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# Trends in Seeking Healthcare Services by the Slum Population in Dhaka City

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## Abstract

*This paper explores the trends in seeking healthcare services by the people living in the slums of Dhaka. It seeks to enhance the understanding and analysis of the trends in seeking healthcare from a behavioral perspective conditioned by the socio-economic and demographic variability. In this context the behavioral factors that were taken into considerations were determined by pre disposing factors, disorder and service characteristics. The study is based on primary data collected from five different slums of Dhaka city. This study found that people living in slum areas are simultaneously very poor and deprived. Due to low income and particular socio economic surroundings the slum population is readily exposed to several health hazards. Because of lack of ability they also failed to properly utilize available health services.*

***Keywords:*** *Health, behavior, slum population, diseases, treatment*

## Introduction

Bangladesh, an agri-based developing country with low per capita cultivable land in the world, is witnessing large number of population move into the urban centres. Urbanisation in Bangladesh is not an outcome of industrialisations rather it is an inevitable and unavoidable feature in the process of development. In the circumstances, the capacity of urban centres to cater to the basic civic needs of growth is heavily challenged [1]. Evidence from Demographic and Health Surveys indicates that the urban poor in Bangladesh have less access to health services, than the rural poor [2]. However, for some illnesses, people in urban slums will chose traditional healers, village homeopaths, or untrained allopathic doctors above formally trained practitioners or government health facilities [3]. Caldwell & Caldwell [4] found disproportionately higher mortality rates in the poorer households in the informal settlements of Dhaka affirming the World Bank's position that children born into poor families have a higher chance of dying before their first and fifth birthday than those born into better-off families [5].

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Poor-quality and overcrowded shelter, lack of public services and infrastructure such as piped water, sanitation facilities, garbage collection, drainage and roads, as well as insecure land tenure imposed disadvantages increase the health and work burdens on the urban poor [6]. Again, these combinations create unhealthy environment and increase health risks from poor sanitation, lack of clean water, overcrowded and poorly ventilated living and working environments and air and industrial pollution. Besides income poverty inadequate diet reduce slum-dwellers' resistance to disease, especially because they live in the constant presence of pathogenic micro-organisms and are vulnerable to communicable diseases [7].

In Bangladesh there is a large and growing sector of non-qualified allopathic service providers. They provide an accessible means of reaching modern medicines to a wider range of the population; nevertheless, they lack formal medical training. Therefore in developing countries traditional and unqualified health professionals need to be recognized as one of the main healthcare providers in relation to some health problems of the slum population [8]. Although people choose traditional and folk medicine in a variety of contexts which have potentially intense impacts on health, some studies recommend ways to build bridges to enable individual preferences that need to be incorporated into a more responsive health care system [3, 9]. In developing countries poverty acts as the most significant determinant of health care seeking behaviors; as a result it has been found that the slum-dwellers are almost two times more likely not seeking any healthcare services [9]. The socio economic status of the slum population appeared as one of the major reasons for not seeking any healthcare at all, especially allopathic care. In Bangladesh medical existence of several individual curative systems in a single cultural setting, is an important feature of health care like much of the developing world. Undoubtedly, a wide range of therapeutic choices is available, ranging from self-care to folk and modern medicine, even though both illness and treatment options are importantly determined by poverty and gender [10].

The seeking healthcare services refer to the sequence of remedial actions that individuals undertake to cure perceived ill health [11]. Healthcare-seeking behavior is initiated with symptom detection, whereupon a strategy for treatment action is devised [12]. It can be inferred that trends in seeking healthcare services are a somewhat over-utilized and under-theorized tool. It is of little use as it stands to explore the wider relationship between populations and health systems development. It is necessary to develop a tool for understanding how population engage with health systems, rather than using healthcare

seeking behavior as a tool for describing how individuals engage with services [13].

Studies on trends in seeking healthcare services mainly acknowledge that health control tools, where they exist, remain greatly under or inadequately used [13]. Understanding human behavior is prerequisite to change behavior and improve healthcare practices. This is evident from health expert's interventions and health policy [14]. In order to respond to community perspectives and needs, health systems need to adapt their strategies, taking into account the findings from behavioral studies [13, 14, and 9].

