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REPRODUCTIVE HEALTH CARE SEEKING BEHAVIOR OF FEMALE STREET DWELLERS OF DHAKA METROPOLITAN, BANGLADESH

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Abstract: This study was conducted on female street dwellers, between the ages of 15 to 49 years, living in New Market Thana area of Dhaka City, to understand their health care seeking behavior and to examine the factors that affect their health care seeking behavior. Following survey research design, data were collected purposively from 110 females by administering an interview schedule. Findings indicate that most of the female street dwellers were married off before candling their eighteenth birthday, which results in early childbearing. Majority of them did not know about the utility of modern contraceptives, therefore, the prevalence of contraceptive use was significantly low. The burden of household chores and intimate partner violence were the commonplace incidences among the women during their pregnancies. However, early marriage, lack of education and insecured income were evidently the most important factors that reduced the female street dwellers' possibility to seek and avail reproductive health care, especially, antenatal and postnatal care, in Bangladesh.

Keywords: Street-dwellers, reproductive health, health care seeking behavior, health services, migration

Introduction

Bangladesh is a densely populated country with over 152 million people squeezed into an area of 147570 square-kilometers (BBS, 2012) and over the past three decades it has been experiencing one of the highest urban population growth rates, 5 percent in 1971 to 27 percent in 2008 (Koehlmoos *et al.*, 2009; Tavares-Goodman, 2010). Between 1974 and 1981, the size of the urban population has more than doubled from 6 million to 13.6 million (BHS, 2008) and in 2001, about 31 million people reside in urban areas, and by 2020, this number will cruise up to 74 million (BBS, 2003; UN-HABITAT, 2003). A sharp rise in urban population is actually resulted from the internal migration of rural people, which is estimated to contribute about two-thirds of urban growth in Bangladesh (UN, 1993). ESCAP (2007) estimated that more than 50 percent of the population in Bangladesh will live in urban areas by the year 2025.

In Bangladesh, Dhaka is the most rapidly growing megacity, with an estimated 300000 to 400000 new migrants, largely poor, arriving annually (BHS, 2008). In 2001, Dhaka held just over 58 percent of the total urban population of Bangladesh (CUS *et al.*, 2006). Its current population is around 12 million (BBS, 2012) and by 2015 it will have 22 million inhabitants, making it the world's second largest city (Democracy Watch, 2010). Pushed away by the deteriorating poverty situation, increasing landlessness and river bank erosion, the rural poor are migrating to Dhaka

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city in search of job opportunities and better living standards (UNICEF, 2010). In return, their contribution to Dhaka's economic growth is not less significant, since they provide almost 70 percent of the labor force, needed in cities for manufacturing, services, and other sectors (IOM, 2010). However, the large influx of in-migrants adds tremendous strain on an already crowded city with an estimated 3.4 million people in some 5000 slums (Islam, 2005) and by 2010, the floating people was expected to cruise up to 60 percent of the total population of Dhaka city (Podymow *et al.*, 2007). Nevertheless, more than three-quarters of migrants, coming to Dhaka, find shelter in urban slums or do not find shelter at all (Islam, 1997), which is estimated to be the fastest growing segments of the urban population (Chatterjee, 2002). BBS (1999) counts as much as 14,999 homeless people in Dhaka only; with an additional 17,082 in other metropolitan areas of Bangladesh. Such tremendous growth of floating residences has generated multifaceted problems in urban Bangladesh, including crowded living conditions, unhygienic surroundings and lack of basic amenities, such as, garbage disposal facilities, inadequate water and sanitation, coupled with lack of primary health care, increasing risk of criminality and violence, and deterioration of environmental conditions (Agarwal *et al.*, 2007; Islam *et al.*, 2006). The growing urban poverty, however, is the most important problem in urban areas, estimated about 7 million in 1985 and 11.5 million in 1997 in Bangladesh, is still continuing to grow (Islam, 1997).

