

Social Pathology in Accessing Reproductive Healthcare Services of Urban Women

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Abstract

Introduction: Reproductive healthcare (RH) services approach to men and women at their reproductive ages and ensure healthy reproduction, regulation of fertility, safe sexual practice among couples, safe pregnancy and childbirth. Various social factors are responsible for inequity in accessing the reproductive healthcare services.

Objective: To find out the social pathology in accessing reproductive healthcare services of women in a selected urban area of Bangladesh.

Materials and Methods: The descriptive cross-sectional study was conducted among 57 respondents to investigate the social pathologies in accessing reproductive healthcare services in Mirpur Bihari Colony of Dhaka during the period of April 2019 to May 2019. Women residing in the study area for at least 6 months and having at least one child below 10 years were included in the study. Data were collected by face-to-face interview using a semi-structured questionnaire.

Result: All of the respondents were Muslim, majority (66.7%) were between age group 21-30 years and the mean±SD age was 26.67±6.48 years. Majority (64.9%) were housewives and 28.1% respondent's husbands owned small business. The mean±SD duration of married life was 9.74±6.04 years and combined monthly income (35.1%) between 5001-10000 BDT with mean±SD income of 9,671.93±6440.41 BDT. Majority (35.1%) had 2 children at 2nd pregnancy (29.8%), without history of foetal death (78.9%). Nearly everyone (96.5%) had ANC and about half of them (49.1%) had 9 antenatal visits, 84.2% had hospital birth, 47.4% had PNC and 70.2% practiced contraception with pill (40.4%). The barriers for ANC, hospital birth, PNC, family size and contraception were expressed by 75.4%, 73.7%, 89.5%, 96.5% and 56.1% respondents respectively. 'Poverty' was denoted as main social pathology for ANC, hospital delivery and PNC by 72.1%, 78.6%, and 51.0% respondents respectively while 'Husband's wish' or 'Husband's non-cooperation' was factor for family size determination (54.5%) and contraceptive practice (43.8%). Significant association has been found between the combined monthly income and barrier to ANC (p-value <0.01), age of respondent and no of child and duration of married life (p-value <0.01).

Conclusion: The women of low-income families in urban community face difficulties in accessing these services mainly due to poverty, husband's noncooperation and unawareness. Appropriate measures should be taken to make RH services more affordable and aware couples through education and counselling for accessing these RH services.

Key-words: Reproductive, Antenatal, Postnatal, Contraceptive, Social Pathology.

Introduction

'Social pathology' is a modern concept of social science that encompasses social structure, behaviour and values attributed to particular social categories which reflects the dominant moral concerns of a particular era¹. It is a technical term used to denote deviant behaviours or actions which are considered immoral or unacceptable by a society like poverty, crime, illiteracy, substance abuse, violence, abuses of women and children, stigmatization, violation of human rights, that augment social disorganization². In medical sense, social pathology is the systematic doctrine inquiring into the relationship between genuine pathological conditions, i.e., human diseases and man in his daily environment³. The relationship between social conditions of the daily environment and health exists almost in any disease in varying in degree and it influences the access to health services⁴.

United Nations' International Conference on Population Development (ICPD) has defined Reproductive Health (RH) as, 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes⁵. RH starts before reproduction and extends beyond and is closely associated with nutrition, sociocultural factors and protection of human rights, especially in regard to sexuality and personal relationships⁶. Disparities in RH is prevalent throughout the world and varies from region to region. Bangladesh has the 4th highest prevalence in child marriage in the world and 59% of girls are married off before they reach 18 years⁷. According to a prospective study, 75% of women in Dhaka slum area face postpartum morbidity and 36% face serious delivery complications⁸. Recent data shows only 39% of mothers receive postnatal care (PNC) within 42 days after birth and the majority within the first two days⁹.

The study aims to identify the social pathology that influences women's access to various reproductive healthcare services like antenatal care (ANC), place of delivery, postnatal care (PNC), determining family size and family planning methods in an urban area. Findings of this study may help policymakers in conforming appropriate strategies to eradicate these social pathologies for the improvement of women's reproductive health status of Bangladesh.

Materials and Methods

This descriptive cross-sectional study was conducted among 57 respondents to detect social pathology in accessing RH services in a Mirpur Bihari Colony, Dhaka, Bangladesh from April 2019 to May 2019. Women residing in the study area for continuous 6 months, having at least one child below 10 years were selected as the study population using simple random sampling technique. Information regarding respondents' socio-demographic characteristics, number

of children, ANC, place of delivery, PNC, family size, contraceptive practice was collected by face-to-face interview with a semi-structured questionnaire. The data were analyzed and processed by using 'IBM SPSS Statistics' software version 20.0. Quantitative data were presented as Mean±SD and qualitative data as frequency and percentage. Chi-square test was performed to see the association between the sociodemographic characteristics and the status of different RH services. P value <0.05 was considered significant.

