care.

Women in developing countries are frequently confronted with a myriad of socio- cultural factors which negatively impinge upon physical well- being and accessibility to appropriate health care services. Factors such as income, legal rights, social status, and education may prove far more important in determining women's access to health care than technology distribution and government strategies.[1]

In rural Bangladesh gender of the patient may be an important determinant of a family's willingness to pay for health care. Urban females also have decreased access care compared to men.[2]

Inadequate access to modern health services and their under utilization are the major reasons for poor health conditions in the developing countries. A variety of private care providers working in village and bazars are the only practitioners unusually available for village people in Bangladesh . Often women problems are treated only by senior female relatives.[3]

A focus group discussion revealed that in the community, pregnancy, particularly was not considered to be a risky event and therefore hospitalization was not considered routinely. Decision to undertake hospital care was taken mostly by males, and rested to a great extent on the existing reputation of a clinic. The reputation of a clinic was found to be a very important factor. An MCWC having a good name attracted a large number of patients. In a lower performing MCWC, a disruption of delivery services for about a year resulted in a major decline of client flow.[4]

1. Associate Professor of Gynae & Obs HFRCMCH
2. Asst. Professor Community Medicine SSMC
3. Ex. Professor of Gynae & Obs Dhaka Medical College Hospital
4. Asst. Professor of Gynae & Obs HFRCMCH

Materials & methods

Study design:

A community based cross- sectional descriptive study was designed to determine the factors of underutilization of health care services.

The study was carried out in Rupgonj thana in Narayangonj district. Rupgonj thana is about 34 kilometers north – east of Dhaka across the river Shetalakhya.

A house to house survey was carried out to interview women of that village Data on socio – demographic variables and knowledge and attitude of the village women regarding utilization of the existing health care services were collected during these interviews. Information on the constraints related to the attendance to the health facility were also collected.

Study population:

There were two study populations, village women and village, leaders. The main study population consisted of village women of reproductive age group.

A total of 100 women of reproductive age group were selected by systematic random sampling method and then interviewed using an interview schedule containing questions on socio–demographic information as well as factors determining under–utilization of existing health care services.

The second study population consisted of the village leaders. living in or near the village who had some influence on the community. They were identified using multiple sources. After data collection, analysis was done. Twenty one village leaders were selected.

Research Assistant:

A research assistant was recruited for data collection. The research assistant was a qualified female village practitioner. House to house survey was carried out by her. She interviewed village women using an interview schedule. She schedule women by random sampling and obtained their consent for interview.

Brief description of the study village:

The study area is about 34 km north-east of Dhaka across the river Shetalokhya. It consists of nine unions, one union, named Kayetpara, about 18 sq. miles consists of 41 village. Total population of the union is 40,57 (according to 1981 census). A village named Magenanadirpar was selected from that union, the village has reasonable access to some Govt. medical facilities so that reasons other than unavailability for the non-use of these services could be detected.

Results:

Table I-Age group of the respondents (n = 100)

Age group (yrs)	No. of respondents	%
15 – 20	10	10
21-25	25	25
26-30	29	29
31-35	25	29
36-40	11	11

The women interviewed varied between 15–40 years in age. Most of them ranged between 21–35 years (79%) only 10% were below 20 years and 11% were more then 35 years of age.

Table II-Number of Family Members

No. of family member	No. of respondents	%
7-9	24	24
5-6	42	42
3-4	30	30

The average family size was 5-6. Amongst them 42% had family members in between 5-6, 30 % had between 3-4 members and 24% had family member between 7-9.

Table III-Education Status
(n = 100)

Level of education member	No.	%
Illiterate	51	51
Some formal education	49	49
- 1 –5 (Primary)	31	31
- 6 –10 (Sec)	13	13
- > 10 (>Secondary)	05	09

Fifty one women had no formal education or were illiterate. Thirty two percent of women had history of some formal education but did not complete primary education, 13% completed primary education, some of them also attended high school, but did not complete secondary school. Only 5% completed is Secondary education and some of them had some exposure to higher education.

