Users discourses about primary health care professionals in rural Bangladesh

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Abstract

Evidence from earlier studies in Bangladesh indicates that an imbalance in status between health professionals and primary healthcare users in rural Bangladesh can lead to corrupt behaviour among health professionals. This behaviour, it has been shown, may negatively impact on the quality of primary health care (PHC) and health outcomes among those using the service. Using narrative interviews with a small sample of PHC users, in a rural population in Bangladesh this study sought to explore the ways in which participants discussed the quality of healthcare provided by their local PHC facility. Issues raised by participants in interviews included misuse of resources and embezzlement of state funding, particularly by doctors. These abuses were buttressed by discourses in local communities – and indeed it has been shown in many other communities – in which healthcare professionals are treated as acting within ethical boundaries. However participants in this study expressed dissatisfaction with what they characterised as the corrupt behaviour of health professionals, and displayed resistance to this in the context of the interview.

Keywords: user resistance; primary health care; Bangladesh

Introduction

Good quality primary health care (PHC) is an important factor in addressing health inequalities, including those of rural populations in low-income countries such as Bangladesh (Starfield, Shi, & Macinko, 2005). Bangladesh is one of the most densely populated countries in the world, and despite rapid urbanisation, 72% still live in rural areas (World Health Organisation [WHO], 2011). As a low-income country Bangladesh has an annual per capita income of around USD1044 (Parvez, 2013); however rural populations are generally less wealthy than urban communities with a poverty rate of 40% compared to 28% (Bangladesh Bureau of Statistics [BBS], 2010). Injuries and preventable illnesses such as tuberculosis, pneumonia, birth asphyxia, neonatal sepsis and diarrhoea remain the leading causes of death (WHO, 2011); and despite improvements in recent years, maternal mortality and infant mortality remain high (WHO, 2010).

Upazila Health Complexes (UHCs) are the focus of PHC in rural Bangladesh where they play a key role in providing health care services to rural populations. Services include diagnosis, treatment, referral services, ante-natal and post-natal care, family planning, child health and curative care (Kabir, 2006). The goals of UHCs, which are free at the point of entry, relate to the Government's target of ensuring 'health for all' and providing 'universal coverage' in order to address community-based health inequalities (Baum, 2008). However despite this there remain significant differences in measures of health outcomes such as life expectancy and mortality rates between rural and urban populations; urban life expectancy is 67.8 years while for those living in rural areas it is 64.3 years, and the rural crude death rate (CDR) is higher at 6.01 per 1000 population, in contrast to the urban CDR of only 4.40 (BBS, 2010; 2013).These differences have led some to describe the quality of public sector health care available through UHCs as inadequate (Mahdy, 2009).

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Much of the research on quality of health care has focused on so-called 'tangible' issues of resource availability, professional training and standards, and quality of management (Starfield et al., 2005; Killingsworth et al., 1999). However users' own discursive narratives of primary healthcare in low-income settings such as this study conducted in rural Bangladesh, represent a novel way of understanding quality.

Method

Participants
Interviews were carried out with a total of 10 participants; six men and four women. Participants were opportunity sampled through word of mouth in the community, with the only criteria for participation being that the participant must have used the local UHC. Participants came from a range of socio-economic and occupational groups; farming, manual work, tutoring, small business, homemakers/housewives and students.

Each participant was provided with a copy of the participant information sheet (PIS) containing detailed information about objectives, procedures, data storage and confidentiality before consenting to take part in the study.

Interviews
Interviews were between 45 and 75 minutes long, with the average length of an interview being 60 minutes. Interviews took place in locations identified by each participant as most convenient for them including shops, office rooms and participants' houses. All interviews were conducted in Bengali which was the participants' and the interviewer's first language. Audio from the interviews was recorded and later transcribed before being translated into English for analysis. All transcripts were made anonymous; names and any potentially identifying information – for example locations – were changed.

Analysis
Data from the interviews was analysed using thematic analysis (Braun & Clarke, 2006). The data were subject to multiple readings to identify key phrases and themes which were coded, and then those extracts analysed in more detail. The data were anonymised and ethical approval was obtained from the University of Auckland Human Participants Ethics Committee.

Findings

Whilst the UHC is located only around 40 kilometres from a city, people from more remote villages travel to the UHC to use its services. The UHC in this study serves a total population of about 400,000. The administrative head of the UHC is a medical practitioner and it is staffed by eight doctors as well as office assistants, cleaners, nurses and a pharmacist. In the interviews participants centred critique of PHCs on quality of medical care, and quality of management. Central to these accounts were claims of corruption among PHC staff, particularly doctors.

Medical care and quality of UHC
Some participants described finding it difficult to challenge doctor's decisions. Ehsan said, '*they are doctors; we have to listen to what they say*'. This might be explained by the 'social distance' in status between doctors and less educated rural people. The data demonstrate that at times patients were afraid to talk to doctors, especially when, as Salim said, 'the doctor was angry' or when 'they had been holding a meeting'. A woman along with several relatives went to the UHC to give birth. The head of the UHC, (the Resident Medical Officer (RMO)) asked them to go to a city hospital. They did not have financial means to go to the city. They were also afraid to talk to the doctor afterwards. They asked an educated male relative to request that the doctors arrange a delivery at the UHC. Soon after the delivery, the RMO went away from the hospital and did not give advice regarding post-natal care.

