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Older Women (User) Perspective toward Service Delivery System of Government Hospital: A Study on Some Upazila Health Complex of Bangladesh

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Abstract

The purpose of this study is to provide an indepth understanding of the challenges faced by older women in relation to their health in health care settings and to understand their special needs from their own perspectives. The primary objective of the study is to explore how rural women as a health care user viewed service delivery provided by of government hospitals. In depth interviews and focus group discussion were used to collect data from twenty five older women who were admitted in the government hospital from five Upazila Health Complex taking one from five divisions of Bangladesh. The findings reveal that health care utilization of older women is impeded by three main factors: perceived discrimination based on age and class; structural aspects of the health care delivery system and quality of care. Structural aspects included inconvenient hours of operation, long waits for service, distance to the health facility, and cost of services and medications. Subthemes within quality of care were listening skills of staff, greed for money, unavailability of medications, and lack of specialized training, lack of technology and lack of female staff. Recommendations for change in the delivery of health care in the upazila health complex of Bangladesh are made based on the insights provided by this marginalized group of health care service users. . The findings of this study will enable policy makers and decision makers to understand, from their perspective, the barriers that older women from a rural region in Bangladesh encounter when trying to access health services. The insights provided by the study will enable policy makers to strengthen the coverage and quality of local health services and to modify services so that they can respond to the particular needs of this marginalized population.

Intoduction

Croft and Beresford (2008) argues that service users have the right to quality and choice, that taxpayers have the right to value for money and that professional need to be accountable. Ensuring that the views of service users are a component of the policy-making and program-development process has come to be recognized as an essential component in meeting these objectives

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(Boote, Telford, & Cooper, 2002; Chui, 2001). The World Health Organization (WHO) identifies the responsiveness of health systems as a crucial component of their overall performance, defining responsiveness as "how the system performs relative to non-health aspects, meeting or not meeting a population's expectations of how it should be treated by providers…" (WHO, 2000:31). Being responsive to the needs of users is understood to be a prerequisite for delivering appropriate and effective services, with countries like the UK now requiring consumer involvement in health research (Boote et al., 2002).

In spite of the recognition that consumer input is essential to develop good health policy and services, documentation of sensitivity to the needs of older women remains uncommon in health policy and program development (Andaleeb, 2001). The health care needs of women are defined almost exclusively in relation to their reproductive roles by male health care providers, administrators, and researchers. This may be particularly true in rural areas of Bangladesh where the importance of the health of older women has largely been ignored in both the traditional and biomedical health care systems (Osmani & Sen, 2003). As a result, services continue to be underutilized by older women in rural areas of Bangladesh (Hosain & Begum, 2003; Lundborg, Wahlin, Ahmed & Kabir, 2008). To minimize these barriers and increase access to health services, it is important to understand the experiences and preferences of older women (Schuler & Hossain, 1998).

Since its independence in 1971, the Government of Bangladesh has undertaken various programs in its five year plans to achieve the goal of Health for All (HFA). One of the major programs was the development of physical infrastructures like the Upazila Health Complex (UHC), district hospitals, medical college hospitals and other specialized institutes and hospitals throughout the country. Bangladesh has four levels of service delivery: the community, the union, the upzila (thana), and the district (zila).

At the community level, the Essential Service Package (ESP) is delivered through a one-stop outlet called the Community Clinic (CC). There are 4,062 Union Health and Family Welfare Centers (UHFWC) now functioning in the country.

In each rural Upazila Health Complex there are both residential and outdoor health service which is a permanent facility offering daily health and family welfare services for in and outpatients as well as supervision of other health services within the upazila. Sixty of the 64 districts have now constructed a hospital. Each of these hospitals has a bed capacity of 50-200, with a few already upgraded to 250-bed hospitals (BMOHFW, 2005).

