Project On

A survey on village health care manner for acute diseases and patient's satisfaction in a selected area of Bangladesh.

Submitted To

The Department of Pharmacy,

Faculty of Allied Health Sciences,

Daffodil International University

In the partial fulfillment of the requirements for the degree of Bachelor of Pharmacy

Submitted By

Student ID: 183-29-1324

Batch: 20th

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27 November 2022

APPROVAL

This project A study of village health care manner and patients' satisfaction in Bangladesh for acute disease in selected area., submitted to the Department of Pharmacy, Faculty of Allied Health Sciences, Daffodil International University, has been accepted as satisfactory for the partial fulfillment of the requirements for the degree of Bachelor of Pharmacy and approved as to its style and contents.

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DECLARATION

I, at this moment, announce that I am carrying out this project study under the supervision of "Ms. Farhana Israt Jahan." Assistant Professor, Department of Pharmacy, Faculty of Allied Health Sciences, Daffodil International University, Impartial Compliance with the Bachelor of Pharmacy Degree Requirement (B. Pharm). This project, I declare, is my original work. I also state that neither this project nor any part thereof has been submitted for the Bachelor's award or any degree elsewhere.

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ACKNOWLEDGEMENT

I am grateful to God for the excellent health and well-being necessary to complete this work. I wish to express my sincere thanks to **Professor Dr. Muniruddin Ahamed,** Department Head of the Department of Pharmacy of Daffodil International University, for providing me with all the necessary facilities for the research.

I am also grateful to my research supervisor **Ms. Farhana Israt Jahan.,** Assistant Professor, Department of Pharmacy, Daffodil International University. I am incredibly thankful and indebted to her for sharing his expertise and sincere and valuable guidance and encouragement extended to me.

DEDICATION

I dedicate this work to my parents and my teachers.

ABSTRACT

More than 50 years after gaining independence in 1971, Bangladesh's health system has seen a number of developments. Village communities still lack adequate health care despite having a robust public and private health infrastructure. My aim was to know the current situation and limitation of village health care system of Bangladesh Using a physical survey, this study was conducted in 3 hospitals of Senbag. According to this data, 40% of patients visit hospitals for a typical cold. 4% of people are burned, while 12% of people were admitted to hospitals for asthma attack. Only 2% of folks visited the local hospital for a broken bone. Only 5% of patients went for sore throats and 7% for runny nose. Only 6% were pleased with the style and service of the medical staff. 94% of people express dissatisfaction because of lack of health specialists, medical equipment and high refer percentage.

Keywords: Diagnostic, Xray, Ultra machine, Nurse.

Table of content

Chapter One: Introduction

S.I	Topic	Page No
1.1	Health Care	02-03
1.2.	Delivery	03-03
1.2.1.	Primary care	03-05
1.2.2.	Secondary care	05-05
1.2.3.	Tertiary care	05-05
1.2.3.	Quaternary care	06-06
1.2.5.	Home and community care	06-06
1.3.	Village Health Worker	07-08
1.4.	Roles of village health worker	09-10
1.5.	Patient	10-10
1.6.	Outpatients and inpatients	11-12
1.7.	Patient health-care service satisfaction in Bangladesh	12-12
1.7.1.	Present health-care situation	13-15
1.7.2.	Collision of the system with conventional medicine	15-15
1.7.3.	Drug cost versus expenditures	15-16
1.7.4.	The Falling Reputation of Commercially Available Medicines	16-17
1.7.5.	Quality of medical education	17-17
1.7.6.	Debasement of health providers' image	17-18
1.7.7.	Future recommendations	18-20
1.8.	Acute diseases	20-21
1.8.1.	Acute disease cause	22-22
1.8.2.	Acute disease treatment	22-22
1.9.	Patients Satisfaction and its Associated Factors in	22-25

1.10.	Local governments and village health services	25-27

Chapter Two: Literature Review

S.I	Topic	Page No
1.	Literature Review	28-30

Chapter Three: Aim of my study

S.I	Topic	Page No
1.	Aim of my study	31-32

Chapter Four: Methodology

S.I	Topic	Page No
1.	Methodology	33-34

Chapter Five: Result and Discussion

S.I	Topic	Page No
1	Result and Discussion	35-46

Chapter Six: Conclusion

S.I	Topic	Page No
1.	Conclusion	47-48

Chapter Seven: Reference

S.I	Topic	Page No
1.	Reference	49-56

List Of Figures-

S.I	Figure name	Page No
1.	Health care	02-02
2.	Primary care	04-04
3.	Village Health Worker	07-07
4.	Patient	10-10
5.	Hospital	14-14
6.	NGO Activities in Bangladesh	26-26
7.	Gender	36-36
8.	Acute disease	37-37
9.	Numbers of doctor	38-38
10.	Free medication	39-39
11.	Satisfaction	41-41
12.	Obstacle	42-42
13.	Response percentage	43-43
14.	Demand of money	44-44
15.	Behavior of nurse	44-44
16.	Wheelchair service	45-45
17.	Refer percentage	46-46

Chapter One: Introduction

1.1. Health care

The process of supporting persons in preserving or recovering their ideal level of physical and mental health is referred to as health care but is more often referred to as medical care. Patients get care from doctors, nurses, and other trained medical and allied health professionals. The term "health care" refers to a broad spectrum of professions, some of which include medicine, dentistry, the pharmaceutical and pharmacological industries, midwifery, nursing, optometry, audiology, psychology, occupational therapy, physical therapy, and sports training. This list is not exhaustive. Activities related to public health, preventive medicine, and the provision of medical treatment at all levels are included. Access to medical treatment could be different from one nation to the next, as well as from one locality to the next and from one person to the next, because of the wide range of socioeconomic conditions and health care policies that exist. "The timely utilization of personal health services to produce the greatest possible health outcomes," [1] according to one definition, is the definition of "health care delivery." When conducting an analysis of access to medical care, it is essential to take a number of different aspects into consideration, including the following: cost (insurance), location (distance traveled and amount of time spent getting there), culture (expectations), disability (inability to communicate), and personal limitations (well-being, mortality rates).[2]

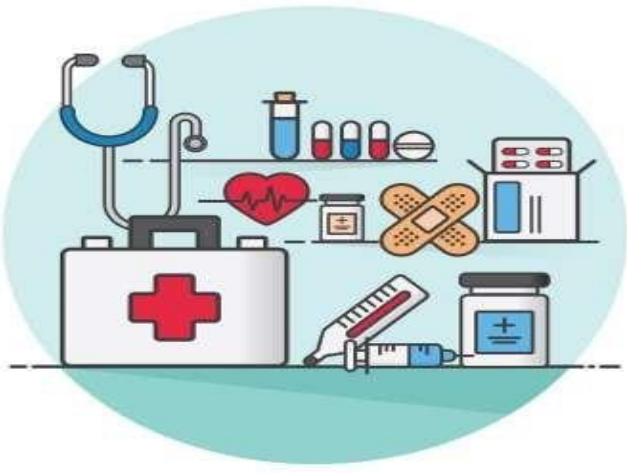

Fig 01: Health care

When a population has particular health-care demands, a health system is developed to meet those requirements and meet the needs of the population as a whole. The World Health Organization (WHO) asserts that a functional health-care system requires a funding mechanism, a workforce that is trained and compensated, credible information on which to base decisions and policies, and well-maintained health facilities in order to provide high-quality medicines and technologies. [3] It is possible for a nation's economic development, urbanization, and industrialization to all benefit from a health care system that is operating well. The eradication of smallpox in 1980, which was

designated by the WHO as the first illness in the history of humankind to be eradicated by means of purposeful health care treatments, is a prime illustration of the widespread belief in the power of health care to improve people's physical and mental health as well as their overall well-being. [4]

1.2. Delivery

It is impossible to provide modern medical treatment without the participation of multidisciplinary teams that include not only physicians and nurses but also other members of the medical staff. [5] Individuals and communities may get preventive, curative, and rehabilitative care services from a variety of professionals, including public health practitioners, community health workers, and assistive staff. It should be noted that Primary care is the first stage of the health care process, which may progress to include secondary and tertiary care. Despite the fact that this definition varies depending on the specific culture, politics, organization, and field being discussed, primary care is always the initial stage. The field of health care may be broken down into two distinct subfields: the public sector and the commercial sector.[6]

1.2.1. Primary care

Care provided by primary care physicians, nurse practitioners, and physician assistants is the foundation of the health care system. [7] Typically, a primary care physician (also known as a general practitioner or family physician) would fill this role. Independent practitioners, such as physical therapists, or non-physician primary care providers, such as physician assistants and nurse practitioners, offer still another option. A pharmacist or nurse may be the first health care provider a patient sees, depending on the structure of the health care system in their area. Referrals to specialty facilities may be made for patients with more complex medical needs. Primary care is a word often used to describe community-based health services.[8] It is often given at walk-in clinics or urgent care facilities where patients may get appointments or treatment on the same day they call. Patients of all ages, from all walks of life and parts of the world, striving to maintain optimum health, as well as those with acute and chronic physical, mental, and social health difficulties, including those with comorbid conditions, are all included in the primary care population. As a result, a primary care physician needs expertise in several fields. Primary care is defined by continuity of treatment, which means that patients want to see the same doctor for all of their health

needs, including annual checkups, preventative care, health education, and new patient consultations for any health issues they may be experiencing. Patients' reasons for seeking primary care are standardized via the International Classification of Basic Care (ICPC), a standardized framework for comprehending and evaluating the information on treatments in primary care. [9] Hypertension, diabetes, asthma, COPD, depression, anxiety, back pain, arthritis, and thyroid dysfunction are all examples of common chronic disorders often addressed in basic care. Basic services for mothers and children are also included in primary care, such as family planning and immunizations. According to the 2013 National Health Interview Survey, the most common diagnoses for which patients sought medical attention in the United States were skin disorders (42.7%), osteoarthritis and joint disorders (33.6%), back problems (23.9%), lipid metabolism disorders (22.4%), and upper respiratory tract disease (22.1%, excluding asthma). [10] Direct primary care, a subset of the better-known concierge medicine, is a new way for primary care doctors in the United States to provide treatment for their patients without using the managed care (Insurance billing) system. In this system, doctors charge consumers directly for their care on a per-visit or recurring basis rather than accepting insurance. Clinics like Foundation Health in Colorado and Qliance in Washington are direct primary care examples. Increased demand for primary care services is anticipated in both developed and developing nations as a result of the aging of the global population, which puts more people in those age groups at risk of acquiring chronic non-communicable illnesses. [11-12] The World Health Organization (WHO) recognizes

