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Hospital improvement initiative in Bangladesh

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Baseline community based user survey

Bangladesh Hospital Improvement Initiative

FINAL REPORT

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Report prepared by
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Executive Summary

This survey was undertaken as a baseline for the Hospital Improvement Initiative (HII) in Sylhet division.

Objectives of the survey:

1. To assess and compare the use and experience of, and satisfaction with, services provided by the four district hospitals and the medical college hospital in Sylhet division.
2. To offer insights into reasons for current community usage patterns, and actionable areas for improvement, that can be incorporated in the HII planning and implementation.
3. To serve as a baseline for measuring the effects of the HII, with a repeat survey later in the project.

Methods

The survey collected quantitative and qualitative information about the use, experience and perceptions of the four district hospitals and the medical college hospital in Sylhet divisions, from households in communities around the hospitals, from hospital outdoor patients, from hospital indoor patients, and from community focus groups. Information was also collected from the hospitals themselves: in a focused institutional review and in interviews with administration.

The evidence base:

- 1149 households
 - 312 OPD visits
 - 142 IP visits
- 308 outdoor patients
- 309 indoor patients
- 5 hospital reviews
- 20 focus groups
 - 10 female groups
 - 10 male groups

Key Findings

Socio-economic status of the survey populations

- A fifth of the households had an average monthly income of 1000 Tk or less.
- About a third of outdoor and indoor patients interviewed came from households with an average monthly income of 1000 Tk or less.

Knowledge and use of hospital services

- Knowledge of the district hospitals was high in the households, except in the case of Sylhet district hospital.
- Two thirds of households chose private medical care for an ill family member in the last year; only a fifth chose a government health facility.
- Some 28% of households had visited the district hospital as an outdoor patient in the last year; in the same period 71% had sought private outdoor patient care.

Many households chose private medical care, especially for outdoor services.

- Some 12% of households had an indoor patient spell in the district hospital in the last year; just 2% had private indoor patient care in the same period.
- Nearly all the outdoor and indoor patients interviewed came from the same district as the hospital, except for the medical college hospital where about a third of the indoor patients came from outside the district.

Referral to hospital services

- More than 90% of outdoor patients and three quarters of indoor patients went directly to the hospitals without being referred from another facility or doctor.

The great majority of indoor and outdoor patients attended hospital without a referral.

- Even in the medical college hospital, 86% of outdoor patients and 73% of indoor patients came there without any referral.
- People go directly to district hospitals because they perceive they will get a better service there, with more doctors and medicines available.

Experience of outdoor patient services

Costs

- Some patients report paying more than the official registration fee.
- Very few patients reported making unofficial payments to staff, although focus groups mentioned this as a problem.
- A quarter of patients had to borrow money to cover the costs of the hospital visit.

Waiting and attendance by doctor or other health worker

- Only a third of patients were able to sit while waiting; the situation was a bit better in Hobiganj and Sylhet district hospitals.
- The reported consultation time with the doctor was one minute or less for 29% of patients and more than five minutes for only 10% of patients.

Nearly a third of outdoor patients reported they saw the doctor for one minute or less.

- Consultation times were rather longer in the medical college hospital: 21% of patients saw the doctor for more than five minutes.

Privacy

- Nearly all (92%) of outdoor patients were seen and examined with the door open and most (74%) without any screen between them and other patients.

Prescription and receipt of medicines

- Only 16% of outdoor patients reported from households reported receiving all prescribed medicines from the hospital.
- But 64% of outdoor patients interviewed in the hospital said they received all the prescribed medicines.

Follow-up to visits

- A third of outdoor patients interviewed in the hospitals were given follow-up appointments and 70% said they would come back to the hospital if their condition worsened.
- A third of outdoor patients reported from households visited another facility (usually private) after the hospital, for the same health problem.

Satisfaction with outdoor patient services

- Less than half the outdoor patients (45%) were satisfied with the service overall.
- Most outdoor patients (82%) were satisfied with cleanliness of the facilities.
- Over half of outdoor patients (59%) were satisfied with privacy arrangements.
- Most outdoor patients (89%) were satisfied with the behaviour of the registration clerk.
- Over half of outdoor patients (58%) were satisfied with the behaviour of the doctor or other health worker.

Outdoor patient criticisms of the doctor's behaviour include lack of explanation of the problem, failure to prescribe medicines and lack of attention.

Experience of indoor patient services

Admission process

- More than half the indoor patients (52%) were admitted as emergency cases.
- Some 65% of indoor patients in the medical college hospital were admitted through the emergency room, but only 7% of those in Sylhet district hospital.
- Nearly a third of indoor patients (30%) paid an agent or used a source in the hospital to secure admission.
- Half (51%) of hospital stays reported by households lasted for five days or less.

Attendants

- Only a fifth of indoor patients reported having more than one attendant staying with them
- But nearly half the patients (48%) were noted to have two or more attendants with them when interviewed in the hospital.

Focus groups pointed out that attendants are necessary to help the patients with basic needs while in hospital.

Bed availability

- At least a quarter of indoor patients did not get a bed on the day of admission and some had to wait several days.

Costs

- Travel costs were higher for patients in the medical college hospital, with a third paying more than 300 Tk for travel
- Most patients paid an admission fee and 60% paid more than the official fee.
- Some 12% of patients on general wards reported paying daily bed charges.
- Two thirds of patients had to buy medicines from outside the hospital.

- Overall, 63% of indoor patients reported having to borrow money to cover the expenses of their hospital stay.

Two thirds of patients had to borrow money to pay for their stay in hospital.

Hospital food

- Most patients received food from the hospital, but half reported that the attendant or someone else ate it.
- Half the indoor patients said they would be willing to pay for better hospital food.

Attendance by doctor(s)

- Most patients (90%) were seen by a doctor on the day of admission and most (87%) reported seeing a doctor at least once a day.
- Some 70% of patients reported being given an explanation of their condition by the doctor; we could not assess the adequacy of this explanation.

Privacy

- Doctors and nurses rarely (about 15%) used a screen when examining or bathing patients and screens were not found on the wards by the visiting teams.
- Use of screens was particularly low in Sunamganj and Maulavibazar hospitals.

Prescription and receipt of medicines

- Almost all indoor patients (89%) were **prescribed** medicines, but nearly half (46%) did not receive any of the prescribed medicines from the hospital.

Referral to other facilities

- Household respondents reported that a third of indoor patients sought medical care elsewhere after discharge, usually from private facilities.
- Only three indoor patients in district hospitals reported being referred to the medical college hospital.

Satisfaction with indoor patient services

- Less than half the indoor patients (45%) were satisfied with the service overall.
- Half the indoor patients (51%) were satisfied with the cleanliness of the ward area.
- Less than half the indoor patients (44%) were satisfied with privacy arrangements.
- Most patients (60-80%) reported they were satisfied with the behaviour of doctors, nurses and cleaners during their hospital stay.
- Nevertheless, patients (especially those reporting from households) had complaints about staff behaviour.

The most common complaints about staff behaviour from indoor patients were lack of attention and bad attitude.

Perceived problems and suggestions about hospital services: views of service users

Main problems

- Household respondents, outdoor patients and indoor patients tended to identify the same problems with services from the hospitals.
- Commonly cited problems include: lack of medicines, bad attitude of staff, overcrowding and lack of beds.

Focus groups suggested that hospital staff treat rich patients better than poor patients.

Privacy

- Focus group discussions confirmed that patients would like better privacy arrangements.
- Focus groups voiced particular concerns about privacy of female patients and were unhappy about women being examined by male doctors.

Complaining about services and staff

- Focus groups suggested reasons for patients being unwilling to complain, including not knowing where to complain, and fears that staff will behave worse towards them if they complain.

Suggestions for improvement

- Suggestions for improvement mirrored perceived problems with the service from the hospitals.
- Common suggestions included: more medicines, more staff, better staff attitudes, more seats (in OPD) and more beds, and cleaner facilities.

Unofficial payments and user fees

- All focus groups condemned bribes and unofficial payments but some thought they were inevitable in order to get a service.
- Focus groups were divided on the question of increased user fees: about half would support them but only if they are accompanied by a better quality service.

Community involvement in hospital management

- Participants in all the focus groups were in favour of community involvement in district hospital management.
- Desired involvement included: giving advice and opinions, participating in supervision and increasing accountability of staff.
- Focus groups felt that community involvement would lead to improved quality of service from hospitals.

The proposal is good. It will form a bridge between government and people.
Female focus group, Sunamganj

Perceived problems and suggestions about hospital services: views of service providers

- Managers in the medical college hospital, and Sylhet and Hobiganj district hospitals considered their service 'good', whereas in Sunamganj and Maulavibazar district hospitals they considered their service 'neither good nor bad'.
- The main concerns of managers included: lack of staff, inadequate materials and equipment, and inadequate supplies of medicines.
- Suggestions for improvement included: devolvement of budgetary control to hospitals, increasing opportunities for revenue generation (such as user charges), increasing the number of beds, and increasing specialist facilities.

