Awareness Regarding Government Primary Healthcare Services and Their Utilization Status Among Women: A Case Study in Kushtia Sadar Upazila, Bangladesh

** Md. Ariful Islam*

Abstract

The study examines the awareness level about the government primary health care services and their utilization among married women in Kushtia Sadar Upazila under the Kushtia district of Bangladesh. To find out the association, the factors such as demographic, socioeconomic, and cultural/community were considered as the control variable. The target population was all married women with their youngest child who was <5 years of age in Kushtia Sadar Upazila, Bangladesh. Primary data was mainly used examine the awareness status of women regarding the utilization of government primary health care services. Secondary data was also utilized for necessary comparison and comments. The findings of study showed that the awareness levels of the rural women in the study area was not up to the mark as compared to the standard level. The study findings also show a significant age differential in the knowledge of various preventable disease vaccines.

Keywords: **health care, rural women, awareness level, health care facilities, vaccination**
JEL Classification: I000, I100, I180, I190

Paper Submission Date : July 7, 2013 ; Paper sent back for Revision : August 5, 2013 ; Paper Acceptance Date : September 9, 2013

Health is an important indicator of development of any country. As per the Constitution of the People's Republic of Bangladesh, as of May 17, 2004, access to health care facilities is a basic right for every citizen. It is an obligatory responsibility of the government to ensure health care facilities for all the citizens of the country (Bangladesh Ministry of Health and Family Welfare, Government of Bangladesh). Bangladesh suffers from relatively higher levels of malnutrition in the world, and it has a high population density with about of 78% people living in the rural areas (Bangladesh Rural Advanced Committee (BRAC, 1997)). The World Bank data shows that about 31.51% (2010 est.) of the people have still been living below the absolute poverty line (The World Bank, n.d.). According to the Human Development Report (HDR), Bangladesh was ranked 146th in HDI with multidimensional poverty index (MPI) of 0.291 (Bangladesh Economic Review, 2010).

The country has been facing many problems, and health care services is one of them (Uddin & Bhuiya, 2003). Poor and inadequate health services have been acting as an obstacle in the overall development of this country (Afsana & Rashid, 2001). The overall health status of the people of Bangladesh is quite low from the acceptable standards. This is particularly true for mothers and children, who have the worst health statistics (Amin, 2000). Kane, Khuda, and Philips (1997) stated that Bangladesh has a long tradition of delivering babies at home. Delivery related complications are one of the leading causes of maternal mortality in Bangladesh. In rural areas, one-third of the women experienced delivery related complications in their last delivery. A recent report on Maternal Mortality and Health Care Survey 2010 showed that maternal mortality per thousand live births in Bangladesh was estimated at 2.16% in 2010, while infant (1<yr) mortality rate was 36 per 1000 live births (Bangladesh Economic Review, 2010, p.164).

Child-bearing starts early and continues at frequent intervals, so maternal depletion syndrome is common in Bangladesh. Malnutrition, which is highly prevalent in Bangladeshi women, makes them more vulnerable to diseases (Akther, 2003). The whole situation is further aggravated by low levels of awareness, ignorance of safe birth practices, poor socioeconomic conditions, poor coverage, and low utilization of the available health care facilities (Barkat, Majid, Akhatara, & Hossain, 1998). Several studies on utilization of healthcare services have found a

**Assistant Researcher (Economics)*, Uttara University, Dhaka, Bangladesh. Email : arifbsbd@gmail.com

relationship between utilization behavior and socioeconomic and demographic factors such as age, education, occupation, place of residence, religion, and family income (Ahmed, 1992; Rahman, Chen, Chakraborty, Yunus, Faruque, & Chowdhury, 1982). Therefore, majority of mothers of the country do not get enough opportunity to take antenatal and postnatal care during their pregnancy period. As a result, every year, 320 women per 100000 women perish due to pregnancy related complications (NIPORT, 2003).

Objectives of the Study

This study attempts to investigate women's awareness regarding government primary health care services and its utilization status in Kushtia Sadar Upazila, Bangladesh. Though there are a large number of indicators that are directly or indirectly related to the utilization status of health care services, the present study focuses on some selected vital issues such as: Knowledge of rural women about health care facilities, knowledge on immunization, knowledge about appropriate time and doses for specific immunization, vaccination given to the youngest child and the place of vaccination, reasons for not getting the child vaccinated, reasons for not visiting a government hospital, and finally, the satisfaction of the respondents from the government primary health care services.