The continuous influx of low-income people often squatted on government lands, roadside lands, abandoned lands and buildings. The situation has worsened over the years, creating severe environmental pollution, health hazard and social problems; and the street dwellers are facing the worst situation, such as, social exclusion and neglect, physical abuse, gender discrimination, sexual abuse, heavy work burden, terrorism and so on. These problems have been addressed and a number of initiatives have so far been taken (ASEAB and TSP, 2000). However, hardly any holistic efforts to study the reproductive health care seeking behavior of female street dwellers of all ages and their occupations have been undertaken, although there are almost an equal proportion of female (50.3%) and male (49.7%) street dwellers found in Dhaka city (Kader, 2008).

In urban Bangladesh, deaths and illnesses from reproductive causes are highest among the poor women as about one-third of the total disease burdened, aged 15 to 44 years, is linked to problems arising out of pregnancy, childbirth, abortion and reproductive tract infections (World Bank, 1993). The heightened prevalence of illiteracy among poor rural migrants often forces them to give their young daughter married off, as about 75 percent of the girls in Bangladesh are married before the age of 16 (MoHFW, 1998), which not only cost the education of the promising young girls, but also causing early or unwanted pregnancy as most of them are unaware of modern contraceptives. In relation to that, poor urban women are often abused, both physically and mentally, by their intimates or in-laws for dowry, which in most cases require medical attention. The non-payment of dowry as well as physical abuse follows desertion and divorce among the spouse, which as a matter of fact cost women only, as they are frequently deserted with children. Subsequently, women get involved in informal income generating activities, especially in sex trade, and it is evident that a high proportion of new HIV infections are transmitted during paid sex (UNAIDS/WHO, 2006). Sex workers in Bangladesh, both in the brothels and on the streets, are reported rather high client turnover, averaging 12-16 clients a week and the consistent condom use is lowest among them (Gharoni, 2007). In addition, the inadequacy and inefficiency of family planning and reproductive health services make it impossible for the female street dwellers to access health care services linked to their livelihoods (Sulabh, 2001). Under such dreadful circumstances, the present study primarily aims at understanding the extent of health care seeking behavior of female street dwellers and to examine the factors that affect their care seeking behaviors in Dhaka City of Bangladesh.

Materials and methods

This study was conducted following survey research design on female street dwellers, between the ages of 15 to 49 years, living in New Market Thana of Dhaka City Corporation (DCC) in Bangladesh, during May 2010 to July 2010. Data were collected by administering interview schedule, containing both open and close ended questions. A sample of 110 women was interviewed following purposive sampling procedure, with the implementation of snowballing, because of unavailability and inaccessibility of street dwellers within a short period of field work. In addition, secondary data, from relevant sources, such as, books, journals and periodicals, were used to strengthen the rationality of the study and for better comprehensive analysis. To give the research a proper logical quantitative ground, descriptive as well as inferential statistics were used for analyzing the data through SPSS and MS Excel programs.

Results

Background information of the respondents: Street dwellers, in general, lead a wretched life as they do not have fixed earnings, mostly because of illiteracy following amateurish work experience, which immediately results in unhygienic living and poor health status due to inaccessibility to effective healthcare services (Ray *et al.*, 2001; ICDDR, B, 2010). Women and children are more vulnerable in such socio-environment condition as they usually constitute the marginalized group within the marginal people. Findings suggest that the respondents were considerably younger as most of them (35.7%) belonged to the age of 15-21 years (Table 1), following 25.9 percent between the age of 22 years to 28 years, and around 6 percent only at the edge of their reproductive age, thus, constituting the average age of the respondents around 26.95 years.