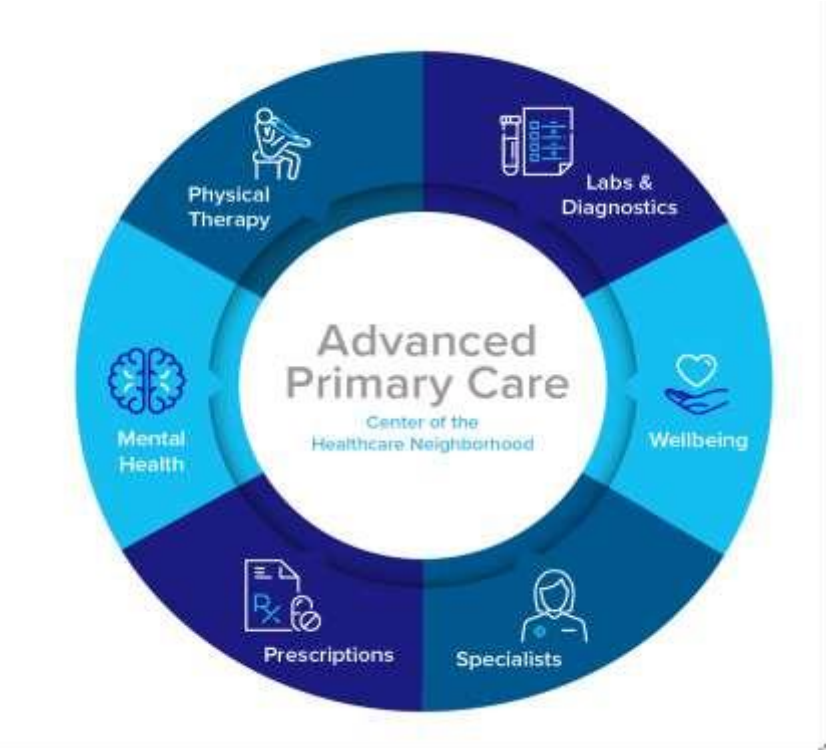

Fig 02: Primary care

the need to provide access to basic care as a cornerstone of a comprehensive primary health care strategy.

1.2.2. Secondary care

Acute care is part of secondary care and refers to the temporary medical attention that is required for severe disease or injury. This treatment is commonly provided in a hospital emergency room. Secondary care also includes obstetrical care provided by trained professionals, critical care, and diagnostic imaging procedures. [13]"Secondary care" is sometimes used interchangeably with "hospital care," although the two terms have distinct meanings. However, many secondary care clinicians do not necessarily practice in hospitals. This includes psychiatrists, clinical psychologists, occupational therapists, the vast majority of dental specialties, and physical therapists. Some primary care services are given inside hospitals. Depending on the structure and regulations of the national health system, patients may be required to contact a primary care physician for a referral before they may obtain secondary care. [14-15] Some medical professionals in nations with a mixed market health-care system only offer secondary care, meaning they refer patients to a primary care physician before seeing them. Payment agreements in individual or group health insurance plans may impose this limitation. In some circumstances, medical professionals may visit patients without a reference, and patients may determine if self- referral is desired. In other countries, patient self-referral to a medical specialist for secondary care is rare as prior referral from another physician (either a primary care physician or another specialist) is considered necessary, regardless of whether the funding is from private insurance schemes or national health insurance. Patient self-referral or physician referral is the most common way to get in touch with allied health specialists, including physical therapists, respiratory therapists, occupational therapists, speech therapists, and dietitians, who typically work in secondary care.

1.2.3. Tertiary care

For patients who have already been seen by a primary care physician or a specialist in secondary care and who have been sent to a tertiary referral hospital, tertiary care consists of consultative, specialized medical therapy.[16] Services like advanced neonatology, burn care, palliative care, and palliative care are examples of tertiary care. Other difficult medical and surgical techniques are also included.[17]

1.2.4. Quaternary care

The phrase quaternary care is occasionally used as an extension of tertiary care in relation to higher levels of medicine which are highly specialized and not commonly available. Quaternary care encompasses experimental medical practices and specialized diagnostic and surgical treatments. These specialties are often only available at a select few hospitals or clinics throughout the country. [18-19]

1.2.5. Home and community care

Many different kinds of medical treatment are provided apart from hospitals and clinics. They cover a wide range of public health initiatives, such as monitoring contaminated food, distributing condoms, and coordinating needle exchanges. Support for self-care, long-term care at home or in a residential facility, assisted living, and drug abuse treatment is also included. Community rehabilitation programs may aid with mobility and independence following the loss of limbs or loss of function. Wheelchairs, prosthetics, and orthotics all fall within this category. It is a top priority for many healthcare systems to ensure that elderly people may continue to age in place in their own homes as their population's age, a reality that is becoming more common in the developed world. Transportation to and from medical appointments is just one example of the many vital daily tasks that may be performed with a little assistance from a caring health care provider. It's possible for family members and care professionals to have conflicting perspectives about their shared responsibility for an elderly family member's home care. As a result, this situation poses a difficulty for the developers of home care ICT (information and communication technology). [20] Since statistics show that over 80 million Americans have taken time off work to care for a family member or friend, many nations have instituted policies like the Consumer Directed Personal Assistant Program to help family members care for loved ones without having to give up their primary source of income. Health services regularly implement programs in schools to combat the growing epidemic of childhood obesity by promoting healthy lifestyle choices, mandating physical activity, and instilling in preteens and teens a healthy sense of self-worth.[21]

1.3. Village Health Worker

A member of the community who has been chosen by their contemporaries or by community-based organizations to provide primary health care to the people who reside in their region, including illness prevention, health promotion, and rehabilitation services, is known as a community health officer. This kind of medical practitioner goes by a few different names in different parts of the world. [22-23] Community health officers are able to help in the development of communities, and communities that have the support of community health officers may have simpler access to primary care. They are able to contribute significantly to the betterment of society after they have acquired the necessary abilities. [24] Community health officers show the greatest promise as a potential solution to the problem of delivering adequate medical care to neglected populations. They are considered a secondary kind of medical treatment in the majority of countries where the GDP per person is quite low. [24] In many countries of the third world, particularly those in Sub-Saharan Africa, there is a severe lack of medical staff that has received extensive and advanced training.[26]

Fig 03: Village Health Worker

Because of factors such as rising demand for health care services, internal and external migration of health professionals, mortality rates caused by AIDS and other diseases, low labor productivity, and rising population, the current crop of medical and nursing schools is unable to produce enough graduates to meet the demand for qualified personnel. Community health officers are responsible for providing the public with essential primary health care services while having limited resources for training, the provision of materials, and assistance. Community health officer initiatives have demonstrated significant outcomes in China, Brazil, Iran, and Bangladesh in improving the health of huge populations in underserved regions [27]. It should be noted that it has been suggested that "task shifting" of primary care tasks from professional health professionals to community health officers could be an effective way to make better use of the existing human resources and improve the health of millions of people at a cost that is not prohibitively expensive.

The following responsibilities are anticipated to be carried out by the Village Health Workers:

- ✓ Visit people at their homes in the community where they are based.
- ✓ Take part in the HMF's programs geared toward health education and awareness.
- ✓ Treatment of mild ailments at the village level, with referrals made to other nearby hospitals and government health institutes for more serious or difficult cases.
- ✓ Take part in the HMF's programs geared toward health education and awareness.
- ✓ Participation in education and training programs offered by the government, as well as health and economic initiatives offered in their own communities.
- ✓ Encourage female education geared at the elimination of violence in the home.
- ✓ Keep an eye on the microfinance operations going on in the villages.
- ✓ Participation in community health activities connected to the prevention of illness and living a healthy lifestyle
- ✓ Participation in a system consisting of institutions of the community, such as the local village is governing committee.[27]

1.4.Roles of village health worker

Community health workers (CHWs) do a variety of tasks that are adapted to the particular requirements of the communities they serve. The function of a CHW is influenced by their education, training, life experience, and prior work with certain demographics. CHWs may take on the following functions:

- Establish links between disadvantaged groups and medical professionals
- Assisting patients in using the health-care and social service systems
- Control the provision of care and the transfer of care for vulned-
- lessen patient social isolation
- Establish eligibility and sign-up people for health insurance schemes
- Make sure health-care professionals serving vulnerable groups are culturally competent.
- Informing stakeholders and health-care professionals about community health requirements
- Give culturally appropriate health information on subjects including preventing chronic diseases, exercise, and diet
- Encourage the provision of services and resources to underprivileged people or communities to meet their health needs.
- Gather information and communicate it to interested parties to develop programs and policies.
- Offer unofficial counseling, examinations, and referrals
- Increase community ability to deal with health concerns
- Discussion of the social determinants of health

The following factors might affect the particular functions of CHWs:

Services offered by the program include things like:

- Advocacy
- Promotion and enrollment
- Navigation
- Education
- Medical assistance

- Assistance with one's emotions

CHW qualifications and experience, such as:

- Education
- Certification
- Training
- Communication
- Developing interpersonal connections
- Cultural sensitivity
- Activism and capacity development
- Motivational interviewing and facilitation

1.5.Patient

A person who receives medical treatment from a physician or other trained medical expert is considered to be a patient. The patient is often suffering from an illness or injury and needs medical attention from a doctor, nurse, optometrist, dentist, veterinarian, or one of the many other professionals that work in the medical field.[29]

