Original Paper

Barriers to Access Reproductive Health Care Services by Urban Women

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Abstract

Introduction: Health care is a continuous care from womb to tomb. Bangladesh has made tremendous achievement in the health sector over the last few decades. Early marriage, perception about pregnancy and high financial cost are the factors for less utilization of health care services. Many other barriers like gender inequality, cultural norms and traditions are important barriers too for seeking reproductive health care services.

Objective: To unpack the pattern of dynamic social barriers faced by urban women in accessing reproductive health care services.

Materials and Methods: This descriptive empirical social study was executed in Dhaka city from January 2019 to April 2019. Interviewer administered face to face in depth interview was employed to collect data from 122 samples, estimated by peer review and picked up by haphazard sampling from among married women of reproductive age 15-45 years. Data were analyzed by SPSS 20. Emic and etic interpretation were done on the information generated. All ethical issues were taken care of.

Results: The perceived barriers to antenatal, natal, postnatal care and family planning practices were poverty, ignorance and husband non co-operation. As many as 78.7% respondents were house wives, about 71.0% respondent's age at marriage was 13-18 years, 36.1% were qualified up to intermediate level, 53.3% are 25-35 years age group, 80% received antenatal care, 32% gone for home delivery and 68.7% were unwilling for postnatal care services. The present study found that ignorance and poverty were the main reasons for non-utilizing health care facilities.

Conclusion: There are scopes to improve the utilization of reproductive health care services of urban women. Social and cultural barriers are more common. Health care services are needed to be scaled up and the health education component should be strengthened in health care delivery system to achieve Sustainable Development Goal (SDG).

Key-words: Reproductive health care services, Urban women, Barriers.

Introduction

Health is now universally regarded as an important index of human development. Ill health is both the cause and effect of poverty, illiteracy and ignorance. Health and development converge and contribute to each other[1]. Globally, approximately 287,000 women died from causes related to pregnancy and childbirth in 2010. Of these, 162,000 were in Sub-Saharan Africa and 83,000 in South Asia. The maternal mortality ratio (MMR) ranges from 16 in the developed countries to 220 in South Asia[2]. Lack of access to and utilization of health care services for delivery are among the main reasons for the high maternal and neonatal mortality rates in this regions[3-6]. To improve maternal health importance has been given to female reproductive health. Reproductive health is defined in the United Nations report on the International Conference on Population and Development (ICDP), Cairo 1994 which states that 'Reproductive Health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity, in all matters related to the reproductive system and to its functions and processes'. The ICPD report highlights that reproductive health covers few dimensions-people are able to have a safe and satisfying sex life; the ability to reproduce; and the right to decide if, when, and how frequently to reproduce. Among the many issues affecting reproductive health, urbanization plays a significant role. Rapid urbanization has occurred throughout low-income countries, where 80% of the world's largest cities are now located[7]. Such rapid urban growth largely manifests itself in the expansion of already crowded squatter settlements and slums, placing enormous strain on public resources and presenting challenges for local health authorities[8,9]. These recent migration flows pose challenges to women needing reproductive health care services in their migratory destinations. Women living in developed countries receive more prenatal care than those who are living in the developing countries[10]. Access barriers, inequitable and low coverage of health services in developing countries include political, financial, operational and socio-cultural barriers[11].

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Access to health services means the appropriate use of individual health services to attain the best health consequences[12]. Access barriers to health services can be divided into 2 categories: Supply and demand barriers. Effective factors on demand barriers are the inability to use health services on individuals, family or society, while the supply barriers involve inherent aspects of health system which can prevent the use of services by individuals, families and society[13,14]. Low-level access may be due to lack of awareness, information, resources, facilities, health care providers, and cost of services. Costs can include the cost of supplies, medicine and transportation[15]. Almost 185,000 South Asian women die from pregnancy-related causes, and millions more are affected by illness or disability brought about by child-bearing[16]. Majority of the population in developing countries reside in rural areas. Drugs, teenage-pregnancy, HIV, tuberculosis, violence, limited knowledge, poverty, family disintegration, racial bias and urban crowding have become the key factors in shaping the profile of urban morbidities. This has formed a huge gap between available reproductive health services and the health need of the urban poor. Bangladesh has shown improved obstetric care which reduces fertility and unwanted pregnancy.