About 67% educated women reported attending THC for treatment while only 33% reported not attending THC and this difference is statistically significant ($P < 0.05$).

Regarding occupational status, 99% were house wife and only 1% was working. She worked as a family welfare assistant (FWA).

Table IV-Monthly Income

Monthly Income	No.	%
Tk. 1000 - 2000	48	51
Tk. 2000 – 3000	23	23
Low Income group	71	71
> Tk. 3000/-	29	29

The association between low and high income group with attendance of THC revealed that the low income women (<Tk. 3,000/-) went to the hospital more than the high income women. Among the high income group, more women went to the hospital for treatment and this relationship between attending and non attending women in high income group is statistically significant ($P < 0.05$).

Although 99% of women were of the service delivery system in the Thana Health Complex (THC), only 56% showed their interest to go to the hospital to get treatment. The remaining 44% were not interested to go to the health center even during sickness.

Table V-Reasons for unwillingness to go to the center

Common reason	Specific reason	Associated reason	Total
Lack of medicine	0	20	20
Unfriendly behavior of doctor	2	15	17
Expense of treatment	4	25	29
Health Center far away	9	28	37
Absence of female doctors'	0	2	2

Table V shows the single and multiple reasons for unwillingness to go the hospital for treatment. Thirty seven percent of the study women told that were not interested to go to the hospital as the health center was far away. Amongst them 28% also mentioned other reasons apart from it. Expensive treatment was the reason mentioned by 29% of the women for not going to the Hospital. Only 4% mentioned it as the only cause unfriendly behavior of the health personnel was the reason of 17% study population and only 2% mentioned it as the sole cause. According to 20% of study population lack of medicine and only 2% mentioned that lack of female doctors was the only cause for them for not going to the hospital.

Table VI-Obstetric & Gynecological reasons for attending Thana Health Complex

Reason	No.	%
Menstrual problem	7	21.21 %
Abortion	2	6.06 %
Vaginal discharge	1	3.03 %
Antenatal care	11	33.33 %
Antenatal care & Family Planning	3	9.10 %
Family Planning	7	21.21 %
Eclampsia	1	3.03 %
Delivery	1	3.03 %
Total	33	100 %

Table VII-Other reasons for attending Thana Health Complex

Reasons	Specific problem	Associated Problem	Total	%
Diarrhoea	6.42	8	14	25.0 %
Eye, Ear & Dental Problem	4	0	4	7.14 %
Fever, headache weakness, burning feet	3	11	14	25.0 %
Peptic ulcer	1	2	12	21.43 %
For vitamin	1	4	3	5.36 %
Pain abdomen	0	4	4	7.14 %
For Antihelminth	0	3	3	5.36 %
Skin disease	0	2	2	3.57 %
Total	15	41	56	100.0 %

Table VI & VII reveals the various reasons for which the village women attended the health center including obstetrics & Gynecological causes.

Referring to the expenditure for attending and receiving treatment from THC, 18 women reported they had spent at least some amount of money including their transport cost. Only 5 women could remember the amount of money they spent in the THC, The amount of money spent by them was between Tk.60/- to Tk.400/-.

When asked about the satisfaction of the service of the Health Center, 48 women (37.85%) reported that they were satisfied with the treatment which they had received in the center. Seventeen women (26.15%) were not satisfied with the treatment in the Health Center.

Table VIII-Reason for not being satisfied (n = 17)

Reasons	Specific cause	Associated cause	Total	%
Lack of medicine	1	12	13	76.47
Unattentiveness of the doctor.	1	10	11	64.70
Unsatisfactory reception	1	7	8	47.06
Demand of money for service & medicines	0	2	2	11.76

Lack of medicine, unattentiveness of duty doctors, unsatisfactory reception were the main reasons reported by the village women for not being satisfied with the services given in Thana Health Complex. Fourteen women reported combination of any of these causes and only 3 women mentioned only one reason of their unsatisfaction.

Relationship between existence of thana health complex and socio-demographic varables:

Education

There was no significant relationship between education and the knowledge about the existence of THC.

