

# Utilization of the Government Primary Health Care Services: A Micro Level Study on Married Women and Children

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## *Abstract*

*The study attempts to evaluate the utilization status of the government primary health care services especially on married women and children in the rural areas of Bangladesh. Although both primary and secondary data have been utilized for the study emphasis has been given on primary data collected through field investigation covering a sample of 487 married women of up to 45 years in four villages of Mirpur Upazila under Khulna district of Bangladesh. Primary data have been used mainly to show and examine the influence of the government health care programme on married women as well as their children. Secondary data have been utilized for necessary comparison and comments. The utilization status of the health care services has been shown in terms of identified aspects, such as: knowledge of married women regarding health care facilities; awareness on immunization; knowledge about appropriate time and doses for specific immunization; vaccination to children and the place of vaccination; reasons for not giving vaccine to children, and finally reasons for not visiting government health care centres in the locality. Findings show that the knowledge of government health care centres as well as health care facilities available there is relatively poor among the rural women. The overall utilization level of primary health care services by the rural women is not satisfactory till now. The study findings also show a significant age differential in the knowledge of various preventable disease vaccines.*

## **1. Introduction**

Health is an important indicator of development of any country. Access to health care facilities is a basic right of the citizen. It is an obligatory responsibility of the

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government to ensure health care facilities for all citizens of the country. The government of Bangladesh, along with the help of UNESCO, UNICEF, WHO, various NGOs and welfare organizations, provide a variety of health care services to its citizens with special focus on women and children.

Bangladesh is one of the poorest countries in the world - with a high level of underutilized and unutilized natural resources, combined with an environment - which has a high natural calamity risk. It has a high population density, with about 78 percent living in the rural areas, about 40 percent being below the absolute poverty line (BBS, HIES-2005, Bangladesh Economic Review 2008, pp. 178-80). The overall health status of the people of Bangladesh is far below any acceptable standard. This is particularly true for the mothers and the children who have the worst health statistics. For example, the maternal mortality rate is estimated to be 3.5 per 1000 live births, while infant (<1 yr) mortality rate is 43 per 1000 live birth (Bangladesh Economic Review-2008, p.164). Child-bearing starts early and continues at frequent intervals, so maternal depletion syndrome is common in Bangladesh. This highly prevalent malnutrition makes women more vulnerable to diseases. The whole situation is further aggravated by ignorance of safe birth practices, poor socio-economic conditions and poor coverage and low utilization of the available health care facilities. Several studies on utilization of health care services have found a relationship between utilization behavior and socio-economic and demographic factors such as age, education, occupation, place of residence, religion and family income (Ahmed A.U., 1992; Rahman, et.al.1995).

Considering the alarming situation of maternal and child health, the government of Bangladesh is implementing a number of priority programmes in the health sector since 1971. Bangladesh as a member of the World Health Organization (WHO) and as a signatory of the 'Alma-Ata Declaration' is committed to achieve the goal of 'Health for All' using Primary Health Care (PHC) as the key approach. The main objective of this approach is to improve the health status of population particularly mothers and children. With this view, the Govt. of Bangladesh merged Maternal and Child Health Care (MCH) services programme with family planning in 1975 with a view to organizing MCH-based family planning programme. In order to fulfill the objectives of the programme, a wide range of service infrastructure and outlet has been established throughout the country. Accordingly, to cater the needs for providing MCH-FP services, Health and Family Welfare Centres (HFWCs) at Union level, MCH at the Thana level and Maternal and Child Welfare Centre (MCWC) in the urban and sub-urban areas were set up.

Along with Bangladesh in most of the developing countries, it has been identified that about one-third of the infant and child mortality can directly be attributed to the six vaccine preventable diseases: diphtheria, tetanus, pertussis, measles, polio and tuberculosis (UCIEF, 1985). Thus, one-third of all child deaths can be prevented by providing immunization services to women and children. In view of this, the Government of Bangladesh launched the Expanded Programme of Immunization (EPI) on April 17, 1979. The Government of Bangladesh was committed to meet the goal of Universal Child Immunization by achieving 90 percent coverage by 2000 through these intensive activities within the context of the primary health care structure, providing special emphasis to mother and children.