Table 1: Background information of the respondents

Age of the respondents (in Years)	*Percent (%)*
15-21	35.7
22-28	25.9
29-35	19.7
36-42	12.6
43-49	6.1
Total	100.0
Mean Age – 26.95 Years	Standard Deviation – 8.719
Religion of the respondents	Percent (%)
Hindu	11.8
Muslim	88.2
Total	100.0
Place of Birth	Percent (%)
Rural area	79.8
Urban area	20.2
Total	100.0
Education of the respondents	Percent (%)
Illiterate	69.5
Only sign name	17.3
Primary (I-V)	11.1
Secondary (VI-X)	2.1
Total	100.0

Marital status of the respondents	Percent (%)
Married	46.2
Separated	21.1
Divorced	18.2
Widowed	14.5
Total	100.0
Age of the respondents at marriage (in Years)	Percent (%)
10-13	16.7
14-17	56.2
18-21	27.1
Total	100.0
Mean age at marriage – 15.94 Years	Standard Deviation – 2.617
Type of Family	Percent (%)
Nuclear	68.3
Extended	31.7
Total	100.0
Family Size (in Number)	Percent (%)
1-3	15.0
4-6	55.4
7-9	29.6
Total	100.0
Average Family Size – 5.46	Standard Deviation – 1.956
Occupation of the respondents	Percent (%)
Domestic helpers	22.1
Pickers and sellers	14.4
Day laborers	35.5
Sex workers	21.0
Beggers	7.00
Total	100.0
Income (in BDT)	Percent (%)
1-1500	37.1
1501-3000	55.4
3001-4500	4.7
4501-6000	2.8
Total	100.0
Average Income – 1841.41 BDT	Standard Deviation – 1014.079

The respondents were predominantly Muslim (88.2%); and even though living in urban areas, only a very few (20.2%) were actually born in urban areas, indicating a consistent movement of people from rural to urban areas in Bangladesh, either pushed away by poverty, unemployment or natural disasters or pulled in for better job opportunities and standard of living. Since the respondents were preponderantly evacuee, they were less likely to complete their primary

education (11.1%) and remained illiterate to a greater extent (69.5%). Findings also unleash that most of the respondents were married off before the dawning of their eighteenth birthday (72.9%). Parents' education, their unstable income, fatalism, social insecurity, *i.e.* eve-teasing, together with the fear of social stigma often trigger the early marriage in both rural and urban areas of Bangladesh (Jahan *et al.* 2010). The subsequent result of early marriage is that a discernible percent of the respondents are either widowed (14.5%) or divorced (18.2%) or living separately (21.1%) from their spouses, though 46.2 percent were still living with their intimates and children. Although the respondents mostly had nuclear families (68.3%), nevertheless, a considerable percent of them (29.6%) had larger family with at least seven members to feed. However, having no fixed income and job security, they were actually struggling as most of them were engaged in informal activities, *e.g.* domestic helpers (22.1%), day laborers (35.5%), sex workers (21%), pickers and seller (14.4%) and beggars (7%). Therefore, their monthly income did not go beyond BDT 3,000 in most cases, which is far-off than the estimated average GDP of Bangladesh (MoF, 2012).

Reproductive health needs and care seeking behavior: Street dwellers are generally the poorest of the poor. They do not have sufficient knowledge and neither aware about health issues, and could not afford the medical expenses (Islam *et al*., 2006). In addition, they are living in extremely poor environment, experiencing lack of basic amenities, public-healthcare facilities, and outreach services (Uddin *et al*., 2008). The findings (Table 2) suggest that most of the respondents (63.6%) did not have counseling by Family Planning Officials or by Non-Governmental Health Workers about contraceptives or did not know anything about the modern contraceptives (20%).

Table 2: Reproductive health care seeking behavior

Contraceptive use counseling	Percent (%)
Yes	16.4
No	63.6
Don't know	20.0
Total	100
Contraceptive use	Percent (%)
Yes	34.5
No	65.5
Total	100
Decision-making regarding pregnancy and childbirth	Percent (%)
Husband	49.1
Own	8.4
Both husband and wife	30.8
Unwanted pregnancy	11.7
Total	100.0
Regular household activities during pregnancy	Percent (%)
Yes	78.2
No	21.8
Total	100