Results

A total of 57 respondents were interviewed for the study and the majority (66.7%) belonged to the age group of 21-30 years with mean±SD age of 26.67±6.48 years. All of them were Muslim; 64.9% were housewives while the rest had small earning; crafting being the occupation of 21.1%. Majority of the respondents' husbands owned small business (28.1%) followed by day labourer and shopkeeper (12.3%). The majority 66.7% of the women's duration of married life was less than a decade and mean±SD was 9.74±6.04 years. About 35.1% of respondents combined monthly income fell in 5001-1000 BDT income group with a mean±SD income of 9,671.93±6440.41 BDT (Table-I).

Majority of the women had 2 live children (35.1%), most of them were 2nd and 3rd gravida (29.8%) with absence of foetal death (78.9%). Almost all the respondents (96.5%) had antenatal checkup and about half of them (49.1%) had free monthly checkup followed by two checkups (19.3%) throughout pregnancy. The majority (75.4%) expressed barrier to ANC. About 84.2% of respondents had their delivery at hospital or clinic while rest had home delivery and barrier to hospital delivery was expressed by 73.7% respondents. Majority (52.6%) did not have access to PNC and 89.5% expressed barriers to it. About 96.5% respondents expressed presence of social factors for determining the no of child while only 3.5% expressed joint decision. Majority 70.2% practised some sorts of family planning method and 40.4% used pill followed by injection 12.3%. Barrier to contraception was expressed by 56.1% of respondents (Table-II).

'Poverty' was a barrier to ANC for 72.1% women followed by 'Unawareness' 27.9%. Regarding hospital delivery, 'Poverty' was barrier to 78.6% respondents followed by 'Mother-in-law' (21.4%) and 'Other like distance from home, transport, husband's time etc' (21.4%). The majority (51.0%) denoted 'Poverty' and 41.2% denoted 'Unawareness' for barrier to PNC. 'Husband's wish' was an important factor for determining family size for 54.5% women followed by 'Other like the desire of male child, mother's wish etc' 32.7%. 'Husband's noncooperation' was a barrier to contraception for 43.8% respondents followed by 'Unawareness' 25.0% (Table-III).

A significant association has been found between respondents' occupation and status of ANC (p-value <0.05); combined monthly family income and barrier to ANC (p-value <0.01). Duration of married life is associated with place of delivery (p-value <0.05); respondents' occupation with barrier to hospital delivery (p-value <0.05) and status of PNC (p-value <0.05). Association have also been found between age of respondent and duration of married life with the no of child (P-value <0.01 and 0.01 respectively).

Table-I: Distribution of respondents by sociodemographic characteristics (n=57)

Characteristics	Categories	N	%
Age of respondent in Years	>20	8	14.0
	21-30	38	66.7
	31-40	10	17.5
	41<	1	1.8
	Range: 15-50 Mean: 26.67±6.484		
Religion of respondent	Islam	57	100.0
Occupation of respondent	Small Business	1	1.8
	Garments	1	1.8
	Housemaid	5	8.8
	Crafting (Puti)	12	21.1
	Sewing	1	1.8
	Housewife	37	64.9
Occupation of respondent's husband	Barber	2	3.5
	Small Business	16	28.1
	Carpenter	1	1.8
	Cowboy	1	1.8
	Dead	1	1.8
	Driver	5	8.8
	Electrician	2	3.5
	Factory work	4	7.0
	Garments	2	3.5
	Guard	2	3.5
	Labour	7	12.3
	Crafting (Puti)	1	1.8
	Rickshaw puller	4	7.0
	Salesman	2	3.5
	Shopkeeper	7	12.3
Duration of married life in Years	>10	38	66.7
	11-20	16	28.1
	21-30	3	5.3
	Range: 1-30 Mean: 9.74±6.049		
Combined monthly income in Tk	>5000	19	33.3
	5001-10000	20	35.1
	10001-15000	9	15.8
	15001-20000	6	10.5
	20001-25000	2	3.5
	25000<	1	1.8
Range: \$400.00 - \$30,000.00 Mean: \$9,671.9298 ± \$6,440.40689			

Table-II: Distribution of respondents according to reproductive eservice status (n=57)

