General and Maternal Health Status of Rural Women in Bangladesh: A Descriptive Study from Two Remote Villages

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Citation

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Abstract

Numerous efforts have been made by the government to reach primary, maternal and neonatal health care services to the doorsteps of the rural Bangladesh. The aim of this descriptive study was to gauge the general and maternal health status of rural women. A pre-tested questionnaire based survey was conducted in two remote villages among 357 women in Bangladesh. Contraceptive methods were used by 55% women and 70% of the antenatal care was provided by untrained traditional birth attendants (TBA) or relatives. About 95% of the women did not receive any antenatal investigations. Nearly 18% of women had one or more induced abortions, while 35% and 41% experienced a stillbirth and a neonatal death respectively. On a positive note, 98% of women had a normal vaginal birth and 83% had received tetanus toxoid immunization. Except tetanus immunization overall health status of the rural women in these two villages was found vulnerable.

INTRODUCTION

Bangladesh is considered a developing country with more than 75% of the total (142 million) population living in rural areas. About 36% of the population continue to live below the national poverty line (<US$1/day). Basic needs of living particularly health and education remain largely unmet and only less than 40% of the population has access to basic healthcare.[1,2] Most (97.6%) rural households have access to clean drinking water but only 33.9% households have access to improved latrine system. More than half (56%) of the rural population are landless.[3] Maternal mortality ratio is still very high (380/100,000 live births) with a lifetime risk of 1 in 59. Infant mortality rate (per 1000 live birth) and neonatal mortality rate (per 1000 live birth) are 56 and 36 respectively. In spite of government's policy of free healthcare, the average cost for uncomplicated vaginal delivery or emergency cesarean section beyond the monthly income of most of the population.[4]

RURAL HEALTH CARE SERVICES INFRASTRUCTURES IN BANGLADESH

Public health sector at the local level consists of 3,275 Union Health and Family Welfare Centres. Additionally there are 391 Upazila (sub-district) Health Complexes and 64 district hospitals. There are also 54 Maternal and Child Welfare Centers established to provide maternal services at the district and Upazila level.[5] Despite impressive expansion of the physical infrastructures in this sector, manpower shortage coupled with, rampant corruption, lack of cleanliness, long waiting time, absence or lack of doctors and nurses, inappropriate behaviour of caregivers, the public health care system has lost its credibility and people have limited confidence in it.[6] This study was undertaken to explore the general and maternal health issues of rural Bangladesh. The specific objective of this study was to identify to what extent do the rural women are getting benefited from available healthcare facilities and what are the socio-demographic factors leading them towards poor health conditions.

MATERIALS AND METHODS

SUBJECTS AND SETTINGS

The study involves 357 randomly selected women who were working in their homes. The two villages selected for the study were Khayerhuda and Monoharpur of Chuadanga district, almost 300 Kilometers away from the capital city, Dhaka.

STUDY DESIGN

This cross-sectional study involved face-to-face interviews conducted at women's home with pre-tested mixed type questionnaire consisting of both open end and closed end

questions. Data were collected mainly on socioeconomic status, pregnancy-related care and services, extent of morbidity during the pregnancy period, general diseases, delivery and abortions. Pregnant or seriously ill subjects were excluded from the study.

DATA COLLECTION AND ANALYSIS

Data were collected during September-November, 2006. One woman from each house was selected to cover a wide range of participants. Total number of households as collected from local government office was 3650 (1895 from Khayerhuda and 1755 from Monoharpur). Every 10th house was selected as by systematic random sampling method. A total of 366 questionnaires were obtained (190 from Khayerhuda and 176 from Monoharpur) during the study period. Nine questionnaires were rejected (three from Khayerhuda and six from Monoharpur) due to incomplete responses. Finally, a total of 357 questionnaires were analysed for necessary data. Statistical parameters calculated in this study include mean, standard deviation and percentile. Microsoft Excel 2002 version Windows XP professional was used to perform data analysis. The study protocol was reviewed and approved by the research ethics committee of Rural Healthcare and Education Development Organization (RHEDO). Informed consents were taken from all the subjects and the household heads.

RESULTS

Forty percent of the households were landless while 44.5% did not have any regular income. Only 1.7% families had a monthly income of more than Taka 5000 (USD 70), while 23.8% had from Taka 1000 (US$ 14) to Taka 2000 (US$ 28) per month. About 9% of the women had any income at all to support their families. All the respondents mentioned that tubewell (hand pump for safe drinking water) as main drinking water source but many of them washed utensils in pond water. Nearly half of the households did not have any latrine at all and used bush or open places for defecation. Seventy two percent of the women used soap to wash hands after defecation but hand-washing was often inappropriate. Sometimes they also used soil or ash when soap was not available.

