

Barriers to access maternal health services among urban poor women in Bangladesh: A Case of Rajshahi City

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Abstract

Bangladesh has made tremendous achievements in the health sector over the last few decades, albeit worse in maternal health (MH) compared to other South Asian countries. The fact that women, particularly poor, have less access to maternal health care (MHC) services is one of the prime reasons. The main objective of this study was to explore what types of barriers poor mothers faced during the service use. A triangulation of method (interviews of service recipients through interview schedule and service providers through checklist, focus group discussion and observation) was used for the collection of primary data (sample 200) from two slum areas in Rajshahi City between March and April, 2013. The study found socio-cultural and organizational barriers to access to MHC services more acute than physical and financial barriers. As suggested, building awareness of bad consequences of early marriage on MH, ensuring a strong coordination among service providing organizations in dispensing free drugs and posting female doctors in study areas are urgently needed for further improvement of MH.

Keywords: Barriers, Maternal healthcare services, Urban poor women, Rajshahi City Corporation, Bangladesh.

Introduction

Bangladesh has made tremendous achievements in the health sector over the last few decades.¹⁻² The population growth rate has come down from 3 in 1975 to 1.58% in 2015, the fertility rate has declined from 6 to 2.55, the contraceptive prevalence rate rose to 56 from 7.7% in 1975, the infant mortality rate has come down to 48 from more than a 100 per 1,000. There was an increase of six years in the life expectancy between 2007 (64 years) and 2012 (70 years). Of course, there are many negative statistics in the health sector. The family planning program is not expanding, rather stalling³⁻⁴ and about 15,000 mothers die annually at the time of delivery (2.4 maternal deaths per thousand) and 7000 infants die every year. About 70% of pregnant women suffer from anaemia, 71% of deliveries take place at home and 45% of babies are born under-weight.⁵⁻⁹

One of the main reasons, as indicated by anecdotal evidence, for worse situation in maternal health (MH) is that women, particularly poor, have less access to healthcare services. In addition, a lot of research¹⁰⁻²² found class and region-based inequity in access to primary, particularly maternal, healthcare services and broadly classified all access barriers into four sections; socio-cultural, financial, physical and organizational/institutional.

This research therefore intended to deal with the issue of maternal health care (MHC) services, provided by different organizations in Rajshahi City. Exploring different barriers poor mothers faced during the service use is an urgent requirement of the hour. How did urban poor women experience this service? Did they have access to

Practice Points

- Maternal health (MH) situation in Bangladesh was worse compared to other South Asian countries.
- Maternal mortality rate in Rajshahi region was more than that in other regions in Bangladesh.
- Socio-cultural and organizational barriers are more keen than physical and financial barriers in study areas.
- Sensitizing community about adverse consequences of early marriage on MH is urgent.
- Proper coordination and distribution of healthcare services of different organizations is one of the best ways of improving MH situation.

MHC services and affordability to pay the service charges and receive good quality of service? These questions demand investigation. Broadly speaking, the main aim of the study was therefore to examine different barriers that discouraged women from going for MHC services.

The next section highlights research techniques adopted in this study which is followed by the discussion of results of the study. The penultimate section highlights main findings of the study while conclusion and recommendations are made in final section.

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Materials and methods

Mixed methods were used for collecting primary data. They include interviews of service recipients through interview schedule and service providers through checklist, focus group discussion (FGD) and observation. The main reasons for choosing mixed methods were to understand and interpret the problems, to explore the barriers to health care, and to watch conditions of poor women from their situations as well as to mitigate methodological problems of validity and bias.²³⁻²⁴

The study was conducted by using multi-stage sampling technique which included purposive for site selection, systematic random sampling for household selection and finally snowball sampling for respondent selection.

Area Selection

The main focus of the study was to highlight access barriers of poor women to MHC services in urban areas. In this regard, out of seven divisional regions in Bangladesh, Rajshahi region was selected due to its worst condition. The following figures suggested that Rajshahi situation was not better compared to other regions in Bangladesh.