Physical abuse during pregnancy period	Percent (%)
Yes	83.6
No	16.4
Total	100
Health counseling during pregnancy	Percent (%)
Yes	5.5
No	85.5
Don't know	9.0
Total	100
Antenatal care	Percent (%)
Yes	5.5
No	80.0
Don't know	14.5
Total	100
Immunization at pregnancy	Percent (%)
Yes	32.4
No	67.6
Total	100
Place of delivery	Percent (%)
At home	65.3
Hospitals/clinics	32.7
Total	100
Birth attendant	Percent (%)
Trained birth attendant	37.3
Untrained birth attendant	62.7
Total	100
Receiving postpartum cheek-up	Percent (%)
Yes	12.7
No	87.3
Total	100
Postnatal care	Percent (%)
Yes	7.3
No	72.7
Don't know	20.0
Total	100

The reasons are more likely associated with their level of education, marital status, and monthly income, and since majority of them did not have any idea about contraceptives, more than half of them were actually non-users (65.5%). In fact, they did not have the privilege to make decisions about the conceptions (49.1%), as the authority was totally vested upon or forsooth controlled by the husbands only. 30.8 percent OF the respondents reported mutual decisions regarding conceptions, following 11.7 percent who considered their first born as a mere accident.

In traditional societies, like Bangladesh, housewives generally have triple roles of a mother, a sister and a wife with a wide range of responsibilities of cooking, preparing, washing and

entertaining as well. Women in poor families are expected to make sure of these responsibilities even when they are carrying babies (Bhuiya *et al.,* 2003). When they are unable to do their imposed household chores, domestic violence, in the form of physical and mental harassment, by both intimates and in laws are common in Bangladesh. The findings correspond that the majority of the respondents (78.2%) did the household chores during their pregnancies and as they failed to conform the imposed household chores, the lion share of them (83.6%) were abused, physically or mentally, by their intimates or in-laws. The miserable situation has worsened further as 85.5 percent of the respondents did not counsel during their pregnancy nor went for antenatal checkup (80%) and around 67 percent of them did not go under the immunization care, provided by both GOs and NGOs, which is very crucial for both mother and infant against infectious and life-threatened diseases. In addition, most of the respondents (65.3%) have given birth of their children at home with the help of none other than the untrained birth attendant (62.7%), with least knowledge and expertise about safe and secured delivery. But, one interesting fact is that more than a quarter of the respondents' (37.3%) deliveries were assisted by the trained birth attendant. This may only be possible with the increasing number of community health hospitals or the knowledge they acquire through their education and interaction with other people. In spite of promising sign of reproductive health awareness among female street dwellers, majority of them did not seek out medical assistance for post-partum check-ups (87.3%), and postnatal care (72.7%). In fact, a considerable percent of the respondents (20%) did not have a clue about postnatal care and its significance for the lives of both mother and children.

Covariates of reproductive health and care seeking behavior: It has been widely accepted that education as well as income of an individual is closely associated with his/her access to and use of reproductive health facilities and the decisions of reproductive health care issues (Hamal, 2010). The findings of the study suggest that the female street dwellers, with least or no education, were less likely take the decisions of conception and the birth spacing of their children than the literate one (Table 3).

Table 3: Covariates of reproductive health care seeking behavior

Correlates		*Chi-square Significance*
Independent Variables	*Dependent Variables*	
Education	Decision-making regarding pregnancy and childbirth	*
Education	Contraceptive use	*
Education	Size of the Family	**
Age at marriage	Size of the Family	**
Education	Health counseling during pregnancy	
Education	Immunization at pregnancy	*
Education	Receiving postpartum cheek-up	
Religion	Contraceptive use	
Occupation	Contraceptive use	
Income	Contraceptive use	**
Income	Immunization at Pregnancy	*
Income	Birth attendant	*
Income	Receiving postpartum cheek-up	

** Significant at 5 percent level

* Significant at 10 percent level

There is also evidence that illiterate women, who were least aware of STIs/STDs and the growing population pressure, did not use contraceptives or any other methods to restrain birth, therefore, they had larger families than those who use contraceptives regularly. In addition, the respondents, who were married of at early ages, conceded more children than those married at the legal age. The possible explanation is that poor illiterate women scarcely use contraceptives, mostly because of their religious beliefs, rarity or unfamiliarity of essentials, and as they were married off at very early, they, therefore, have more children than those with late marriage.