The legal age of marriage in Bangladesh for women is 18 years, but a large proportion of marriages still take place before the legal age. The early marriage influences the reproductive health negatively. The Bangladesh Demographic and Health Survey 2011 (BDHS 2011) found that among women aged 20-49, 74% were married by 18 years, and 86% were married by age 20. Early marriage mostly results in teenage pregnancy leading to poor maternal and new born health. Bangladesh Urban Survey 2013 showed, the level of teenage pregnancy is highest in the slums, followed by other urban areas, and lowest in the non-slums[17]. The reproductive health status of the adolescent (i.e., 10-19 years of age) around the world reflects that they are still facing heavy challenges in meeting their sexual and reproductive health needs. Inadequate access to health information services, as well as inequitable gender norms, creates serious impact on their health and welfare, as well as financial sustainability and poverty reduction as a whole. Relatively high level of contraceptives is used in Bangladesh, still there is a high contraceptive discontinuation rate, possibly resulting from a lack of sufficient information, knowledge and awareness about contraceptive[18,19]. This results in unwanted pregnancy in many women that compel them to adopt various methods to terminate it and avoid the burden of an unplanned birth[20].

It appears that a network of multiple factors influence reproductive health in Bangladesh. This study is an exploration to understand the interplay of multiple socio-cultural barriers, and attempt to find way to overcome those.

Materials and Methods

This is a descriptive empirical study in the health social sciences conducted in Kurmitola area of Dhaka city. All conventionalities, including data collection, for the study were executed during January 2019 to April 2019. A pre-tested semi-structured interviewer administered face to face in-depth interview was employed to collect data from 122 samples, estimated by peer review and picked up by haphazard sampling, from among married women of reproductive age 15-45 years. The respondents were verbally explained the purpose of study, verbal consent was taken and females were interviewed in detail about socio-demographic profile, their reproductive behavior and intentions, details of antenatal care, delivery, postnatal care, family planning practices, and attitude and level of satisfaction related to perceived barriers for non-utilization of reproductive health care services. No coercion, deception; and physical, chemical, biological, or psychosocial intervention were given to data source. Ethical clearance from Ethical Committee of Armed Forces Medical College, Dhaka has duly been taken for the execution of the study. Descriptive statistical analysis of data was done using Statistical Package for Social Science (SPSS 20.0). Emic and etic interpretations were done on the information generated.

Results

About 53.3% women were in the age group 25-35 years, 82.0% were followers of Islam, 78.7% were homemakers, 71.3% were married by the age of 13-18 years age group, and about 36.0% had up to 12 years of schooling. Main occupation of 41.8% of husbands of data source was government service. Family income of 59.8% of participants was BDT 14000–24000. Utilization of antenatal, natal and postnatal services along with Family Planning services are shown in Table-II. About 16.4% respondents did not access antenatal service. Hospital and home based delivery accounted for 68.0% and 32.0% respectively. It is accounted that 67.2% and 33.6% respondent did not access postnatal and family planning services respectively Barriers to antenatal, natal, postnatal and family planning services are shown in Table-III. Major barrier to receive antenatal services was ignorance and poverty which accounted for 60.0% and 20.0% respectively. About 43.6% faced ignorance as barrier to home based delivery, and about 71.0% faced ignorance as barrier to postnatal services. Each of ignorance and superstation were barriers to access family planning services in 31.7% cases.

