

Health seeking behavior during pregnancy and child birth among Muslim women of Biratnagar, Nepal

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ABSTRACT

Maternal mortality remains one of the biggest public health challenges in Nepal. This paper explores the health seeking behavior, during pregnancy and child birth in certain ethnic group. The poverty, illiteracy, women's low status in the society, lack of access and difficult geographical terrain are major reasons for poor maternal health status in Nepal. Cross-sectional study was conducted among 200 Muslim women of ward # 7 of Biratnagar municipality. They were interviewed to understand their health seeking behavior during pregnancy and childbirth, factors associated with use of health services and their role in the family. Information's on usages of health services, education level, family stricture, and occupational status, information were collected using a pre-tested and structured questionnaire. The overall institutional delivery in study population was found 24.5%. Low socio-economic status, Illiteracy and poverty in women are the major challenging features of pregnancy and child birth.

Keywords: Antenatal visits, Health seeking behavior, Institutional delivery, Muslim women, Pregnancy, child birth; Nepal.

INTRODUCTION

Health care seeking behavior is a central issue in the treatment of morbidity.¹ The comprehensive health care, including reproductive health, have been advocated in the year 1978 by Alma Ata Declaration in which the World Health Organization emphasized the need for citizen participation through Primary Health Care (PHC).²

There were 535,900 women died from pregnancy related causes and child birth, World wide in 2005.³ Maternal mortality is estimated to be 281 per 100,000 live births in Nepal in 2009,⁴ Sri Lanka the maternal mortality ratio is 43 per 100,000 live births in 2005,⁵ and 400 per 100,000 estimated World wide.⁶ The majority of the maternal deaths (62%) occur soon after birth with post partum hemorrhage being a major cause of maternal death.⁷ In rural districts, the proportion rate of institutional deliveries is as low as 4%.⁸ Even in urban Kathmandu, a significant proportion of women, approximately 19% still deliver child at home, despite supposedly accessible institutional maternity services are available.^{9,10} Gross national income per capita per annum is \$ 340, while female literacy is improving (45%).^{11,12} Neonatal mortality rate in Nepal is 33 per 1,000 live birth and only 19% of women deliver child with a skilled birth attendant.¹² There are very few data available on pregnancy related morbidity in Nepal and

no data are available based on different ethnic groups. Therefore this study was conducted to determine the health seeking behavior during pregnancy and child birth among Muslim women in Biratnagar.

MATERIALS AND METHODS

This cross-sectional study was undertaken in Biratnagar Municipality ward no. 7 between January to June 2009. The study population comprised married women with Islamic religion in the reproductive age group (15-49 years), residing in the study area, who have at least a live baby about 5 years preceding the survey. Health seeking behavior during pregnancy and child birth was defined as the women having attended whether government (including sub-health post/ health post, PHC or hospitals) or private institutions during birth and number of antenatal care (ANC) visits. With the experiences gathered, questionnaires were modified House-to-house visits were done in the targeted municipal location to find out the eligible women by the investigator before data collection were made with the cooperation of Female Community Health Volunteers (FCHVs) and community leaders. The purposive sampling method was adopted to identify the eligible mothers who met our required criteria. The total number of respondents was 207. Among these women 5 eligible mothers were unwilling to participate in the study and two had left the area. Therefore the study population consists of 200

mothers. All the 200 mothers were interviewed by using questionnaire with the help of FCHV and community leaders after taking their consent.

Data were entered and analyzed using SPSS version 10. Bivariate analysis was done to find the association of socio-economic, demographic and behavioral characteristics with previously used health seeking behavior in pregnancy. Analysis was also done to determine any relationship between their self reported education level including their spouses occupation, monthly household income and health seeking behaviour among reproductive age group (15-49 yrs) women. P value was set at 5% level of significance. The Center for Population and Development studies, affiliated by Purbanchal University, has given ethical clearance to conduct this study.