In the public sector, performance evaluation is the primary tool for assessing the quality and accessibility of health care delivery system. In this respect, clients' opinions on aspects of care have gained prominence over the past few decades in the west, and only recently in the context of developing countries. Clients' perspectives in assessment of services quality are critical not only to empower clients to assess the services received, but also for the purpose of monitoring and improving the quality of services. In this paper, an attempt is made to assess the quality and coverage of primary health care

services delivered at government services facilities on the basis of clients' perception on quality of care. The findings of this study will enable policy makers and decision makers to understand, from their perspective, the barriers that older women from a rural region in Bangladesh encounter when trying to access health services. The insights provided by the study will enable policy makers to strengthen the coverage and quality of local health services and to modify services so that they can respond to the particular needs of this marginalized population.

The Conceptual Framework

The social-determinants-of-health (SDOH) perspective used in this study is based on a synthesis of a diverse public health and social scientific literature which suggests that the most important antecedents of human health status are not influenced by medical care rather by socioeconomic factors. The World Health Organization (n.d.) describes the social determinants of health as "the conditions in which people are born, grow, live, work and age, including the health system". The SDOH perspective draws attention to the importance of material disadvantage and inequality and emphasizes the social structures within which people live their lives, describing how these structures determine the choices that people can make (Kirby, 2002; Wilkinson & Marmot, 1998).

Objectives of the Study

The purpose of this study is to provide an indepth understanding of the challenges faced by older women in relation to their health in health care settings and to understand their special needs from their own perspectives. The primary objective of the study is to explore how rural women as a health care user viewed service delivery provided by of government hospitals. The questions to be explored in this research are: What are the barriers older women of village experience when seeking health care from publicly-funded health services? Explore the level of satisfaction and perceived quality of services (with respect to availability of doctors, their attitude/empathy, availability of medicine, cleanliness, privacy and confidentiality, etc). What are their recommendations about how to make publicly-funded health services better meet their needs?

Methodology

Design of the Study

With the objectives of an in-depth exploration on older women's perspective on health care system, the research project used a qualitative design. The goal of the qualitative design is to represent the participants' reality as faithfully as possible from their points of view (Morgan and Kunkel, 2001).

Selection of Area and Sample

Five administrative divisions were chosen and from them one district and from that district one UHC were selected by using multistage sampling method. From each UHC we have selected five women (60+) who were admitted in the hospital during the data collection periods. This way we got twenty five participants. In order to get a total picture of a Upazila Health Complex one UHC were selected (from the above five) purposively and

conduct extensive fieldwork that include observation, interview and focus group discussion with five participants.

Data Collection

Data were collected using unstructured interview guides and tape recordings. All interviews were conducted in Bangla and the typical length was 2 to 3 hours. A semi-structured interview established a general direction for the interview while offering opportunities for participants to direct the conversation to areas of concern to them. The interview guide focused on the following general topics such as types of health problem experienced; types of treatment used; types of barriers experienced; suggestions for addressing the barriers.

A Focus Group Discussions (FGDs) was conducted with elderly patient. Extensive field notes were collected through observation and informal discussion. The successful collection of qualitative data depends largely on the mutual understanding between the researchers and the participants. The researchers and the research assitant spend a fair amount of time at the research sites to develop rapport with the participants so that information can be gathered in a free, friendly, and trustworthy manner.

Data Analysis

The approach used to analyze the data was a phenomenological thematic analysis (Ezzy, 2002; van Manen, 1997). The approach was inductive, with transcripts first being read through then reviewed again, line by line, to develop initial codes that conceptualized the meaning in the data. Transcripts were coded openly (Charmaz, 2006), that is, they were read through and coded according to the concepts that were discussed at any point in the interview and without a predefined code book.