- MH situation in Rajshahi division was worse than other divisions in Bangladesh. The maternal mortality rate in Rajshahi and Bogra regions within Rajshahi division was 2.9 and 3.0 respectively while the figure for Barisal, Pabna, Tangail and Dinajpur was 2.6, 2.6, 2.6 and 2.8 interchangeably.²⁵
- The proportion of delivery done by qualified doctors in Rajshahi was 22.1 % which was lowest compared with other divisions.⁸
- The percentage of delivery held in a facility centre in Rajshahi was 13.2 whereas that in Khulna and Dhaka was 22.4 and 16.9 respectively.²⁶
- The percentage of mothers with at least one ante-natal care (ANC) visit in Rajshahi was 71.3 while the figure for Khulana and Rangpur was 77 each.⁸
- Around 60 % of mothers in Rajshahi division had less or least access to ANC provided by medical personnel whereas only half of mothers in Khulna division had less or least access.²⁷

Site selection

The Rajshahi City, one of the largest cities in the northern region, was targeted to study. The area was then chosen by using the 'multistage sampling' method. Reproductive aged women, living in remotest areas and disadvantaged position, were main sources of information relating to access barriers. Zianagar and Baze Kazla are two remotest areas in Rajshahi City where poor people live in.²⁸ The main target of the research was to interview slum dwellers. One hundred respondents from each area were targeted to be interviewed.

The study site

i. Zianagar

Bulanpur is in the 4th Ward of Rajshahi City

Corporation. This ward consists of five areas (Nowabgong, keshabpur, Ghoshpara, Haragram and Zianagar). The selected area (Zianagar) is 1.5 kilo meter on the east-west and 1 kilo meter on the north-south. Many NGOs, particularly ASA, BRAC, Grameen Bank, CSS and Tilottoma, are operating their activities in this area. Most of the people here have been involved in micro-credit programs, do not have agricultural lands and are day labourers. As it is a border area, few people earn money from smuggling goods. As observed, most of the people had less access to safe drinking water because of their full reliance on supply water which was fully electricity based. Total number of households was 820 as per ward counsellor's office information.

ii. Baze Kazla

Baze kazla belongs to Ward no 24 in Rajshahi City Corporation. This place is nearby *Padma* River which is now turned into a char land area. It is one of the densely populated areas in Rajshahi City. As observed, sanitation facility was not adequate. So they lived in a dirty and filthy environment which was a threat to their health. They did not have nearby medical service delivery centre. They travelled long distance for getting a healthcare service delivery centre. There were 390 households in this area.

Development of research instrument

With some addition and correction of an initially developed draft interview schedule, a semi-structured interview schedule (including both open and close ended questions) was finalized for pre-testing. One-day long intensive training was given to research assistants (RAs) with objectives of giving them orientation about issues to be studied and how interview schedule should be filled up. Getting feedbacks from the pre-testing, necessary correction and modifications were made in the interview schedule. It was then ready for conducting interviews among recipients of MHC services.

Once the interview schedule was finalised after the pre-testing, RAs prepared themselves for conducting interviews. Field investigation began in early March and ended in early April 2013. One street from selected areas was chosen randomly. Then a married woman was randomly picked up for interview. Based on her knowledge regarding the availability of nearby mothers/women with pregnancies/babies, the consecutive respondents were selected (by using snowball sampling technique). It should be mentioned here that RAs were instructed that they should interview mothers from different clusters and avoid the next door neighbour of the interviewee. The basic principle for giving this instruction is to collect information from heterogeneous respondents, albeit they are homogenous in basic socio-economic parameters, thereby maintaining quality of the study. One hundred females from each area were interviewed. On an average, time required for interviewing females is 45 minutes. The total number of respondent is 200.