Conclusions and recommendations

- The survey has generated baseline data on a number of indicators against which to evaluate the effectiveness of the Hospital Improvement Initiative in the five hospitals (see Table).
- *A repeat survey at the end of the HII is recommended*, including repeat measures of these indicators (table), as a way of assessing the impact of the various aspects of the initiative on the use of government hospital facilities by households and on the experience and perceptions of outdoor and indoor patients.
- Clear problems are demonstrated with the hospital outdoor and indoor services, many of which could be tackled as part of the HII programme.
- *It is recommended that the HII programme is considered in the light of this evidence*, to ensure that planned activities will address the problem areas. This should help to emphasize a client centred approach and accountability in the programme.
- The process of the survey has set the stage for increasing community involvement in the way the hospitals operate.
- *Discussion of the findings of this baseline survey with hospital management and community representatives is recommended* as a concrete way to move forward with involving communities in planning for improvement of the service they receive from the hospitals.

Main indicators from baseline survey that can be used to assess effects of HII on experience and perceptions of hospital patients.

Indicator	Baseline value*
<i>Household opinion and use of hospital services</i>	
% households with overall opinion of local hospital as good	21% District hospitals 28% Medical College Hospital
% households using government and private outdoor patient facilities in the last year	28% government 71% private
% households using government and private indoor patient facilities in the last year	12% government 2% private
<i>Referral</i>	
% outdoor patients without referral	97% District hospitals 86% Medical College Hospital
% indoor patients without referral	75% District hospitals 63% Medical College Hospital
<i>Costs</i>	
% who borrowed money for OP attendance	25%
% who borrowed money for IP admission	63%
% patients on general wards paying bed charges	12%
<i>Outdoor patient experience</i>	
% able to sit down while waiting to be seen	35%
% doctor/health worker spent >5 minutes on consultation	10%
% doctor/health worker spent >1 minute with them	71%
% with screen used for consultation/examination	26%
% examined physically	27%
% received all prescribed medicines from hospital	16% from household reports 64% from OP interviews
% satisfied overall	45%
% satisfied with cleanliness	82%
% satisfied with privacy	59%
% satisfied with doctor or other health worker	58%
<i>Indoor patient experience</i>	
% admitted as emergency	52%
% used agent/source in hospital to secure admission	30%
% with two or more attendants at time of interview	48%
% given bed on first day of admission	73%
% with screen always used by doctor when examining	15%
% received all prescribed medicines from hospital	7%
% who bought medicines from outside	60%
% satisfied overall	45%
% satisfied with cleanliness	51%
% satisfied with privacy	44%
% satisfied with doctors	65%
% satisfied with nurses	76%

* The values of the indicators vary between individual hospitals.

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We also thank the civil surgeons and hospital superintendents for their cooperation and assistance.

Not least we thank the households, outdoor patients, indoor patients and community focus group participants who gave us their time to answer questions and take part in discussions.

Abbreviations

SMCH	Sylhet Medical College Hospital
SyDH	Sylhet District Hospital
SuDH	Sunamganj District Hospital
MDH	Maulavibazar District Hospital
HDH	Hobiganj District Hospital
HII	Hospital Improvement Initiative
HPSP	Health and Population Sector Programme
IP	Indoor patient
MOHFW	Ministry of health and Family Welfare
OPD	Outdoor patients department

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4. Summary tables of focus group discussions
5. Information from institutional review of hospitals

Background

The Hospital Improvement Initiative (HII), part of the Health and Population Sector Programme (HPSP), has stated goals to:

- C improve the health of the poor, particularly women and children
- C increase access to and use of cost effective health services by the poor, particularly women and children

The purposes of the HII include: to improve the quality of services delivered; and to ensure the delivery of the hospital element of the ESP.

As part of the HPSP, the HII intends to make hospital services more client centred, more responsive to needs (especially of the poor, women and children) and more accountable to the communities they serve. Thus, the use and experience of, and satisfaction with, hospital services by community members are important parameters in assessing success of the HII. The baseline survey described here will be one of the benchmarks for measuring the effects of the HII, with a planned repeat survey later in the project. The survey will also be complementary to the information collected through the national annual CIET Service Delivery Surveys.

The survey serves other purposes beyond providing a baseline. It offers insights into reasons for current community usage patterns and has provided an opportunity to ask community members (users and current non-users) about the acceptability of aspects of the HII (such as user charges). In the spirit of promoting the meaningful participation of communities in the planning of services, the survey has provided a chance to hear their perspective about service priorities, both in individual interviews and in focus group discussions. The baseline survey provides information to be fed into the process of the HII, allowing for fine tuning and increasing the chances of success.

The objectives of the survey are as follows:

- * To assess and compare the use and experience of, and satisfaction with, services provided by the four district hospitals and the medical college hospital in Sylhet division
- * To offer insights into reasons for current community usage patterns, and actionable areas for improvement, that can be incorporated in the HII planning and implementation.
- * To serve as a baseline for measuring the effects of the HII, with a repeat survey later in the project.

Methods

The methodological approach follows that used in the CIET baseline Service Delivery Survey for the HPSP. Annex 1 gives an outline of the methodological approach.

The survey sample

Community sample

The four district hospitals and one medical college hospital in Sylhet division are included in the pilot HII. For each of these hospitals, a community sample was designed to include communities close enough to the hospital to make access to the hospital for primary as well as secondary care feasible and to include both urban and peri-urban communities. Communities within the agreed access area were stratified into urban and peri-urban/rural types. Within each group of communities a sample ward or village was selected, based on local knowledge, giving two sample communities (sites) per hospital. Each sample site will consist of an enumeration unit of around 100-150 households, and all households in the site were surveyed.

Hospital outdoor patients

For each hospital, consecutive patients from morning and afternoon clinics were interviewed as they left the hospital. In the Medical College Hospital, the sample included patients who had attended different specialty clinics.

Hospital indoor patients

For each hospital, a randomly selected group of indoor patients was interviewed. If a patient was unable to respond to the interview, his or her attendant relative was approached for the interview.

The survey instruments

Survey instruments were developed in consultation with the HII programme managers, the DPM in the Directorate of Hospitals and Clinics and other relevant individuals and agreed with the Director of Hospitals and Clinics. These instruments drew on experience of similar surveys elsewhere and used standard questions where possible to allow relevant comparisons. The instruments were piloted before finalisation, with minor changes as a result. The survey instruments are reproduced in Annex 2.

Training and fieldwork

Two field teams were recruited from among university students and graduates in Sylhet. Each field team comprised six female interviewers and two supervisors: one male and one female. A four day training course, covering the survey process and instruments and including both classroom and field training, was held in Sylhet. This included a practical test and only those who were successful in the test were included in the final fieldwork teams. The female supervisors had previously taken part in the 1999 CIET national baseline Service Delivery Survey so had experience of the CIETeurope April 2000

methodology. The training was undertaken by a CIET researcher and by the Bangladeshi field coordinators of the survey, who had previous experience with field supervision in the baseline SDS survey. The supervisors of the field teams received additional training, both classroom and in the field, in the conduct of focus group discussions.

Data collection took place over about two weeks in November 1999, including the household survey and the interviews with hospital patients and the hospital Institutional Reviews. Each team covered the households in the sample communities and the district hospital in two districts and the two teams together covered the Sylhet medical college hospital outdoor patient and indoor patient interviews.

After preliminary analysis of the findings from the household and patient interviews, focus group discussions were held in February 2000 in the same communities where the household survey was conducted. The focus groups were homogeneous with respect to factors such as socio-economic status and age (as well as being single-sex) with 8-10 participants in each group.

Data management and analysis

Data entry took place in Dhaka and was programmed using the Epi Info software package. All data were entered twice and verified. After cleaning, preliminary analysis investigated frequencies and major relationships in the data. The results of the preliminary analysis were discussed in community focus groups.

More definitive analysis explored contrasts in the data and incorporated the qualitative data from the focus groups and data from the institutional reviews and interviews with hospital administrators. Analysis made use of the Epi Info software package.

Quality control in data collection, data management and analysis

The training emphasized the importance of care and attention to detail in interviewing and recording responses. Only interviewers reaching a good standard in the training were selected. During fieldwork, the team supervisors checked the work of the interviewers, checking with some of the visited households and checking the quality of the data recorded. Any problems were thus rectified. The field coordinators and the CIET researcher also visited the field sites to check on the progress of the field teams in the different districts.

Data entry operatives were trained and supervised. A data entry programme created in Epi Info reduced logical errors during initial data entry and double data entry with validation helped to identify and correct keystroke errors. Further cleaning with logical checks was carried out on the completed data set prior to analysis.

Findings

Note that detailed tabulations of the findings are given in Annex 3. This section of the report describes the findings and shows them graphically.