Findings

The purpose of this study is to provide an in-depth understanding of the health system related factors that are identified as barriers to utilization of health services among older women in rural Bangladesh by the women themselves. In depth interviews and focus group discussion were used to collect data from twenty five older women who were admitted in the government hospital from five Upazila Health Complexes taking one from five divisions of Bangladesh. The findings reveal that health care utilization of older women is impeded by three main factors: perceived discrimination based on age and class; structural aspects of the health care delivery system and quality of care. Structural aspects included inconvenient hours of operation, long waits for service, distance to the health facility, and cost of services and medications. Subthemes within quality of care were listening skills of staff, greed for money, unavailability of medications, and lack of specialized training, lack of technology and lack of female staff. Recommendations for change in the delivery of health care in the upazila health complex of Bangladesh are made based on the insights provided by this marginalized group of health care service users.

Perceived Discrimination by Health Care Providers

Ageism

Interviews with participants revealed that many government health care providers were perceived to have a negative attitude toward older adult women. This affected the care provided and the interaction between the person seeking care and the caregiver. One participant explained, "Other day I went to hospital. I was hesitant to explain my health problems (she has a problem with vaginal infection) to a male doctor. The doctor became angry at me and told me to go for a female doctor in a private clinic. Another participant found that doctors behavior are disrespectful and that limits her access to government health care centre. She mentioned that, "They (doctors, nurse, and guard) treated us (women) like stupid. But they forget they come from a woman".

Classism

The current health systems are frequently ineffective in reaching the poor, generate less benefit for the poor than the rich, and impose regressive cost burdens on poor households. Participants said that service providers would not dare to "misbehave" by overcharging those who are economically influential and that the better off and more educated "know how to talk" to health care providers. The comparatively wealthy were also more likely to be personally acquainted with doctors or to have a kinship tie to them, which increased access to services and led to more respectful treatment.

Preferential treatment goes to those who are well dressed, or have influence or money, while those without money are penalized. One participant said, "In order to get treatment in the hospital, you have to be staff relatives, or have to spend money. If you don't have power you cannot expect anything from there." These comments illustrate a perception of a hierarchical social order of relations in which the rich or more powerful received preferential treatment in the health care system.

Structural Aspects of the Health Care Delivery System

Inconvenient hours of operation

Hospital hours of operation were often mentioned as a factor that influenced participant's ability to seek health care. The participants disclosed that they found it difficult to make time to seek health care services in spite of the fact that many of them were in need of the care. In some cases the participant lacked the time to make the required follow-up visits while in other cases they could not make even the first visit to a health care facility. One participant said: "We begin our day's right after *Fozorer Azan* call for first prayer of the day before the sunrise and work until evening. In the evening we get *obsoshor* leisure time for a while. Unfortunately the hospital remains closed in the evening."

Long Waits for Service

As their daily activities leave them with no spare time the women felt they could not afford to spend long hours in hospital waiting lines to see a doctor. One participant explained:

You go to the hospital, buy a ticket and wait for several hours to see the doctor. If you are lucky you may be able to talk with a doctor for two minutes. After seeing doctors when you return it is already evening. Who is going to do your homework?

Another echoed "I find it difficult to have time for myself. I don't want to wait for seven hours in the hospital and be absent from housework."

Distance to Health Facility

Distance plays a major role in when and how participants seek care for their health problems. Not only is the actual distance from the home to the practitioner or facility is often a deterrent to the use of health care, the poor quality of the roads in the area and the lack of transportation worsen the situation. Illustrating this theme, one participant said:

The people in town …..can go in the afternoon. We in the village get up at 6 a.m. to take the bus. We arrive. We go to the doctor at the hospital. You arrive at 10 a.m. Your are stuck there until the afternoon, without eating, without being able to drink water….you spend hours and hours and get hungry. You have to go back before the doctor has seen you. You miss the bus. You have to go however you can…so you can get home, even walking.

Although participants understood that the specialized hospital provided high quality services, they were reluctant to go there, mainly because of the long traveling times to the hospital. For participants, good quality meant more inconvenience. As one participant explained, "The medical college hospital has modern equipment, efficient doctors and a good reputation. The problem is, we need to spend more than one day and a lot of money to get the services."