Dhaka is the fastest growing mega city in the world with an estimated 300,000 to 400,000 new migrants mostly arriving here annually [15]. In terms of population size of the urban agglomeration, eleven years ago Dhaka used to rank 24th in the world. It was projected in 1997 that by 2010 the population will be 17.6 million with up to 60% in the slum [1]. However, at present in the year 2007 its population has risen up to 12 million and is projected to grow to 20 million in 2020 making it the world's third largest city [15]. Dhaka is increasingly characterised by large slums, poor housing, excessively high land price, traffic congestion, water shortages, poor sanitation and drainage, irregular electric supply, unplanned construction increasing air pollution and poor urban governance which results in growing problems of law and order [15].

## Methodology

This paper is based on data collected in 2010 from five slums in Dhaka City. Study areas were divided into five parts of the Dhaka city. Where the dividing principle involves selecting areas from the four sides: north, south, east and west part of the city and another area from the central part of the city. The five sites were selected randomly for this study. The study areas were Rayer Bazer slum (1), Mohamadpur slum (2), Mugdapara (3), Aam bagan slum (4), and Uttar Khan (5). The sample size was 250. The study focuses on diseases pattern and trends in seeking healthcare services by the slums dwellers to obtain the representative unbiased study population. 50 women were interviewed from each area. The study is based on both primary and secondary sources. Questions were focused on their health problems, types of diseases occur in this environment, and what type of treatment they seek during various illnesses. Secondary data were collected from various publications of BBS, Ministry of Health and Family Welfare, World Bank, ADB, World Vision and NGO's working with the slum.

## Findings

### Socio- Demographic Data of the Respondent

Among the respondents the majority were between the ages of 22 to 32 years. Most of them were working as domestic workers and others were engaged as daily labour, garments industry. Only few were housewives. Most of the spouses of the respondent were working as drivers, rickshaw pullers, vendors, security guards, small business men and tailors. The major problems they identified were that due to their low income status it is difficult for them to afford better healthcare facilities when they are sick. The decision to engage with a particular medical channel is also influenced by a variety of socio-economic variables, sex, age, the social status of women, the type of illness, access to services and perceived quality of the service [16]. There are also other factors such as distance, availability, the appropriateness and adequacy of services as perceived by users influence seeking healthcare services.

The maintenance of good health needs proper food, housing, water and environments but rapid growth of densely populated, predominately low-income settlements in Dhaka is causing serious threats to health. It is found that poverty, lack of education, unemployment; poor working conditions social, cultural and economic factors have an influence on healthcare seeking behaviour. The scenarios in the slums are more serious compared to the rural and other parts of urban areas. Slum-dweller prefers private sources of ambulatory care; public facilities are more likely to be utilized in the event of fewer, or lack of options. The difference in the cost of ambulatory health care in private and public facilities is, however, not large. For the slum-dwellers, the utilization of public hospitals for in-patient treatment is much higher than that for ambulatory care. In this context the present study concentrated on disease patterns and healthcare seeking behavior of slum dwellers.

### Major Types of Diseases

Generally the illnesses or diseases that occur in slum areas are communicable diseases for example; fever, cold, cough, influenza, diarrhoea, dysentery, jaundice, acidity, gastric problem, peptic ulcer, asthma, skin diseases, chickenpox, tetanus, polio and bronchitis etc. All these diseases are associated with the environment and people's life style, which are conditional by social values, attitudes, activities, income and habits. The factors that play a major role in the causation of a disease are [17]:

- Predisposing factors, such as age, sex and previous illness, may create a state of susceptibility to a disease agent.
- Enabling factors, such as low income, poor nutrition, bad housing, inadequate health care, may favour development of disease.
- Precipitating factors, such as exposure to a specific disease agent, may be associated with the onset of a disease.
- Reinforcing factors, such as repeated exposure and undue hard work may aggravate an established disease.

In the study areas most common diseases were dysentery, fever, tonsillitis, and headache. Together they account for almost two thirds of all sickness. However, malnutrition, headache, female gynecological disease and skin disease can be interpreted as disease of women in the sample. Information on illness during last one year was sought on all members of households. From the following table (table 1) the distribution of households by number of respondents who have been sick during the last one-year has been explained. Out of the 250 households in the study areas, the most common disease was the dysentery; a total 50 family members were suffering from this disease. Around 42 family members suffer from fever cold/cough. Then headache and tonsillitis were common for 31 and 25 members.