Rationale of the Study

The utilization of the government primary healthcare services is vastly dependent on the awareness level of the respective beneficiaries. In view of high incidence of the infant and maternal mortality rates and related health problems, it is important to investigate how these vulnerable groups are utilizing the health care services provided by the government, and examine the problems related to health care services experienced by them. Since no elaborate study is available on this important issue, the present study provides significant information about the awareness level of the rural women regarding the utilization of the government primary healthcare service and their limitations in the locality - which will tremendously help the policy makers and as well as the government to take appropriate steps for the maximum welfare of women and children, especially in terms of getting health services from government interventions.

Research Methodology

The main purpose of the study is to assess the status of women's awareness on government primary health care services and its utilization in rural areas of Kushtia Sadar Upazila under the Kushtia district of Bangladesh. The primary study was conducted in between February - June 2012 in the same area of Bangladesh. The sample population were all such women who had given birth to at least one child in last five years in this region. A single-stage cluster sampling design was adopted because of its principle of simplicity, low cost, expeditious nature, and ease of operation. A total 10 villages were divided into five different clusters (geographical area), each of them having two villages. Then, one village was randomly selected from each of the clusters. After selecting five villages, all women between the age group of 15 to 49 years were considered, and finally, a total sample of 300 married women agreed to participate in the survey. In-depth interviews using individual questionnaires were conducted to collect the information. The collected data was entered in the data file using statistical software called SPSS (Statistical Package for Social Sciences), and the data were analyzed statistically. Frequency distribution and descriptive statistics were used to explore the background characteristics of the sample population.

Results and Discussion

This section focuses on the analysis part comprising of the socioeconomic and demographic information and awareness level of rural women regarding the government primary health care services and also, it sheds light on the attitude of the sample respondents towards the utilization of different healthcare services provided by the government. The Table 1 shows that about two thirds of the respondents fell in the age group of 21-34 years. Nearly 37% of the respondents were found to be illiterate, and there was a big gap in the percentage of respondents who were

Table 1. Socioeconomic and Demographic Information of the Sample Population (n=300)

Variables	(n)	%
Age		
Below 20 yrs	27	9.0%
21-34 yrs	217	72.3%
35-49 yrs	56	18.7%
Education		
Illiterate	111	37.0%
Primary Education	132	44.0%
Secondary Education	37	12.3%
Higher Secondary	15	5.0%
Graduation	5	1.7%
Occupation		
Housemaid	7	2.33%
Housewife	266	88.7%
Service holder	27	9.0%
House Type		
Kutcha	134	44.7%
Semi-pucca	145	48.3%
Pucca	21	7.0%
Access to Pure Drinking Water		
Yes	267	89.0%
No	33	11.0%
Basic Sanitation		
Yes	169	56.0%
No	131	44.0%
Landownership		
landless	23	7.7%
0-17 decimals	74	24.7%
17-33 decimals	99	33.0%
Land>33 decimals	104	34.7%

Source: Field Survey 2012

Table 2.Awareness Level of Rural Women about Health Care Facilities in their Locality (Actual & Percentages) (n=300)

Awareness level of rural women about health care facilities in their locality			
	Yes	**No**	**Total**
Have knowledge about government health care centre in their locality.	243(81.0%)	57(19.0%)	300(100.0%)
Know the name of the health care center in their locality.	177(59.0%)	123(41.0%)	300(100.0%)
Have knowledge about the service delivered by the health care center.	182(60.7%)	118(39.3%)	300(100.0%)
Have knowledge about whether to utilize the govt. health care facility or not.	115(38.3%)	185(61.7%)	300(100.0%)

Source: Field survey 2012

Table 3. Distribution of the Women in Terms of Awareness of Different Vaccines

Sl. No	Name of Vaccine	Awareness Level (Actual & percentages)			
		Age <20	Age 21-34	Age 35-49	Total
1	TT	27 (100.0%)	206 (94.9%)	49 (87.5%)	282 (94.0%)
2	DPT	13 (48.1%)	127 (58.5%)	28 (50.0%)	168 (56.0%)
3	Polio	27 (100.0%)	210 (96.8%)	55 (98.2%)	292 (97.3%)
4	BCG	19 (70.4%)	101 (46.5%)	28 (50.0%)	148(49.3%)
5	Measles/Ham	27 (100.0%)	212(97.7%)	56 (100.0%)	295 (98.3%)
6	Hepatitis B	4 (14.8%)	83 (38.2%)	5 (8.9%)	92 (30.7%)
7	Pentavalent	0 (0.0%)	9 (4.1%)	0 (0.0%)	9 (3.0%)
8	**Total**	**n=27**	**n=217**	**n=56**	**n=300**

Source: Field survey 2012.