1. The survey populations

Household respondents

Information was collected from 1149 households. Some 50% (578) were in urban sites and 50% (571) in peri-urban sites. The respondents in most of the households were female (79%; 905/1148), the proportion being slightly higher in the peri-urban sites (82%; 467/571) as compared with the urban sites (76%; 438/577). In 71% (817/1149) of the households the respondents were either heads of the household or their spouses.

Most of the household heads were reported to be male (81%; 925/1148). This proportion was higher in urban areas (84%; 483/577) than in peri-urban areas (77%; 442/571). Just over half of the household heads (57%; 655/1147) were reported to be literate. The literacy rate of the household head was higher in urban (77%; 442/577) than in peri-urban (37%; 213/570) settings. The average household size was six people (with no significant difference between urban and peri-urban areas).

In male-headed households, the main occupation of the head was reported to be sales/business (34%) followed by public service (16%) and labourer either skilled (11%) or un-skilled (10%). Only 9% of the male head of the households were reported as unemployed. Most of the female heads, on the other hand, were housewives or unemployed (62%), 12% reported sales/business as their main occupation and 8% reported working as unskilled labourers (see Table 2, Annex 3).

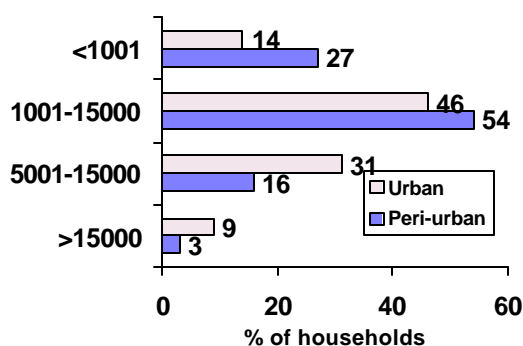


Figure 1. Average monthly income (Tk) among households.

areas (9%; 49/578). One third of the households (34%; 389/1149) interviewed reported living in a rented house. As expected, there are more rented houses in urban areas (49%; 286/578) than in peri-urban areas (18%; 103/571). (Table 1, Annex 3)

Figure 1 shows the average monthly income in urban and peri-urban households. Overall, some 21% (235/1145) households reported an income below 1001 Tk per month. Urban households tended to report higher incomes.

Nearly a fifth (20%; 229/1148) of the households were living in the poorest housing conditions (Katcha-2), the proportion being higher in peri-urban settings (32%; 180/571) than in urban

Hospital outdoor patients

Some 308 outdoor patients were interviewed in the five hospitals as they left the hospital.

Virtually all the outpatients interviewed were from the same district as the hospital was situated except for the Medical College Hospital and Sylhet district hospital where about 5% of the patients interviewed were from outside Sylhet district. In the case of the district hospitals, nine out of ten patients were from the district headquarter town or the urban area in the immediate vicinity of the hospital. Even for for the medical college hospital eight out of ten patients were from Sylhet town. Although District hospitals are meant to be secondary or tertiary referral centres, it seems that use of district hospital outdoor services is mainly by patients who live nearby.

Almost all the hospital outdoor patients lived very close to the hospital.

Slightly more than half the outdoor patients interviewed were women. The majority (74%; 227/308) were over 14 years of age. Less than half of the outdoor patients interviewed were literate (39%; 120/308).

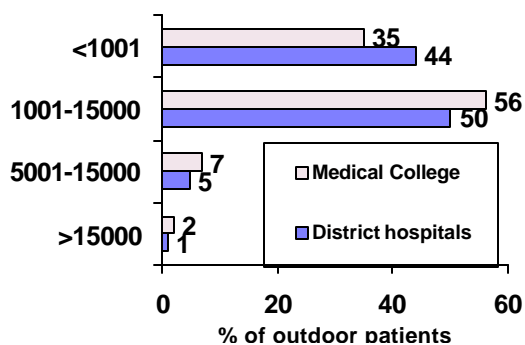


Figure 2. Average household monthly income (Tk) among outdoor patients

Figure 2 shows the average household monthly income reported by the outdoor patients interviewed. A relatively high proportion come from households with a monthly income less than 1001 Tk, compared with the general household survey (see Figure 1). Among the outdoor patients interviewed in the medical college, there are less with a monthly income less than 1001 Tk and less living in Katcha-2 houses (11% vs 23%) than among the patients visiting the other district hospitals. (Table 4, Annex 3).

Hospital indoor patients

Some 309 indoor patients were interviewed in the five hospitals. Most (84%; 258/304) were from the same district where the hospital was situated. However, Sylhet Medical College Hospital received more patients (33%; 34/104) from other districts compared with the district hospitals (8%; 17/205). An indoor patient in a district hospital is five times more likely to be from the same district where the hospital is situated, compared with a patient in Sylhet Medical College Hospital (OR; 5.37; 95% CI: 2.68-10.84). Among the four district hospitals, Sylhet district Hospital had the highest proportion (23%; 11/48) of inpatients from districts other than Sylhet.

More than half the indoor patients (56%; 170/306) were from the district head-quarter town or urban area in the immediate vicinity of the hospital. The proportion was higher for Sunamganj district hospital where 81% (43/53) of the indoor patients were from the district head quarter town, followed by Maulavi Bazar (64%; 33/52).

The intention was to include a spread of age and sex among the indoor patients interviewed. In the district hospitals, just over half (57%) the indoor patients interviewed were male, but a higher proportion (71%) were male in the medical college. Some 28% of those interviewed (directly or by proxy) in the district hospitals were under 15 years old, while only 11% were in this age group in the medical college. The more complex distribution of patients in different specialized wards at the medical college hospital made it difficult to get a balanced age and sex distribution among the patients interviewed.

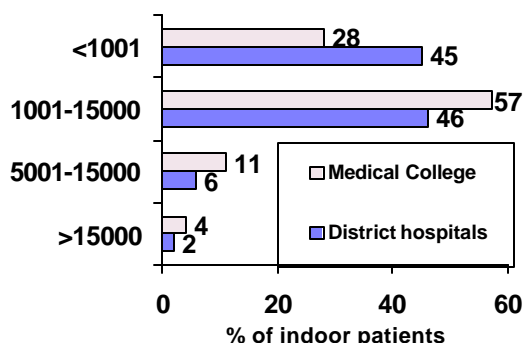


Figure 3. Average household monthly income (Tk) among indoor patients

Figure 3 shows the distribution of average household income among indoor patients. This is similar to that among outdoor patients (Figure 2) and again rather higher than in the household survey (Figure 1). Indoor patients in the medical college are apparently better off. Compared with an indoor patient in the medical college hospital, a patient interviewed in a district hospital was twice as likely to belong to a household with an average monthly income less than 1000 Taka

(OR 2.09; 95% CI 1.21-3.62); and two and a half times more likely to be living in a Katcha (katcha1 or katcha2) house (OR 2.56; 95% CI 1.50 – 4.37).(Table 6, Annex 3)

2. Household knowledge and opinions about the hospitals

Virtually all the households have heard of their local district hospital except for Sylhet District Hospital where only 80% (195/243) of peri-urban households have heard of it. Overall, nearly half (45%) of the households had a bad opinion about their district hospital (Figure 4).

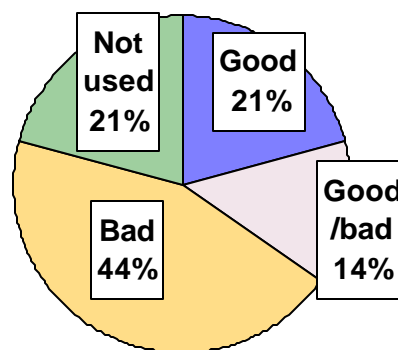
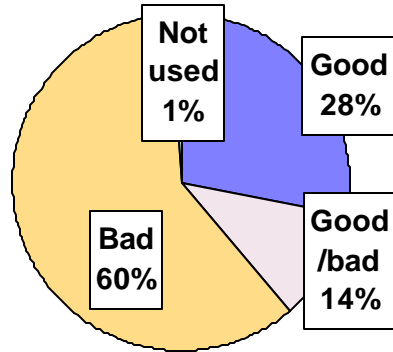


Figure 4. Household opinions of their district hospital.

The situation was apparently worse for Sylhet Medical college hospital (this question was only asked in communities in CIETeurope April 2000

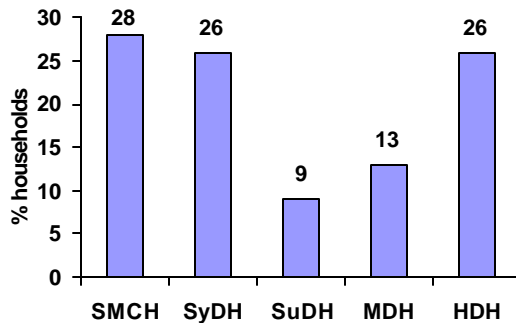
Sylhet district) for which 60% (296/496) of the households expressed a bad opinion. (Figure 5). However, the proportion of households having a good opinion of the medical college hospital was higher than for the district hospitals (compare Figure 4 and Figure 5); the main difference is that less people have 'no opinion' about the medical college.