RESULTS

The total numbers of 200 women under representative age groups were interviewed from above area for data collection. Number of women living in nuclear family was (64.5 %) (Table-1). Family head were mainly their husbands (67.5 %) followed by father in laws (26 %). Only 2.5 % women were head of family among the study population. They live mainly in thatched houses (69 %), and don't have toilet (59 %). Their main source of household energy of cooking fuel was firewood (80.5%), followed by cow dung (10.5%). Only (6.5%) used both LPG gas and firewood for the same purpose. Most (90 %) of the households used tube wells for drinking water. The most (60.5%) of women were married between 18 – 20 years of age. However 7% women were married above the age of twenty years.

The percentages of antenatal visits were found to be more (64.2%) among 20-34 years of age (Table-2). However, the age group did not show any significant role in antenatal visit. Among the literate groups the percentages of antenatal visits were more (81.1%). Only five women had SLC and above educational level, all of them completed at least the four and more antenatal visits. The literacy status of the respondents has a significant association with the antenatal visit (p<0.001).

The pregnant women from nuclear family were more (64.5 %). But the percentage antenatal visits by the joint family women are more (80.3%). There is significant association in between type family and the antenatal visit (P<0.001). The occupation among the pregnant women surveyed were house wives (83 %), daily wages earners (13.5 %) and business (3.5%). Though the number were far less in business groups but their percentage of antenatal visits were more (85.7%), where as antenatal visits among house

Table-1: Socio economic and demographic characteristics of respondents

Socio-Economic & Demographic Characteristics	Women (n= 200)	(%)
Family structure		
Nuclear	129	64.5
Joint	71	35.5
Household head		
Father in law	52	26.0
Mother in law	8	4.0
Husband	135	67.5
Herself	5	2.5
Type of house		
Concrete	20	10.0
Tiled	42	21.0
Thatched	138	69.0
Toilet facility available		
Water seal Latrine	30	15.0
Pit Latrine	52	26.0
No Latrine	118	59.0
Source of cooking fuel		
Fire wood	161	80.5
Dung	21	10.5
LPG Gas	3	1.5
Firewood and dung	2	1.0
Firewood and LPG gas	13	6.5
Main of source of drinking water		
Well	11	5.5
Tube well	180	90.0
Municipal tap	5	2.5
Tube well and Municipal tap	4	2.0
Age at marriage		
<18	65	32.5
18-20	121	60.5
20 and More	14	7.0

wives were found least (57.2%). The proportion of institutional delivery, in the interviewed population, was found 24.5 %. Fig. 1 shows the reasons of not delivering children in hospital: 60 % express lack of awareness and 34 % thought high cost in the hospital. An interesting finding was that 6 % respondents were not allowed hospital delivery by the head of the family. They thought that delivering child at hospital might not be necessary since it is a natural process which is gifted by the God, he himself will save the life of mother and new born baby.

Table-2: Characteristics of antenatal visits

Age Groups	Total Respondents (n=200)	Antenatal Visits				χ^2 value	P value
		Total no. of Antenatal visit	1-3 Antenatal visit	4 and above Antenatal visits	Without any visits		
15-19	13 (6.5%)	6 (46.2%)	4 (30.8%)	2 (15.4%)	7 (53.8%)	4.89	0.086
20-34	162 (81%)	104 (64.2%)	80 (49.4%)	24 (14.8%)	58 (35.8%)		
35-49	25 (12.5%)	11 (44%)	11 (44%)	0 (0.0%)	14 (56%)		
Educational Status							
Illiterate	126 (63%)	59 (46.8%)	53 (42.1%)	6 (4.7%)	67 (53.2%)	24.63	<0.001*
School Education	69 (34.5%)	56 (81.1%)	43 (62.3%)	13 (18.8%)	13 (18.9%)		
SLC and above	5 (2.5%)	5 (100%)	0 (0.0%)	5 (100%)	0 (0.0%)		
Family structure							
Nuclear	129 (64.5%)	64 (49.6%)	57 (44.2%)	7 (5.4%)	65 (50.4%)	18.02	<0.001*
Joint	71 (35.5%)	57 (80.3%)	38 (53.5%)	19 (26.8%)	14 (19.7%)		
Occupational status							
Business	7 (3.5%)	6 (85.7%)	5 (71.4%)	1 (14.3%)	1 (14.3%)	3.67	0.159
Daily wage earner	27 (13.5%)	19 (70.4%)	17 (63.0%)	2 (7.4%)	8 (29.6%)		
House wives	166 (83%)	95 (57.2%)	72 (43.4%)	23 (13.8%)	71 (42.8%)		