Other participants reported that the quality of doctor's consultations were poor. Doctors were described as spending very little time with patients and as being reluctant to listen to patient's own characterisation of their illness. Nahar said, 'That's like, patients start describing their problems, like, I have fever .... Before they finish, doctors finish writing prescriptions'.

Some participants described doctors' prescribing 'unnecessary' diagnostic tests and 'unnecessary' referrals to district hospitals. Rohit said:

> *Doctors are prescribing to do many tests where only a blood test is required. They're being paid 40 percent [of the total diagnosis costs] by diagnostic centres. They tell patients the name of the diagnostic centres to do tests. They aren't supposed to say that. Patients can do tests anywhere, but they tell the names of diagnostic centres... the names of those with which they've contracts. They ask to do three/four unnecessary tests.*

Essential diagnostic services such as X-ray or blood tests are supposed to be available at the UHCs. The data suggests that the majority of the participants were asked to undergo diagnostic tests at other centres named by the doctor, and they reported feeling that they had little power to challenge this even when they knew the tests were unnecessary. As Ehsan put it:

> *Doctors insist on patients repeating the same tests, if these are done in other diagnostic centres or advised by other doctors. They wouldn't even look at it [test results]. They'd throw them away*

The participants added that doctors often continue treatment or provide the wrong medication even when they have limited knowledge of the health problem. Salim stated that most patients 'don't really know where to complain' about doctors providing inappropriate medication.

The stories suggest that doctors and supporting staff, in addition to diagnostic centres and medical product suppliers, sometimes maintain a close relationship to promote mutual benefits and interests. The participants said that doctors receive gifts from medical representatives; 'commission' from diagnostic centres and so prescribe unnecessary diagnostic tests and drugs. In other words, the apparent unavailability of drugs is not merely due to an absolute resource shortage, as Salim made clear:

> *'...and the medicines that they provide in the Emergency [Department], those that 're for the cure of cuts,... bandages, ...or cure of itching or sickness,... things like that, ...those ointments, ... they sell outside and patients need to buy them from outside'*

Management and quality of UHC

The data suggest that the RMO of the UHC plays a key role in the management of both human and physical resources in the hospital. In Salim's words, 'He is business-minded', and 'he has turned this hospital into a business centre' and so 'he makes a lot of money'. Some participants said that the RMO himself, other doctors and support staff, remain absent from the UHC during office hours. Sometimes they are busy with meetings, and have patients waiting for a long time while providing private services elsewhere. Referring to the involvement of the UHC doctors in private practice, Salim also said the 'health service has now become a business'.

Some participants suggested that the lack of physical resources such as electricity, drugs and diagnostic facilities may be linked to corruption among those managing the facility; for example the generator and X-ray machines at the UHC are deliberately kept inoperative. Salim thought 'they [the UHC staff] do not turn on the generator' when the electricity is out 'to [save and] embezzle money from the [hospital] budget'.

Those interviewed reported they and others they knew had been coerced into paying for services which are meant to be free, and therefore limited some people's access to healthcare. Elias narrated a story of an old hawker who 'died without treatment because he could not pay'.

The participants claim that the UHC doctors refer patients without explaining why they are referred. Salim pointed out that 'they always neglect people and refer people to the medical college hospital in the city far from this place'. The lower socio-economic groups are more likely to be referred to city hospitals. As Salim observed, 'if they see the patient's condition is weak or economically weak they send them to the city. That brings a lot of sufferings'.

User Resistance

While it was clear that users were dissatisfied with quality of care and what they described as corruption among the medical staff, it also became apparent that such dissatisfaction might provide the basis for 'user resistance'. Resistances are reflected in Salim's questioning of the RMO's absence; 'You are the head of this big hospital, but you were away throughout the day?' and during absence 'Who did you delegate responsibility to?' Resistance is also reflected in Ehsan's questioning of doctors' credentials and knowledge 'Who are they? What do they know? Their treatment does not cure'.

Discussion

This paper offers some initial evidence for directing future research into UHCs and primary healthcare in Bangladesh. In the interviews participants were critical of the quality of healthcare provided by their local UHC, and attributed this to self-serving behaviour among the doctors who managed the facility. Although participants did not name it as such, we might conclude that the actions described by those interviewed amounted to corruption, for example referring users to testing facilities from which doctors receive a commission, when this should be offered for free at the UHC. The evidence also suggests that the shortage of doctors, drugs and diagnostic facilities may not merely be explained by resource shortages.

Many participants reported feeling reluctant to challenge doctors, even when they believed the doctor was acting in an unethical or corrupt manner. However, despite this there were also moments of resistance in the interviews. Participants displayed their frustration with the situation and some recounted occasions on which they had challenged a doctor's decision, thereby demonstrating rural UHC users' potential to affect positive change in their UHC.

Findings from this study suggest that future research into the operation of UHC facilities taking into consideration user's opinions and experiences is of paramount importance. Investigating day-to-day operations will help to provide the information necessary to ensure a minimum standard of primary health care is provided to those living in rural areas of Bangladesh, like that in which this research took place. The field would also benefit from studies examining the discursive accounts of doctors and staff at UHCs, which would function as a comparison with the accounts of users. Study of the different perspectives might help in identifying ways that quality of PHC in Bangladesh can be improved.

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