Fig 04 : Patient

1.6.Outpatients and inpatients

A patient who visits an outpatient clinic with the intention of leaving at the conclusion of their scheduled appointment is said to be an outpatient (sometimes written as out-patient). Even if the patient will not be formally admitted with a note as an outpatient, their attendance is still registered, and the provider will typically give a note explaining the reason for the visit, tests, or procedure/surgery, which should include the names and titles of the participating personnel, the patient's name and date of birth, signature of informed consent, estimated pre- and post-service time for history and exam (before and after), any anesthesia, medications, or other treatments. Even if the patient will not be, the term "ambulatory care" refers to medical treatment that is delivered in this manner. Outpatient surgery, also known as day surgery, refers to surgical procedures that are performed on patients who do not have to be admitted to a hospital or stay there overnight. This type of surgery has a number of advantages, including lower overall health- care costs, a reduction in the amount of medication that is prescribed, and more effective use of the time of the attending physician or surgeon. Patients who are in relatively good health and who have relatively small or intermediate treatments are the greatest candidates for outpatient surgery (limited urinary tract, eye, or ear, nose, and throat procedures and procedures involving superficial skin and the extremities). Office-based surgery refers to the practice of performing surgical operations outside of a hospital's traditional operating rooms. This practice is becoming more common.[30]

On the other hand, a person who is "admitted" to stay in a hospital overnight or for an indeterminate amount of time, typically several days or weeks, though in some extreme cases, such as with coma or persistent vegetative state, patients can stay in hospitals for years, sometimes until death. An inpatient (or in-patient) is a person who stays in a hospital overnight or for an indeterminate amount of time. Inpatient care refers to any kind of treatment that is administered in this setting. The creation of an admission note is part of the process of being admitted to the hospital. The process of leaving the hospital is referred to as discharge, and it is accompanied by a letter called a discharge note. In certain cases, an evaluation procedure is also performed to examine continuing requirements.[31] This may be referred to as a "Discharge to Assess" in the English National Health Service (NHS), which indicates that the evaluation will take place after the patient has been discharged and returned home. In outpatient care settings, the most common cause of medical

mistakes is an incorrect diagnosis. [32] The seminal study To Err Is Human, published in 1999 by the United States Institute of Medicine, estimated that up to 98,000 hospital patients in the United States die each year as a result of avoidable medical mistakes. [3] As a result, early initiatives concentrated on improving inpatient safety. Even though inpatient hospital settings have been the primary focus of patient safety efforts for more than a decade, the likelihood of a medical mistake occurring at a doctor's office or an outpatient clinic or center is far higher.[33]

1.7. Patient health-care service satisfaction in Bangladesh

A demographic and epidemiological shift has taken place in Bangladesh, a South Asian country with a low-middle-income economy. This shift has been accompanied by increasing urbanization and a steady rise in life expectancy. [34-36] It is now the ninth most populated nation in the world, and experts predict that by the year 2050, the country's population will have almost doubled. The rising urbanization of Bangladesh is a contributing factor to the growing burden of non-communicable diseases (NCDs) in the nation. The Dhaka division is home to roughly half of all of the country's slum residents. According to the Country Environmental Analysis 2018 report published by the World Bank, air pollution is responsible for the deaths of 46,000 individuals in Bangladesh each and every year. There are less than 10% of hospitals in this nation adhere to Medical Waste Management Policies. The Institute of Epidemiology, Illness Control, and Research looked at twenty-six different instances of disease outbreaks in 2017. (ICR). The out-of-pocket (OOP) cost of therapy has increased by over 70 percent over the course of the last decade. [37] Out-of-pocket expenses account for about two-thirds of the overall expenditures related to health care, and sixty-five percent of this total is spent at private drug retail outlets. There is a lack of evaluation of the quality of the care that is provided by providers, low levels of professional knowledge, and ineffective application of skills. Complaints lodged against health care professionals in Bangladesh are not heard by a formal authority since the country lacks such an institution. Complaints and conflicts are resolved freely by the officials at the hospital or clinic without the involvement of the government or other legal agencies. [38] The phrases "oversight of physicians" and "inappropriate treatment" have become commonplace in the print and electronic media of Bangladesh, at the same time that violence against the physician in Bangladesh has increased in both frequency and severity. "Oversight of physicians" and "inappropriate treatment" have also become common phrases in Bangladeshi media. [39]

1.7.1. Present health-care situation

Bangladesh is on track to meet the 2015-MDG5 goal of reducing the maternal mortality ratio of 1990 by three-quarters, according to Professor Sue Goldie of Harvard University. Bangladesh is also credited with having the highest reduction in mortality rates for children under the age of five in South Asia. According to the World Health Organization (WHO), the current doctor-patient ratio in Bangladesh is just 5.26 per 10,000 inhabitants. This positions the nation in second-to-last position among South Asian countries. [40] According to data provided by the Bangladesh Medical and Dental Council, the number of registered male physicians in the nation fluctuated between 25,739 (representing 47%) and 28,425 (representing 53%) between the years 2006 and 2018. The duration of an average consultation is utilized as an outcome indicator in the primary health care monitoring tool. This tool discovered that a consultation with an outside patient takes less than one minute on average. [41] It takes an average of one and a half hours to see a doctor at Dhaka Medical College and other public hospitals outside; however, owing to post-vacancy issues, there are not always physicians available. Patients often have a difficult time obtaining vital care during any illness epidemic, whether it occurs inside or outside of a hospital. People are responsible for covering 67% of the total cost of health care, which is much more than the worldwide average of below 32%. Due to a lack of financial resources, there is only one hospital bed available for every 1667 people, and 34 percent of all positions in the health sector are now unfilled. [42] In Bangladesh, a nation with a poor socioeconomic standard, nurses have significant challenges in providing care to the population within a health care system that is woefully underfunded. According to Akter et al., 2019, the following factors were cited as contributing factors: heavy workloads; a lack of government accommodations and transportation, poor health status; a lack of support from nursing supervisors; a lack of promotion opportunities; incomplete hospital policies and procedures; and a lack of night shift and risk allowances. The Bangladesh Health Facility Survey, which was conducted in 2017, found that more than 70 percent of rural health facilities lacked all six essential pieces of basic equipment (thermometers, stethoscopes, blood pressure gauges, weighing scales for infants and adults, and torchlights). Only over half of the doctors who work in public hospitals on levels ranging from district to union sub-center are content with the availability of medications in their facilities, which suggests that there is a general scarcity of medicines stocks in public facilities. [43] The Infant Mortality Rate increased to approximately 70 in urban slum areas in 2013/2014. This is a significant increase from the general

infant mortality rate of 34 per 1000 live births in urban areas and 40 in rural regions. "One of the foremost jobs of the physician is to teach the populace not to use medication," Sir William Osler once observed. It is believed that Bangladesh has 100,000 retail drug outlets that are licensed, in addition to another 100,000 that are not licensed. [44-45]

Fig 05: Hospital

They are run by salespeople who are mostly trained informally through a process known as "apprenticeship, "where the majority of medicines are dispensed irrationally without any prescription, and OTC dispensing of many low-safety profile drugs is commonplace. They are largely unregulated and unaccountable. More than eighty percent of the population receives medical attention from unskilled or inadequately qualified village physicians and retail pharmacists. [46] The post-disaster management in Bangladesh is inadequate as a result of a lack of appropriate compensation, inadequate or inaccessible health-care facilities, and a slow rehabilitation process to accommodate survivors of disasters within the mainstream society. This is due to the fact that the survivors of disasters cannot be accommodated within mainstream society. The latest epidemic of dengue fever was responsible for more than 50,000 hospitalizations in only the month of August 2019. and almost 100,000 hospitalizations and claimed 112 fatalities from January to October 2019, when hospitals were not able to manage the enormous number of

patients flooding the hospitals. The nation is now housing 1.1 million Rohingya refugees, who present a significant risk of diphtheria, HIV transmission, and other sexually transmitted diseases (STDs). [47-50]

1.7.2. Collision of the system with conventional medicine

The nation is home to around 86,000 communities, and the majority of those villages are home to at least one or two traditional practitioners. Over sixty-five percent of the people living in Bangladesh rely on their local village physicians as their primary source of first-line medical treatment. It is believed that between 70 and 75 percent of the population relies on traditional medicine for their medical needs. [51] In addition, seventy percent of the women reported using at least one herbal medicine during their most recent pregnancy, the vast majority of them doing so without first seeing a licensed medical professional. Except for the Ayurvedic Medical College of Bangladesh, the curriculum of medical schools does not contain complementary or alternative medicine or traditional medicine. Patients' decisions to seek help from alternative medicine rather than orthodox medicine can be attributed to a number of factors, including illiteracy, poor economic status, cultural context, unpredictable diagnosis and treatment cost, absenteeism of doctors in rural health complexes, divergent medical opinions, unhealthy competition between health providers and their tendency to linger treatment procedure, negative perception of costly medical tests and unnecessary food supplements, as well as easy availability and accessibility of alternative medicine. [52]

1.7.3. Drug cost versus expenditures

The pharmaceutical sector is highly competitive, leading to increased use of high-pressure sales tactics by various drug manufacturers. In almost all cases, physicians get absorbed into the system whether they want it or not. Because of this unethical advertising, doctors are more likely to recommend expensive, often needless, medications. [53] In the name of the survey, medical reps routinely rush during busy times and forcefully withdraw prescriptions from patients. Antibiotics were prescribed in 44% of visits, whereas in urban areas, it was 46%, and in rural areas, it was 33%. In a country where roughly 22% of the population lives below the poverty level, physicians definitely enhance OOP expenses and generate considerable revulsion for modern treatment. [54] And physicians are commonly accused of receiving a 30-50% commission on tests ordered via hospitals and diagnostic facilities. [55] There are no functions for the regulatory body,

professional, or consumer rights organizations to oversee or correct the process. According to the joint World Bank and WHO publication "Global Monitoring Report on Financial Protection in Health 2019," around 7% of families are driven into poverty owing to OOP outlays, with chronic NCDs being the primary contributor. Khan et al. (2017) also found that health care accounts for 11% of household budgets, with 9% of families experiencing financial disaster; this number rises to 16.5% for the poorest households and 9.2% for the wealthiest. Studies have shown that poor coping techniques and a lack of health-care spending protection may have a multiplier effect on people's vulnerability and suffering by reducing their potential future income. [56]