Table 4. Distribution of the Respondents According to Knowledge on Correct Age Range for Specific Immunization (Actual & Percentages)

SL. No.	Name of Vaccine	Age Group						Total	
		Age <20		Age 21-34		Age 35-49			
		Yes	No	Yes	No	Yes	No	Yes	No
1	TT	17(63.0)	10(37.0)	120(73.8)	82(37.8)	26(46.4)	26(46.4)	163(54.3)	118(39.3)
2	DPT	11(40.7)	16(59.3)	88(40.6)	129(59.7)	22(39.3)	34(60.7)	121(40.3)	179(59.7)
3	Polio	6(22.2)	21(77.8)	47(21.7)	170(78.3)	13(23.2)	43(76.8)	75(22.0)	225(78.0)
4	BCG	3(11.1)	24(88.9)	50(23)	167(77)	7(12.5)	49(87.5)	60(20.0)	240(80.0)
5	Measles	10(37.0)	17(63.0)	97(44.7)	120(55.3)	19(33.9)	37(66.1)	126(42.0)	174(58.0)
6	HepB	1(3.7)	26(96.3)	9(4.10)	208(95.9)	6(10.7)	50(89.3)	16(5.3)	284(94.7)
7	Penta.V	0	0	0	0	0	0	0	0
	Total		**n=27**		**n=217**		**n=56**		**n=300**

Source: Field Survey 2012. Note: - **TT:** Three injections given to mother at monthly intervals during the last trimester.
DPT: Two to three doses to baby at 1-3 months of age. **Polio:** One to two drops three times to baby at 1-3 months of age.
BCG: One injection within one month of age. **Measles:** One injection at 9-10 months of age

educated till the primary and secondary level. About 44% of the respondents were educated up to the primary level, while only 12.3% of the respondents had studied up to the secondary level, and only a handful, that is, 1.7% of the respondents were found to be graduates. Regarding occupation of the sample respondents, a majority of the women (88.7%) were found to be home makers, and about 9% of the respondents were employed in service. Semi-pucca (48.3%) and kutcha houses (44.7%) were the most common types of houses found in the study area . About 89% of the respondents were found to have access to pure drinking water and about 56% of the respondents had access to proper (closed) toilets, while about 44% of the respondents did not have access to proper (closed) toilets. Land ownership was found between 17-33 decimals in 33% of the respondents.

The Table 2 reveals that about 81.0% of the total respondents knew of at least one health care centre in their locality which provided different types of health care services, while 19.0% women reported that they did not know about the government health care centre in their locality. Similarly, we asked the mothers whether they could mention the name of at least one centre in their local area, and about 59 % of the total respondents answered in the affirmative, while little higher than 40% of the women were unable to mention the name of the health care centre. As per the Table 2, the women who did not utilize the services of the government health care centres were about 61.7%, while 38.3% women utilized the services offered by the government health care centres. The study found that a significant portion of the rural women (about 60.7%) had knowledge about the services delivered by the government health care centres, and the remaining 39.3% women did not have enough knowledge about the services delivered by the government primary

Table 5. Distribution of the Respondents According to the Vaccination of the Youngest Child and the Place of Vaccination

A		
Sl. No	**Respondents**	**Actual & Percentages**
	Vaccination given to the youngest child	
1	Yes	270 (90.0)
2	No	24 (8.0)
3	No response	6 (2.0)
	Total (n=300)	**300 (100)**

B		
Place of Vaccination	**Frequency**	**Percent**
Government Hospital	56	18.7%
EPI Centre	197	65.7%
Satellite Clinic	9	3.0%
Others	14	4.7%
Total	276	92.0%
Not Answered	24	8.0%
Grand Total	**n=300**	**100%**

Source: Field survey 2012

Table 6. Reason for not Visiting the Government Health Care Centre in the Locality

Reason for not visiting	Frequency	(%)
Far away from home	87	29.0
Staff pays little attention	56	18.7
Misbehavior	103	34.3
Non availability of medicines	49	16.3
Others	5	1.7
Total	**300**	**100.0**

Source: Field survey 2012

health care centres.