This study attempts to investigate the utilization status of the government primary health care services on women and children in the rural areas of Bangladesh. Though there are a large number of indicators directly or indirectly related to the utilization status of health care services, we have chosen here to focus on some selected crucial issues such as: knowledge of married women regarding health care facilities; knowledge on immunization; knowledge about appropriate time and doses for specific immunization; vaccination to youngest child and the place of vaccination; reasons for not giving vaccine to child/children and finally reasons for not visiting government hospital.

This paper is organized as follows. Section 2 presents the rationale of the study and section 3 outlines its principal objectives. Section 4 discusses the methodology and section 5 explained the findings of the study, Finally, section 6 makes some concluding observations along with providing some policy recommendations based on study findings.

## **2. Rationale of the Study**

In view of high incidence of infant and maternal mortality rates the related health problems, it is important to investigate how these vulnerable groups are utilizing the government's health care facilities and the problems related to health care. Since no elaborate study is available regarding this important issue, this study will provide valuable information about the utilization level of the services 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.

### 3. Objectives of the Study

The main purpose of the study is to assess the utilization status of the Government health care services on married women and children in the rural areas of Bangladesh. For that the specific objectives are:

- to assess the awareness level of married women regarding various Government health care facilities;
- to investigate mothers' knowledge on immunization, appropriate time and doses for specific immunization;
- to review the utilization level of the health care facilities provided by the government;
- to investigate the sources from where the married women get health service, and finally,
- to identify the reasons for not visiting Government hospital available in the locality.

### 4. Methodology of the Study

The study is based mainly on primary data collected through field investigation using structured questionnaire. Secondary data have also been sometimes used for necessary comparison and comments. Both quantitative and qualitative data have been collected for the study, with emphasis on the former.

#### 4.1 Study Area Selection

The location of our study area 'Mirpur Upazila' is under Kushtia district of Bangladesh. It is around 300 K.M. west of the capital city of Dhaka. The Thana is bounded on the north and west by Daulatpur Thana of Kushtia district, on the east by Kushtia sadar and on the south by Alamdanga Thans of Chowadanga district. The Thana consists of 12 unions and 187 villages having a total population of 2,85,089 persons (Community Series of Bangladesh Population Census, Kushtia, 2001, pp. 4-7). In considering the indicators mentioned in Table:4.1 the Mirpur figures suggest that the thana is close to being of 'average' status except that it has the lowest female literacy as well as larger growth rate of population as compared to the district, division and national averages.

**Table 4.1 : Some Selected Indicators of Mirpur Thana, Kushtia District, Khulna Division and National Levels of Bangladesh**

Sl. No	Indicators	Mirpur Thana	Kushtia District	Khulna Division	Country
1	Annual growth rate of population (%)	1.90	1.28	1.32	1.48
2	Density of population (per sq. km)	898	1073	682	843
3	Average household size	4.5	4.7	4.7	4.8
4	Sex Ratio (M/F)	106	106	104.2	103.8
5	Literacy Rate (7 years & above)	Percent			
	Male+ Female	37.1	40.4	47.1	44.9
	Male	39.2	43.4	51.7	49.5
	Female	34.9	37.2	42.1	40.1

Sources: i) Bangladesh Population Census 2001, pp. 4 -7, 16-18  
 ii) Population Census 2001, Community Series, Kushtia District.  
 iii) Report of the Household Income and Expenditure Survey, 2000, p.53

#### 4.2 Sampling Techniques and Size of Sample

In this study, our target population was married women of age up to 45 years. Primarily, information was collected from 'Civil Surgeon Office-Kushtia' and 'Mirpur Upazila Health Complex' regarding the programme performance status of the 12 Unions and their respective villages of the Upazila. From the official record we were informed that except Poursobha area there are no significant high or low performing Unions among the 12; further that all of them were officially treated as average performing Unions.