Once interviews of females were over, a check was made where respondents invariably went for MHC services. Heads of these healthcare centres be it formal organisation or local pharmacy were targeted to interview. The total number of interviews conducted is nine. Out of nine, only three are organizational heads. As most of the respondents initially went to their local

doctors, who were basically drug peddlers and had minimum level of medical training, for treatment, this fact stimulated us for interviewing them.

Five FGDs were held. Three were done with service recipients and two with service providers of the NGO health centre. The head of organization and friendly respondents were used as gate keepers for arranging meetings. The date and time for FGD was fixed with their consent. Three FGDs (one with service provider and two with clients) were done in Baze Kazla and two (one with service recipients and providers each) in Zianagar. The main aim of doing FGD was to find out what types of barriers service recipients faced during the use of healthcare services and service providers encountered when they provided services. How all these barriers could be mitigated was another objective of conducting FGDs. Each FGD lasted for two hours. Each group consists of six people.

After completing the field investigation, all the interview schedules were edited and some errors were detected and corrected accordingly. All data was coded and analyzed through the Statistical Package for Social Sciences (SPSS) program. Then it was presented in a tabular form. Comments made by service providers and FGD participants were quoted in the text. This study got ethical permission from the National Academy for Planning and Development (NAPD), Dhaka for doing this research.

Results

Socio-demographic profiles of the respondents

As Table 1 revealed, more than half of the respondents were below 25 years old and almost all of them were married. Forty-six percent respondents had secondary level of education which is followed by respondents with primary level of education (31.5) and respondents without formal education (13.5). Six in ten respondents had families with four to six members whereas three in ten had three-member based families. Slightly over half of the respondents had sanitary latrines and the rest had kutchcha type of latrine. This figure is as same as the national figure — 56 % people have sanitation facilities at present.²⁹ That means, the study area is not fully covered by sanitary facilities. Six in ten respondents had access to safe drinking water (tube well or pump) which is really good for keeping health free from water-borne disease.

Most of the respondents (85%) were unemployed (Table 2) — they were not economically empowered and fully dependent on incomes of their family male members, particularly husbands. A half of the respondents had monthly family income from 5000 to 10000 Taka which is followed by respondents with below 5000 (31%) and over 10,000 (11%) Taka income. Seventy-seven percent respondents had their own houses. However, slightly over half of respondents lived in a single room. That indicates that they live in a congested environment which does not ensure their privacy and is prone to spread diseases. Almost all respondents lived in a house with tin roof. Forty percent respondents had walls with brick/cement or hemp/hay/bamboo each. Nearly half of the respondents had electricity, fan, clock and television. Almost all respondents (nine in ten) had mobile and khat (a wood-made bed).

Around 31% respondents lived below the US\$2 poverty line as per Table 2. If poverty is multi-dimensionally measured, around 40 % respondents were deprived of a decent living standard. According to a study,³⁰ one household can be rated as deprived if its members have not finished five years of schooling and have no access to electricity; it has dirt, sand or dung floor; and it does not own more than one consumer goods. In light of the above given study, a half of the respondents lived below the multi-dimensionally determined poverty line.

Barriers to access to maternal healthcare services

The whole range of access barriers can be divided into four broad sections, such as socio-cultural, physical, financial and organizational. Here, the results of the study are highlighted in the light of the above given division of access barriers.

i. Socio-cultural barrier

Patriarchal social norm and early marriage

Bangladesh is a traditional and patriarchal society where women mainly have limited freedom to move outside of household and to take decision about reproductive health independently. This patriarchal