The proportion of households having a bad opinion of the medical college hospital was higher in peri-urban areas than in urban areas. (Table 7, Annex 3)

Figure 5. Household opinions of Sylhet Medical College Hospital.

Figure 6 shows the proportion of householders who rated services from individual hospitals as good. Of the four district hospitals, those in Sunamganj and Maulavibazar districts fared worst in terms of people's opinion with only 9% and 13% rating their services as good. The situation superficially looks better for Sylhet district hospital where 26% of the households rated the services as good. However, for Sylhet district hospital a good proportion of people (47%; 230/494) did not express any opinion:



they either did not know about the hospital or did not use its services (see Table 8, Annex 3). These figures suggest that the presence of Sylhet Medical College Hospital nearby has resulted in under-use of Sylhet District Hospital. The proportion who reported not using the services of Sylhet District Hospital was higher for peri-urban areas (53%; 127/241) than for urban areas (41%; 103/253).

Figure 6. Proportion of households who rated hospital services as good

3. Illness and use of health facilities reported by households

Reported illness in households

Over half (54%; 624/1149) of the households reported at least one member ill in the last month. Of those reported ill over half (55%; 592/1083) were female. One fifth (22%; 230/1083) of the reported ill members were less than five year of age, while over half (53%; 580) were aged 15 years or more.

Choice of health facility for illness

Information was collected from households about their use of different types of health facilities. Two different sets of information were obtained. First, household respondents were asked about which health care facility they visited first for ill family members in the last month, in an open question. Second, they were asked direct questions about their use in the last twelve months of the District Hospital, Sylhet Medical College Hospital, private medical care, and traditional and religious methods.

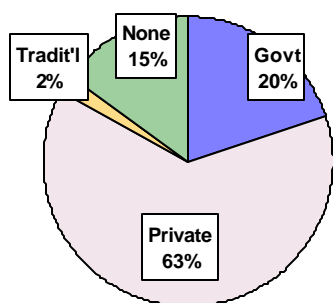


Figure 7. Household choice of health care for ill family members

Figure 7 shows the first choice of health facilities reported by households. Almost two thirds of ill family members were first taken to a private health facility. For only a fifth a government health facility (UHFWC, THC or hospital) was preferred. Very few ill members reported visiting traditional or religious healers as their first choice. Some 15% of ill family members were not taken anywhere and were either self treated or received no treatment at all.

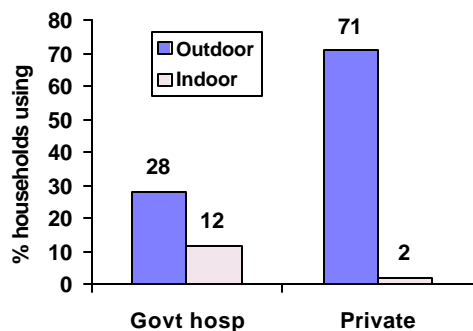


Figure 8. Household use of government hospitals and private care in the last year

Responses to direct questions about use of facilities as outdoor and indoor patients in the last year revealed that households seem to choose private medical care for outdoor patient services and government facilities for indoor patient services (Figure 8). More than a quarter of the households had at least one member who had visited the medical college or a district hospital for *outdoor patient* services. On the other hand, nearly three quarters of the households reported using outpatient private medical care during the same period. One out of ten households reported a visit to the district or medical college hospital for *indoor patient* services, whereas for only 2% households reported using private medical care for indoor patient services.

A quarter (24%; 278/1143) of the households had at least one member who visited a traditional or religious healer for health reasons in the last year. Households in peri-urban areas were three times more likely to report a member visiting a traditional or religious healer in the last year, compared with households in urban areas¹. Among the total of 532 people who visited a traditional or religious healer, less than a third (28%; 151/532) also attended for conventional medical care.

Household use of hospital services

Further information was collected on the total reported 312 outdoor patient visits in the last three months and the 142 indoor patient stays in the last twelve months.

The proportion of female outdoor patients was slightly higher than males. The majority of the patients in both the groups were 15 years of age or older (Table 11, Annex 3). The socio-economic status indicators for patients using hospital services are similar to those in the overall household sample (see Annex 3), suggesting that there is not differential use of district hospital facilities by socio-economic status.

Households were asked about their use (as outdoor or indoor patients) of the district hospital in their own district. In Sylhet, they were asked about their use of both the district hospital and the medical college hospital. Almost all the hospital contacts reported from Sylhet households were with the medical college hospital (96% of the 190 outdoor patient visits and 90% of the indoor patient stays). The presence of the medical college hospital in Sylhet district is apparently undermining the use of the district hospital by the local communities. The medical college hospital seems to be functioning as a district hospital rather than as a referral centre.

¹ 193/567 (34%) vs 85/576 (15%); Odds Ratio 2.98 (95% CI 2.21-4.03)
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4. Referral to hospital services

Household reports

One reason for the apparent under-use of the Sylhet district hospital could be the lack of an effective referral system from the district hospital to the medical college hospital and failure to share the client burden appropriately between these hospitals. There is clearly not a well-functioning referral system. Almost all (97%; 302/312) of the outdoor patients reported from households and 87% (123/142) of the indoor patients visited the hospitals directly without going to any other primary or secondary level facility. The medical college hospital was no exception: 98% (178/182) of the outdoor and 84% (65/77) of the indoor patients came directly. Figure 9 shows the main reasons reported by household patients for choosing to visit the hospital directly instead of going to any other health facility first.

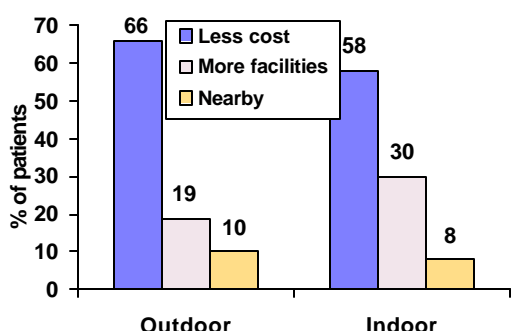


Figure 9. Main reasons reported from households for visiting hospitals directly

Figure 9 shows the main reasons reported by household patients for choosing to visit the hospital directly instead of going to any other health facility first.

Focus groups in the same communities as the household survey confirmed that people prefer to go directly to the medical college or district hospital because they consider there are more and better services and facilities there

I went to the gynae department with my wife but there was no lady doctor. Then a male doctor wanted to examine and treat my wife, to which I did not agree. I was therefore compelled to take my wife to Sylhet Medical College hospital from a long distance.

Male Focus group, Maulavibazar

(see Annex 4). Male groups in particular mentioned that doctors and medicines are not available at the UHFWC or the THC, or that the THC is often closed. The focus groups, unlike individual household respondents, did not mention cost as a major reason for going directly to the medical college or district hospital.

Outdoor patient reports

Nearly all (94%; 288/308) of the outdoor patients interviewed as they left the hospitals had visited both district and medical college hospitals directly, bypassing other health facilities or providers. The proportion who visited directly was somewhat lower for the medical college hospital (86%; 88/102) than for the district hospitals (97%; 200/206). Figure 10 shows the main reasons reported by the outdoor

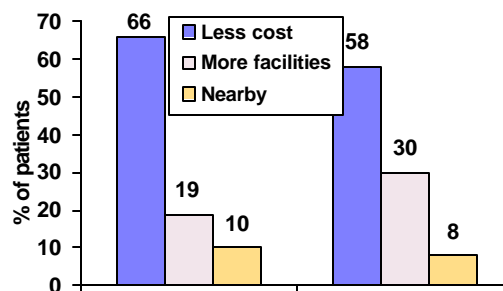


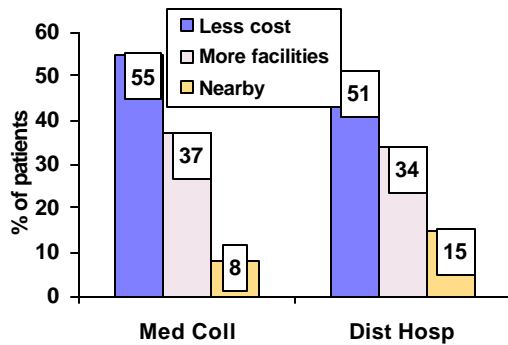
Figure 10. Main reasons of outdoor patients for visiting hospitals directly

Figure 10 shows the main reasons reported by the outdoor

patients for choosing to visit the hospital directly instead of going to any other health facility first. A quarter of the patients mentioned good quality of services or better facilities as the reason for visiting the hospital directly. Being nearby was an important factor for the district hospitals but not for the medical college hospital.