About 20% women arranged some polythene sheets on which to give birth, and 42.1% gave birth on soil while 36.1% gave birth on a piece of mat. Only 7% of women had the opportunity to visit nearby satellite clinics or FWCs (Family Welfare Centers) accompanied by untrained TBA (Traditional Birth Attendants) or FWA (Family Welfare Assistants). Self-motivated sterilization was almost absent among all the women. Many of the participants disclosed that sterilizations were attended with financial allurement or sometimes forcibly, even under the threat of police. A summary of the socio-demographic and health status characteristics has been depicted in the following table:

Figure 1

Table 1: Socio-demographic and maternal health statistics (Total subjects: N=357)

Characteristics		Number / (%)
Age Group (year)	Mean/ SD	
15-25	21.0/(2.39)	104/(29.1)
25-30	27.3/(1.11)	107/(30.0)
30-45	35.4/(3.94)	104/(29.1)
45-50	47.6/(1.23)	42/(11.8)
No regular family income		159/(44.5)
Self earning women		32/(9.0)
Sanitary latrine use		29/(8.1)
Routine check-up during pregnancy period		18/(5.0)
Abortion experiences		64/(17.9)
Stillbirth cases		127/(35.5)
Neonatal deaths		148/(41.5)
Contraceptive uses		195/(54.6)
Rate of normal vaginal delivery		351/(98.2)
Delivery occurred at home		344/(96.4)
Formal antenatal care services		Nil
Antenatal care by untrained TBAs		251/(70.3)
Tetanus toxoid immunization		297/(83.3)

Most of the respondents attended quacks or kabiraz (traditional healers) for general illnesses. Diarrhea was the most common disease experienced by participants. Of those affected by diarrhea, only 13.4% took ORS (Oral Rehydration Saline). Approximately, 75.1% women consumed fish once a week, 88.2% took meat once a month during any special occasion and 8.1% women reported that they ate meat only during the Eid-ul-Adha (a religious festival of the Muslims).

DISCUSSION

The study results showed that women living in the two villages suffered from various general and maternal health complications mainly due to little access to healthcare facilities, inadequate nutritional status, lack of significant

financial activities and lack of proper sanitation systems. Except tetanus toxoid immunization and contraceptive use, all other health indicators were found below satisfactory level in this study. Total formalized perinatal care services appeared to be of primitive level among the study population. Ill health, low income, lack of access to health education, proper sanitary systems, lack of clean water, and lack of other essential health care services were found predominant in this study. On a positive note significant portion of the population had adequate access to clean drinking water in the study areas.

It is evident that about 12,000 women die from maternal causes each year in Bangladesh.[7] Moreover, nearly 37% of rural women in the country are considered as thin or malnourished (body mass index <18.5 kg/m^2).[8] Previous study showed that only a small percentage of households regularly consume animal foods, vegetables and other good sources of micronutrients in Bangladesh.[9] The present study further showed that women in these two villages also took inadequate food stuffs during the study period. Available reports suggested that nearly half (49.1%) of the rural women did not receive any type of ANC during pregnancy for the most recent birth in Bangladesh. The proportion of pregnant women receiving tetanus toxoid immunization has risen substantially to 84.2% in Bangladesh.[5] Results of the presents study also showed similar rates of tetanus immunization among women.

In Bangladesh, most (93.2%) of the deliveries in rural areas took place at home and the remainder at public health facilities.[6] Recent data showed that around 75.5% care services were attended by untrained TBA and friends or other relatives. The present study also showed nearly equal incidents of pregnancy care services. Only 13.1% children and 13.5% mothers are said to receive postnatal care (PNC) from a trained provider within 42 days of delivery in the country. Contraceptive prevalence rate in rural Bangladesh is 52.3%, whereas the present study showed about 55% of contraceptive uses among rural women. Many (78.7%) of the rural women are not involved in any type of income-generating activities.[5] Truly, this fact was revealed in the present study where only 9% women had self income capabilities.

LIMITATIONS OF THE STUDY

Though such studies require information on multiple variables, this study was confined only to major variables including socio-demographic, economic, maternal, pregnancy, health care services and family planning issues. The study results may not be generalized from Bangladesh context where cultural and traditional practices vary widely.

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