Table 1: Socio-demographic profiles of respondents

Different categories	Frequency
<i>Age</i>	
14-19	49 (24.5%)
20-25	86 (43%)
26-31	50 (25%)
32-37	12 (6%)
38-43	3 (1.5%)
Total	200 (100%)
<i>Marital status</i>	
Married	198 (99%)
Divorcee	2 (1%)
Total	200 (100%)
<i>Educational qualification</i>	
No education	27 (13.5%)
Primary	63 (31.5%)
Secondary	92 (46%)
Higher secondary	4 (2%)
Can write & read	13 (6.5%)
No response	1 (0.5%)
Total	200 (100%)
<i>Number of family members</i>	
1-3	56 (28%)
4-6	119 (59.5%)
7-9	21 (10.5%)
10-12	3 (1.5%)
13-15	1 (0.5%)
Total	200 (100%)
<i>Types of latrine</i>	
Sanitary/water sealed/pit	104 (52%)
Kutchcha	93 (46.5%)
Bush	1 (0.5%)
Open space	1 (0.5%)
Other	1 (0.5%)
Total	200 (100%)
<i>Sources of drinking water*</i>	
Tap	96 (48%)
Tube well/pump	120 (60%)

*Multiple responses

Table 2: Socio-economic characteristics of respondents

Different characteristics	Respondents (%)
<i>Occupation</i>	
Service	2 (1%)
Business	2 (1%)
Non-agricultural labourer	4 (2%)
Household worker	6 (3%)
Self-employed	11 (5.5%)
Student	2 (1%)
Unemployed	170 (85%)
Others	3 (1.5%)
Total	200 (100%)
<i>Income level (family and monthly)</i>	
1-5000	62 (31%)
5001-10000	105 (52.5%)
10001-15000	22 (11%)
15001-	11 (5.5%)
Total	200 (100%)
<i>Ownership of the house</i>	
Yes	154 (77%)
No	46 (23%)
Total	200 (100%)
<i>Number of living rooms</i>	
1	107 (54.3%)
2	55 (27.9%)
3	28 (14.2%)
4	5 (2.5%)
5	2 (1%)
Total	197 (100%)
No response	3
<i>Types of roof</i>	
Cement	5 (2.5%)
Tin/wood	190 (95.5%)
Tile/wood	2 (1%)
Other	2 (1%)
Total	199 (100%)
No response	1
<i>Types of wall</i>	
Brick/cement	80 (40%)
CI sheet/wood	2 (1%)
Mud brick	11 (5.5%)
Hemp/hay/bamboo	83 (41.5%)
Other	24 (12%)
Total	200 (100%)
<i>Types of consumer goods</i>	
Electricity	98 (49%)
Mobile	175 (87.5%)
Refrigerator	7 (3.5%)
Fan	93 (46.5%)
Clock	99 (49.5%)
Television	88 (44%)
Almira	38 (19%)
Khat	178 (89%)

and traditional mentality creates a barrier for women to receiving MHC services. The study found (Table 3) that more than half of the respondents had less control over resources. Their husbands were main controllers of all household resources. This indicates that the study women were economically not empowered suggesting that they naturally had few opportunities in making decision about seeking reproductive healthcare services.

However, a significant number of decision makers about receiving MHC services in an urgent situation were both husband and wife (Table 4). The number of husbands (56) making decision solely about reproductive health

Table 3: Who controls family resources?

Types of people	Respondents (%)
Self	43 (21.6%)
Husband	115 (57.8%)
Mother-in-law	15 (7.5%)
Father-in-law	11 (5.6%)
Other	15 (7.5%)
Total	199 (100%)

treatment was doubled as many as the number of females (28) making self decision. Likewise, as indicated in Table 5, 67.5% women had a lesser amount of freedom to go outside. That means, the permission for going outside for treatment comes from male household heads. Only 24 % women had freedom for movement outside and only 8.5% enjoyed free movement rights.