The findings also indicate that female street dwellers, especially, the non-educated, were more reluctant to counsel with doctors/FPWs during and after pregnancy to confer about pregnancy related complications. Moreover, they were less intense to undergo the immunization process, which has been provisioned to secure pregnant women against infectious diseases as well as to assure their new born against the life-threatening diseases, *e.g.* pneumonia, polio, and so on. Respondents' income as well as their occupation also determines the trends of using contraceptive. Since the monthly income of the respondents did not cross over BDT 2,000 and were involved largely in informal activities, their use of contraceptive was low, except the sex workers. Their incomes also have no effect on their attitude towards the birth attendants, as most of them relied heavily on the untrained birth attendants (known as *Dais*) than the trained attendants. Furthermore, the respondents were reluctant to check for postpartum condition. This may be because of the unavailability of the trained personnel and the remuneration, demanded by the attendants to deliver child, as well as the conventional attitude, intrigued generally by religious beliefs.

Discussion

The findings of this study clarify that the majority of female street dwellers were not autochthonous; instead they have migrated from the country-side of Bangladesh to the capital for the search of better job opportunities and better living standard. Since they were poor and drifting away from the places of origin, most of them could not complete or even attend schools for education, therefore, remained illiterate to a great extent. The respondents, following non-completion of education, were actually married off at the very early age, in many cases even before the age of thirteen, and thereby, live in a very large family that may cruise up to nine members for each family. This is because; early marriage is directly related to early conception, which in fact increase the number of family members as well. One interesting finding is that a considerable number of the respondents were living without their spouse, either because of their husbands' deserted or divorced them, or because they are dead. As the respondents, in most cases, constituted single parent families, they just get involved in income generating activities, mostly informal in nature, taking responsibility of the family of their own. However, their monthly income barely crosses over BDT 3,000, which is insufficient to live in city like Dhaka, where price hike is marching towards peak of the sky.

The findings also explicate that majority of the respondents were not aware of availability or use of modern birth control methods, thereby, a very few of them use contraceptives to restrain unwanted pregnancy. The data reveals that even if they conceive, the decisions were more often made by their husbands and in some cases the decisions were taken by mutual understanding between husband and wife. The respondents were destined to do their household chores during their pregnancy period, because in most cases they were living in nuclear families with no guardians available to help them out or they did not have the privilege to get help from housemaid since they were not in such condition to afford it. In addition to burden of household chores, the respondents were abused repeatedly by their intimates during pregnancy, which is reportedly accepted in patriarchy dominated Bangladeshi society (Garcia-Moreno *et al.*, 2005).

The findings of the present study illuminate that the respondents were reluctant to check out for doctors during pregnancy and were not likely to care of antenatal services, and thus did not go through the immunization process. Furthermore, they were stick to the traditional birth attendants for the delivery, instead of the trained medical assistance. One reasons for such behavior is that they were not aware of such facilities, or there were insufficient medical facilities or officials to provide services or they believe that it may violate their curtain fallacy. The respondents, in addition, were unwilling to check-up for postpartum complications and for postnatal care, which generally cost the lives of poor women in Bangladesh.

The preceding discussions indicate that the female street dwellers were hardly making any progress *vis-a-vis* their reproductive health needs and care seeking behavior, therefore, require a much more attention of the governments and the developments bodies, including NGOs, donors and civil society of Bangladesh.

Conclusion

Bangladesh, one of the most populous countries of the world, has a numerous problems, especially, in the health issues. There are various factors which can influence the reproductive health of the female street dwellers, such as, income, education, family composition and so forth. The empirical findings suggest that poor income cost the lives as well as the health of the women and their children. Another important finding of the study is that lower educational status possesses lower consciousness regarding reproductive health care seeking behavior. To up-lift such dreadful condition of female street dwellers, it is important to create low-cost housing facilities, income-generating activities, credit extensions to start small businesses, and targeted education and awareness programs for the female street dwellers and for their spouses. The government, together with the donor agencies, and civil society, may address the levels of basic health care services and urban poverty and may create employment opportunities for possible rural-urban migrants to restrain rapid urban population growth.

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