All women who had some formal education knew about the existence of Thana health Complex, and about 98% of illiterate women know about it as shown in Table I.

Table IX-Knowledge of the existence of Thana Health Complex

Education	Knowledge of the existence of Hospital		Total
	Yes	No	
Illiterate	50 (98.04%)	1 (1.96%)	51
Formal education	49 (100%)	0	49
Total	99	1	100

While about 98% of the illiterate women reported their knowledge about the existence of THC, only about 2% of them reported their ignorance about the existence of THC. This relationship was the opposite of what might have been expected.

Educational status and attendance of THC:

Table X Educational Status & Attendance of THC

Education	Yes	No	Total
Illiterate	32 (62.75%)	19 (37.25%)	51
Some formal education	33 (67.35%)	16 (32.65%)	49
Total	65	35	100

Women who had some formal education were somewhat more likely to attend THC for treatment than women with no education or who were illiterate. However this difference was not statistically significant. About 67% of educated women reported attending THC for treatment while only 33% reported not attending THC and this difference is statistically significant (P<0.05).

Economic factors

Table XI-Association between income group with attendance of THC

Income	Attending Thana Health Complex	
	Yes	No
< Tk. 3,000/-	43 (44.79%)	29 (30.21%)
> Tk. 3,000/-	17 (17.71%)	7 (7.29%)
Total	60	36

The study reveals that the low income group women (<Tk. 3,000/-) went to the hospital more than the high income group and this relationship is not statistically significant. Amongst the high income group more women went to the hospital for treatment and this relationship between attending & non-attending women in high income group is statistically significant (P<0.05).

The second study population are village leaders. Twenty – one village leaders/ respected persons of the study village were also interviewed.

Table XII-Occupation of Village

Occupation	Number
Business	6
Village Chairman	2
Union Paris had Secretary	1
Service	6
Agriculture	4
Politics	1
Imam	1
Total	21

Educational qualification and occupation

Among these 21 leaders, five completed Primary education and four of them completed Secondary education. Among those who have completed Primary education, two work in the field of Agriculture, one is a service holder, one is the owner of a truck and one owns a troller.

Among the leaders who completed Secondary Education were one Imam, two Businessman, one an Agriculturist. The Chairman qualified SSC Examination. Five leaders who were working in the Thana post office had completed secondary education. One service holder was also HSC qualified.

The Union Parishad secretary, politician and another service holder were graduate. A Diploma Engineer was doing Business at present.

Knowledge regarding health center

All men reported that they knew about the nearest Govt. health center and that they had some idea about the type of health care service provided by them.

All of them also reported that they had the knowledge that village women must go to the health center during illness. When asked whether they wanted to go to the health center when the need for treatment arose, eleven said affirmative. The rest, who were not interested to attend the clinic mentioned several reasons for that. Scarcity of medicines was the most common cause ; other reasons being lack of doctors ; rude behaviors of health providers ; expense of treatment and long distance of the health center from their village.

When asked about their opinion regarding negative interest of village women to attend the clinic, distance ; lack of female doctors ; scarcity of medicine ; expense of treatment and distance of the health center were the main reasons mentioned.

Only three of the village leaders said that they did not advise village women to attend hospital during illness, the main reason behind it being poor quality of health care services provided in THC.

One – third of this study population thought that unavailability of female doctors in the THC was the main and most important reason for village women for not attending THC. According to the village leaders, many women could not attend the center as they did not get permission from the husbands or mother–in–law to attend the clinic.

The village leaders were also asked how the village women could be encouraged to attend the Govt. THC. They replied that ensuring adequate facilities for modern treatment, providing good care and free medicine, ensuring the presence of qualified doctors and through counseling about the availability of existing health care facilities and health education may help to increase the number or village women attending the health centers.

In reply to the question of what steps the Govt. should take in favour of increasing attendance in THC, the leaders responded by saying that improving health administration and increasing publicity about the advantages of attending THC were important factors. They also advised to increase the frequency of home visits by the existing CHWs and providing proper counseling to them to encourage them for attending the health center. Publicity through mass media, according to them is an important step to encourage village women to attend THC.

