

Morbidity Pattern Among the Rural Household in a Selected Area of Dhamrai Upazila, Dhaka

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ABSTRACT

This is a descriptive type of cross sectional study among 477 family heads as respondents. It is aimed to identify morbidity pattern, duration of illness among households' members and also to determine treatment seeking behavior during illness. The socio-demographic characteristics of the respondents are points of investigations. It reveals from the findings that the mean age of the respondents is 35.16 years. They are mostly female (66%) and married (90%). Only 30% respondents are illiterate, 69% respondents are found from nuclear family. The study shows 73% respondents family are suffering from illness during last two months and majority sufferers (19%) and (44%) were less than 5 years and more than 31 years old respectively. However, male sufferers were more among <5 years (9.63%) and female sufferers more (26.84%) among >31 years old. Moreover about 43% respondents' family members are suffering for more than 4 weeks and about 29% less than 01 week. On the other hands, Fever, Cough and Pain are found prominent sign/symptoms among 38%, 28% and 29% sufferers respectively. Common cold, Arthritis and Diarrhoea are found as diagnosis among 53.5%, 22.5% & 8.5% respondents' family members respectively. Nevertheless majority 56% are seeking treatment from MBBS doctors. The study findings highlight awareness program among family heads and adult sufferer towards preventing infectious and chronic diseases as well as to undertake modern scientific treatment. Improved surveillance system in the locality may be considered for early detection of cases to treat accordingly to avoid complications.

Key words : Health seeking behavior, Surveillance, Morbidity pattern

Introduction

Information on the existing morbidity pattern and health seeking behavior is essential to provide need based health care delivery to any population. This information is rarely available. Mainly hospital data are available for disease pattern. Community based study can only reflect the true picture of the disease pattern in a given community and what are their preferences in seeking health care services.

The prevalence of period specific sickness and economic condition predictably hold an inverse relationship in rural area. Episodes of illnesses are reported to be higher for poor people due to

their living conditions and nutritional status. The high incidence of morbidity cuts their household budget both ways i.e not only they have to spend large amount of resources on medical care but also unable to earn during this period. One possible consequences of this could be pushing families into a zone of permanent poverty¹.

Health seeking behavior refers to the sequences of remedial actions that individuals undertake to rectify perceived ill health². It is initiated with symptom definition, whereupon a strategy for treatment action is devised. Treatment choice involves a myriad of factors related to illness

type and severity, pre-existing lay beliefs about illness causation, the range and accessibility of therapeutic options available and their perceived efficacy, convenience, opportunity costs, quality service, staff attitudes as well as the age, gender and social circumstances of the sick individual³. Health care system, in almost all the developing countries, the public and private health sector co-exist, complementing or conflicting with each other. Yet, in health planning least consideration is given to harmonize this co-existence in the larger benefit of the users⁴. Number of studies show that trends in utilization of a health care system public or private, formal or informal, by and large vary depending on factors such as age, gender, women's autonomy, urban or rural habitat, economic status, severity of illness, availability of physical infrastructure, type and cadre of health provider, etc⁵.

Like much of the developing world, medical pluralism, or existence of several distinct therapeutic systems in a single cultural setting is an important feature of health care in Bangladesh. Indeed a wide range of therapeutic choices is available ranging from self-care to folk and western medicine, although both illness incidence and treatment options are importantly determined by poverty and gender⁶. The type of symptoms experienced for the illness and the number of days of illness are major determinants of health seeking behavior and choice of care provider. In case of a mild single symptom such as fever home remedies or folk prescriptions are used. Whereas with multiple symptoms and longer period of illness, biomedical health provider is more likely to be consulted⁷. Traditional beliefs tend to be intertwined with peculiarities of the illness itself and variety of circumstantial and social factors. This complexity is reflected in the health seeking behavior including the use of home prescriptions. The attitude of the health provider and patient satisfaction with the treatment play a role in health seeking behavior⁸.

The overall situation of health care system is poor in developing countries like Bangladesh due to inadequate access to modern health services and poor utilization. One of the public health challenges in Bangladesh is therefore to identify vulnerable groups and to provide them

with needed preventive and curative health services⁹. The poor in Bangladesh are specially disadvantaged in assessing quality health care due to their marginalized position in society. In order to make existing health care delivery system more pro-poor, knowledge of their health seeking behavior is needed¹⁰. Identification of individual factors that may facilitate or impede the effective use of health care services may help us to identify those who may be particularly vulnerable and provide information that policy makers can use to target services to those in greatest need. Therefore, this study has been designed with expectation to determine the disease pattern and health seeking behaviours in rural Bangladesh.