A positive relationship between women’s involvement in different organizations located outside home and receiving MHC services found in the literature. Only one hundred and seventeen women among two hundred were actively involved in activities of different organizations (Table 6). Almost all of them were involved in micro-credit activities. Only twenty eight reported that their organizations arranged

Table 4: Types of decision makers of reproductive health-related problems

Types of people	Respondents (%)
Self	28 (14%)
Husband	56 (28%)
Both	94 (47%)
Other	22 (11%)
Total	200 (100%)

Table 5: Freedom to move anywhere

Free movement	Respondents (%)
Yes	48 (24%)
No	135 (67.5%)
Sometimes	17 (8.5%)
Total	200 (100%)

Table 6: Types of activities organisations per-

Different issues	Respondents (%)
<i>Organisational involvement</i>	
Yes	117 (58.5%)
No	83 (41.5%)
Total	200 (100%)
<i>Types of program performed</i>	
Micro-credit	116 (99%)
Health-related	1 (0.5%)
Other	1 (0.5%)
Total	117 (100%)
<i>Arranging meeting</i>	
Yes	28 (24%)
No	89 (76%)
Total	117 (100%)
<i>Types of information provided</i>	
Female empowerment	1 (3.5%)
Maternal healthcare issue	14 (50%)
Child health issue	22 (78.5%)
Immunization	14 (50%)
Other	6 (21%)
Total	28

different types of meetings main focuses of which were child health (78.5%), MHC (50%), and immunizations (50%).

Marriage at an early age is another reason for poor women that causes in disempowering them to talk about healthcare seeking behaviour. Early marriage is a prevalent factor in less educated and financially insolvent households.³¹⁻³³ In this case, there is no exception. Most of the respondents got married at their earliest ages as they all had at least one baby. One girl, aged 13 years standing beside one FGD meeting place at Zianagar, had two-year old baby.

It has been reported in a daily newspaper that poverty, social insecurity and a trend to increase dowry with the rise in girl age push poor parents to give their daughters marriage at early age.³³ The early married women get pregnant when they are not physically and mentally ready for this. Even in most cases, they have less financial and mental capabilities to reach a right decision about seeking healthcare at the proper time. This lack of physical, mental and financial capacities due to marriage at an early age pushes lives of both young mothers and their would-be born babies at greater risks.

ii. Physical barrier

Distance

Distance of healthcare service delivery centre and time to reach there are significant issues that can influence people decisions on going to centres for treatment. In this study, these two factors are positively influencing mothers' decisions for receiving treatment from nearest healthcare centres. Ninety-two percent respondents reported the availability of healthcare centres at their nearest places. Nearly half of respondents travelled one and more than three quarters travelled two kilo meters for reaching the nearest healthcare centre (Table 7). It indicates that distance from household to healthcare centre is not a significant barrier for mothers to avail MHC services.

Table 8 showed that more than three-fourth respondents reached their nearest centres by walking while only one

Table 7: Distance respondents travelled for healthcare

Distance (Km)	Respondents (%)*
0.50	8 (4%)
1.00	84 (42%)
2.00	65 (32.5%)
3.00	31 (15.5%)
4.00	7 (3.5%)
5.00	2 (1%)
6.00	1 (0.5%)
Total	198 (99%)

*Multiple responses

Table 8: Ways of travelling healthcare centre

Different ways	Respondents (%)
Auto-rickshaw	55 (27.5%)
Rickshaw	37 (18.5%)
Boat	1 (0.5%)
On foot	153 (76.5%)
Other	1 (0.5%)

quarter used auto-rickshaw for the same purpose. Almost all respondents (97%) reached from their households to healthcare centres within a half an hour (Table 9).

Waiting time

The perception of people about waiting time for starting treatment is one of the indicators which creates significant influence in making decision about seeking healthcare from a particular centre. The study found that treatment of 65% respondents and of 30% respondents started 30 minutes and 60 minutes later respectively (Table 10). This suggests that service providers initiated treatment after they were reached. However, in some cases, the waiting time might differ.

iii. Opportunity costs

People with less education and social status feel discomfort to go to hospital because of their unfamiliarity with hospital environment. They certainly search knowledgeable people of hospital environment who can give them time during their visits. Accompanied people can use time given to them for productive purposes. For this reason, people are nowadays unwilling to go to healthcare centres for others. The study also found the same pattern. Table 11 revealed that around 44.5% respondents travelled alone and 21% travelled with husbands for getting to healthcare centres. The next available accompanying persons were either parents or mother-in-laws. That means, near relatives give their time when patients wish to visit medical centre and stay there.