Table-I: Socio-demographic characteristics of respondents (n=122)

Characteristics		n	%
Age (years)	25-35	65	53.3
	35-40	57	46.7
Religion	Islam	100	82.0
	Hinduism	20	16.4
	Christianity	2	1.6
Education (years of schooling completed)	0 (Illiterate)	22	18.0
	1-5	42	34.4
	6-12	44	36.1
	13+	14	11.5
Occupation	Homemaker	96	78.7
	Service	19	15.6
	Others	7	5.7
Occupation of husband	Government Service	51	41.8
	Business	26	21.3
	Driver	16	13.1
	Day Labor	24	19.7
	Others	5	4.1
Family income (BDT)	4000-14000	34	27.9
	14000-24000	73	59.8
	24000-34000	11	9.0
	34000-44000	4	3.3
Age at marriage (year)	13-18	87	71.3
	18-23	27	22.1
	23-28	3	2.5
	>28	5	4.1

Table-II: Utilization of antenatal, natal, postnatal and family planning services (n=122)

Nature of service	Service received	n	%
Antenatal	Yes	102	83.6
	No	20	16.4
Natal	Health facility based	83	68.0
	Home based	39	32.0
Post-natal	Yes	40	32.8
	No	82	67.2
Family planning	Yes	81	66.4
	No	41	33.6

Table-III: Barriers to antenatal, health facility based delivery, postnatal and family planning services

Service	Barrier	n	%
Antenatal	Poverty	4	20.0
	Ignorance	12	60.0
	Husbands non co-operation	1	5.0
	Others	3	15.0
	Total	20	100.0
Health facility based delivery	Poverty	7	17.9
	Ignorance	17	43.6
	Social-Superstation	1	2.6
	Husbands non co-operation	3	7.7
	Mother in laws non co-operation	6	15.4
	Others	5	12.8
	Total	39	100.0
Postnatal care	Poverty	12	17.4
	Ignorance	49	71.0
	Husbands non co-operation	1	1.4
	Mother in laws non co-operation	2	2.9
	Others	5	7.2
	Total	82	100.0
Family Planning	Ignorance	13	31.7
	Social-Superstation	13	31.7
	Husbands non co-operation	5	12.2
	Mother in laws non co-operation	1	2.4
	Others	9	22.0
	Total	41	100.0

Discussion

Maternal mortality is the outcome of a complex web of casual factors that include social, economic, educational, political and cultural causes as well as issues such as gender inequality, state of physical infrastructure and health system. Utilization of heath care services is affected by multitude of factors and many researchers have tried to identify the factors that contribute to differential of utilization of health care services.

This quantitative study focused that 82% respondents are Muslims, 96% are housewives and 71% of the respondent's age at marriage are 13 to 18 years. This findings are supported by many studies[21-27]. The findings of this study observed that the participant's family income was between BDT14000-BDT24000 which is similar to many studies[27-30]. Through the study it was found that 41% did not practice family planning methods where ignorance (31%) and social stigma (51.7%) were the main reasons. Most of the respondents practice OCP and other modern methods[26-29]. Eighty four percent respondents received and ANC. Undoubtedly the rate of ANC utilization was good but it was also found 16% did not receive Antenatal checkups Respondents barrier are mainly ignorance (60%) and poverty (20%) which are also revealed by other qualitative conducted studies[23,24,27].

Among 122 respondents 32% received home delivery and 68% received institutional delivery. Regarding barriers to access place of delivery were ignorance (17%), poverty (17%) and mother in laws non co-operation (6%) were revealed. Forty one percent institutional delivery also reported by a study conducted by Madhulika Sahoo et al. It was evident that 53% of women choose home delivery as they didn't face any complications during pregnancy[23].

In this study postnatal care service utilization were 69% where focused barrier were ignorance (49%) and poverty (12%). Study conducted by Madhulika Sahoo et al reported postnatal care service utilization was 72.5%. This low level utilization of postnatal care service could be explained by that the mothers may believe that it is not necessary to go back for checkups after delivery without complications.

Conclusion

Utilization of health care services in urban women needs attention of individual and health authority. Social, cultural and economic barriers influence the individual and families not availing the family planning method, antenatal care and postnatal care services. Mothers and pregnant women queries and doubts should be judiciously addressed during home visiting by health workers and at the time of antenatal care.

The health education program should be strengthened to bring about changes in attitude and practice. Dedicated effort both by community as well as health staffs is essential for achieving Sustainable Development Goals.

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