Methodology

This was a descriptive cross sectional study carried out in Dhamrai Upazila, Dhaka under Dhamrai union in Taltola, Choibaria, Kumrail, Islampur, Chandrail, Ambagan, Palara and Sadamath villages. The family heads/respondents during data collection period were the study population. Total size of the sample was 477 and purposive in nature. Structured Questionnaire duly Pre-tested were the instrument for data collection. It was collected through Face to face interview by 4th year MBBS students of Anwer Khan Modern Medical College, Dhanmondi, Dhaka (AKMMC -01). It was processed and analyzed manually and by using computer.

Results

Table I Distribution of respondents by age & sex

n = 477

Age in years	Numbers of respondents		Total
	Male	Female	
16-30	61 (12.79)	151 (31.66)	212 (44.45)
34-45	79 (16.56)	86 (18.01)	165 (34.57)
46-60	42 (8.81)	36 (7.55)	78 (16.36)
61-75	14 (2.94)	8 (1.68)	22 (04.62)
Total	196 (41.10)	281 (58.90)	477 (100.00)

N.B: Figure in the parenthesis indicates percentage.

About 80% respondents were found within age of 16-45 years of age and about 60% respondents were female.

Mean age : 35.16 years.

Standard deviation : ± 13.16

Figure 01. Distribution of respondents by level of education

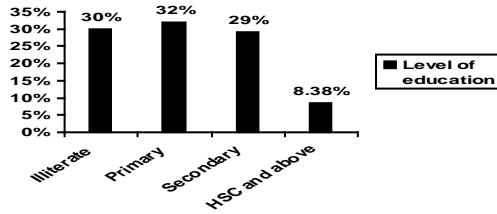


Figure 01 shows that 30% respondents were found illiterate.

Table II. Distribution of respondents by occupation

n = 477		
Occupation	Number of respondents	Percentage (%)
Service	121	25.37
Business	65	13.63
Others	291	61
Total	477	100.00

About 61% respondents were found other occupations apart from service and business.

Figure 02: Distribution of respondents by monthly income

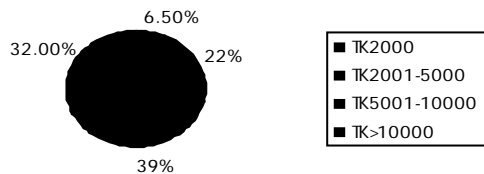


Figure 02 shows that most of the respondents 61.42% were found having monthly income from TK 2001 to TK 10000. However 6.50% were found monthly income below TK 2000 only.

Figure 03: Distribution of respondents by type of family

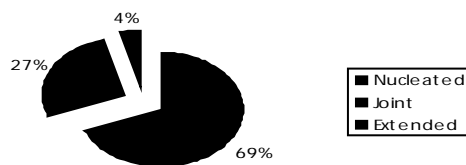


Figure 03 shows that about 69% respondents were found nuclear family

Table III Distribution of respondents by number of family members sharing common kitchen

n = 477		
Number of family members	Number of respondents	Percentage (%)
2	51	10.69
3	87	18.24
4	134	28.09
5	87	18.24
> 5	118	24.74
Total	477	100.00

About 57% respondents were found family members of 2-4 and about 43% had 5 and above members sharing common kitchen.

Table IV. Distribution of respondents' family members suffering from illness by age and sex during the last 02 months

n = 436			
Age in years	Number of respondents' family members suffering from illness	Sex	
		Male	Female
<5	81 (18.6)	42 (9.63)	39 (8.94)
6-10	42 (9.7)	25 (5.73)	17 (3.90)
11-15	20 (4.6)	06 (1.38)	14 (3.21)
16-20	36 (8.2)	12 (2.75)	24 (5.50)
21-25	26 (6)	05 (1.15)	21 (4.82)
26-30	41 (9.4)	08 (1.83)	33 (7.57)
31+	190 (43.6)	73 (16.75)	117 (26.84)
Total	436 (100)	171 (39.22)	265 (60.78)

N.B: Figure in the parenthesis indicates percentage.