Indoor patient reports

Only three out of ten (29%; 89/308) indoor patients interviewed reported being



referred to the district or medical college hospital. The proportion was somewhat higher in the medical college hospital (37%; 38/104) than in the district hospitals (25%; 51/204). More than half of the patients who were in the hospital without referral reported going there directly because of low cost and a third mentioned good service or more facilities as the main reason. (Figure 11).

Figure 11. Reasons of indoor patients for going directly to the hospital

5. Experience of hospital services for outdoor patients

Nearly all (95%; 298/312) the outdoor patients reported from households visited the hospital to seek treatment for illness. Only 5% reported visiting for services such as vaccination, antenatal care or family planning. This may be appropriate since the purpose of these hospitals is to provide tertiary care.

The data from the outdoor patients interviewed as they left the hospitals confirmed the household data: only one patient in the medical college hospital and 8 in the district hospitals reported being there for services such as vaccination, antenatal care or family planning.

Four out of ten outdoor patients (40%; 40/101) had two or more relatives accompanying them. In the district hospitals this proportion was lower, and only 18% of the patients had two or more attendants with them.

Costs and payments

Cost of travel

The overall average cost of travel for outdoor patients interviewed was 34 Taka (range 2-300 Taka). The travelling cost was higher for the medical college hospital (51 Taka; range 2-300) than for district hospitals (25 Taka; range 2-200), probably reflecting the wider catchment area for the medical college hospital.

Indirect costs due to loss of earnings

Overall 23% (50/220) of the patients reported that they or their companions took time away from money earning activities to visit the hospital. The proportion was slightly higher for the medical college hospital (27%; 23/86) than for district hospitals (20%; 27/134) but this difference could have occurred by chance. In both the settings the average loss of income was 71 Taka.

Cost of services

Outdoor patients were asked how much they paid for the registration fee, medicines, and laboratory investigations

and x-rays (where applicable).

The official registration fee for the hospitals ranged from

Outdoor patients frequently pay more than the official registration fee.
--

2.2 Tk at Maulavibazar hospital to 5 Tk in the medical college hospital. Only two patients at the medical college hospital reported a payment that was more than the official registration fee. However, the situation is different in district hospitals. Thus at Sunamganj and Hobiganj 6% of the patients paid more than the official registration fee. At Sylhet district hospital 23% of the patients paid one Taka more than the payable amount. In Maulavibazar hospital, 87% of the patients paid more than the official fee. What apparently happens in Maulavibazar hospital is that the official fee is 2.20 Tk, but the registration clerk does not give change when the patient gives them 3 Tk, and hence they receive 0.80 Tk per patient more than the official fee.

There were not enough data to comment upon the charges for x-rays and laboratory services, as of all the patients only eight (five from the medical college hospital) reported requiring an x-ray while only 11 (eight from the medical college hospital) required laboratory investigations.

Officially no separate charge is made for medicines in government hospitals: they are distributed free to the patients on official prescription. Of 255 patients who received at least some medicines from the hospital only three (two from the medical college and one from Sunamganj district hospital) reported having to pay for the medicines they received. One at Sunamganj paid 20 Taka whereas two at the medical college paid 60 and 100 Taka respectively.

Un-official and extra payments

None of the outdoor patients interviewed in the medical college hospital reported making an unofficial or extra payment. However, five patients in Sunamganj hospital and four in Maulavibazar hospital reported making un-official or extra payments. When asked to whom they paid extra, eight of them reported that they had paid the registration clerk.

Some 5% (17/312) of the outdoor patients reported in the household interviews said they made unofficial or extra payments: six paid extra to the registration clerk, four to the doctor, three to the ward-boy and two to the pharmacist.

There may be under-reporting of extra or unofficial payments made by outdoor patients, and patients may not understand which

Few of the outdoor patients interviewed reported making an unofficial payment.

payments are official and which are unofficial. Focus groups expressed concern about having to make unofficial payments to health workers and agents (see section 7 below), so they may be more common than is apparent from the reports of the outdoor patients interviewed.

Source of funds to cover costs of outdoor patient visits

Overall three quarters (74%; 218/308) of the patients reported using their own money to make the necessary payments. A quarter (25%; 74/308) reported that they had to borrow money to pay the costs. A few patients also reported having to sell assets (3%) or take help or donations (6%) from others to cover their expenses. The high reported need to borrow money to meet costs may seem surprising. However, many of the patients are very poor and the visit requires not only direct costs but also indirect costs as well as unofficial or extra

A quarter of outdoor patients had to borrow money to cover the costs of the visit.

payments which some of the patients have to bear. This need to borrow money to cover costs suggests patients have difficulty coping with the present costs of outdoor patient hospital visits and would have even more difficulty if fees were increased.

Waiting time

Among the outdoor patients interviewed as they left the hospital, the average waiting time for registration was 18 minutes with almost 70% of the patients reporting that they did not have to wait for more than 15 minutes for registration. There was no major variation between hospitals except for Hobiganj district hospital where the average waiting time for registration was 12 minutes with 82% reporting that they got registered within 15 minutes.

The average waiting time to be attended by a doctor or health worker following registration was 32 minutes with 74% of the patients reporting that they were seen by a doctor within 30 minutes of registration. The waiting was lowest for Hobiganj (9 minutes) and highest for Sunamganj (58 minutes).

Only 35% (104/308) of the outdoor patients reported that they were able to sit down while waiting to

Only a third of outdoor patients were able to sit while waiting to see the doctor.

be seen by the doctor or other health worker. The situation was worst at Sunamganj hospital where only two patients reported they were able to sit while waiting. Hobiganj hospital had the best arrangements so that 84% (43/51) were able to sit down while waiting, followed by Sylhet hospital (35%). The data agree with the findings from the institutional review where seating arrangements were noted to be adequate only in Hobiganj and Sylhet district hospitals (see Annex 5).

Attendance by doctor or other health worker

Among the household reports of outdoor patient visits, all but five of the 312 reported patients were attended by a doctor or health worker. The majority (70%; 216/307) were seen by a male doctor or health worker; female patients were somewhat more likely to be seen by a female doctor or health worker compared with male patients².

Similarly, all but 13 (4%) of the 308 outdoor patients interviewed reporting being attended by a doctor or other health worker. Overall, 71% (208/293) were seen by a male doctor or health worker. In Sunamganj and Hobiganj district hospitals, all the patients were attended by a male doctor or health worker. The situation in Sunamganj was not surprising, since it was reported during the institutional review that they do not have any female medical officers. However, it was surprising for Hobiganj as they reported having three female medical officers including a gynaecologist on the staff. The proportion seen by a female doctor or health worker was highest (68%; 32/48) for Sylhet district hospital.

Nearly three out of ten (29%; 85/290) of the patients reported that the health worker or doctor spent one minute or less with them and only 10% (28/290) reported that the doctor or health worker spent more than five minutes in the consultation. The

² 62/180 (34%) vs 29/126 (23%). Odds Ratio 1.76 (95% CI 1.01-3.06)
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reported time spent with doctor or health worker was longer in the medical college hospital than in the district hospitals (Figure 12). Some 21% of outdoor patients in the medical college hospital had a consultation lasting more than five minutes,

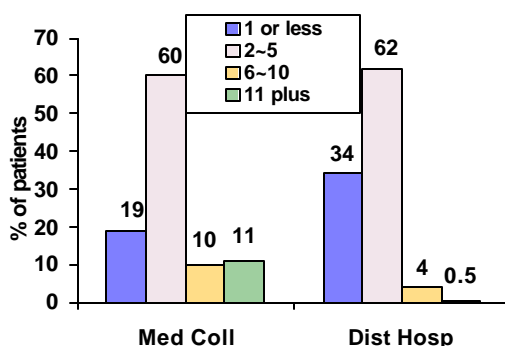


Figure 12. Consultation times (mins) in medical college and district hospitals

compared with only 4.5% of those in the district hospitals. Consultation times were somewhat longer in Hobiganj hospital, with 8% (4/51) longer than five minutes, compared with the other district hospitals. In Sylhet district hospital, all consultations were five minutes or less (see Table 18, Annex 3).

and the duration of the clinics allowed a calculation of the maximum average time per patient consultation, assuming all doctors worked the full hours of the session and there were no non-consultation activities (see Annex 5). Actual consultation times will clearly be shorter than these potential maximum times. Nevertheless, the longest potential consultation times were in the medical college hospital and the shortest in Sylhet district hospital, tending to validate the outdoor patient reports of their consultation times.

Data collected in the institutional reviews on the number of outdoor patients on the day of the survey, number of doctors attending the clinics

Privacy during consultation and examination

Nine out of ten (92%; 269/295) outdoor patients interviewed reported that they consulted the doctor or health worker in a room with the door open. Nearly half (46%; 133/295) reported that there were other patients in the same room at the time of consultation, while three quarters (74%; 216/295) reported that there was no screen between them and any other patients in the room. The situation for privacy was reported as more or less the same for the medical college and district hospitals.