Discussion

Women is developing countries are frequently confronted with various sociocultural factors which has negative impact upon the physical well- being and accessibility to appropriate health care services. Poor quality of health servicess, distance money and low status of women in the society inhibit women for utilizing available health care services.

In this study, utilization of existing health care services available in or near the study village was not satisfactory. There are a number of reasons for the current under utilization of the existing health care facilities.

This can be considered under several headings in the following.

Limited facilities

In rural areas, care for most health problem is provided by other health personnel (such as medical assistants, health assistants FWVS, FWAS) because of scarcity of doctors, in particular female doctors. However, the activities of these field workers is mostly limited to family planning . Facilities for health care that are available at village level or even at the union level are not satisfactory. In fact, health care services are only available at the district level and even the services that are available in the village are not appropriate.

Educational Status

The educational status was assessed and it was found that 51% of women had formal education or were illiterate. Thirty two percent of women had history of some formal education but did not complete primary education and only 5% completed secondary education.

There was no significant relationship between education and the knowledge about the existence of THC. No significant relationship was found. between educational status & willingness to attend THC but willingness of attending THC of illiterate women were more than women who had some formal education.

Women who had some formal education were somewhat more likely to attend THC for treatment than women with no education. About 67% educated women reported attending THC for treatment while only 33% reported not attending THC and this difference is statistically significant ($P < 0.05$).

Most rural women, are illiterate and have little or no 'control over the family's income or assets'.

A study on women's access to health care in developing country revealed that health related activities such as family planning may be more influenced by education than any other single factor. Educated women are more likely to

know about and use contraceptives than their less educated counterparts.[1]

Economic Factor

The monthly income status revealed that 7% are of low income group and 29% are in the middle income group.

The association between low and high income group with attendance of THC revealed that the low income women (< Tk. 3,000/-) went to the hospital more than the high income women. Among the high income group, more women went to the hospital for treatment and this relationship between attending and non attending women in high income group is statistically significant ($P < 0.05$).

A study on user for health care in developing countries revealed that only a small percent of household resources are spent on health. Among 3284 rural household surveyed in 1986 to determine current expenditure on health (services and medicine) 53% reported expenditure on medicine with amounted to less than 1% of their stated annual income. Only 26% reported expenditures greater than 5% of their annual household income. The observation that food expenditure accounts for 72% of all household expenditures in approximately one half of Bangladeshi households suggests that the small percentage spent on health may be all that is affordable; to spend more may result in with – holding of other subsistence resources which are also essential to health maintenance. [2]

Another study has revealed that government health care services carry a number of hidden costs. Firstly most medications are not dispensed free of cost, secondly there is the cost of transport, thereby many clinic staff demand money for their services. Many families live a long way from the health center, and can not afford the cost of transport.

The reasons for unwillingness to go to the center revealed the following

Health care center far away; expensive treatment; lack of medicines and rude behaviors of doctors.

Conclusion

From this study, among the many reasons identified for underutilization of health care services, the one most important issue is unfriendly behavior of health personnel which needs to be addressed seriously. It reflects the unsatisfactory state of physician patient communication. Probably, the problem is in the Medical Education. We should humanize health care rather than mechanize it. Still then, further research is urgently needed to explore the factors behind the hostile physician patient relationship & make the Medical Education more community oriented.

Reference:

1. Durrenda Nash Ojunaga , Cathy Gilbert. Women's access to Health Care in developing countries Sec. Sci. Med. Vol 29, no. 11, PP 613 – 617, 1992.
2. Bouita Stanten, John Clemens. User fees for Health Care in developing Countries : A Case Study of Bangladesh Sec. Sci. Med. Vol 129, no. 11, PP 613 –617, 1992.
3. Zaman Ara , Gynaecological illness in a rural community of Bangladesh. Thesis University of Western Australia August 1994.
4. Yasmin H. Rahman, Hafizur Rahman, Fazlul Karim et al. A report on Baseline survey for assessment of Emergency Obstertiric care service in Bangladesh, BIRPERNT March, 1995