Suffering from illness were found highest among <5 years (18.6%) and above 31 years (43.6%) respectively. However, male suffered more (9.63%) among <5 years and female suffered more among above 31 years (26.84%) respectively.

Figure 04. Distribution of respondents' family members by signs/symptoms

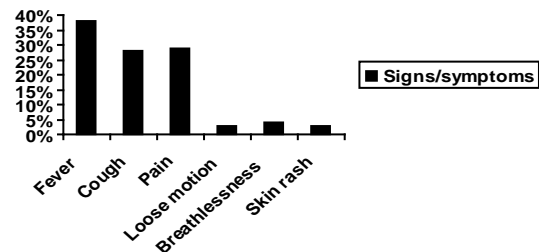


Figure 04 shows that Fever, Cough and Pain were found predominant signs/symptoms among 38%, 28% & 29% respondents family members.

Table V Distribution of respondents' family members by diagnosis
n = (multiple response) 200

Diagnosis	Number of respondents	Percent age (%)
Common cold	107	53.50
Diarrhoea	17	8.50
Arthritis	45	22.50
Chicken pox	07	3.50
Measles	04	2.00
Tuberculosis	05	2.50
Typhoid fever	04	2.00
RTI	07	3.50
RF	04	2.00
Total	200	100.00

Common cold, Arthritis and Diarrhoea were found predominant diagnosis among 53.5%, 22.5% and 8.5% respondents family members.

Discussion

It reveals from the findings that among the respondents 30% were illiterate and about 69% were literate which correspondent to the adult literacy rate of Bangladesh¹¹. About 61% respondents were found other occupation apart from service (25%) and business (14%) . However the study showed that most of the people are engaged in different occupation. The monthly income of the respondents in this study ranges from TK 2000 to more than TK 10000. Most of the respondents (61%) were found monthly income from TK 2001 to TK 10000. However, (6.5%) and (32%) were found monthly income below TK 2000 and more than TK 10000 respectively. This was quite low even in relation to per capita income of Bangladesh¹².

The study also revealed that (73%) respondents were suffering from illness. Among them majority (19%) and (44%) were less than 5 years and more than 31 years old respectively. This morbidity pattern was similar with the study conducted in rural population of Tamil Nadu¹³⁻¹⁶. However male suffered more (9.63%) among less than 5 years old respondents family members and female suffered more (26.84%) among more than 31 years old respondents family members respectively. It was found that Fever, Cough and Pain were the predominant sign/symptoms among 38%, 28% & 29% respondents family members. Regarding diagnosis of their illness

53.5%, 22.5% & 8.5% respondents were diagnosed as Common cold, Arthritis & Diarrhoea respectively. Ahmed et al found the similar disease pattern in their study¹³.

In this study mode of seeking treatment were different. Majority 56%, 21% & 10% received treatment from MBBS doctors, Specialist doctors and Pharmacist respectively. About 11% respondents had no consultation for their illness. Overall utilization of public health facility in this study area were found satisfactory which differ with the similar study in Pakistan¹⁴ and still far better than the health seeking behavior in Chararia seen by ICDDR'b.

Conclusion

Existence of several distinct therapeutic systems in a single cultural setting was found to be an important feature of health care system in the study area. In this respect, effort to increase health related knowledge and skills to facilitate decisions to seek appropriate health care service should emphasized as a key component of primary health care. Finally, in an increasing pluralistic health care system, it is essential that health sector reform takes into account the full range of health providers, both private and public and qualified and unqualified. It is essential that basic pharmaceutical training be made available to the full spectrum of health care providers. Managerial and regulatory measures to be enforced to control the misuse of potentially dangerous therapeutic options. Investing in health necessitate an in depth research to visualize the real picture of the need and habits and practices of the people towards health. Further in depth research should be conducted and findings of the current study should be replicated to formulate policy to improve the overall scenario of health system of rural Bangladesh.

Recommendations

Considering the findings of the present study, there are following recommendations:

" The members of the nucleated family in the study area needs awareness program towards motivation in preventing infectious diseases.

" Respondents having family members 3 or more needs motivation in adopting family planning.

" Respondents with under 5 children and family members aged more than 31 years needs special attention in regards to their health related problems and illness in particular.

" Early detection and treatment regarding infectious diseases & the members suffering from chronic ailments (arthritis) need special attention by improved surveillance system in the study area.

" The family members seeking non scientific treatment need motivation through awareness program towards modern treatment.

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