Reproductive Healthcare Information		n	%
No of child alive (Para)	1	19	33.3
	2	20	35.1
	3	13	22.8
	4	4	7.0
	5	1	1.8
No of pregnancy including present one (Gravida)	1	14	24.6
	2	17	29.8
	3	17	29.8
	4	7	12.3
	5	2	3.5
Foetal death at 28 th wk	0	45	78.9
	1	9	15.8
	2	3	5.3
ANC status during pregnancy	Not attended	2	3.5
	attended	55	96.5
Number of Antenatal Check-up	0	2	3.5
	<4 ANC visits	23	40.4
	>4 ANC visits	32	56.1
Barrier to Antenatal Care (ANC)	No	14	24.6%
	Yes	43	75.4%
Place of delivery	Home	9	15.8
	Hospital	48	84.2
Barrier to hospital delivery	No	15	26.3%
	Yes	42	73.7%
Status of Postnatal Care (PNC)	No	30	52.6
	Yes	27	47.4
Barrier to Postnatal Care (PNC)	No	6	10.5%
	Yes	51	89.5%
Factors for determining family size	No	2	3.5%
	Yes	55	96.5%
Status of contraception	No	17	29.8
	Yes	40	70.2
Contraceptive method adopted	Safe period	5	8.8
	Pill	23	40.4
	Injection	7	12.3
	Cu T	1	1.8
	MR	2	3.5
	Condom	2	3.5
Barrier to contraception	No	25	43.9%
	Yes	32	56.1%

Table-III: Distribution of respondents according to barrier* faced (n=57)

Barrier responses	Types	Responses		% of Cases
		N	%	
ANC	Poverty	31	41.9%	72.1%
	Husband	6	8.1%	14.0%
	Mother in law	7	9.5%	16.3%
	Noncooperation by family members	0	0.0%	0.0%
	Unawareness	12	16.2%	27.9%
	Superstition	4	5.4%	9.3%
	Addiction of family member	2	2.7%	4.7%
	Familial disharmony	5	6.8%	11.6%
	Other	7	9.5%	16.3%
	Total	74	100.0%	172.1%
Hospital delivery	Poverty	33	45.2%	78.6%
	Husband	6	8.2%	14.3%
	Mother in law	9	12.3%	21.4%
	Noncooperation by family members	1	1.4%	2.4%
	Unawareness	8	11.0%	19.0%
	Superstition	1	1.4%	2.4%
	Addiction of family member	2	2.7%	4.8%
	Familial disharmony	4	5.5%	9.5%
	Other (distance)	9	12.3%	21.4%
	Total	73	100.0%	173.8%
PNC	Poverty	26	33.8%	51.0%
	Husband	8	10.4%	15.7%
	Mother in law	4	5.2%	7.8%
	Noncooperation by family members	2	2.6%	3.9%
	Unawareness	21	27.3%	41.2%
	Superstition	4	5.2%	7.8%
	Addiction of family member	1	1.3%	2.0%
	Familial disharmony	4	5.2%	7.8%
	Other (housework, time)	7	9.1%	13.7%
	Total	77	100.0%	151.0%
Factors for determination of no of child	Poverty	8	9.9%	14.5%
	Husband's wish	30	37.0%	54.5%
	Mother in law's interest	11	13.6%	20.0%
	Family members' interest	3	3.7%	5.5%
	Unawareness	6	7.4%	10.9%
	Superstition	3	3.7%	5.5%
	Addiction of family member	0	0.0	0.0%
	Familial disharmony	2	2.5%	3.6%
	Other (male child, mother's wish)	18	22.2%	32.7%
	Total	81	100.0%	147.3%
Contraception	Poverty	10	23.8%	31.2%
	Husband	14	33.3%	43.8%
	Mother in law	0	0.0%	0.0%
	Noncooperation by family members	0	0.0%	0.0%
	Unawareness	8	19.0%	25.0%
	Superstition	4	9.5%	12.5%
	Addiction of family member	0	0.0%	0.0%
	Familial disharmony	1	2.4%	3.1%
	Other	5	11.9%	15.6%
	Total	42	100.0%	131.2%

Discussion

A total of 57 respondents of Mirpur Bihari Colony, Dhaka, Bangladesh were interviewed to collect data regarding their socio-demographic characteristics and access to RH services. Majority (66.7%) belonged to the age group of 21-30 years with mean±SD age of 26.67±6.48 years, Muslim and majority (64.9%) housewives. The findings of the study are consistent with the findings of Parkhurst JO et al¹⁰ and Ahmed NU et al¹¹ and Basaleem HO¹². About 35.1% respondents combined monthly income fell in 5001-1000 BDT income group with mean±SD income of 9,671.93±6440.41 BDT (Table-I). Majority of the women had 2 live children (35.1%), most of them were 2nd and 3rd gravida (29.8%) with absence of foetal death (78.9%) and the findings are consistent with Bangladesh Demographic Health Survey (BDHS)¹³ data 2007.