In identifying the sample, we adopted a two-stage cluster sampling design. In the first stage, we divided the total geographical area of the Upazila into four different clusters, each of them having 3 Unions. In the second stage, we randomly selected one village from each of the four clusters and finally our sample villages became 4. After identifying the sample villages, we decided to cover all the married women up to 45 years.

After identifying the sample of married women, data were collected through household survey using a structured questionnaire and finally we interviewed a total of 487 married women. The survey was conducted during March 2009 and June 2009. After collecting data various statistical tools and methods have been

applied to analyze the data. Data analyses have been done dividing the responding women into two groups: i) age up to 19 years i.e. married adolescents group and ii) age group 20-45 years i.e. group of adult married women.

*Table 4.2-1 : Previous forms of Vaccines, Doses and Preventable Diseases*

Sl.	Name of Vaccine	Doses and time period	Preventable Diseases
1	TT	Three injections given to mother at monthly intervals during the last trimester	Tetanus
2	DPT	Two to three doses to baby at 1-3 months of age	Diphtheria
3	Polio	One to two drops three times to baby at 1-3 months of age	Poliomyelitis
4	BCG	One injection within one month of age;	Tuberculosis
5	Ham vaccine	One injection at 9-10 months of age	Ham/Measles

*Table 4.2-B, New forms of Vaccines, Doses and Preventable Diseases.*

Sl.	Name of Vaccine	Doses and time period	Diseases
1	BCG vaccine	One injection within one month of age	Tuberculosis
2	Pentavalenta Vaccine <sup>1</sup> (DPT, TT, Hep-B, and Hib-vaccine)	Three doses to baby at 4 weeks interval just after 6 weeks of age.	Diphtheria, Pertusis, Hemophilia influenza-B, Tetanus, Hepatitis-B,
3	Opv vaccine	Four doses to baby at 4 weeks interval just after 6 weeks of age.	Poliomyelitis
4	Ham vaccine	One injection to baby at 9-10 months of age.	Ham/ Measles

Source: EPI Shahayeka, and Civil Surgeon Office, Kushtia. Note: The implementation of the new forms of vaccination has been started in the region on 15<sup>th</sup> June 2009, and by 25<sup>th</sup> June 2009 its operation has been started all over the country.

It should be mentioned here that, recently the forms of vaccination/immunization (especially in terms of names, types and their respective preventable diseases) have been changed to some extent. But during field survey, it has been observed that the previous forms of vaccines are only known to the women, and nobody knows the present forms, which have just been started to implement in the region since 15<sup>th</sup> July 2009. So, the findings of this paper have been shown interviewing

the respondents regarding various aspects of the previous forms of vaccinations instead of the recent one.

### **Findings of the Study**

The findings of the paper that emerge from the evaluation of the utilization status of the Government primary health care services in the rural areas of Bangladesh are Presented in this section.

- i) knowledge of married women regarding health care facilities;
- ii) mother's knowledge on immunization;
- iii) knowledge about appropriate time and doses for specific immunization;
- iv) vaccination to youngest child/children and the place of vaccination;
- v) reasons for not giving vaccine to children, and finally
- vi) reasons for not visiting government hospital to get health services.

#### **5.1 Knowledge of Health Care Facility**

To evaluate respondents knowledge about government's health care services that are available in their locality they were asked about some selected aspects. In response to the question whether they had heard of or knew any of the health care centers at their union/area, about 72 percent reported that they were aware of health care centers in their locality which provided different types of health services (Table:5.1). This knowledge was found to be higher (75.1%) among the older women (age 20-45 years) than the younger (age <20) counterpart of married adolescents (60.5%).