Table 1: Common Disease pattern of in the slums

| **Disease** | **N** | **Percentage** |
|---|---|---|
| Dysentery | 50 | 23.81 |
| Fever /cold/cough | 42 | 20.00 |
| Tonsillitis | 25 | 11.90 |
| Headache | 31 | 14.76 |
| Female gynecological disease | 30 | 14.28 |
| Skin disease | 18 | 8.57 |
| Malnutrition | 14 | 6.66 |
| Total | 210 | 100 |

The other common disease patterns are presented in table 2. These common diseases pattern had the tendency to concentrate among middle age persons. The diseases were high blood pressure, low blood pressure, *gete bat* or joint pain, ear disease, eye disease and pain in body. The majority population 62.20% reported about low blood pressure, influenza and body pain among other common diseases.

Table 2: Other Common Disease Pattern

| Disease | Number | Percentage |
|---|---|---|
| High blood pressure | 10 | 10.42 |
| Low blood pressure | 22 | 22.92 |
| Joint Pain (*Gete bat)* | 14 | 14.58 |
| Influenza | 21 | 21.88 |
| Body Pain | 17 | 17.70 |
| Ear disease | 4 | 4.17 |
| Eye disease | 8 | 8.33 |
| Total | 96 | 100 |

In table 3 different types of acute disease patterns are explained. The acute diseases were jaundice, typhoid, heart diseases, tumor, whooping cough and old age problems. It was found that about 64% of total sick persons reported that they suffered from jaundice and typhoid. These types of diseases incurred high treatment costs and caused more morbidity. Diseases which occurred mostly in the children were measles, pneumonia, cold related problems. It was also found that children under 10 year of age suffered from stomach problems (worms) and influenza.

Table 3 Acute Disease Pattern

| Disease | Number | Percentage |
|---|---|---|
| Jaundice | 18 | 36 |
| Typhoid | 14 | 28 |
| Heart disease | 3 | 6 |
| Tumor(small + big) | 8 | 16 |
| Whooping cough | 3 | 6 |
| Old age problem | 4 | 8 |
| Total | 50 | 100 |

## General Healthcare Practices

Health of an individual is mainly dependent on two sets of factors. One set is governed by his or her genetic constitution and the other is his or her environment. In most countries healthcare service functions are restricted to curative services because of the prevailing limited understanding and inadequate conceptualisation of health itself. As a concept, health has broadened from mere absence of diseases to healthcare services, clearer understanding of its scopes, responsibilities and varieties of activities relevant to health development. Healthcare service alone does not produce better health, but it certainly contributes towards health development by increasing health awareness through health education, information on immunisation and family welfare services. A well-planned and well-managed healthcare service system

helps to raise general health status of a community or nation at large that at the end contributes to economic growth of a nation. Two major factors would determine the success or failure of the healthcare service system. Firstly, is the services is balanced in terms socio economic context of the people of primitive, preventive, curative and rehabilitative components. Secondly, whether the service is equitably distributed, accessible at a cost the country and community can afford and socially acceptable to fulfil their needs [17].

The urban health care infrastructure in the country consists of a range of care provided by three sources. These sources are: [18]

a. the government health care facilities
b. the private sector health care facilities
c. the NGO facilities

In the urban areas of Bangladesh, the government healthcare service system plays a relatively low in the delivery of healthcare because non-governmental organisations and commercial concerns are the most common providers. There is a lack of effective co-ordination and cross referral among the various facilities and multiple providers of services that results in low utilisation of existing infrastructure, gaps in coverage, duplications in areas of responsibility and limited access and availability of services to the population, particularly the urban poor care [19].

Despite the existence of a large and extensive public health care system in Dhaka city, there has always been some criticism regarding its quality and accessibility, especially in the recent past [20]. With regard to the direct provision of public services, the entire system is grossly overloaded and under-funded. Problems like crowded outpatient departments, poor physical conditions of the infrastructure, and primitive health information continue to plague the public health care system. On the other hand, the private sector, which is easily accessible and is seen as delivering quality services, is much more expensive and is largely supported by direct out-of-pocket payments. This discrepancy in the cost of treatment in the private sector is much higher in the urban areas than in the rural areas. Various studies demonstrate that decision to engage with a particular medical channel is influenced by a variety of socio-economic variables, sex, age, the social status of women, the type of illness, access to services and perceived quality of the service [21, 22, 23, 24]. These issues are very complex in nature and play an influential role in determining the contact between patients and services. The following table (table 4) maps out the categories of determinants behind healthcare seeking patterns. Basically, there are two broad trends. In this approach, there are as many categorizations and variations in terminology as there

are studies, but they tend to fall under the divisions of geographical, social, economic, cultural and organizational factors [14].