1.7.4. The Falling Reputation of Commercially Available Medicines

More than 250,000 children every year are lost to the world because of fake medications. The previous DGDA of Bangladesh said that the availability of medications is essential to guaranteeing excellent health care, since it is one of the fundamental necessities of people. In poor and middle-income nations, in particular, the use of counterfeit pharmaceuticals may cause drug resistance, premature death, ineffective treatments, and a loss of trust in the health-care system. People in rural areas are more likely to fall prey to contaminated drugs since they are less likely to be aware of the problem. Due to lesser levels of health awareness and formal education, rural regions are more likely to see sales of counterfeit or sub-standard medicine, according to the Dean, Faculty of Pharmacy at the University of Dhaka. [57] Bangabandhu Sheikh Mujib Medical University found that between 1982 and 1992, as many as 2700 children died from renal failure after ingesting poisonous syrup. Companies under scrutiny responded more sensibly. They admitted that 90% of their goods lacked any kind of scientific backing, but maintained that the FDA was responsible for allowing them to hit the market. Many individuals these days are duped into purchasing fake insulin [58]. There is an annual estimated Tk 600 crore worth of counterfeit medication trade in Bangladesh's Tk 18,000 crore pharmaceutical industry, according to drug market intelligence. In 2016, the government canceled the licenses of 20 drug manufacturers for manufacturing substandard and potentially dangerous medications. [58] The legislative panel also suggested suspending the production licenses of 22 pharmaceutical businesses and revoking the licenses of 14 companies to produce antibiotics (penicillin, non-penicillin, and cephalosporin families). [59] The government was also ordered by the court to immediately cease working with these corporations so that they could no longer produce pharmaceuticals. To yet, however, no official

action has been taken by the government. According to the DGDA, there have been 370 reports of counterfeit pharmaceuticals in the first half of 2019. [60] Hospitals as prestigious as Apollo and United have been accused of stocking and dispensing inferior reagents and medicines. It's also worth noting that Bangladesh is home to not one but two government-run drug testing labs: one in Chittagong and another in the capital, Dhaka. [61-62] When considering the current demand, where over 275 pharmaceutical businesses with over 25,000 brands generate over 100,000 batches of medications, their performance is much lower than (5% of the total production). [63]

1.7.5. Quality of medical education

In a June 2019 parliamentary session, the health minister reported that over half of all teaching vacancies in public medical and dentistry institutions remain unfilled, with the majority of these openings being for fundamental courses. The respected prime minister of Bangladesh made the observation that private medical schools had performed dismally at a seminar on the treatment of essential diseases. [64] It has also been stated that there is a 65% shortage of faculty in both public and private medical schools. Students should spend the majority of their time in medical school on practical skills, with just 20% spent on theoretical concepts. The opposite is true, however, at certain elite medical schools where students spend all four years learning theory without ever seeing a patient.[65] Patients are being put in danger by doctors who lack appropriate practical and field-based applied expertise. It's embarrassing for both the doctor for the country as a whole if he or she needs a nurse's aid to administer anything as simple as a saline push-in. There is no doubt that all of these factors are intrinsically linked to the development of medical education and the caliber of future physicians in Bangladesh.[66]

1.7.6. Debasement of health providers' image

Bangladesh is plagued with a serious dearth of health care services that are of high quality and can be relied upon, as well as an inadequate supply of health-care organizations to meet the ever-increasing demand. [67] To be more specific, there is a significant supply gap between the care that is accessible to the affluent and the care that is available to the poor, particularly in light of the expanding middle class. One of the most important takeaways from the study of patients' households was the realization that patients are dissatisfied with the manner in which health-care professionals at public institutions treat them. One of the most important factors that determine whether or not people who utilize public health services are happy with such services is the attitude

that health personnel has toward them. [68] Even though the number of private hospitals and clinics in the nation has increased significantly over the last several decades, the majority of them are regarded as having substandard levels of treatment. Surprisingly, almost forty percent of private hospitals, clinics, blood banks, and diagnostic institutes are not registered with the government organization that oversees such matters. It has been shown that patients and their families feel more grateful for the services provided by physicians, nurses, and other medical staff members at hospitals located in other countries. They report that the medical professionals there, in particular, are communicative and compassionate. There are quite a few hospitals in Dhaka that are up to international or regional standards, and the city is the only place where they can be found. Other cities and towns do not possess modern medical facilities in the way that we understand the term. It is becoming more customary for certain hospitals to hold the corpses of deceased patients as hostages in an effort to force payment of outstanding medical bills. Other allegations include the following: switching a deceased child with a newborn baby, abducting or stealing a newborn baby, staff not attending to patients in a coma, keeping clinically dead patients in ICU and raising hospital bills, wrong diagnosis and treatment, absence of human touch and care from the hospital staff, [69] lack of proper medical history or lack of an electronic health record, or illegible prescription writing. According to Shahida et al., 2016, the incidence of hospital-acquired infections in Bangladesh may surpass 30 percent in a few of the country's hospitals. In addition, rural practitioners made mistakes in death certification processes on a regular basis (more than 95% of the time), and the quality of medical records was poor (more than 70% of the time). It has not yet been included in curriculum 1 for graduate medical students in this nation on the topic of emergency and critical care medicine. In our hospitals, the Basic and Advanced Life Support courses have not yet been integrated as a required component of the physician's credentials, particularly for those who work in the fields of medicine, pediatrics, anesthesia, emergency medicine, and other related fields. The concept of emergency health-care does exist, but only in a figurative sense. [70]

1.7.7. Future recommendations

Healthcare expenditure in Bangladesh is very low in comparison to other countries, at less than one percent of GDP. The World Health Organization suggests investing 15% of a country's overall budget in health care. Government should spend additional resources directly on government

doctors, drugs, hospitals, and health centers and also increase the allocation in education to ensure quality by recruiting qualified teachers, retaining them by providing incentives, and ensuring better infrastructural facilities and resources. Better preventative and curative treatment can only be achieved via the education of medical professionals. [71] Therefore, plans should be made to train two groups of health professionals year-round: (1) doctors and nurses, who will learn about health-care management and administration, and (2) village doctors and SSC/HSC graduate young men and women, who will learn about preventative and primary therapeutic care at their local Thana Health Complex and be designated as a village health worker (VHW) to serve in their home communities. Some of the women will be accredited as birth attendants after completing midwifery training. Patient-centered care, in which physicians and nurses see their work as a collaborative effort with their patients, should be a central emphasis of medical education. Doctors will have the incentive to ask patients for testimonials regarding their care. The management of a hospital should establish guidelines for all operations and procedures and implement treatment uniformity. Nurses will get instructions on how to utilize checklists, which will be posted on each ward, to ensure that proper hygiene measures are being taken. VHWs and Birth Attendants provide health and nutrition education to patients and their families, as well as keep track of the health history of individuals and their households. Assigning ward clerks will help reduce some of the burden on nurses. The next step toward better health-care would be to strengthen existing institutions. The Prime Minister will be in charge of the National Health Council, and this body may advise on health-care policy and assess the sector's overall performance. To ensure that all hospitals and other health care providers adhere to a baseline level of quality, the government should establish a National Accreditation Council headed by the health minister. There has been a dearth of government support for all types of pharmacies in Bangladesh, including hospitals, community pharmacies, and clinical pharmacies. About 8,000 pharmacy students graduate each year from Bangladesh's about 100 state and private colleges that provide pharmacy programs. Good hospital and community practices may have a greater impact on society if they are implemented effectively. Health care delivery that is both competent and well-coordinated benefits greatly from interprofessional education.[72] This is crucial for enhancing both medication reconciliation and medication evaluations involving many professionals. Although the safety and efficacy of treatment are still crucial for patients with chronic diseases, especially those in quarantine, there is a bigger problem in the supply of pharmaceuticals and compliance with

prescriptions. Because hospitals may not be a safe haven during pandemic outbreaks, home care becomes even more crucial. Health officials often advise the use of social distance systems like telemedicine and telehealth during epidemic outbreaks because they are so successful in preventing and treating the spread of disease. Unnecessary diagnostic procedures, like cesarean sections and blood testing, are also widespread and place a heavy financial strain on low-income families. The management of potentially fatal problems in pregnant women and babies requires the imposition of litigation and specific rules in the health policy. All hospitals may benefit from appointing a patient and family advisory council to address patient issues, such as the use of unneeded diagnostic tests and treatments, and to work in tandem with the hospital's management board.[73]

1.8. Acute diseases

Acute diseases are those that develop suddenly, are accompanied by clear symptoms that call for immediate or short-term medical attention, and improve after treatment has been administered. A fractured bone, which can be the consequence of a fall, for instance, has to be treated by a doctor and will recover over the course of time.