Cost of Services and Medication

Lack of money also made it difficult for participant to obtain medical care when they were ill. I asked many participants who were seriously ill why they did not seek medical help. The most frequent answer given was their lack of money. Health care has become more expensive for people since the introduction of the Structural Adjustment Programs (SAP), there is the likelihood that many more women like this participant will go on with their lives with little or no medical attention. Hospital fees are a major deterrent to participants seeking medical care. Another participant explained, "I have been suffering from eye problems for the last five years…I would really like to go to hospital but due to my son's financial condition I cannot. If I needed to go for an operation it would be impossible to bear the cost."

Quality of Care

Dissatisfaction with the quality of health care was widespread among participants, particularly in reference to listening skills of staff, greed for money, availability of medications, lack of specialized training, lack of technology and lack of privacy.

Listening Skills of Staff

Participants expressed dissatisfaction with the way they were treated by health care providers, especially physicians. Several felt that their concerns received little attention within the health care system; some complained about

physicians who would not answer their questions, and to whom the senior's personal identity seemed to be invisible. One participant elaborated:

Whenever you go, doctors will ask, *ki shomoshaya* 'what's wrong with you?' Well, I have been suffering from lower abdominal pain. 'Well you will take these pills and that's that.' They don't let you to talk with them. You may have other concerns to talk about but they become rude. You can never be satisfied with this kind of service."

She continued to talk about the pain she experienced and her frustration with her doctor:

I am now seventy. I cannot see well and one of my hand got *obosh* numb. I cannot pull anything with this hand. My book chest *dhorphor* palpitating and I have *shashkoster beram* breathing problems. Whenever I go to the doctor and try to *shobkisho khole bholte* explain everything in detail, he stopped me in the middle and only laughs at me, so I have stopped going to him because I felt he has not been taking me seriously enough.

Greed for Money

Others distrusted the motives of certain physicians whom they had visited. One participant said "Some doctors don't want you to ask. They don't give you time." She said maybe some don't want you to ask so they can treat you again in the private clinic where they will be paid more for their services. Another complained, "In the government hospital doctors don't want to talk. Last time the doctor gave me an address to go where he has a private practice."

Demands for money for the services by the staff discourage participants from seeking medical care from the government hospital. One participant added, "Staff demands money for medicine which should be free. I am not going there again" This was confirmed by another participant who stated: "To visit a hospital is a hassle, the guards, nurses, everybody is greedy for money. No money, no service"

Availability of Medications

Participants reported that medications were unavailable at government facilities or that all illnesses were being treated with the same medications irrespective of their severity. Some participants believed health care providers sold their pharmaceutical stock to local drug distributors who re-sold the medication at a higher price. The perceived poor quality or complete lack of medicines available through the sub-center discouraged participants from seeking help.

One participant reported, "They give the same medicines to all patients…I was given six capsules and they did not work for me….the building is the only change…the mentality and the services have not improved." Another participant stated, "Last year I went to hospital to see a doctor. After two visits, I stopped because I did not get better… They give the same medicines for different problems.

Understaffing

Participants also complained about the lack of medical staff. One participant mentioned, "if you go to hospitals sometimes you don't find anybody. If you

ask what happened? Where are the doctors? They may answer he got transferred to other places for now we can not do anything." Or sometime they say "doctor has a meeting and he can not see anybody today."

Even when staff is present, the participants said, they give rushed, misleading and conflicting information. According to one woman, "You go to the hospital, wait for two-three hours, the nurses are chatting, 'Is the doctor here?' 'No, the doctor isn't here, he is in a meeting.' They lie."

Lack of Geriatric Training

The services that are most needed by the older women like those interviewed, such as laboratory testing, gynecological, menopause, and breast cancer services, are difficult to access because they are concentrated in big hospitals and clinics in urban areas. As one participant mentioned, "In the hospital you will not get anything for the senior people. The hospitals are only dealing with children and family planning issues. Another explained, "You will find nothing in the hospital…there are no medicines…no specialized doctors, it is a disaster."