Table 4 Determinants of health care seeking behavior

| Category | Determinant | Details |
|---|---|---|
| Cultural | Status of Women | Elements of patriarchy |
| Social | Age and sex | |
| Socioeconomic | Household resources | Educational level Maternal occupation Marital status Economic Status |
| Economic Cost | Cost of care | Treatment |
| | Type and severity of illness | Travel<br>Time |
| Geographical | Distance and physical access | Cost<br>Time |
| Organisational | Perceived quality | Standard of drugs Standard of equipment Competence of staff Attitudes of staff Interpersonal process |

*Source: (Susanna Hausmann-Muela ,2003) [14]*

## Available Health Services

Dhaka has quite a concentration of government and non-government healthcare facilities. These include teaching hospitals and specialised medical institutions beside the departmental hospitals run by the army, police, railway and others. While talking with the respondents it was found that they had clear knowledge about healthcare service providers. This showed that knowledge and trend in seeking healthcare services are closely associated. However, most of the slum dwellers in Dhaka obtain treatments from quacks, *hakims*, and *kabiraj* and the pharmacies. The health services in the private sectors are out of reach of the slum dwellers, because of their high cost. They also face difficulty in accessing the government and other institutional hospitals, as they have to compete with socially and economically better off patients [18]. In this sample out of 250 respondent 185 accessed healthcare services when their family members fell ill and only 65 of them did not seek any care (see table 5).

Table 5 Trends in Seeking Healthcare Services among the Slum Population

| Seeking Healthcare | N | Percentage |
|---|---|---|
| Seeking healthcare | 185 | 74 |
| Not seeking healthcare | 65 | 26 |

They sought healthcare services from various service providers including formal and informal. The healthcare seeking was primarily from seven broad categories: the majority of the people went to government doctors

(22.70%) followed by pharmacies (18.92%). Some of them also sought treatment from other places. About 14.59% sought treatment from the government practitioner hospitals. In all the slums some of them also visited the *kabiraj* and homeopath, (8.12% and 6.49%). In the slums families receive health services from the health assistants (11.35%). Some of them also seek help from the health centre run by NGO (17.84%).

Table 6: Available Health Services

| Mode Of Treatment | Number | Percentage |
|---|---|---|
| Government Hospital | 42 | 22.70 |
| Health Assistant | 27 | 14.59 |
| Health Centre run by NGO | 33 | 17.84 |
| Pharmacies | 35 | 18.92 |
| Private Doctors | 21 | 11.35 |
| Homeopathy | 12 | 6.49 |
| *Kabiraj* | 15 | 8.12 |
| Total | 185 | 100 |

It was found in a study that the respondents made a distinction between a government doctor and a private **o**ne. For them, private doctors were more competent. They preferred private doctors to government ones because aside from being more competent, private doctors were more available and their clinics were more accessible and they had medicines. Moreover, private clinics or hospitals had adequate facilities. They would only see government doctors and admit themselves in government h**o**spitals as a last resort, when either because they did not have any money to seek private health services or they needed immediate relief from their illness and the nearest clinic or hospital where they could get such relief was a government one. However the respondent said that as an out-patient they preferred to go to a private healthcare system because the service was better and doctors were more competent. On the other hand as in-patient treatment they preferred the public healthcare system because the cost is much less those private clinics. According to the analysis of the data, showed that there were significant associations exist between healthcare seeking behavior and determinant factors like, members status in the household, respondents' health related decision making process, perceived severity of the disease and also on the respondents' educational status.

## Problems of Health Care Services

The government is committed as per Bangladesh Constitution Article 15(A) to make necessary basic medical utilities available for people of all strata. In this context, Government of Bangladesh has committed to the HFA (Health for All) goals through PHC (primary healthcare) approach

to achieve the targets of MDG's (millennium development goals). To this end, the government follows the principle of universal health coverage and accessibility, priority to the poor and the most vulnerable groups, improvement in the quality of life, and promotion of health in national health policy.

Bangladesh as a member state of WHO, has endorsed the HFA strategy and has adopted a comprehensive Primary Health Care programme. There is a basic tool for healthcare development in successive national health development plans within the five year development plan. The plan has given priority to the development of Thana Health Complex and other Health complex located both in urban and rural areas. NIPSOM, DSK, ICDDR, B, DCC, DCH Ganashasthya, World Vision and other urban-based local NGOs have initiated this new Urban Health Care programme. The programmes of the organisations are designed to provide primary healthcare services and reproductive healthcare services to the underprivileged population living in urban slums. The programme plays a significant role in co-ordinating with other service providers and the community. The Health Department will require a larger degree of autonomy at the zonal level for the establishment of mechanisms which will link this slum-dweller to view their own needs and the overall performance of health services [25].