Costs relating to treatment and others sometimes deter poor households from seeking care of highly

Table 9: Time for reaching healthcare centre

Time (minute)	Respondents (%)
1-15	94 (47%)
16-30	100 (50%)
31-45	0 (0%)
46-60	3 (1.5%)
Total	197 (98.5%)

Table 10: Waiting time for treatment

Time (minute)	Respondents (%)
1-15	61 (30.5%)
16-30	69 (34.5%)
31-45	10 (5%)
46-60	60 (30%)
Total	200 (100%)

Table 11: Types of accompanying persons in healthcare centre

Accompanying person	Respondents (%)
Parents	27 (13.5%)
Husband	42 (21%)
Sister	15 (7.5%)
Mother-in-law	26 (13%)
Sister/brother-in-law	25 (12.5%)
Neighbour	7 (3.5%)
Health worker	5 (2.5%)
None/self	89 (44.5%)
Other	11 (5.5%)

*Multiple responses

sophisticated hospitals. As indicated in Table 12, only 40% respondents paid money for initial treatment of the nearest centres and the range of payment was from one to sixty Taka. That means, the centres they went for treatment charge very minimal amount of money.

Table 13 suggested that nearly three quarter respondents spent not more than 2000 Taka for the last treatment. Only 16.5% spent more than 5,000 Taka for the same purpose. The percentage of respondents borrowing money from relatives for bearing exorbitant costs of treatment was 18 (Table 14). It is important to mention here that, as found from the conversation with service providers, the cost of normal delivery in NGO centre was 1000 or 1200 Taka while that of Caesarean delivery was 8000. Mariam, one FGD participant, mentioned that she needed more than 10,000 Taka for Caesarean baby delivery. This cost included no medicine costs. However, a poor woman delivered a baby normally at

Table 12: Money paid for visiting the centres

Range of amount	Respondents (%)
1-15	35 (17.5%)
16-30	32 (16%)
31-45	8 (4%)
45-60	5 (2.5%)
Total	80 (40%)

Table 13: Treatment costs

Range of money	Respondents (%)
1-1000	117 (58.5%)
1001-2000	30 (15%)
2001-3000	10 (5%)
3001-4000	7 (3.5%)
4001-5000	3 (1.5%)
5000+	33 (16.5%)
Total	200 (100%)

Table 14: Borrowed money and its related issues

Different issues	Respondents (%)
<i>Self expenditure</i>	
Yes	158 (79%)
No	36 (18%)
Total	194 (97%)
No response=6	
<i>Types of sources*</i>	
Relatives	36 (100%)
Neighbour	3 (8%)
Friends	2 (5.5%)
Money lender	1 (2.7%)
NGOs	10 (27.7%)
Total	36
<i>Methods of repayment*</i>	
Instalment	13 (36%)
Extra work	5 (13.8%)
No need to repay	23 (63.8%)
Other	7 (19.4%)
Total	36
<i>No of days needed for repayment</i>	
1-30	15 (68%)
31-90	4 (18%)
91-365	3 (13%)
Total	22

*Multiple responses

free of costs. In contrast, half of the Caesarean delivery expenses were waived for poor women. A person with a LA (least advantage) card could receive medicine worthy 150 Taka free. He or she could receive free medicine four times in a month. This facility was available up to four members of a family and one year. Most borrowers repaid nothing as they borrowed money from their kins. Those who repaid used instalment method or did extra work. In most of the repayment cases, it took a month.

iv. Organisational barrier

Gender dynamics

Males were the main service providers in most centres we made visits. Naturally respondents hesitated to explain their problems to them due to social construction of mind. Most participants in FGDs complained that they could not express their physical problems to male doctors. When the condition became worse, they purchased medicine from local pharmacy showing paper on which symptoms were written.