Examples of acute diseases include:

- Fever
- Sore throat
- Cough
- Sneezing
- Earache
- Diarrhea
- Runny nose
- Nausea
- Rash
- Headache
- Asthma attacks
- Bronchitis
- Burns

- The common cold
- The flu
- Heart attacks
- Pneumonia
- Strep Throat
- Respiratory infections
- Broken bones

Fever

A fever is a transient increase in the temperature of the body. It's a piece of the puzzle that makes up the immune system's overall reaction in the body. An infection is almost always the root cause of a fever. A fever is likely to be distressing for the majority of children and adults. In most cases, however, this should not raise any concerns.[74]

Diarrhea

The problem of diarrhea, which is characterized by bowel movements that are more frequent, loose, and watery, is quite common. It is possible for this symptom to exist on its own or in conjunction with other symptoms, such as nausea, vomiting, abdominal pain, or a loss of weight. The good news is that diarrhea rarely lasts longer than a few days on average.[75]

The common cold

The common cold, sometimes known simply as the cold, is an infectious illness of the upper respiratory tract that is caused by a virus. The respiratory mucosa of the nose, throat, sinuses, and larynx are the primary areas affected by the cold. It may take less than two days after being exposed to the virus for signs and symptoms to manifest. Symptoms include coughing, a sore throat, a runny nose, sneezing, a headache, and fever may be present. The average time it takes for people to recover from an illness is seven to 10 days, although certain symptoms might linger for as long as three weeks. People who already have various health issues have an increased risk of developing pneumonia. [76]

1.8.1. Acute disease cause

Acute disorders are often brought on by a virus or an illness; however, they may also be brought on by an injury sustained as a consequence of something like a fall or a car accident, as well as by the improper use of pharmaceuticals or treatments.

1.8.2. Acute disease treatment

A great many of the acute illnesses that people have may be self-limiting, meaning that they can heal themselves, or they can be treated with a straightforward regimen of antibiotics or other prescription drugs. However, there are illnesses known as acute diseases that manifest themselves rapidly and create symptoms that are potentially fatal.[77]

1.9. Patients Satisfaction and its Associated Factors in Rural Health Center

It is the amount of patient satisfaction that is indicative of the quality of treatment provided by a healthcare institution. A health care system should provide compassionate, empathetic, and professional service to its patients. Statistics on patients' levels of contentment are used heavily in shaping healthcare institutions' policies and procedures. Primary health care management models all across the globe have included collecting data on patient satisfaction. Further, several nations need it as part of their quality assurance and endorsement procedures. Donabedian calls it an essential metric since it reveals whether or not doctors are fulfilling patients' most crucial expectations. Research shows that in order for patients to get the full benefits of medical treatment, they must take their prescribed medications and follow their doctors' orders. Research shows that the quality of health care in poorer countries is poor [78]. Patient discontent has been linked to a number of variables, including a shortage of medications and other supplies, excessive wait times, a lack of privacy, and insufficient visiting hours, according to research done in Ethiopia . Poor patient care and services, especially in government hospitals, have been an issue in Ethiopia's health system in recent years. Consequently, the bulk of the people in need of medical care was not adequately served by the public health system. This, of course, has a negative impact on tax income for health care, which in turn prevents the government from modernizing public health facilities in a fashion that would be acceptable to patients 'In order to address this issue, the Bangladesh government has launched a three-pronged health care rescue system as part of its Health Sector Development initiative (HSDP). The goal of the HSDP is to improve people's health

by expanding access to primary care providers (PHCU). Different routine administrationsystems, such as Balanced Score Card (BSC) and Business Process Re-engineering (BPR), have been permitted by the Federal ministry of health in healthcare institutions to recover institutional structure and the value of health service supplied to the public. It had also initiated CEOs for hospitals and the dominating team in health centers, which improves the relationship with people and engages in resource mobilization. [79] These are some of the most important features of modern initiatives for enhancing healthcare facilities' quality . Khulna district health facilities, especially those in rural regions, need to take use of the possibilities presented by the government's plans in order to improve the quality of care they provide to the local community. However, to the best of our knowledge, no research has been conducted thus far on the levels of patient satisfaction with outpatient health care services provided by Khulna rural health clinics. This research set out to evaluate the quality of care provided by three rural health clinics in the region, specifically focusing on the satisfaction of their patients with regard to the services provided by their respective Outpatient Departments (OPDs). We anticipate that the project will provide baseline data that may be used by anybody with an interest in enhancing the quality of health care in Bangladesh health facilities and beyond.[80]

Participant satisfaction score with service provided

The study found that 6.8% of participants reported feeling "satisfied" with the examination and advice offered by the health service provider or experts participating in the health care service, while 10.8% reported feeling "dissatisfied." Of the respondents, 279 (or 68.5%) were unsatisfied with the explanation of the root reasons of their health issue, whereas 128 (or 31.5%) were content with the explanation provided. There were 337 pleased respondents (82.8%) and 70 unsatisfied respondents (17.0%) who had consulted regarding preference over other treatment choices. 277 (68%) of those surveyed were happy with the amount of time allotted for their appointment, while 130 (32%) were very unhappy.[81]

Bi-variable analysis of explanatory variables score of patient satisfaction

In the end, the model was able to account for 15.4% of the observed variance in the sample. Time spent waiting for an injection, time spent waiting for a lab specimen, receipt of all services, medications, and supplies requested, receipt of all medications prescribed, and kinds of visits all played important roles. Patients who waited 1-2 hours for a staff member to give them an injection reported higher levels of satisfaction than those who waited less than an hour (95% confidence interval [CI], 0.675, 5.092), while those who waited less than an hour to get a lab specimen reported lower levels of satisfaction than those who waited 1-2 hours (-4.003%, -5.475 to -2.532).[82]

Factors associated with patient satisfactions

The reliability test for the factor analysis variables was carried out with the help of the coefficient alpha (). The reliability statistics came in at =0.815, which is better than the minimum requirement of Cronbach's >0.7 and is thus considered to be outstanding. The goodness-of-fit of the model, which had a p-value of 0.001 and was less than 0.01; this indicates that the overall goodness-of-fit was 1%, which is a highly significant number. The model's adjusted R-square was 63.8%, which is more evidence that the model was accurate. With the assistance of SPSS 20.0, the backward technique was used for the purpose of developing a multivariate model. The multivariate model reveals that the mean score of patient satisfaction is a significant variable, whereas the other factors are deemed to be irrelevant and are thus eliminated. The significant variables included the procedures for the laboratory that were ordered, the amount of time spent waiting to receive the lab specimen, the amount of time spent by other staff members attending to the injection, the number of drugs and supplies that were ordered, and the amount of services obtained from a health center. As shown in multi-co linearity by Variance Inflationary Factor (VIF) of the values, which were less than 2 from all variables, the results measured for patients getting the prescribed drugs and supplies from the health center pharmacy and patients waiting time to get the lab specimen for more than two hours were not significantly associated with patient satisfaction mean score. Patient satisfaction mean score was significantly lower for patients who have not gotten drugs and supplies from health center pharmacy as compared to patients who get some ordered drugs and supplies from health center pharmacy (-0.541, 95% confidence interval [CI], -0.977, -0.104), and Patient satisfaction mean score was significantly lower for patients who have not gotten all ordered services as compared to patient who got some ordered services (-0.967, 95% confidence interval

[CI], -0.216, -1.717). Patient satisfaction mean score Patients who had not waited to get the lab specimen had an average increase in satisfaction score of 1.068 units as compared to patients who waited 1-2 hours (95% confidence interval [CI], 0.403, 1.732). On the other hand, patients who had waited to get the lab specimen for less than one hour had an average decrease in satisfaction score of 0.929 units as compared to patients who waited 1-2 hours (95% CI], -1.265, -0.594). Patients who had attended time by other staff for injection of 1-2 hours had an average increase in satisfaction score of =0.461 unit when compared to patients who had attended by other staff for injection of 1 hour (95% confidence interval [CI], 0.185, 0.737).[83]

1.10. Local governments and village health services

Human Development often includes health security. The People's Republic of Bangladesh's Constitution states that "Health is the basic right of every citizen of the Republic" since health is essential to human development. Life quality depends on health. Health facilities affect a nation's economy and society. A nation's health-care system reflects its socioeconomic and technical growth and its commitment to its citizens' health. Bangladesh has increased its response to large-scale health threats such as natural catastrophes, disease outbreaks, and terrorism during the last decade. Bangladesh's health sector development throughout the decades is seen below. "Health is the fundamental right of every citizen of the Republic," according to the People's Republic of Bangladesh Constitution. The Ministry of Health and Family Welfare develops, plans, and enforces policies. Health Services, Family Planning, Nursing Services, Drug Administration, and Health Engineering include this. In recent years, health policy has prioritized providing basic services for everybody, especially in underserved rural regions. Bangladesh's lowest local government tier, the Union Parishad, helps rural development. Its responsibility is to provide health security to rural Bangladeshis, which is difficult considering that just 30% of Bangladeshis reside in cities and rural regions that lack infrastructure and health specialists. Bangladeshi Upazilas (district subunits) must have Union Parishad Health & Family Welfare Centers and local Community Clinics. The Welfare Centre provides free general health services and basic reproductive, maternal, and child health care to local residents. Each has a Medical Assistant trained for three years in disease prevention, health education, and basic first aid, and a Family Welfare Visitor trained for 18 months in family planning, reproductive health, and pre-and post-natal care. Community Clinics, which replaced local clinics, are government-run. They are

generally utilized by those within a half-mile radius; however, 50% of rural women are unaware of their existence, and many rural people prefer to consult with a pallichikitshak, a village doctor, without official medical training. Clinics are poorly managed and understaffed, resulting in poor patient treatment. Entrepreneurs, NGOs, and international organizations support public health-care. Local NGOs like BRAC provide prenatal and safe birth programs. There are also several private clinics around the nation, and many physicians from public hospitals give services part-time in these clinics to augment their wages. The clinics operate on a purely commercial basis and are consequently pricey, but individuals who have the money choose them since they are perceived as giving superior quality than state hospitals. Private clinics are unaccountable since the government cannot control them. Rural health-care in Bangladesh remains insufficient despite government and private/NGO funding. Two hundred forty-one doctors, 136 nurses, and ten hospitals per million people (making the availability of hospital beds 1 for every 4000 people).

