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Barriers to Health Care Access among Rural Women: A Qualitative Study in a Village of Bangladesh

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ABSTRACT

Rural women's health inequalities have an extensive discussion on both a global and regional scale. Access to health care is a universal challenge, but the task is even harder for rural people, particularly women. This paper attempts to assess critical barriers to rural women's health. In this regard, a qualitative approach has been followed using a case study method. The respondents were selected from Kosha Raniganj village of Pirganj Upazila under the district of Thakurgaon in the division of Rangpur, Bangladesh, and data were collected in two consecutive months, i.e., May and June 2024. 20 rural women were interviewed through face-to-face communication, with the help of an unstructured interview schedule, to obtain the necessary data. The research findings showed that the health care coverage for rural women remains low because of multifaceted and interwoven barriers. These are: Economic Barriers, Geographic barriers, Socio-cultural barriers, Shortages of workforce and Healthcare Infrastructure, Educational and Awareness Gaps. Of these barriers, economic challenges were considered to have the greatest impounding effect on the health care access of women in rural areas. The findings of this work are useful in understanding how to reduce health disparities and increase the health care services for rural females.

1. Introduction

Bangladesh is a developing country. The health condition of the country's people is not favorable, and women's health is more neglected. Women's health has become an opportunity rather than a right. However, women should pay more attention to health issues. Ignorance of women's health in this country, on the one hand, and inadequate infrastructure, on the other hand, has made women's health more complex. There are several barriers that rural women encounter when seeking the healthcare services they need, and these barriers ought to discourage them from receiving the proper healthcare services they need. The rural area still persists as one of the factors that hamper women from gaining access to this facility because of the geographical inconvenience (Sithole et al., 2021). In South Africa, rural women noted the longest travel time and the highest delivery charges compared to their counterparts in urban dwellings (Birch et al., 2012). Likewise, the women in the Upper West Region of Ghanas face poor transportation

road networks, which hinders their chance to use maternity services regardless of policies enacted to support it (Rishworth et al., 2014). Additionally, a study in rural Zambia shows that the probability of delivering at a health facility reduces tremendously as the distance to the nearest facility increases; it appears that women reside far away from the facility with basic emergency obstetric care, that is over 25 km (Campbell et al., 2011). These geographic factors are disadvantageous; they are worst during fertile times, including childbirth, thus resulting in high maternal mortality rates. These are issues that must be addressed as they relate to geographic barriers to attainable health care for rural women.

The major problem of access to health care is further made worse by economic constraints in the rural areas affecting women's health. Despite the fact that poverty is a major issue in both developed and developing countries, this creates an economic problem that heightens the core issue of healthcare access and often has a ripple effect that affects women's health. They could not afford payment for medical services, which led to their decision not to seek medical care, especially when pregnant (Robinson et al., 2024). Rural women can rarely seek healthcare without spousal or familial approval, and cultural expectations discourage rural women from seeking healthcare for reproductive and mental health issues (Reddy et al., 2018). Research from rural Pakistan showed that 60 percent of women needed males' permission to visit healthcare providers, which delayed treatment (Shaikh & Hatcher, 2004). There is a chronic shortage of healthcare professionals, including general practitioners, obstetricians, and mental health specialists; this shortage is especially acute in rural areas. According to the World Health Organization (WHO), 67 percent of the world's population lives in rural areas, and only 23 percent of the global healthcare workforce provides services in rural areas. Moreover, limited healthcare infrastructure and under-resourced facilities exacerbate the poor quality of care provided to rural women.

In rural areas, women from minority or indigenous groups are merely more marginalized. Discrimination, language barriers, and mistrust of formal healthcare systems discourage many from care. Hispanic and Native American women living in rural areas in the United States are at high risk of poor perinatal outcomes due to both structural racism and inadequate culturally appropriate healthcare (Anderson et al., 2020).

The prior research in this area was primarily conducted in the African, global, or American regions. There is no research on Barriers to healthcare access among rural women in the northern region of Bangladesh. A critical study on this topic could not be done in the Thakurgaon district. In present times, because of the lack of financial solvency, people of the country, especially women in the villages, face different difficulties in availing of health care. The present study would be a good resource for the government and non-government policymakers to make an all-round policy to mitigate the challenges to healthcare access among rural women. Nevertheless, this study has focused on barriers to healthcare access among rural women in the Thakurgaon district only, which covers a specific area of Bangladesh, and therefore, findings can not be generalized for all regions of Bangladesh.