However, while implementing Primary Health Care programme, there have been a number of problems faced by all the organisations. These problems are discussed below:

- The slum dweller have limited access to good quality medical care and the high expenses of time and money in acquiring care at public centres, letting them get services from pharmacies, traditional medical practitioners and even quacks.
- The local government bodies and other service providing government agencies are low in number. The institutions hardly reach their targets.
- Shortages of skilled or trained personnel to plan implement monitor and evaluate the programmes or projects under taken by the institutions.
- NGOs have specific programmes for the poor people/households/ communities. There main focus of NGO programmes is the poor and their practical needs.
- NGOs delivery service system varies from clinics, satellite clinics and field workers. Some organisations have had the experience of working with community volunteers in the slum areas of Dhaka.

Urban healthcare services are the responsibility of the Ministry of Local Government, Rural Development and Cooperatives. The Municipal

Administration Ordinance of 1960, the Pourashava Ordinance of 1977 and the City Corporation Ordinance of 1983 clearly assigned the responsibility of preventive health and limited curative to the City Corporation and Municipalities. Nevertheless due to limited resources and manpower, public sector health services cannot meet the needs. Private health care providers are the main source for delivery of curative care, including tertiary and specified services to the urban people, but not preventive and primitive health services.

## Conclusion

The study made an effort to explore the trends in seeking healthcare services of a particular group of people who lived in the slums of Dhaka city. One of the main objectives was to identify pattern of diseases and the response of these people when they were affiliated by diseases. The study findings reveal that 74% of the total respondent seek healthcare when they fell ill. It was found that the common diseases were dysentery, fever, tonsillitis, and headaches. Jaundice exhibited interesting characteristics which was found to be more prevalent. Healthcare seeking for jaundice was traditional healer though touching other care giver. The findings of this study are similar to earlier studies in this area [9, 10, and 26].

Health related decision making is an important dimension in seeking healthcare services because healthcare-seeking behavior is initiated with symptom detection, and then a strategy for treatment action is devised [27, 28]. Basically it involves the accessibility criteria for seeking healthcare services. Ability to spend on healthcare, accessibility for proper treatment and concern for good health and other factors get mixed up in this process. The study also found a strong association between several explanatory factors and trends in seeking healthcare services. The significant explanatory factors were income level, respondent and her spouse educational and occupational status, number of years staying at Dhaka city. As for disorder characteristics included morbidity and reasons for seeking care and in terms of service characteristics knowledge about service provider, health related decision making process were pre dominant.

According to Barkat and Akhter, [6] in Bangladesh urbanization is not caused by the natural population growth in the urban areas, rather it is an outcome of push factored rural to urban migration. These factors not only impose pressure on the smooth growth of urbanization but also cause heterogeneity among the life style of slum people and expose the health care system to different threats, patterns and utilization. Again given the large populations in urban areas the private public mixed healthcare

system withdraw impede their efficiency and increase the scope for health care market manipulation.

The primary recommendation in Bangladesh is that efforts should be made to raise community awareness regarding the importance of seeking healthcare from trained personnel and the availability of services. The option for more flexible healthcare systems is another important practical strategy in the contexts of Bangladesh. For example, clearly any research interest in health care seeking behavior, focusing on end point utilization needs to address the complex nature of the process involved, cognizant of the fact that the particular 'end point' uncovered may be multi-faceted and not correspond to the preferred end points of service providers. Through this they recognized, as have others that some groups appear to 'wander' between practitioners rather than seek care through one avenue or provider. Similarly, Rahman [8] found that different facilities will be frequented for different needs, according to a complex interplay of factors, sometimes regardless of the intended purpose of those facilities.

There is also an urgent need for strengthening the urban primary health care system policy. Fundamentally health awareness, education and important aspects of health information dissemination should get priority in that health care system. In the urban areas the health demand estimation by policy planners is very crucial as policy planner need to identify exact mix of service providers for the various health care seekers in a cost effective way. Policy change should make to initiate some health security oriented programmes to make the present health systems more catchy and responsive to slum population. Government and private sector should work together to cover the gap in the primary health care sector. However some positive alteration of present policy will open the opportunity and scope for the healthcare system to address the basic need for slum population and will cause a proper and effective utilization of the present healthcare system.

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