At aggregate level, about 66 percent of the respondents could mention the name of at least one health care center. Interestingly a slightly higher proportion of women (68.2%) could mention the name of services delivered from the centers. However, such knowledge was found much higher among the older group (71.7% and 73%) as compared to their respective counterpart of married adolescents (48.6% and 51.4%). However, in this case, no attempt was made to ascertain how far this knowledge was effective in terms of correct knowledge about the name of health care centers and the services delivered from these centers.

Only 53 percent of the respondents ever visited any of the government health care centers in their locality. This figure is lower than that of the findings of the study of Kamal et. al. (1992), but higher than the findings of Islam et. al (1995), their

**Table 5.1 : Knowledge about Some Selected Indicators Regarding Health Care Facilities Available in the Locality (Actual & percentages)**

Sl. No	Indicators	Age of Married Women (in years)		
		age<20 N=109	20-45 N=378	Total N=487
1	Knowledge of health care center in the locality	66 (60.5)	284 (75.1)	350(71.9)
2	Knows the name of health care centers	53 (48.6)	271 (71.7)	324(66.5)
3	Knows the services delivered by the Health Care Center	56 (51.4)	276 (73.0)	332(68.2)
4	Ever visited any local HCC	43 (39.4)	217 (57.4)	260(53.4)
5	Utilization of existing health care facility	36 (33.0)	181(47.9)	217(44.5)

Source: Survey of 487 married women. Note: Figures in the parentheses indicate percentage.

respective findings being 59 percent and 47.9 percent. Thus there is a gap between the prevailing knowledge and the use, if at all, of health care facilities available in the locality.

About fifty-five percent (100- 44.5=55.4%) of the women never utilized the existing health care facilities. Table: 5.1 also indicates that knowledge and proportion of ever visiting the health care centers along with with utilization of the services are higher among the older women (age 20-45) years) their younger counterpart of married adolescents (age <20 years).

### Mothers' Knowledge on Immunization

Mothers' awareness regarding immunization for children and their knowledge of the appropriate age range of children at which specific immunization should be given are the most important indicators for measuring the utilization level of

**Table 5.2 : Proportion of the Respondents in terms of Awareness of Different Vaccines (Actual & percentages)**

Sl. No.	Name of Vaccine	Awareness Level (Actual & percentages)		
		Age<20	Age 20-45	Total
1	TT	64 (58.7)	275(72.8)	348 (71.5)
2	DPT	60(55.0)	265 (70.1)	325 (66.7)
3	Polio	66(60.5)	279 (73.8)	345(70.8)
4	BCG	55 (50.5)	241(63.7)	296 (60.8)
5	Measles/Ham	54 (49.5)	238(62.9)	292 (59.9)
6	Any vaccine	72 (66.1)	290(76.7)	362 (74.3)
7	Total	N=109	N=378	N=487

Source: Survey of 487 married women. Note: Figures in the parentheses indicate percentages.



government health care programmes. In this study, attempts were made to examine whether the married women were aware of immunization and whether they knew the appropriate time of vaccination to their children. To evaluate the general knowledge of immunization, the respondents were asked whether they had heard about immunization in general. Data on knowledge of immunization were collected using the structured questionnaire through recall method. Knowledge about immunization was assessed through asking the respondents about the name of the diseases preventable by the vaccine. Table 5.2 shows the percentage of married women who were aware of any of the vaccine for immunization.

It is evident from Table: 5.2) that at aggregate level about 74 percent of the married women had knowledge about at least one vaccine. Among the individual vaccines, TT was known to the highest proportion (71.57%) of the respondents, followed by Polio (70.8%), DPT (66.7%), and BCG (60.8%). The lowest percentage of women (59.9%) were found to be aware about Measles. Regarding awareness about vaccine, a significant difference was observed between younger and older women; irrespective of category at aggregate level the difference being about ten to fifteen percent; i.e. young mothers had consistently lower knowledge about different vaccines than that of their older counterparts.