Fig 06: NGO Activities in Bangladesh

The research argues that a lack of doctors, workers, and nurses, misdiagnosis, indifference toward patients, irresponsibility, absenteeism, and a lack of professional ethics harm rural health security. Furthermore, while the majority of the population of Bangladesh lives in rural regions, most physicians are headquartered in cities and towns. Capacity development, lodging, quality education, transportation, and career possibilities hinder doctors from working in communities. The Union Parishad also struggles to push for reforms because of the shortage of resources and

dynamic leadership. In 2011, a comprehensive National Health Policy reaffirmed every citizen's entitlement to decent health care and the state and government's constitutional duty to provide the infrastructure. Its declared aims were to enhance primary health and emergency care for everyone, extend the provision of client-centered, equity-focused, and high-quality health care services, and promote individuals to seek treatment based on rights to health. Over the previous five years, this has not been implemented, resulting in inconsistent health service throughout the nation and prohibitively costly treatment for rural Bangladeshis. Union Parishad oversees rural health security but lacks the means to handle chronic issues. Union Parishad standing committees are vital to improving grassroots service delivery. Union Parishad provides services, although its effectiveness and competence are questionable. Union Parishad should make its standing committee functioning for transparent, responsible, and sustainable local government service delivery. Union Parishad does not favor standing committee effectiveness. Most Union Parishads created it for formal purposes, but its effects are seldom noticed. The Standing Committee on Health activates health officials to check EPI program status, local sanitation, and safe drinking water sources. Standing committee members check hospitals and clinics frequently. A functional standing committee is still over. Union Parishad is unable to deliver health care to rural communities due to the elected officials' lack of dedication and vision, notably the Chairperson. Rural health security is threatened by a shortage of doctors, nurses, and staff who won't work in small communities. Bangladesh needs a participative, need-based, pro-poor, and practical health security program. Public policy should use bottom-up planning. To ensure rural health facilities, increase central monitoring and assessment. Local governments should be empowered to provide rural health care to everybody. Bangladesh's 2011 National Health Policy. This is a strategic direction and indicative of how to use resources to achieve the government's health goal. Enforcement promotes health security globally. Above all, central government backing and enforcement of current regulations and increased collaboration with civil society organizations, the media, academia, and funders are required to help local governments improve rural health-care. Finally, sociological studies on rural health behavior may help policymakers develop health security initiatives.[84]

Chapter Two: Literature Review

2.1. Muhammed Muazzam Hussain, Mohammed Mojammel Hussain Raihan "Patient's Satisfaction with Public Health Care Services in Bangladesh: Some Critical Issues" Malaysian Journal of Medical and Biological Research Volume 3, No 1/2016

This essay makes an effort to investigate the experiences of Bangladeshi patients with government-run health-care services, as well as the clients' perceptions of their own health and the expectations and needs they have of government health-care professionals and service providers. The research identifies the problems and challenges people encounter while receiving care or other services and offers some suggestions for enhancing public hospital services. The study was conducted utilizing the interpretivist paradigm and a qualitative research methodology. To get the required data, a variety of data-collecting techniques, including interviews, focus group discussions (FGD), documentation surveys, etc., were used. The data show a persistent cycle of marginalization brought on by the interactions between providers of health services and their commercial counterparts, such as private pharmaceutical companies and diagnostic facilities, which limits the opportunity to effectively protect patients' consumer rights. In order to counteract the marginalization and exclusion of these impoverished patient groups, the research advises policymakers and service providers to act more quickly and decisively.

2.2. Priti Biswas, Zarina Nahar Kabir, Shahaduz Zaman "Dynamics of Health Care Seeking Behaviour of Elderly People in Rural Bangladesh" Vol. 1 No. 1 (2006): Theorizing and Social Gerontology

By the end of the next decade, Bangladesh's old population is expected to double, rising from the current 7 million to 14 million. This article focuses on senior people's coping mechanisms in disease instances and the contributing elements that affect how they seek out health care, drawing on qualitative data from rural Bangladesh. Elderly males and females who were 60 years of age or older, as well as their caretakers, made up the sample for this research. Thirty in-depth interviews and nine focus group sessions were done. According to research, old age and poor health are seen as being intertwined. Costly medical treatment from a licensed physician is shunned by many people. The familiarity and accessibility of medical professionals are key factors in how older people seek out medical treatment. One of the most important factors in determining whether or

not to seek treatment—and even the kind of therapy sought—is the flexibility of health care providers in obtaining payment.

2.3. M. A. Mannan "Access to Public Health Facilities in Bangladesh: A Study on Facility Utilisation and Burden of Treatment" The Bangladesh Development Studies Vol. 36, No. 4 (December 2013)

Although the Bangladeshi government invests a significant amount of money in health-care, there is often discontent with the accessibility and quality of these services. The research evaluates whether public health facilities have deficiencies and identifies reasons that prevent their effective use. It does this by utilizing primary data from a survey. The results demonstrate that women and the underprivileged are more likely to utilize these facilities in general. Physical accessibility is no longer a significant obstacle, according to the report, but economic accessibility is still a significant roadblock. The poorest people utilize public health services the most, yet they also endure a disproportionate amount of illness and pain. Additionally, there are a variety of governance problems that lower service quality. The results of the quantitative and qualitative data analysis show that the government's attempts to enhance the provision of health services have not yet yielded the expected outcomes. In order to restore patients' optimism, urgent governance concerns must be resolved so that service providers are present at the facilities, a minimal number of medications are administered to patients, and unofficial payments are kept to a minimum.

Chapter Three: Aim of thestudy

Aim of the study

My aim of this study is,

- To know the current situation of health care manner in the Bangladeshi village.
- Look at the people's satisfaction levels who get village health care management.
- To observe the diagnostic tools that the hospitals in rural areas have.
- Determine the available facilities in a rural area hospital.
- To know the importance of the rural health care system.
- To know the limitations of health care system

Chapter Four: Methodology

4.1. Introduction

A survey-based study of village health care manner and patients' satisfaction in Bangladesh for acute disease. Totally 100 respondents participated in this survey.

4.2. Research Methodology

This work was physically performed. The area of Noakhali, 3 village hospital patient were taking part in this survey. The hospitals are,

1. Kankirhat Govt. Hospital.
   -30 beds.
2. Jahan Medical Center.
   -100 beds.
3. Senbag Upazila Health Complex.
   -50 beds.

Here No.2 Hospital are private hospital & others are public hospital.

4.3. Data Analysis Method

After compiling the numerous pieces of information, each one was checked for correctness and internal consistency to remove any missing or conflicting information. The widely used upgraded version of Microsoft was used for information research.

4.4. Ethical Considerations

Before beginning the information assortment, educated verbal permission was taken from the investigation members. The respondents' identities were kept secret, and participants in the research were informed that they might drop out at any point throughout the information-gathering process. The Department of Pharmacy supported the investigation.

Chapter Five: Result and Discussion

5.1. Gender

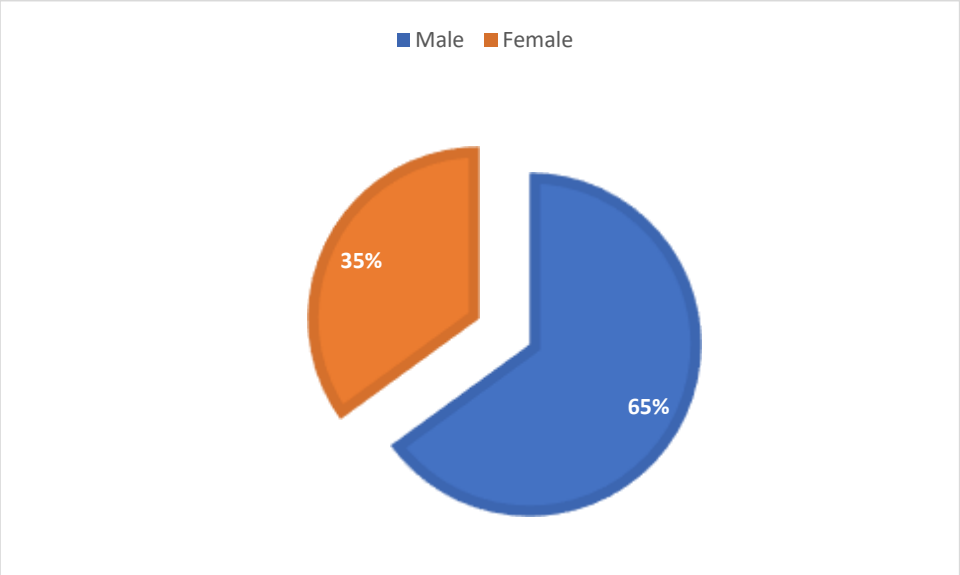

Fig 07: Gender

According to this survey 65% male are take healthcare service from village healthcare center. And only 35% people are taking the service.

5.2. Type of acute diseases patients suffer most:

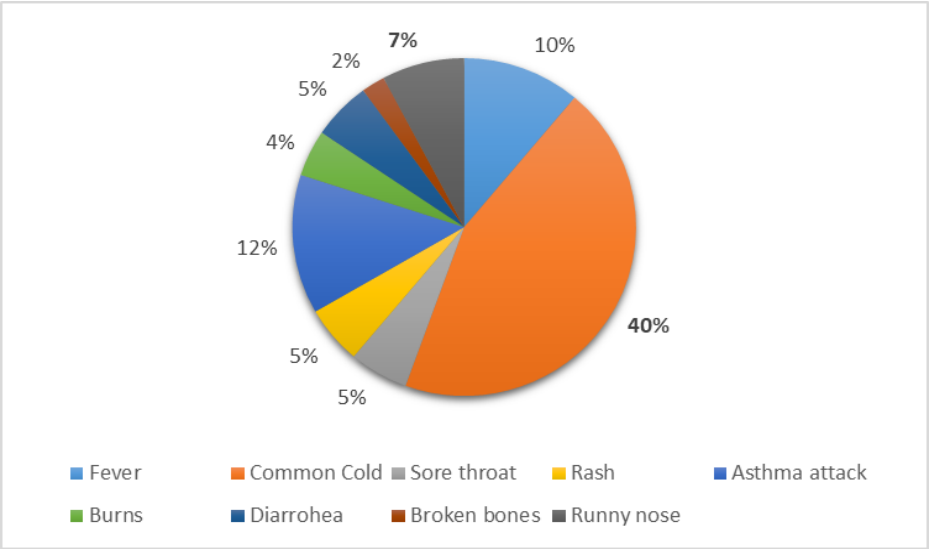

Fig 08: Acute diseases

According to this survey, 40% people visit hospital for common cold. 12% people were going to hospital for asthma attack. 4% people are burned. Only 2% people were going to village hospital for broken bone. and 5% people were going for sore throat.