Only a quarter of the outdoor patients (27%; 79/308) reported being physically examined by the health worker. The proportion reporting a physical examination was higher for the medical college hospital (35%) than for district hospitals (23%; 47/206). Since the consultation and examination were done in the same place, the privacy during examination was no better than that for consultation.

Prescription and receipt of medicines

From the household reports, among the 307 outdoor patients seen by a health worker or doctor, 95% (291) were prescribed medicines. However, only 16% (48/291) reported that they received all the prescribed medicines from the hospital and 41% (120/292) did not receive *any* of the prescribed medicines from the hospital. Most of them (78%; 93/119) reported they had to buy the unavailable medicines from an outside drug shop. There were five patients who reported that they could not get the prescribed medicines at all as they were not able to buy them from outside.

According to household reports, only 16% of outdoor patients received all the prescribed medicines from the hospital.

All but five of the outdoor patients interviewed in the hospitals and seen by a doctor or other health worker were prescribed medicines, nearly always (98%; 278/284) using an official prescription. Of those prescribed medicines, almost two thirds (64%; 181/283) reported that they received all the prescribed medicines from the hospital. One out of ten patients (10%; 28/283) reported that they did not receive any of the prescribed medicines from the hospital.

Among outdoor patients interviewed in the hospitals, two thirds (64%) reported they received all the prescribed medicines.

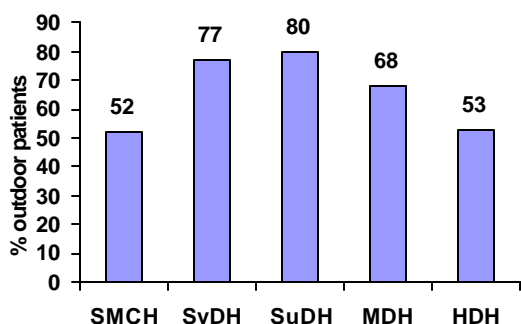


Figure 13. Proportion of outdoor patients in hospitals getting all prescribed medicines.

There was some variation in the proportion of outdoor patients getting all the prescribed medicines between hospitals (Figure 13). Outdoor patients were less likely to get all the prescribed medicines from the hospital in the medical college hospital (52%) and in Hobiganj hospital (53%) (See Table 19, Annex 3). The highest proportion of patients receiving all prescribed medicines was in Sunamganj hospital (78%). It could be that there are prescribing differences between the hospitals. The hospitals with the

longest consultation times (the medical college hospital and Hobiganj hospital) have the least availability of prescribed medicines, while Sunamganj has the shortest consultation times and the highest availability of prescribed medicines. Perhaps fewer medicines are prescribed in Sunamganj, or only very basic medicines, while perhaps more, and more specialised, medicines may be prescribed from the medical college hospital and Hobiganj hospital.

The reason for the big discrepancy in reported availability of prescribed medicines between household reports of outdoor patient visits and interviews with outdoor patients in the hospitals is not clear. There may have been bias in the recall of the

events by household respondents, although it is unclear why their recall should be biased towards not having medicines available. The hospitals were aware of the days when patient interviews were taking place, so they may have tried harder to ensure medicines were available on those days.

Table 20 in Annex 3 gives the list of medicines reported by outdoor patients as not being available from the hospital pharmacy. These medicines were noted down from the prescription provided to the patient. This list is incomplete; there were other prescriptions which interviewers could not read due to poor hand writing.

Outdoor patients who did not receive all the prescribed medicines from the hospital were asked whether they would buy the medicine from outside. Most of these patients (81%; 83/101) said they intended to buy the medicines from outside. Seven out of ten such patients showed a strong willingness to do so by saying that they would somehow buy them even if they could not afford them.

Follow up to the outdoor hospital visit

Three out of ten (31%; 89/289) of the outdoor patients interviewed as they left the hospital said they were advised to come back to the hospital for follow-up. From all five hospitals only 11 patients reported that they were referred to some other health facility. Asked what they would do if their condition got worse, most (70%, 198/284) patients said they would come back to the same hospital. A quarter (25%; 70/284) said they would go to another (usually private) doctor or facility and 5% (16/284) said they would 'do nothing' or 'not come back here'.

Most (70%) outdoor patients said they would come back to the same hospital if their condition got worse.

Household respondents were asked about hospital visits after the event and so could report on where they went subsequently (if anywhere), with the same health problem. Almost a third (32%; 100/312) of the patients reported visiting another health facility after visiting the hospital, for the same health problem. In nine out of ten cases (92%; 88/96), the second visit was to a private health facility. Visiting another health facility after visiting the hospital, for the same health problem, can be seen as an indirect indicator of dissatisfaction with the services of the hospitals.

A third of outdoor patients reported from households visited another health facility after the hospital, for the same health problem.

6. Satisfaction with hospital outdoor patient services

Overall satisfaction

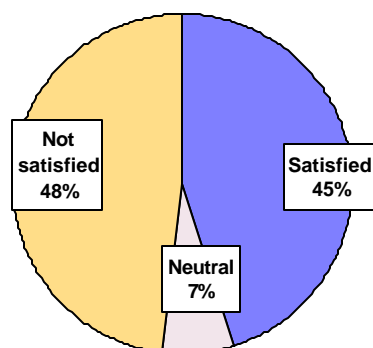


Figure 14. Overall satisfaction of hospital outdoor patients

Less than half (45%; 131/288) the patients interviewed on leaving the hospital expressed overall satisfaction with the visit (Figure 14). Satisfaction was lowest for visits to Sunamganj hospital (30% satisfied) (see Table 21, Annex 3).

Cleanliness

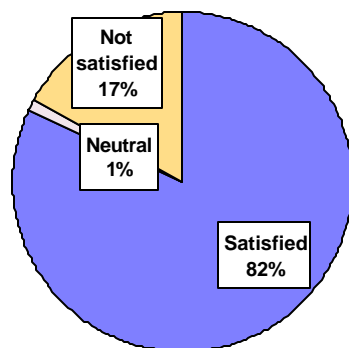


Figure 15. Satisfaction of hospital outdoor patients with cleanliness.

Most (63%; 192/304) household respondents who reported an outdoor patient visit said they were satisfied with the cleanliness of the facilities (see Table 22, Annex 3). Satisfaction with cleanliness was rather higher (82%; 239/290) among outdoor patients interviewed as they left the hospitals (Figure 15). (see Table 23, Annex 3).

The highest proportion of outdoor patients satisfied with cleanliness of the facilities was amongst those interviewed in Hobiganj hospital (100%) and lowest among those interviewed in Sunamganj hospital (66%).

The visiting teams who undertook the institutional reviews of the hospital outdoor patient facilities noted them to be adequately clean, including the consulting room. However, toilets were dirty in most cases, except in Hobiganj hospital where they were noted to be clean. None of the outdoor patient areas had a separate toilet for women.

Privacy

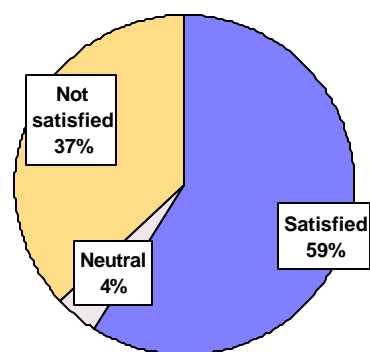


Figure 16. Satisfaction of hospital outdoor patients with privacy

Most (65%; 200/288) household respondents reporting outdoor patient visits said they were satisfied with the privacy of the facilities. Among outdoor patients interviewed in the hospitals, more than half (59%; 169/288) said they were satisfied with the privacy of the facilities (Figure 16). Satisfaction with privacy was lowest (32%) among outdoor patients interviewed at Sunamganj hospital (see Table 24, Annex 3).

Behaviour of staff

Satisfaction with staff behaviour

There was generally high reported satisfaction (83%) with the behaviour of the registration clerk among household respondents reporting outdoor patient visits (see Table 22, Annex 3). Similarly, among outdoor patients interviewed in the hospitals, 89% said they were satisfied with the behaviour of the registration clerk (Table 23, Annex 3). There was little difference between hospitals in satisfaction with the registration clerk.

Satisfaction with the behaviour of the doctors and other health workers was less high. Among household respondents reporting outdoor patient visits, 57% (174/306) said they were satisfied with the behaviour of the doctors and other health workers (Table 22, Annex 3). Among outdoor patients interviewed in the hospitals, 58% (168/289) were satisfied with the behaviour of the doctors and other health workers (Table 23, Annex 3). Satisfaction with the doctors and health workers was lowest in Sunamganj hospital (38%) and highest in the medical college hospital (70%). (See Table 24, Annex 3).