2. Methods

In the present research, the researchers have chosen Kosha Raniganj village of Pirganj Upazila of Thakurgaon district of Rangpur division in Bangladesh as the study area. Based on the objective of the study, a qualitative approach was adopted. In this research work, the case study method was used to collect data from rural women. The qualitative method was used as it helped the researchers meticulously identify the obstacles that women faced while accessing health-related services. The researchers have developed some inclusion criteria to select the respondents. The respondents of this research were women who were 14-40 years old and faced different challenges when accessing healthcare services. In this research, primary data were gathered directly by employing purposive sampling from the 20 participants with the help of face-to-face interviews. Secondary data used in this study were collected from the local administration office, study reports books, journals, daily newspapers, and others. Purposive sampling is a cost-effective time-sampling method. Since this work has been completed with the researcher's financial support, the researchers have chosen this sampling method to save time and money. There was no incentive for the participants. In the interview schedule, an informed consent letter was included in which the participants were made aware of the purpose of the study, the aspects of confidentiality, anonymity, and the right to withdraw from the study for no reason

asked of them. Informed consent was obtained from all the respondents. The researchers had to gain the trust of the respondents and then ask them about issues related to the research in order to elicit the required information. The interviews were done entirely in Bangla. With participants' permission, all the interviews were done and taped in audio format. However, all interviews were kept confidential, and participants could stop participating in the study at any moment without being asked the reason. Pseudonyms were used to anonymize the participants. On average, each discussion lasted 25-30 minutes. The responses were also documented in field notes form. The duration of data collection was from May 24 to June 24.

A thematic analysis was used, and some of the sequential steps were performed. The first step was to have their statements transcribed and translated into English. The researchers then read through the themes. Once themes were derived, they were reorganized. After the analysis and interpretation of the collected data, the final paper was made. The authors checked the collected data for any logical error or incompleteness.

3. Results & Discussions

3.1 Economic barriers

Economic factors such as the reduced capacity for rural women to earn sufficiently and the high prevalence of poverty in rural regions exacerbate health disparity. According to the World Bank Report 2021, healthcare costs are burdensome and have undesirable impacts on low-income countries because of unaffordable healthcare services. Poverty among rural women is more than that of urban women. Due to the financial crisis, most rural women are suppressing their treatment needs in order to secure their daily bread. A study by Smith et al. (2017) found that 45% of rural women in sub-Saharan Africa delayed or avoided health care because of the costs.

In this study, 6 respondents said that the most important obstacle to healthcare access among rural women was economic constraints. A participant named Parul (pseudonym) expressed that,

> "Sob jinispotrer dam eto bere geche je savabikvabe tike thakatai ekhon challenge hoye dariyeche. Tai ami osustho holeo khub proyojon na hole cikitsar jonno ortho bay kori na. (The prices of all goods have increased so much that it is now a challenge to survive normally. So even if I am sick, I don't spend money on treatment unless absolutely necessary."

She also said that,

> "My husband is a farmer. I am a house wife. My husband is single bread earner from our side and we have 3 kids so it became very difficult for him to manage all these expenses without any hurdle. Obviously, when I fall ill, I do not go for check-up because of the charges or even fare to get to the doctors."

Asha (pseudonym), a daily wage laborer stated that,

> "Since I am a day laborer, if I have to visit the doctor on that particular day I could not go to work. I do not receive any pay for the day. Therefore, for me it is a decision between contributing to the family's income or taking a break to concerns to health issues."

Another respondent who faced constraints in the health sector for a similar reason was named Kamala (pseudonym). Kamala is a widow. She lost her husband 5 years ago, and she has four children. She admitted how economic crisis acts as a hindrance to accessing health services:

> "After my husband died, the responsibility of all the expenses of the family was on me. Although we were not a very wealthy family, we were living fairly well with him. After his death, as the main bread earner of the family was no longer there, our financial situation started deteriorating day by day. I must cover all the costs of the family, including children's tuition fees and, therefore, we rarely visit a doctor unless we are extremely sick because the cost of medical services is extremely high. Even our village has a government health complex; all diseases are not treated in that complex. If we have a complicated disease, we have to go to the doctor in Thakurgaon city. The charges for seeing

> a physician in the city, charges for the purchase of medicines, and the charges for many forms of tests are still very expensive. These are the expenses that a widow from a poor family will find it extremely hard to meet."

In the words of a participant of the study named Nabila (pseudonym), a school cleaner:

> "I try to save money in order to pay for a doctor's appointment, but the costs of tests, follow-up appointments, and other procedures are still too expensive. It is impossible to cover these expenses as a low-paid employee. There is finally no one to address the problems of the poor. I've lost hope of getting proper treatment."