Lack of Female Staff

The participant mentioned they prefer a female provider because "she is my kind" and because it would be easier to share problems with a woman. One participant explained, " *Mohila dactar shobjane* A female doctor knows everything we have, and I can *khole bholbo* (freely tell her) everything without being embarrassment."

Another problem is lack of geriatric specialist in the hospital that makes the older patient unhappy and they also expressed their dissatisfaction about it. As one participant mentioned, "The hospital is for children and young women. They cannot treat elderly. They give same tablet for everybody." Another participant explained the problem, "Here we are nobody. For older patient only Allah is for us. Hospital is not for us. They are not ready to treat frail body."

Discussion

The findings reveal that three main themes describe the impediments to utilization of health services by older women in rural Bangladesh. The findings from this study are consistent with earlier studies which observed that women are generally not satisfied with the health care services, citing understaffing and absence of some of the most required services such as medicines and laboratory-testing facilities (White, Small, Frederic, Joseph, Bateau & Kershaw, 2006; Needham & Bowman, 2003). Finally, findings reveal that women prefer female providers because of religious prescription, cultural tradition and greater comfort talking to them compared to male doctors. The government needs to ensure that the primary health care centers have the necessary medical equipment and that it is in proper working order. The centers should also have qualified technicians to operate the medical equipment. The center also needs to be open longer hours and have provision for emergency care at night. This will require a strong and sustained commitment from all levels of government.

Studies in other developing countries have shown that physical proximity of health care plays an important role in utilization of these services (Needham

& Bowman, 2003). This distance is of particular concern for observant Muslim women, since in a strict Muslim society like Bangladesh cultural guidelines restrict the mobility of females (WHO, 2000). In Bangladesh, one in every five people has mobile phone. Telehealth may be one option to address the distance problem, the use of mobile in health sector may make an important contribution. This may also help to disseminating public health messages to individuals, families and communities (Sandberg, 2005).

Poverty clearly influences the likelihood of accessing health care. The most salient factor was cost of medications and services, which has been found to be a barrier to health care in other areas in Bangladesh as well (Ahmed, Adams, Chowdhury & Bhuiya, 2003). These findings are consistent with other studies which showed that when people in rural areas of developing countries decided to seek health care, they had to resort to less educated providers who charged lower prices (Rana, Lundbarg, Wahlin, Ahmed & Kabir, 2008).

The study found that poor quality of care; disrespectful treatment and hierarchical modes of interaction by the providers constitute a strong disincentive for older adult women to use available services. Women's higher sensitivity to negative attitudes and behavior of staff and other deficiencies in the health facilities have also been reported by other authors (Shaikh, Haran & Hatcher, 2008; Rana, Lundborg, Wahlin, Ahmed & Kabir, 2008).

Conclusion

Development and expansion of health care facilities has been an integral part of government policy to improve the health status of the Bangladeshi population. However, experience shows that existing health care practices limits the health care opportunities and choices of older women because of its inherent limitations. The women, especially the older adult women, continue to receive fewer health services have been widely recognized, and confirmed in national data as well as in many local studies

The voices and views of clients are considered indispensable in efforts to improve the quality of care in health care setting. Health professionals in several countries have reported the importance of client participation in health care, emphasizing the need for receptivity to and respect for clients' perspectives in the planning of health interventions (Hansen, Hatling, Lidal & Ruud, 2002). In Bangladesh, older health has received little attention from Primary Health Care (PHC) services. Knowldedge and skills about treating older adult is not covered within the medical or para-professional curriculum. In order to serve the older adult it is important to incorporate training courses on interpersonal and communication skills into medical education, and to arrange training sessions for practising doctors. Providers should be encouraged to adopt simple actions that are highly valued by older, such as addressing women in the culturally appropriate way; reassuring them; treating them gently and respectfully; providing clear information about their condition.

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