Problems noted with staff behaviour

Four out of ten patients (41%; 119/282) interviewed in the hospitals reported some problem in the way doctor or other health worker treated them. For the registration clerk this proportion was less (12%; 33/287). The most common problem (25% of patients) noted with doctors' behaviour was 'bad service', which includes such things as not explaining the problem, not examining the patient, not prescribing medicines, being very slow to get to the patient. Some 11% of patients complained that the doctors were not attentive to them and 5% complained of a bad attitude of the doctors or other health workers.

Some 45% of the household respondents reporting outdoor patient visits noted a problem with behaviour of the doctor or health workers and 17% of them noted a problem with behaviour of the registration clerk. The type of problems noted were much the same as those noted by the outdoor patients interviewed in the hospitals.

7. Experience of hospital services for indoor patients

Process of admission

Port of admission

In household reports of hospital admissions, two thirds (65%; 92/142) of the patients said they were admitted through the emergency room, with the remainder (35%; 50/142) being admitted through the outdoor patient department. Similarly, over half (52%; 158/307) the indoor patients interviewed in the hospitals were admitted through the emergency room. The high proportion of emergency admissions in part reflects the high rate of self-referral to hospitals (see section 4 above). It also suggests that many people do not attend the district hospitals or medical college hospital unless they have an acute health problem or injury. Patients with less acute health problems probably attend private medical care if they can (see section 3 above on household use of health facilities). The hospital indoor patients are predominantly emergency self-referrals.

More than half the hospital indoor patients were admitted as emergency cases.

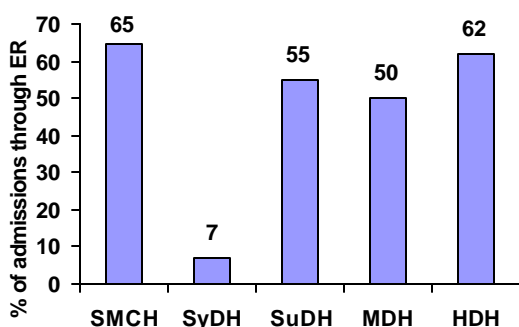


Figure 17. Proportion of indoor patients admitted through ER in different hospitals

Perhaps surprisingly, a somewhat higher proportion of the indoor patients interviewed reported being admitted through the emergency room in Sylhet Medical College hospital (65%; 68/104) than in the district hospitals (56%; 113/203). Only 7% (3/46) of the indoor patients interviewed in Sylhet district hospital were admitted through the emergency room. The striking difference in route of admission of patients in Sylhet Medical College hospital and Sylhet district hospital

(Figure 17) suggests that patients with acute health problems or injuries choose to go directly to the medical college hospital, rather than going first to Sylhet district hospital. The district hospital is under-used and the medical college hospital is not functioning as a tertiary referral centre.

Use of agents to secure admission

Three quarters of the household respondents reporting hospital admissions (77%; 106/138) said they were admitted directly. A quarter (23%; 32/138) of them either had to pay an agent or use some other source within the hospital to secure admission. Similarly, nearly a third (30%; 89/301) of indoor patients interviewed in the hospitals reported that they either had to pay an agent (23%; 70/301) or use a source within the hospital (7%; 19/301) to secure admission.

Nearly a third of indoor patients paid an agent or used a source in the hospital to secure admission.

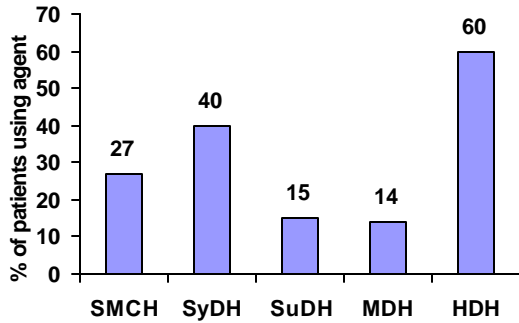


Figure 18. Use of an agent or source in the hospital to secure admission

The proportion using an agent or source in the hospital to secure admission varied between hospitals (Figure 18), being highest at Hobiganj hospital (60%; 27/45) and lowest at Sunamganj (15%) and Maulavibazar (14%) hospitals. The reason for the difference between hospitals is not clear. Part of the reason could be that there is a lower demand from patients for admission to Sunamganj and Maulavibazar hospitals.

Duration of stay in the hospital

About half (51%; 72/142) the indoor patient stays reported by households were for five days or less. Some 18% (26/142) of admissions were for more than 10 days. The mean duration of stay in the hospital was 7.9 days.

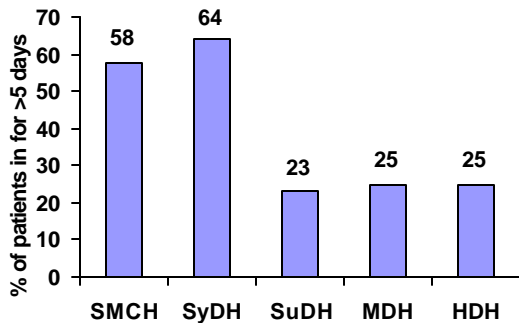


Figure 19. Length of hospital stay at the time of interview

Indoor patients interviewed in the hospitals were asked how long they had been in hospital by the time of the interview. Although this does not give completed length of stay as in the household interviews, it is an indicator of the relative length of stay in the different hospitals. (Figure 19). Overall, about four out of ten (42%; 128/308) of the indoor patients had been in hospital more than five days at the time of the interview. The proportion of patients who had been in

hospital more than five days was higher in the medical college hospital (58%; 60/104) than in the district hospitals (33%; 68/204) (see Table 27, Annex 3). This could be because more complex cases are treated in the medical college hospital, or because more surgical cases are treated there. Figure 17 also shows a high proportion of cases in hospital for more than 5 days in Sylhet district hospital.

Diagnosis

The diagnosis was ascertained, as far as possible, by reference to the patients' charts. A wide variety of diagnoses were noted, with 'injury' (22%; 68/305) and 'delivery' (12%; 36/305) standing out as relatively frequent. (see Table 28, Annex 3). The mix of diagnoses in the sample patients does not necessarily reflect the overall mix in the hospitals, as the sample is relatively small in each hospital and the survey happened on just one day.

Number of attendants staying with the patient

About a third (36%; 51/142) of the household respondents reporting hospital stays said they had two or more attendants staying with them in hospital.

Only one fifth (21%; 62/308) of the indoor patients interviewed in hospital reported having more than one attendant staying with them in the hospital. However, the interviewers noted that almost half the patients (48%; 148/308) had two or more attendants with them at the time of interview. These attendants may not have been actually staying in the hospital, but they nevertheless pose a problem on the wards. The number of attendants per patient was similar for the medical college and district hospitals.

Almost half the indoor patients interviewed in hospital had two or more attendants with them.

The issue of too many attendants and visitors poses a serious problem to the management of hospitals as the environment becomes very crowded and cramped. The institutional review (see Annex 5) noted that the wards are already cramped, with an average space between adjacent beds of about three feet. Excessive numbers of attendants make the hospital more dirty and unhygienic and increase the risk of infection for both the patients their attendants. And attendant(s) staying with the patient in the hospital add some indirect costs to the total expenditure (see below).

Community focus groups discussed the issue of the excessive numbers of attendants with patients in hospital. Some people pointed out that attendants are necessary to help the patients with basic needs.

There is nobody to look after our sick in the hospital. If the patient needs to go to the bathroom, the sweeper and nurse do not help. If he needs medicine nobody is there to run. How can we leave our patient like this in the hospital?
Male focus group, Sunamganj

Asked how to solve the problem of excessive attendants and visitors, most focus groups (see Annex 4) felt that the hospital administration should be stricter and a few groups mentioned that there would be less need for attendants if the doctors and staff provided better care. Groups agreed that communities should help with this issue and suggested educational campaigns to make people aware of the consequences of having too many attendants with indoor patients.

There should be a separate waiting room for visitors to sit and wait to find out about their patients instead of crowding the ward.
Male focus group, Hobiganj

Bed availability

Among the 142 hospital admissions reported by households, information on bed availability was collected on 137 patients. Only seven reported that they did not get a proper bed throughout their stay in the hospital and had to use makeshift arrangements such as a mattress on the floor or on the verandah of the ward. Six of these seven were admitted to the medical college hospital and one was admitted to Hobiganj district hospital. Of those who were able to get a bed (n=130), 79% (102) got it on the day as of admission and 21% (28) had to wait for a bed for a day or more.

Four patients in the medical college hospital and 16 in district hospitals had not been provided with a proper bed by the time of interview and were using makeshift arrangements such as a mattress on the floor or on the verandah. All of these patients had been in the hospital for a day or more. (One at Sunamganj hospital reported that he had been admitted 12 days ago and was still unable to get a bed). Only five of the interviewed patients (two at the medical college and three at district hospitals) were in cabins, the rest being on the general wards. Of 285 patients who were found to have a bed at the time of interview, three quarters (73%; 206/284) reported getting it on the day of admission. The rest of them got a bed on the day after admission.