Quality of care

The perception developed about quality of healthcare services sometimes influences people's decisions on taking care from any particular healthcare centre. The study found satisfaction of respondents about treatment quality of centres. Most respondents (92%) had opportunities of talking with doctors about their problems (Table 15). nearly half of the respondents reported that they could talk about their problems from six to ten minutes whereas 33% talked up to five minutes. Nine in ten women were satisfied with treatment of centres visited and 96% expressed their opinion of revisiting these centres in need of future. However, only 30% reported that everything was clearly explained to them. That means, though most

Table 14: Quality of care of the centres visited

Different criteria	Respondents (%)
<i>Types of consultants*</i>	
Doctor	194 (92%)
Nurse	25 (12.5%)
Health assistant	18 (9%)
<i>Consulting time (minute)</i>	
1-5	66 (33%)
6-10	85 (42.5%)
11-15	20 (10%)
16-20	17 (8.5%)
21-25	0
26-30	11 (5.5%)
Total	199 (99.5%)
<i>Satisfaction</i>	
Yes	180 (90%)
No	19 (9.5%)
Total	199 (99.5%)
<i>Revisit in future</i>	
Yes	192 (96%)
No	5 (2.5%)
Total	197 (98.5%)
<i>Explaining issues</i>	
Yes	60 (30%)
No	138 (69%)
Total	198 (99%)

*Multiple responses

respondents were satisfied with treatment quality, seven in ten were not happy with the doctors' seriousness of their physical problems. Lack of sufficient time of the service providers due to their huge involvement in the administrative work and non-development of culture of explaining everything to patients could be reasons for this dissatisfaction.

The overall quality of service centre can be improved further if genuine coordination is established among different organisations with the same bundle of healthcare services, thereby producing no inclusion or exclusion error in the project area. The study found lack of coordination among service providing organisations, therefore providing same services by different organisations in same area, as one of the prime organisational barriers to further improvement of health service quality.

Lack of coordination and overlapping

Almost all organizational centres visited had a provision of delivering 40 or 30 % services at free of costs to poor. They introduced a card for administering this free service. The main criteria they used for identifying poor were level of income (not more than 2000 Taka), widow or divorcee, landless and household size. They distributed the card for free services in 2003. Ten years later criteria were revised. The consultation made with service providers and opinion expressed during FGD hinted that they were not sure about criteria of measuring free services. They opined that they provided services full free in a whole day. Even in some cases, patients bargained for free services and they also provided free services. The lack of clear-cut criteria about free services and of a clear definition of the poor was one of the main reasons for generating low amount of revenues. For instance, one centre reported that they earned only 20,000 Taka against 100,000 (total costs of the centre) last month.

A few number of good service delivery organizations were available in study areas. People had more than one card for receiving free services from different organizations. Resultantly, patients took same medicine from different organizations that might cause physical problems in their bodies. Most organizations set target for field workers (FWs). This target exerted pressures on FWs for dispensing medicine among people who received same service from other organizations. In some cases, FWs crossed their catchment areas for fulfilling the target.

Doctors in NGO centres were less attentive to patients and efficient in service delivery. An experienced doctor showed unwillingness to dispense services result of insecurity in job. Therefore, centres had no alternative options rather recruiting a newly graduated doctor. This insecurity in job pushed newly appointed doctors to involve in other activities, such as giving time to get a permanent job, which diverted their time from delivering services attentively. In some cases, doctors left organizations after providing services for two years. If doctors are well-mannered and reputed, people naturally seek them during their next visits. The absence of the same doctor in healthcare centre was one of the main reasons for which mothers hesitated to go there again for further treatment.