The Table 3 indicates that among the individual vaccines, the Measles/Ham vaccine was known to the highest proportion (98.3%) of the respondents, followed by knowledge about Polio vaccine (97.3%), TT (94.0%), DPT (56.0%), BCG (49.3%), Hepatitis B (30.7%), and Pentavalent (3.0%). The awareness levels about the vaccines namely, TT, Polio, and Measles were satisfactory among the respondents. On the other hand, in case of vaccines like DPT, BCG, and HepB, only 56.0% of the total respondents knew about the DPT vaccine, and 49.1% and 30.7% knew about BCG and HepB vaccines respectively. These findings are not satisfactory, and this indicates that the awareness levels of the respondents about the said vaccines was found to be low.

The Table 4 reveals that about 54.3% of the respondent rural women knew at what age their child was to be given the vaccination of TT, and only 20% of the total women respondents knew the proper age for vaccination of BCG. On the other hand, about 80.0% of the women either knew partially or did not know the proper age for vaccination of BCG. An astonishing 94.7% of the respondents either knew partially or did not know anything about what age their child was to be given the vaccination of HepB. Thus, the awareness level of rural women about health care services was not up to the mark.

The Table 5A reveals that about 90% of the women reported that their youngest child was immunized (Table 5A). The Table 5B shows that about 71.4% percent of the respondents reported that they had taken their child to the EPI center for immunization followed by taking the child to the government hospital (20.3%), satellite clinic (3.3%), and

Table 7. Respondents' Satisfaction with the Government Primary Health Care Services

Sl. No	Respondents	Actual & Percentages
1	Yes	250 (83.3)
2	No	50 (16.7)
	Total (n=300)	**300 (100)**

Source: Field Survey 2012

others (5.1%) respectively.

The Table 6 shows that about 29.0% (n=87) of the women reported that because of the long distance from their place of residence, they were reluctant to visit the government health care centre. Highest proportion of women (34.3%, n=103) did not visit the government health care centre due to the staff misbehaving with them, and 18.7% (n=56) of the women reported that the staff paid little attention to them. About 16.3% of the married women reported that the doctors, midwives, or the duty nurse often said they did not have the required medicines to treat their ailments. Many of the respondents reported that they did not receive proper health care services at the government health centre, however, the Table 7 shows that 83.3% (250) of the respondents were satisfied with the government health care services, mainly the immunization facilities provided for the children and women (conducted by the EPI). However, considering the health care services (in totality) provided at the government health care centre, about 16.7% (50) of the respondents were not satisfied with the services provided to them.

Conclusion

Based on the findings from the study, this section provides a brief discussion and conclusion. It was observed that the knowledge about government health care centers as well as type of health facilities available was relatively poor among the rural women within the study area. About 41.0% of the rural women did not know anything about at least one service delivered by the govt. primary health care centre. It was found that the overall utilization level of health care services by the rural women was not satisfactory. At the aggregate level, 38.3% of the women reported to have utilized the govt. healthcare services to some extent, and the remaining 61.7% had not utilized the existing health care facilities. The study findings show a poor statistics with regards to the respondents' knowledge of correct age range for specific immunizations. Rural women were found to be less aware in this regard. About 94.7% of the total women respondents reported that they did not have the knowledge on correct age range for Hepatitis B vaccine. In the same fashion, poor statistics were found in case of BCG vaccine, where only 20 % respondents had the knowledge about the correct age range for the respective vaccine. The respondents were also questioned about the main reasons for them not visiting a govt. hospital . Among the identified reasons, bad behaviour of the lower class medical staff of the hospital was the most important reason (34.3%), followed by long distance from the respondents' residence (29.0%), and staff not attending them properly (18.7%) . It was observed that for the treatment of sickness, a significant proportion of the rural mothers still relied on the rural quacks despite the availability of qualified government physicians in the health care centres.