According to the study, almost everyone (96.5%) had antenatal checkup and about half of them (49.1%) had free monthly checkup. About 19.3% had two checkups throughout their pregnancy. Although 75.4% of the respondents expressed barrier to ANC, their ANC status is considerably high (Table-II). 'Poverty' was a barrier to ANC for 72.1% women followed by 'Unawareness' 27.9% (Table-III). This response is in contrast with the utilization of ANC service which is due to the active support from the Government and NGO health facilities in poor urban communities of the country. Majority of the respondents received free antenatal checkup from Bangladesh Rural Advancement Committee (BRAC) health service. A significant association has been found between respondents' occupation and status of ANC (p-value <0.05) and; combined monthly family income with barrier to ANC (p-value <0.01). According to previous studies cost and unawareness represents a significant barrier for the poor in accessing ANC services and results in maternal and foetal mortality¹⁴.

About 84.2% respondents had their delivery at hospital or clinic while rest had home delivery and barrier to hospital delivery was expressed by 73.7% respondents (Table-II). Duration of married life was found to be associated with place of delivery (P-value .011) and it was seen that new mothers preferred to deliver their babies in the hospital. It is also revealed that respondents' occupation is associated with barrier to hospital delivery (P-value .040) as housewives tend to make time for hospital visits. 'Poverty' was barrier to 78.6% respondents followed by 'Mother-in-law' and 'Other like distance from home, transport, husband's time, caretaker etc' equally by 21.4% respondents (Table-III). The study findings are similar to the findings^{15, 16} where cost of service and the distance to the facility greatly affected hospital delivery^{12, 17}. It was also found that distance and cost barriers do not restrict the use of antenatal care and when women are aware of the benefits of the service¹⁵.

The study revealed, majority (52.6%) did not have access to PNC which is also consistent with a study in Ethiopia where only 20.2% had utilized PNC service¹⁸. About 89.5% of respondents expressed barriers to it (Table-II). About 51.0% expressed 'Poverty' and 41.2% expressed 'Unawareness' for barrier to PNC (Table-III) which is in contrast with the findings of Basaleem HO 88.4% women did not feel the need for PNC¹². The study also reveals that the respondent's occupation is associated with the status of PNC (p-value <0.05). A similar study in India has also found the literacy level of respondent and knowledge regarding RH is significantly associated with accessing PNC services¹⁹.

About 96.5% of respondents expressed presence of social factors for determining the no of child while only 3.5% expressed joint decision (Table-II). 'Husband's wish' was an important factor for determining

family size for 54.5% women followed by 'Other like desire of male child, mother's wish etc' 32.7% (Table-III). Similar results have been found in a study by Shah I et al in Pakistan, were 67.5% of respondents expressed that their husbands decided how many children the household should have along with contraceptive practice²⁰. Choudhury et al have also mentioned about the religious belief and preference of male child of women regarding family size and child birth²¹. From the study, association have also been found between age of respondent and duration of married life with the no of child (p-value <0.01).

Majority 70.2% practised some sorts of family planning (FP) method and 40.4% used pill followed by injection 12.3% which is consistent with similar studies¹². Barrier to contraception was expressed by 56.1% respondents (Table-II). 'Husband's noncooperation' was barrier to contraception for 43.8% respondents followed by 'Unawareness' 25.0% (Table-III). A study by Basaleem HO 2012 showed that in 25.8% respondents could not adopt FP for husband's opposition¹² along with other studies^{20, 22}. Unawareness and considerable information gap about the selection of contraceptives suitable for the couple and proper use of contraceptives^{23, 24}.

Limitations

The main limitation of this study is the number of respondents. Future study is suggested in different urban areas along with FGD for a better understanding of the social pathology.

Conclusion

Poverty and unawareness are major social pathology which bolsters underutilization of RH services. Husband plays an important role in married woman's RH decisions like family size and contraceptive practice. Combined monthly family income is associated with barrier to ANC services. Unemployed women or housewives access RH services compared to the earning women in urban area. Alleviation of poverty and creating awareness among the couples about the benefits of accessing these services can improve the RH status of Bangladesh and help to achieve Sustainable Development Goals (SDG).

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