* Highly significance

DISCUSSION

The study is an attempt to look into the health seeking behavior during pregnancy and child birth among 200 Muslim women of Biratnagar ward number seven. Almost all eligible mothers were at home when we interviewed, most of them were house-wives and few mothers refused to participate in the study. Along with our strivings to locate eligible women by house to house survey conducted with the cooperation of Female Community Health Volunteer (FCHVs) and community leaders, there must be only a few, if any, women not included in our study population. The type of family (joint/nuclear) has also impact on the health seeking behavior of the women in this paper. Women from joint family (80.3%) have more antenatal visits than nuclear family (49.6%). This indicates the support for other family member than husband. Because in nuclear family husband are busy in their job. Similarly occupation has a important role in health seeking behavior- it also seen in this paper educated women doing business (85.7%) had more antenatal visits than housewives (57.2%). The proportion of institutional delivery, in the interviewed population, was found 24.5 %, which is more than the national average 18 % 2006.¹³ Similar observations were recorded by the same authors from other parts of Nepal.¹⁰ These variations of percentage distribution about institutional

delivery due to various authors are likely to be due to difference in study samples sizes, ethnic groups, adopted research methodology and definition of health seeking behavior in their study. One base line survey was conducted on sexual and reproductive health in Dhankuta, Sunsari, Kathmandu, Kapilvastu, Banke, Surkhet, Doti and Kailali districts in the year 1983 in Nepal. Their result had shown that health professionals assisted 18% deliveries in health institutions in those districts.¹⁴ In our study group, we recorded 24.5% institutional delivery; it is 7% more than earlier recorded, which is good signs, but considering the interval of 25 years (1983-2008), it can not be considered very ideal. The effects of key socio-demographic characteristics on the utilization of institutional maternity services were found to be: education and household wealth was reported by various others.^{13,15-17} The striking feature in our study, revealed that lack of awareness, cost involved in availability health facilities, and prohibition by the head of the family are the reasons of not delivering children in health institutions. Nepalese

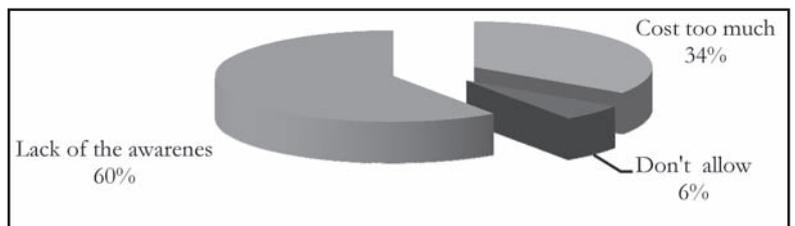


Fig. 1. Reasons of not delivering children at the health facility

husbands generally do not want their pregnant wives to be examined by male doctors.¹⁸ However the numbers of other studies in various countries have clearly demonstrated that women's autonomy has strong and consistence effect on reproductive health outcomes. Bloom et al. demonstrated that women's autonomy is a major determinant of maternal health utilization among urban poor to middle-income women in a north Indian city.¹⁹ Similarly the Nigerian study, 41% of mother who did not deliver the child in hospital explained that they could not afford the hospital bill.²⁰ In Kenya, the most significant predictors of choosing home delivery are the distance from the household to the nearest maternity bed.²¹ Le Bacq and Rietsema reported that hospital delivery in Kasama, Zambia seemed generally to be possible only for mothers living within walking distance of that institution, and that dose-response relationship between distance and maternal mortality existed.²² Availability of health facilities, prohibition of head of the family, less education and low family income among them are silent features having less recorded institutional delivery in our sample population. This information will assist in planning public health intervention to change the behavior of Muslim women and other ethnic group as well.

Maternal mortality is the major cause of death in South East Asian countries and Nepal. The variables in our study: educational status (school leaving certificate and above), nuclear family structure, 20-34 years age women group and business occupation women were utilized maternity services more in our sample population. Decision making power of women their education status and family income helps to improve maternal health morbidity have been shown in this study.

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