3.2 Geographic barriers

Health access in rural areas is greatly influenced by geographical isolation. It is well known that rural women often do not live near hospitals, and so, in many cases, they cannot access preventive, diagnostic, and emergency care. A review of rural health systems in the United States shed light on the fact that rural women are 50% less likely to get timely mammograms as compared to women living in metropolitan areas because of access to transportation and limited healthcare practitioners in their vicinity (Rural Health Information Hub, 2021). Just like this, in sub–Saharan Africa, there are no paved roads or established transportation networks, and this causes delays in reaching maternal healthcare services (Gabrysch & Campbell, 2009). Urban women in the United States travel an average of 12 miles for specialized care, while rural women travel an average of 40 miles (Wilson et al., 2019). A participant named Hafsa (pseudonym), who narrated her experience, said that one of the main and prominent challenges to accessing healthcare services is remote areas. She said that some treatment can be done in the village, but since it is far from the city, sometimes we have to face many problems. At one time, my son had terrible diarrhea during the night during the rainy season. The village doctor immediately asked him to be admitted to the city hospital. But Thakurgaon city is about 30 kilometers away from our village. I could not get any kind of transportation at night. Also, since it was raining, it was impossible to use any means of transport other than walking on the road; they were so muddy.

The 28-year-old mother of two babies named Hasina (pseudonym) lives across the river in the research area. While in her third pregnancy period, she faced some complications, which included prolonged labour. Travelling during the monsoon season was not safe because the current of the river was too strong for safe travel, and there were no boats at night. Even working hard to get her to the clinic in time, Hasina could not make it to the clinic in time and, during delivery, relied on TBA, who did not have the skills to handle complications. Her baby did not live, but Hasina did. Problems, including the absence of emergency obstetric care with other essential elements and transportation in inaccessible geographical areas, have led to the occurrence.

3.3 Socio-cultural barriers

Social values and patriarchal traditional norms also act as barriers, restricting the women in the rural setup from approaching health care. Women in conservative, rural communities are often heavily restricted in terms of mobility and decision-making autonomy, which can interfere with their ability to seek care. Studies from rural Pakistan showed that 60% of women needed male authorization to seek help from health facilities, which caused delays in getting treatment (Shaikh & Hatcher, 2004). Social stigmas related to reproductive health issues further prevent rural women from seeking care for infertility, sexually transmitted infections, and postpartum depression. In India, a study revealed that women need authorization from their husbands or other relatives to seek medical care; therefore, direct access is often impossible (Reddy et al., 2018).

A 28-year-old participant, Mariam (pseudonym), was having chronic abdominal pain, but she avoided going to the local health clinic. Her husband, who made most of the family's decisions, brushed aside her concerns as trivial and didn't prioritize bringing her to the clinic. Mariam said it felt uncomfortable to travel alone because of the stigma against women's independence in society.

One of the respondents of the present study was Safika (pseudonym). She said that:

> "I had anemia during my pregnancy period. I wanted to visit a health center, but my mother-in-law prevented me from doing so. She explained that the secrets about the sickness at home did not need to be told to people out there; they will they will recover on their own."

In the words of an informant named Samiya (pseudonym):

> "I have had pain in my hands for quite some time now. My family members prefer to take treatment from local healer even though there is a doctor available for the treatment. I have not gotten any better after seeking help from the local healer and my family members still do not want to visit a doctor."

3.4 Shortages of Workforce and Healthcare Infrastructure

General practitioners, obstetricians, and mental health specialists are chronically insufficient in most rural areas. The World Health Organization (WHO) states that 45% of the world's population lives in rural areas, yet only 23% of the world's healthcare workforce is located there. One respondents of the present study, Rabeya (pseudonym), stated that:

> "This place does not have any specialist doctor. The unfortunate thing is that there is only one village doctor. He practices on almost all illnesses existing in the village. Sometimes there is no doctor at the government health center's so people have to go to Thakurgaon city for better treatment. For instance, it is impossible to find good drug stores in the area. There are no diagnostic centers here because there is no hospital in this place. For any special medicine, we need to go to the city for purchasing such a thing."

3.5 Educational and Awareness Gaps

The low levels of education and health literacy found among countryside women create a challenging environment. Because of this barrier, they cannot manage their health condition or understand the instructions provided by health authorities. Concerning the predictors of delayed care, low health literacy was pointed out as a factor that affects rural populations (Fisher et al., 2020).

This case focuses on a female respondent named Rahima (pseudonym), aged 32 years, a mother of three children, and a resident in the research area; she experienced difficulty in getting better health care for her youngest child, who was suffering from diarrhea problem. Because the woman was illiterate, she thought that the illness was caused by "evil eyes" and cured her child with herbs. A health worker paying a home visit saw that Rahima's household had a poor standard of hygiene. The health worker taught Rahima about using safe water and the necessity of vaccinations. Rahima made some of the changes and had her child take regular vaccinations and change the diet, which tremendously reduced cases of constant sickness.