**Table: 5.3 Proportion of Respondents by Knowledge on Correct Age Range and Doses for Specific Immunization (Actual & percentages).**

Sl. No	Name of Vaccine	Age<20		Age 20-45		Total	
		Accurate knowledge	Inaccurate knowledge	Accurate knowledge	Inaccurate knowledge	Correct knowledge	Incorrect knowledge
1	TT	28(25.7)	81(74.3)	138(36.5)	240(63.5)	166(34.1)	321(65.9)
2	DPT	22(20.2)	87(79.8)	110(29.1)	268(70.9)	132(27.1)	355(72.9)
3	Polio	16(14.7)	93(85.3)	86(22.8)	292(77.2)	102(21.0)	385(79.0)
4	Measles	13(11.9)	96(88.1)	76(20.1)	302(79.9)	89(18.3)	398(81.7)
5	BCG	14(12.8)	95(87.2)	73(19.3)	305(80.6)	87(17.9)	400(82.1)
Total		N=109		N=378		N=487	

Source: Survey of 487 married women and EPI Shahayeka-2009. Note: Figures in the parentheses indicate percentage.

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.

### 5.3 Knowledge of Appropriate Time and Doses for Specific Immunization

In addition of assessing mothers' knowledge of Immunization in general, we investigate whether they knew the appropriate time and doses for specific immunization (e.g. TT injection) and as well as the correct age range of their children at which vaccine should be given. In order to examine the knowledge regarding correct age range and doses for different vaccines, we considered the age range and doses as suggested by the EPI programme in Bangladesh. Knowledge of the respondents was considered correct if they could mention the name of the vaccine, its doses and the age of child at which the vaccine should be administered.

Table:5.3 shows that only 34 percent of the married women knew the accurate age range and doses of the TT vaccine and the remaining 66 percent either knew partially or did not know at all.

Knowledge about appropriate age range and doses for other vaccines was found to be even lower than for TT. At the aggregate level, only 27 percent of the respondents knew correctly the appropriate age and doses of DPT. About 17 percent to 21 percent knew the correct age range and doses at which polio, measles and BCG vaccine should be taken; and the remaining 79 to 83 percent either knew partially or did not know at all. Again in this case, the age of the married women showed a significant differential effect on the accurate knowledge of the timing & doses of vaccination. Older mothers have been found much more knowledgeable, regarding this issue than their younger counterparts of married adolescents. This is true for almost all of the vaccines. So, considering the very low rate of correct knowledge regarding appropriate time and doses of vaccination, proper steps should be taken to increase the status of correct knowledge regarding the appropriate time and doses of the vaccine in order to serve the purpose- 'health for all'.

### Vaccination to Child/Children and the Place of Vaccination

limited attempt was made in this study. an overall idea about immunization coverage especially in terms of vaccination to youngest child and the place of vaccination. Respondents with at least one child were asked whether their youngest child was given all prescribed vaccines. However, no attempt was made to prove whether full course of immunization was completed or not. So the response shown in Table 5.4 may exaggerate the immunization coverage rate.

**Table 5.4 : Distribution of Mothers according to the Vaccination of youngest Child/Children and the Place of Vaccination.**

Sl. No	Responses	Actual & Percentages
A Vaccination to youngest child		
1	Yes	430(89.5)
2	No	42 (8.8)
3	No response	8 ( 1.7)
	Total (N=480)	480(100)
B Place of vaccination		
1	EPI centre	161 (37.4)
2	Govt. Hospital	129 (30.0)
3	Private clinic	73 (17.0)
4	Satellite clinic	54 (12.6)
5	Others	13 (3.0)
	Total (N =430)	430 (100)

Note: Among the 487sample married women 480 women had at least one child and the remaining couples had no children. Figures in the parenthesis indicate percentages.

About 90 percent of the mother reported that their youngest child was immunized. We further wanted to know from the young mother (who immunized their children) from where they got their children immunized. The results are shown in Table: 5.4. About 37 percent of the respondents reported that they had taken their child/children to the EPI centre for immunization. The Government hospital (30%) and private clinic (17.0%) were the next choices respectively. Satellite clinics were utilized by 12.7 percent of mothers for vaccination (Table: 5.4).