Discussion

Physical and financial barriers are less acute than socio-cultural barrier

Girls' marriage at early age is prevalent in Bangladesh.³⁴⁻³⁷ This causes pregnancy at an earlier life of their reproductive span. Women getting pregnant at early age may face many complications compared with women being pregnant at matured age. Less access to safe drinking water and to sanitary latrines, and congested living room resultantly hampering privacy, may jeopardize their complications. All these complications may push their lives at greater risks. In addition, patriarchal social norm disempowers women physically, mentally and financially. These women lastly fail to go outside for different purposes, particularly receiving treatment from outside doctors. This argument has been corroborated by other studies.³⁸⁻⁴⁴

The Government of Bangladesh has taken many initiatives for reaching people's doorsteps with healthcare services since independence.⁴⁵⁻⁴⁸ Other private and NGOs have also been trying to provide healthcare services at people's convenient places. All these endeavours have resulted in building healthcare service delivery centres and providing healthcare services at people's doorsteps. Three-fourth respondents have healthcare centres (within two kilometres radius) where they can reach on foot in a half an hour. As many organisations are available for providing services on a competitive basis, they always like to keep patients less waiting for treatment. Waiting time found in most cases is maximum a half an hour.

Most women in study areas receive free treatment. They spend money for convenience or drugs. It is important to mention here that they receive drugs in subsidised prices. In complicated situations, here the need for caesarean delivery, it is necessary for mothers and their families to manage huge amounts of money, although the number of such cases was insignificant (1.5%). When needed, they usually borrow money from either relatives or micro credit organisations/money-lenders. Customarily, money borrowed from relatives need not to be repaid. It seems that physical and financial barriers do not create hindrances to making decisions for receiving MHC services.

Organisational barriers are keen

Most of the centres in study areas have male doctors to whom respondents feel shy talking about their physical conditions. This shyness is socially and culturally constructed. They were forced to open their mouths when they found that their physical conditions were at high risks. Almost all centres visited during the study period had a provision of dispensing 30% or 40% services free to poor. Inconsistencies in definitions of poor family of different organizations resulted in generating exclusion or inclusion error in the project. In addition, poor family had more than one card which ensured free treatment and subsidized medicine to a limited extent. Consequently, poor family had same services and treatment at free of costs from different organizations at a time. These two factors (more than one card in each poor family and crossing the catchment areas result of fulfilling targets set by organizations)

caused in overuse of free medicine. Realizing this issue at the field level, all experts in a roundtable discussion urged for strengthening the coordination between government and NGOs in order to meet the reproductive health-related target, including the reduction of high maternal deaths.⁴⁹

As most organizations are project based, experienced doctors are usually unwilling to serve there with due attention. Even if some experienced doctors join there, they always want to discontinue their jobs once they find any suitable and permanent jobs. Their sudden leave from organizations results of availing suitable and permanent jobs hampers continuation of organizational activities that jeopardizes poor mothers' access to MHC services. A plethora of studies^{17-19,50} also identify organizational barriers, such as lack of good quality services, unavailability of service providers, untimely response from healthcare providers, that detract women, in particular poor, from receiving due service at due time.

Conclusion

Girls are getting married at their early ages because of social customs and norms. This causes women getting pregnant earlier that create their lives at greater risks. Less access to safe drinking water and to sanitary latrines and living in a dirty environment also aggravate their risks. As most services of different organizations — providing free treatment and subsidized drugs for the poor to a limited extent—are readily available, physical and financial factors seem not to affect poor household's decision about seeking care from their nearest centres. However, the lack of a clear-cut definition of the poor creating troubles in fulfilling target thereby causing in/exclusion errors in the project, absence of doctors in service centres owing to sudden leave, overlapping service delivery (providing same services by different organizations in same area at a time) and lack of coordination among different organizations about catchment areas resulting in over use of free healthcare services, including medicine, are the prime factors that hamper further improvement of MH in study areas. The study therefore suggests the following recommendations for further improvement of MH in urban areas.

- Building awareness of bad consequences of early marriage on MH through mobilization of community and using print and electronic media.
- There should be coordination about free healthcare services. The government should fix one centre which provides free services in a particular area. So that over use of free services can be stopped.
- Female doctors should be encouraged to work for poor.
- Developing a method how to retain doctors in the project areas for a longer time.

Competing interest

The authors declared that there is no conflict of interest.

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