Policy Implications and Recommendations

The study confirmed that the government primary healthcare services are not utilized at the expected level in the rural community within the study area. Our study identified three main factors resulting in the services being out of reach for many rural women: First, low awareness level of rural women and the second reason is that these govt. health care centres are located at a great distance from the respondents' residence, and finally, culturally defined limitations restrict the mobility of the rural women. To decrease the maternal and child mortality in the rural community, it is important to increase the health awareness among the women. Proper steps should be taken to create awareness among rural women as well as their parents and the community leaders about the importance of mother and child health. Awareness also needs to be raised among the people about the social, economic, and health related consequences of early marriage, early pregnancy, and a large family.

Government health care facilities available at the rural health centers remain underutilized by the rural women. These women do not have proper access to modern health care facilities due to their ignorance and traditional beliefs. Distance of the health care centers from the respondents' residence also acts as a dominant factor for not utilizing the services rendered by the health care centers. The government should take appropriate measures to enhance the confidence of the rural women as well as of their husbands and other family members regarding modern health care facilities through motivation, health education, and improved quality of care. Finally, proper steps should be taken to bring the health care services at the doorstep of the rural women. For that, a number of health care centers can be increased so that the health care facilities fall within the reach of the rural women (are near to their place of residence). Measures should be taken to arrange mobile clinics within short distances in the heavily populated areas, as well as steps should be taken to ensure home visits by the Government health personnel. Despite some limitations, the study is very important from the viewpoint of the rural women and the policy makers. Rural women in this study were identified as being less knowledgeable regarding the utilization of the government health facilities. This implies that utilization of govt. primary healthcare services depends on the enthusiasm as well as awareness level of the rural women.

References

Afsana, K., & Rashid, S. E. (2001). The challenges of meeting rural Bangladeshi women's needs in delivery care. *Reproductive Health Matters, 9* (18), 79-88.

Ahmed, A. U. (1992). Socioeconomic determinants of age at first marriage in Bangladesh. *Journal of Biosocial Science, 18* (1), 35-42. DOI: http://dx.doi.org/10.1017/S0021932000006477

Akther, H. H. (2003). *Baseline survey for assessment of EOC services in Bangladesh*. Bangladesh Institute for Promotion of Essential and Reproductive Health Technologies (BIRPERHT): Dhaka.

Amin, M. N. (2000). *Knowledge on safe motherhood among the eligible couples in selected unions, Bangladesh*. MPH (Community Medicine) Session (1999-2000). Dhaka: National Institute of Preventive and Social Medicine (NIPSOM).

Bangladesh Ministry of Health and Family Welfare. (2002). *Program implementation plan (PIP), Part-II.* Dhaka: Government of Bangladesh.

Bangladesh Rural Advanced Committee (BRAC). (1997). *A study on domestic violence against women in rural Bangladesh*. Dhaka: BRAC.

Barkat, A., Majid, M., Akhatara, S., & Hossain, M. (1998). *Maternal mortality and morbidity in Bangladesh: Situation analysis, lessons learned and future strategies*. Presented at inter-regional workshop on South-South Collaboration on the reduction of maternal mortality and morbidity, partners in population and development and CARE International, Harare, Zimbabwe, October 5-9, 1998.

Government of Bangladesh. (2010). *Bangladesh economic review 2010* (p.164). Ministry of Finance, Government of Bangladesh.

Kane, T. T., Khuda, B., & Philips, J.F. (1997). *Reproductive health in rural Bangladesh: Policy and programmatic implications.* Dhaka : International Centre for Diarrheal Disease Research, Bangladesh (ICDDRB).

National Institute of Population Research and Training (NIPORT) (2003). *Bangladesh maternal health services and maternal mortality survey 2001*. Retrieved from http://www.measuredhs.com/pubs/pdf/FR142/FR142.pdf

Rahman, M., Chen, L.C., Chakraborty, J., Yunus, M., Faruque, A.S., & Chowdhury, A. I. (1982). Use of tetanus toxoid for the prevention of neonatal tetanus. 2. Immunization acceptance among pregnant women in rural Bangladesh. *Bulletin of the World Health Organization, 60* (2), 269- 277.

The World Bank (n.d.). *World development indicators*. Retrieved from http://data.worldbank.org/country/bangladesh

Uddin, K., & Bhuiya, A. (2003). *Utilization of the government health care services: A study on married adolescents in rural Bangladesh*. The Islamic University Studies, Part-C.