### 5.5 Reasons for Not Giving Vaccine to the Child/Children

Although already it has been seen in Table 5.4 that majority of the young mothers (89.5 percent) immunized their children, about eleven percent of them denied having immunization for their children. In response to the question why they had not immunized their children, a variety of causes they mentioned. The distribution of young mothers along with their responses for which they had not immunized their children is shown in Table: 5.5.

Ignorance about effectiveness and timing of immunization appeared as the most important factor (42.9%) for not giving vaccine to their children. Fear of side effect (28.6%), no faith on vaccination (11.9%), and distance of the vaccination

**Table 5.5 : Proportion of the Respondents by Main Reasons for not giving Vaccine to the Child/Children (Actual & percentages)**

Sl. No.	Reasons	Actual & Percentages
1	Lack of effective knowledge about vaccination	18(42.9 )
2	No faith on Vaccination	5(11.9 )
3	Far distance of vaccination centre	4(9.5)
4	Fear of side effect	12(28.6)
5	In adequate supply of vaccination	3(7.1)
6	Total (N= 42)	100%

Note: Figures in the parentheses indicate percentage.

centre (10.0%), were other vital reasons. Thus to increase the immunization coverage, knowledge about immunization and its impact on child health should be increased further among the rural women through designing appropriate educational and training programme.

**Table 5.6 : Proportion of the Respondents by Reasons for not visiting Govt. Hospital**

Sl. No	Indicators	Actual & Percentages		
		Age<20 N= 67	Age 20-45 N=234	Total N= 301
1	Far distance	34(50.7)	87(37.2)	121(40.2)
2	Pays little attention	17(25.4)	83(35.5)	100(33.2)
3	Misbehavior	11(16.4)	35 (14.9)	46(15.3)
4	Non-availability of medicine	4(5.9)	21 (8.9)	25(8.3)
6.	Others	1(1.5)	8(3.4)	9(3.0)
6	Total	67(100)	234(100)	301(100)

Note: Figures in the parentheses indicate percentage.

### Reasons for Not Visiting Government Hospital

Table 5.6 reports the main reasons for never visiting Govt. hospital. Distance of the health care centre from the respondent's residence appeared as the most important reason. About forty percent of the respondents reported that the health care centre was too far from their residence. Comparatively a higher proportion of younger women (50.7%) identified this cause as an obstacle to visit the centre as compared to their older counterparts (37.2%). Long distance of the health care centres could be important reasons for not visiting government hospital in the context of rural Bangladesh, where modern communication facilities are still

lacking. The next important reason behind not using Govt. health care facilities was that the hospital paid little attention to the treatment (33%), followed by misbehavior of the hospital staff (15.3%), and non-availability of medicine (8.3%) at the centre.

### **5.7 Differential in Utilization of Health Facilities**

An attempt was made to assess the influence of land possession and education of the respondents in utilizing health facilities. Our analysis should that it is not the land possession, but education that motivated the rural women more to pay visit to the health care centers. However, statistically no significant difference (Mantel-Haentzel Chi-square) has been found between the level of education and land possession with respect to the respondents' visiting behavior.

## **6. Conclusions and Policy Recommendations**

Based on study findings, we can draw the following conclusions and relevant policy recommendations.

The knowledge of government health care centres as well as health care facilities available there is relatively poor among the rural women. Younger women (married adolescents, age <20) are relatively more unaware than other women in this regard..

The overall utilization level of primary health care services by the rural women is not satisfactory till now. At aggregate level 44 percent of women reported to have utilized the govt. health care services to some extent, and the remaining 56 percent has not utilized the existing health care facilities. Findings also indicate that the proportion of ever visiting the health care centers along with utilization of the services are higher among the older women (20-45 years) as compared to the younger group of married adolescents (age <20 years).

The study findings show a significant age differential in the knowledge of various preventable disease vaccines. Younger mothers have been found less knowledgeable in this regard. For example, about 77 percent of the older mothers were aware of any vaccine as against only 66 percent of the adolescent mothers. Knowledge of proper timing of vaccination was also similarly poor among the younger group.