10% for fever and 5% for rash.

5.3. Numbers of doctor

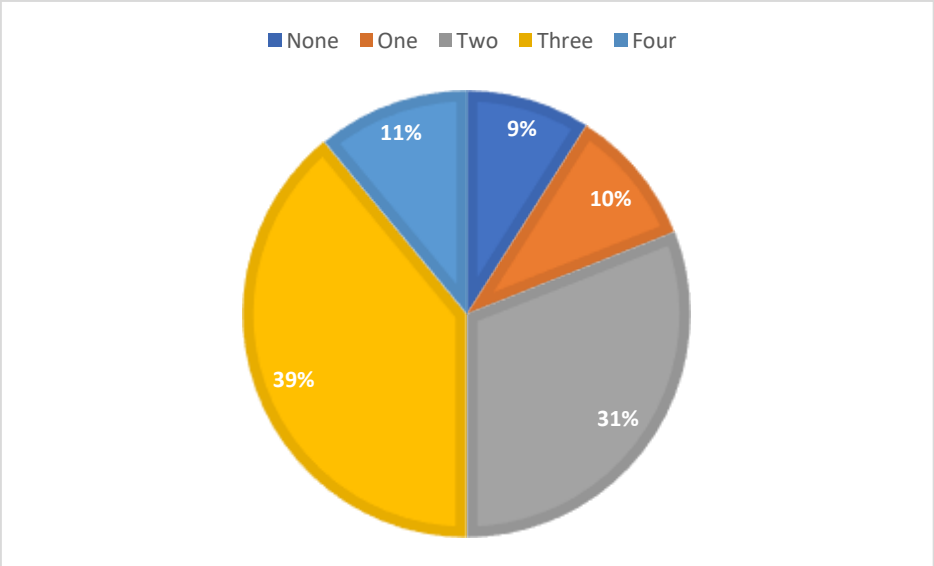

Fig 09: Numbers of doctor

According to this survey, 9% people find no doctor when they visit in the hospital. 31% people saw two doctors in the hospital. 39% people saw is three doctors. And 11% people find there is four doctors in the village hospital.

5.4. Free Medication

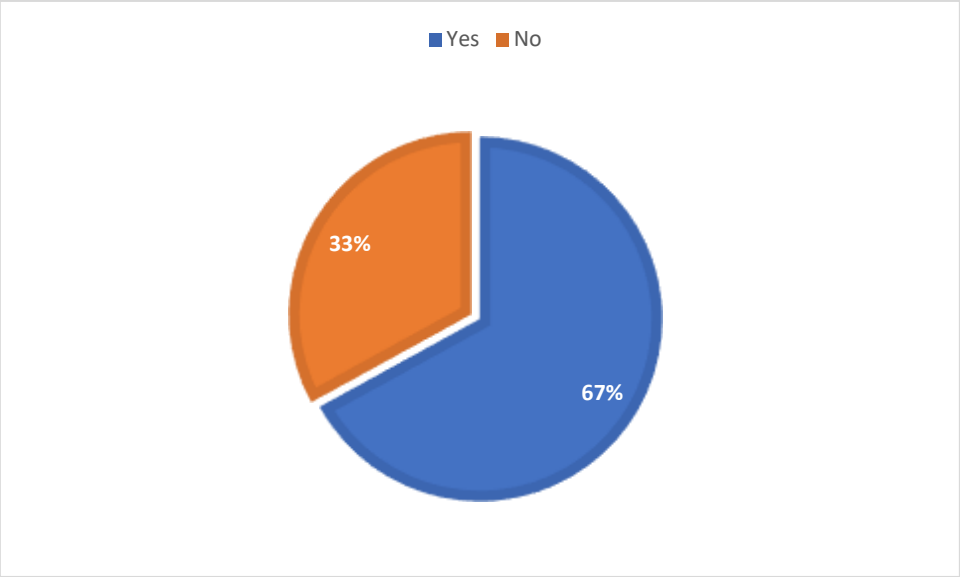

Fig 10: Free Medication

In this survey, 67% people took free medication from village healthcare center. And 33% people think there is no free service.

5.5. Machinery

Some special machine used in village hospital:

X-ray

Electromagnetic waves are a category of radiation that includes X-rays. Using X-ray imaging, your body's inside may be seen. The photos depict the various bodily parts in various colors of black and white. This is due to the fact that various tissues absorb radiation in different ways.

MRI

Radiologists use magnetic resonance imaging (MRI) as a medical imaging technique to create images of the body's anatomy and physiological functions. Strong magnetic fields, magnetic field gradients, and radio waves are used in MRI scanners to produce images of the body's organs.

Sphygmomanometer

A sphygmomanometer, also known as a blood pressure monitor or blood pressure gauge, measures blood pressure by using a mercury or aneroid manometer to measure the pressure and an inflatable cuff to collapse and then release the artery under the cuff in a controlled manner.

Primo Ferro

Primo Ferro is a height-adjustable bathing system designed to enable the care and treatment of burns and chronic skin conditions.

Machine Name	Used in Number of Patients
X-ray	40
MRI	20
Sphygmomanometer	30
Primo Ferro	2

Table 01: Machinery

5.6. Satisfied

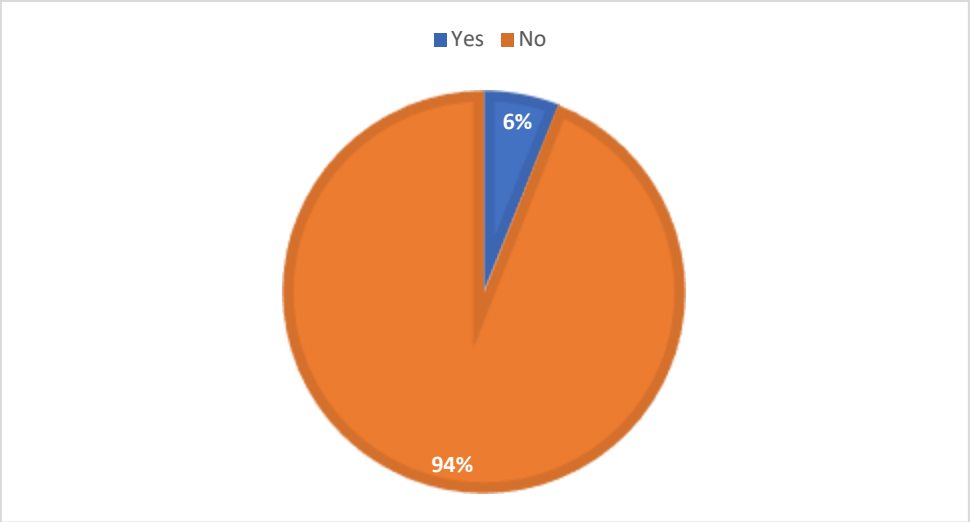

Fig 11: Satisfaction

In this survey, I saw only 6% people are satisfied with the healthcare worker manner and service. 94% people are not satisfied.

5.7. Obstacle

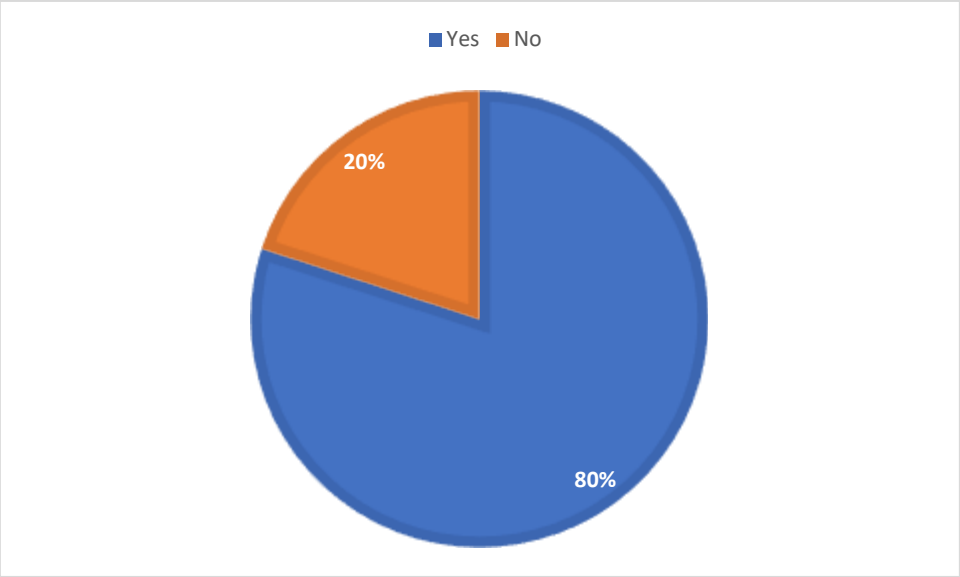

Fig 12: Obstacle

According to this survey, 80% people face obstacle to take healthcare service. And 20% people face no obstacle.

5.8. Problems

During this survey I find out some problem from patients:

No immediate response to emergency patient

96% patients complained about this.

Healthcare worker are not helpful with the patient. They took too many time to response with them. Patients suffer a lot in that delay time.