4. Conclusion

Healthcare is a right of all, and it is a persistent challenge for rural women in developing countries like Bangladesh. Over the last few decades, significant strides have been made in global health, yet rural women continue to face unique and multi-dimensional barriers to receiving the necessary medical care they need in a timely manner. Economic disadvantages, geographic remoteness, cultural barriers, poor health facilities, and the poor level of health literacy were acknowledged as the main challenges that keep rural women away from getting health care facilities in Bangladesh. Such factors have resulted in poor health and health linkages that have a negative impact on the lives of rural women. Among those barriers, economic challenge is the prominent one.

For these problems to be tackled, a multi-sectoral strategy is inevitable. Recommendations should, therefore, include policy reforms that include monetary support, improving infrastructure for transport and healthcare, launching and promoting campaigns, and supporting the removal of cultural barriers and the support of health literacies. In this way, it is possible to involve all stakeholders, including policymakers, non-governmental organizations, and local communities, to respond to further enhancement of rural women's health. Such steps will not only enhance the status of rural women but will also go a long way in the development of the nation by promoting a healthier nation. The findings are localized and do not reflect the rural women's healthcare access issues in other areas of Bangladesh where

the socio-economic, cultural, and infrastructural conditions are different. As such, generalizations cannot be made to other regions in the country. Individual and community-level barriers are the focus of the study, and structural and systemic factors, e.g., governmental policies or mechanisms of healthcare financing, are not considered in detail. The study exclusively uses qualitative methods. Qualitative insights offer a very rich understanding of people's experiences, but without quantitative data, there is no way to measure how many people are experiencing or how severe particular barriers are. The findings of this study suggest that future research might study different healthcare access barriers specific to various rural regions in Bangladesh and pinpoint variations on the basis of geographical, cultural, and economic contexts. Future research could be done to look at the differences between rural and urban areas in order to show the disparities and factors that exacerbate the rural healthcare situation. Adding mixed methods that combine qualitative narratives with quantitative data could deliver a more fulsome understanding and also empower policymakers with the ability to apply this information to provide targeted and evidence-based solutions. The study of these would ultimately help understand the root cause of disparity in the healthcare system and work toward a more inclusive system in rural Bangladesh.

References

Anderson, J., Houle, J., & Bushy, A. (2020). Health disparities in rural maternal health. *Journal of Rural Health, 36*(3), 223–231.

Birch, S., Harris, B., McIntyre, D., Penn-Kekana, L., & Silal, S. (2012). Exploring inequalities in access to and use of maternal health services in South Africa. Retrieved from https://core.ac.uk/download/185412296.pdf

Campbell, O. M. R., Cousens, S., Cox, J., & Gabrysch, S. (2011). The influence of distance and level of care on delivery place in rural Zambia: A study of linked national data in a geographic information system. Retrieved from https://core.ac.uk/download/13093984.pdf

Fisher, J. (2020). Health literacy in rural populations: Challenges and opportunities. *Journal of Rural Health, 36*(4), 554–567.

Gabrysch, S., & Campbell, O. M. R. (2009). Still too far to walk: Literature review of the determinants of delivery service use. *BMC Pregnancy and Childbirth, 9*(1), 34.

Reddy, S. (2018). Gender norms and healthcare access in rural India. *International Journal of Public Health, 63*(9), 1020–1032.

Rishworth, A. C. (2014). Women's navigation of maternal health services in Ghana's Upper West Region in the context of the National Health Insurance Scheme. Retrieved from https://core.ac.uk/download/61644848.pdf

Robinson, S. (2024). Readmission rates of mothers experiencing preeclampsia or complications after delivery in underserved populations. Retrieved from https://core.ac.uk/download/604052029.pdf

Rural Health Information Hub. (2021). Rural health disparities. Retrieved from https://www.ruralhealthinfo.org

Shaikh, B. T., & Hatcher, J. (2004). Health seeking behaviour and health service utilization in Pakistan: Challenging the policymakers. *Journal of Public Health, 27*(1), 49–54.

Sithole, L. (2021). Women's right to access family planning and maternal health care services in Hwange rural district, Zimbabwe: Challenges and opportunities. Retrieved from https://core.ac.uk/download/479335585.pdf

Smith, A. (2017). Economic barriers to healthcare in Sub-Saharan Africa. *Global Health Reports, 15*(3), 249–265.

World Health Organization. (2020). Rural and remote health workforce. Retrieved from https://www.who.int