About 90 percent of the mothers reported that their youngest child was immunized, which is less than that of the coverage demanded (above 95%) by

Civil Surgeon office, Kushtia. The highest proportion of women (37%) reported that they had taken their child/children to the EPI centre for immunization, followed by Government hospital (30%) and private clinic (17.0%). About ten percent children are not immunized yet. In response to the question why they had not immunized their children, a variety of causes were cited by the respondent mothers. Among those causes, ignorance about the effectiveness of immunization appeared as the most important factor (42.9%) for not giving vaccine to children, followed by the fear of side effect (28.6%), no faith on vaccination (11.9%), the distance of the vaccination centre (10.0%) etc.

We also tried to investigate the main reasons for not visiting govt. hospital by a large proportion of rural women. Among the identified reasons, distance of the hospital from the respondent's residence appeared as the most important one, followed by little attention paid on the treatment delivered from hospital (33%), lack of good behavior of the hospital staff (15.3%), and non-availability of medicine (8.3%) etc.

**Policy Recommendations:** Based on the study findings the following policy recommendations can be drawn:

- Proper steps should be taken to create awareness among rural women as well as their husbands, parents and the community leaders about the essentiality of vaccination in order to prevent their children from the vaccine preventable diseases. This could be done through social information, education and communication campaigns, regular home visit by Family Welfare Visitors (FWVs) and Family Welfare Assistan (FWAs). In this respect our present basic education system should be rearranged to meet the needs of the present day. These include: education on family life, human sexuality, demographic, health, socio-economic development, the role of women both in the family and the society etc.
- For adolescent mothers who have dropped out of schools due to early marriage or other socio-cultural reasons, special measures should be taken to educate them through non-formal education. Education of girls will not only ensure basic literacy for all but will also provide realistic training for women in income-generating activities and primary health care.
- Government should take appropriate measure to employ potential young women in the jobs, especially in the field of health and education. This is expected to encourage changes in the attitude of the society that has confined women to low level jobs.

- Government health care facilities available at the rural health centres have yet remained underutilized by the rural women. Government should take appropriate steps to overcome the obstacles (reported by the respondents) related to the govt. hospital in order to enhance the utilization status of health care facilities by the rural men and women.
- Finally, proper steps should be taken to bring the health care services at the doorstep of the rural women. For that, the number of health care centres can be increased so that the health care facilities come within the reach of the rural women. Measures should be taken to arrange mobile clinics within the short distance in the heavily populated area and steps should be taken to ensure home visits by the government health personnel.

### *References*

1. Ahmed, A. U. (1992), "Socio-economic Determinants of age at First Marriage in Bangladesh", *Journal of Biosocial Science*, Vol.18, pp.35-42.
2. Alauddin, M. (1986), "Maternal Mortality in Rural Bangladesh: the Tangail District". *Studies in Family Planning*; Vol.17, No.1; pp.13-21.
3. Bangladesh Bureau of Statistics: *Bangladesh Population Census 2001*, pp. 4 -7, 16-18
4. Bangladesh Bureau of Statistics: *Bangladesh Population Census 1991, Community Series, Kushtia District*.
5. Islam, et. al (1995), "*Fertility and Reproductive Health Status of Married Adolescents in Rural Bangladesh*", PDEU, Dhaka, 1995.
6. Islam, et.al (1996), "*Biological and Behavioural Determinants of fertility in Bangladesh*"; *Asia Pacific Population Journal*, Vol.8, No.1.
7. Kamal, et. Al (1992), 'Impact of Credit Programme on Reproductive behavior of Grameen.
8. Bank Beneficiaries", NIPORT, Dhaka.
9. Rahman, et. al. (1995), "Immunization Acceptance among Pregnant Women in Rural Bangladesh"; *Bulletin of the World Health organization*; Vol. 60, No.2.