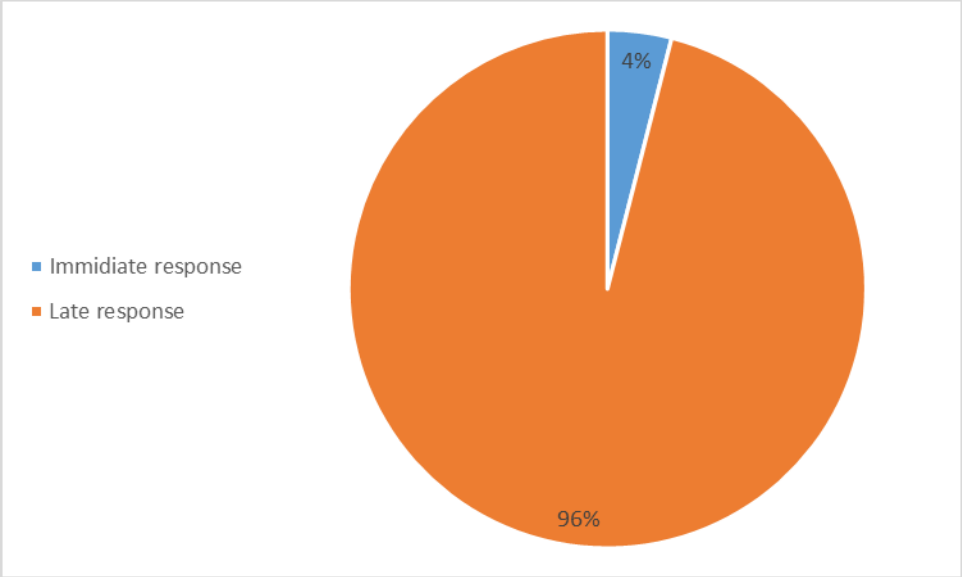

Fig 13: Response percentage

Demand money in govt. hospital

80% of people complained about this.

We all know govt. hospital are free of cost. But some village hospitals are demand money for service.

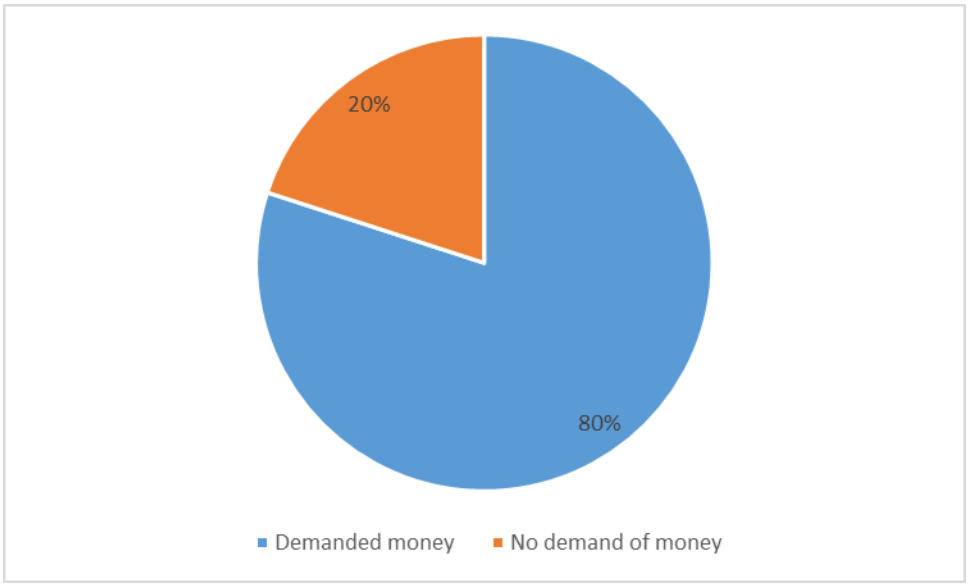

Fig 14: Demand of money.

Behavior of nurses was very rude even in private hospital

Nurses are not helpful enough they demand money for even pushing injection more surprisingly 67% people also complained about private hospital nurses.

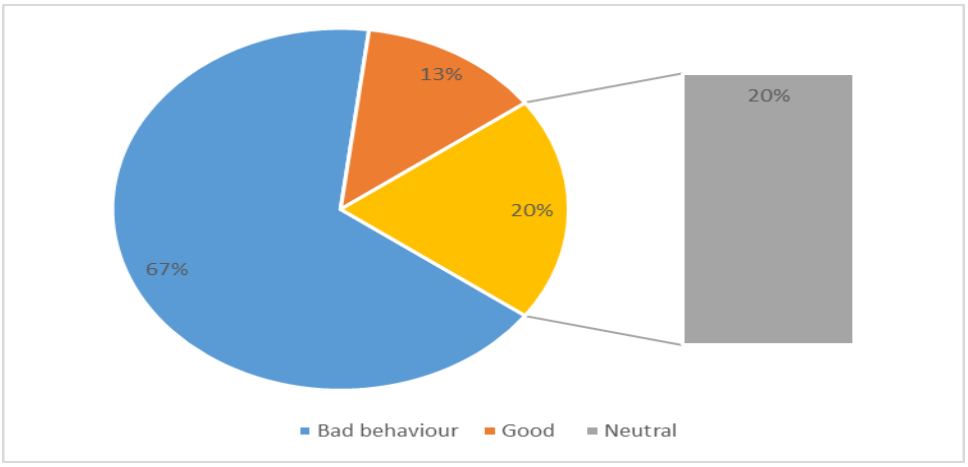

Fig15: Behavior of nurse.

Wheelchair for critical or old patient in govt. hospital

75% people complained about shortage wheelchair in govt. hospital for critical patient.
In private hospital they have to pay extra money for that service.

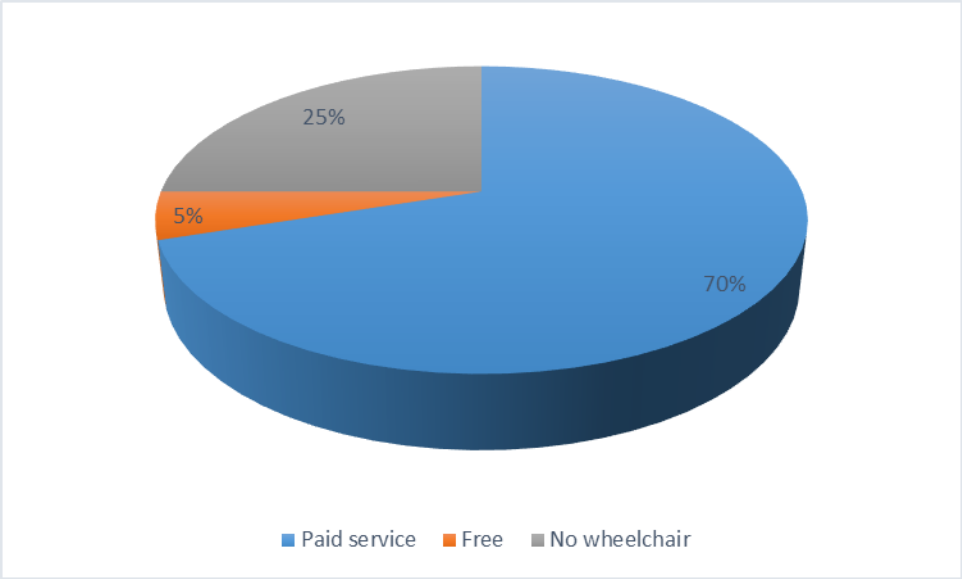

Fig 16: Wheelchair service.

Shortage of doctor and equipment

In govt. hospital, there is shortage of doctor and equipment.
Patient have to wait for a long time to get service. They have to visit upazila hospital for some mandatory test

Refer to Dhaka or Chittagong's hospital

Most of the cases, doctor is referring them in divisional hospital for more treatment. Its sometime not properly work for villagers. The refer percentage is 40% and only 30% people get primary treatment.

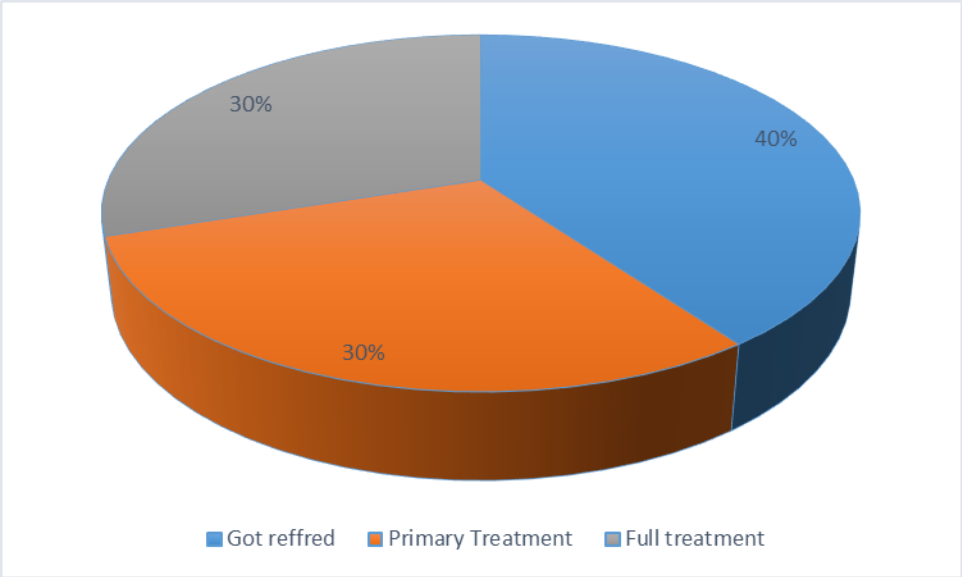

Fig17: Refer percentage.

Chapter Six: Conclusion

Conclusion

In Bangladesh, the Ministry of Health and Family Planning is in charge of overseeing the country's health care system. Building hospitals and other medical facilities in urban and rural regions are within the purview of the government. Having good health is one of the prerequisites for having a higher quality of life. The state of a country's medical infrastructure is directly proportional to the level of economic and social growth that the nation experiences. A country's health care system is a reflection of its socioeconomic and technical progress. It is also a measurement of the responsibility that a community or government accepts for the health care of its citizens. This research was carried out in the village areas of Bangladesh by means of a survey in order to investigate the current situation involving health care in Bangladeshi communities.

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