A quarter of indoor patients did not get a bed on the day of admission.

Costs and payments

Cost of travel

The average cost of travel for indoor patients in all the hospitals was 323 Taka (range 5-6000 Taka). However, eight out of ten (80%) patients reported paying 300 Taka or less, and only one out of ten reported paying 1000 Taka or more. As expected the travelling cost was higher for the medical college hospital (584 Taka; range 6-6000) where 65% of the patients paid 300 Taka or less on transportation. Two out of ten patients reported paying 1000 Taka or more. In district hospitals the average travelling cost was 193 Taka (range 5-3000). Three quarters of the patients said that they paid 150 Taka or less and only 5% reported paying 1000 Taka or more. The higher travel costs for patients in the medical college hospital reflect its wider catchment area.

Indirect costs due to loss of earnings

Four out of ten (41%; 118/290) indoor patients reported that they or their attendants took out time from money earning activities to attend the hospital. The proportion was more or less the same for all the hospitals. The average loss of income reported was 121 Taka (range 15-1000).

Cost of services

Two types of costs are incurred by indoor inpatients. First, they have to pay the hospital for services provided by the hospital. These include admission fee, daily bed charges, charges for food, medicine, and where applicable for ECG, X-ray,

laboratory, surgery, surgical supplies blood and oxygen. Second, they have to pay for services which are not available from the hospital and have to be obtained from outside.

Most patients paid an admission fee. And some 60% or more paid more than the official admission fee for the hospital (as confirmed with the hospital administration). (see Table 29, Annex 3). Not only do many patients report paying more than the official fee but also they pay varying amounts at the same hospital. People are not clear about how much they are required to pay and do not know if they are paying more than the official admission fee.

The main payments of indoor patients to hospitals during their stay are the daily bed charges (see Table 30, Annex 3). Some of the patients who were admitted to the general ward reported paying bed charges whereas according to hospital management they do not charge for general beds. The proportion paying for general beds was higher (24%; 23/97) in Sylhet Medical College Hospital than in district hospitals (6%; 10/183). At the medical college hospital, a patient in a general bed is five times more likely to pay daily bed charges than a patient in a general bed in a district hospital³.

Some 12% of patients on general wards reported paying daily bed charges.

The main external costs for hospital indoor patients are for medicines that they are not able to get from the hospital (see Table 31, Annex 3). Over 60% of all hospital indoor patients have to buy medicines outside the hospital, whether in the medical college hospital or in the district hospitals. For other costs the denominator used was all inpatients, but not all inpatients needed these other services. Hence the proportions paying for these items among only those who require them would be higher.

About two thirds of indoor patients have to buy medicines from outside the hospital.

Unofficial and extra payments

Only six patients in the medical college hospital and seven in the district hospitals reported making any unofficial or extra payment. When asked whom they paid, most of them reported paying ancillary staff such as the aya, cleaner and ward boy.

Source of funds to cover costs of hospital admissions

Six out of ten (63%; 193/309) indoor patients reported that they had to borrow money to pay for their admission. Four out of ten patients (39%; 119) reported using their own money to meet admission costs. A fifth (19%; 60) also reported that they had to sell assets, and 16% (49) mentioned that they were given donations or help from relatives and friends.

Two thirds of indoor patients had to borrow money to cover the expenses of their admission.

³ 23/97 (24%) vs 10/183 (6%). Odds Ratio 5.38 (95% CI 2.28-12.91)
CIETeurope April 2000

Hospital food

Most of the indoor patients (87%; 270/309) received food from the hospital. However, almost half (45%; 122/269) of those who received food reported that it was eaten either by the attendant or someone else rather than the patient. Half (50%; 154/308) the patients said they would be willing to pay for better food from the hospital.

Attendance by the doctor

A total of 13 patients (4%) reported, when interviewed, that they had yet to be seen by a doctor. Of these 6 had already spent two days or more in the hospital. However, of those who were attended by a doctor, nine out of ten (90%; 260/290) reported being attended on the day of admission, three quarters (75%; 217/290) being seen within six hours of admission. Most of the patients (87%; 239/275) reported that the doctor visited them at least once a day. Seven out of ten (70%; 198/281) patients said that the doctor(s) had explained their health problem to them. This proportion did not vary much between hospitals. It was not possible to assess the adequacy of the explanations about the health problem from the doctors; in many cases it may have been no more than telling the patient the diagnosis.

Most (70%) patients reported they were given some explanation of their health problem by the doctor.

Privacy

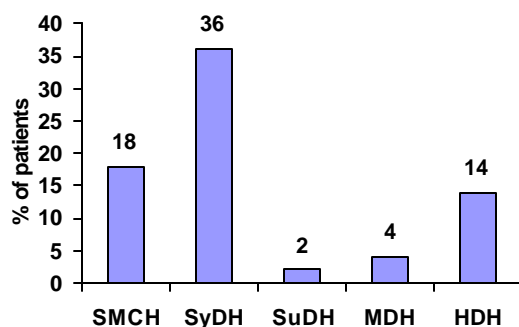


Figure 20. Patients reporting doctors used screens always or sometimes.

Few patients reported that doctors (15%; 44/304) or nurses (14%; 42/305) used a screen always or sometimes when they examined or bathed them in the ward. This is borne out by the findings in the institutional review (Annex 5). In none of the hospitals did the visiting team find a screen available in the wards to be used for examining the patients. The reported use of screens varied between hospitals (Figure 20), being particularly low in Sunamganj and Maulavibazar hospitals.

Prescription and receipt of medicines from the hospital

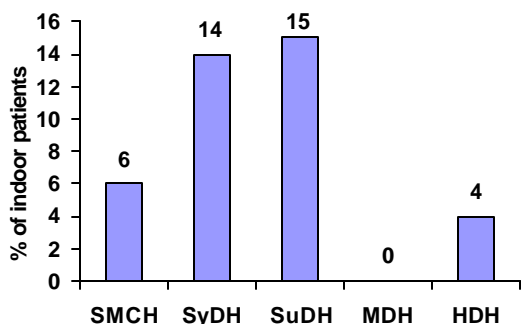


Figure 21. Proportion of indoor patients reporting all prescribed medicines available.

Nine out of ten (89%; 263/294) patients said they were prescribed medicine by the doctor. However, only 19 (7%) patients reported receiving all the prescribed medicines from the hospital. Almost half (46%; 123/263) the patients reported they did not receive any of the prescribed medicines from the hospital; they had to buy them from outside (see above). The proportion of indoor patients receiving all the prescribed medicines

was highest in Sylhet district hospital (14%; 6/42) and Sunamganj district hospital (15%; 6/40) (Figure 21). This variation in availability of all prescribed medicines between hospitals may be partly due to different prescribing habits and different patient mixes between the hospitals.

There is a big discrepancy between indoor patients and outdoor patients in their reporting of availability of medicines. More than half of outdoor patients reported receiving all the prescribed medicines from the hospital, compared with less than 10% of indoor patients. The medicines required for outdoor patients may be simpler and in better supply than the more complex regimes required for indoor patients.

Surgical treatment

A third of the indoor patients (34%; 101/298) reported they were advised surgery, the proportion being higher in the medical college hospital (54%; 54/101) than in the district hospitals (24%; 47/197). This could be due to the lack of appropriate facilities for specialized surgical procedures at district hospitals; hence these hospitals do not admit patients requiring complex surgery.

Of those advised surgery, two out of three (66%; 64/97) reported that they had the surgery done, the proportion being higher for patients in the district hospitals (75%; 33/44) than in the medical college hospital (59%; 33/44). Of 35 patients who had not had their surgery done, 20 reported that they were waiting for their turn while five were declared by the doctors as not fit for surgery due to medical reasons. Seven of the patients could not mention any reason for not having surgery. Only three patients said that they did not have their surgery because of lack of facilities at the hospital.

The institutional review of facilities confirmed the higher capacity for surgical procedures in the medical college hospital, with 12 operating rooms, all functioning. The district hospitals had a maximum of 3 operating rooms. In Sunamganj hospital the one operating room was not working because there was no surgeon on the staff, and in Hobiganj two of the 3 rooms were not working because of lack of equipment.

Referral to other facilities of hospital indoor patients

Household respondents reported that a third (34%; 48/142) of hospital indoor patients visited another health facility for the same health problem after discharge from the hospital. Mostly they went to private medical care (78%; 36/48). This suggests they were not entirely satisfied with what had happened to them in the hospital and still felt the need for further medical intervention.

A third of indoor patients sought medical care elsewhere after discharge, mostly from private facilities.

A quarter (24%; 73/300) of the indoor patients interviewed reported they had been referred to another facility for treatment or investigations. In nearly all cases (96%; 69/72) the referral was to a private facility. Just three patients in the district hospitals reported that they had been referred to the medical college hospital for consultation and advice.

8. Satisfaction with indoor patient services

Overall satisfaction

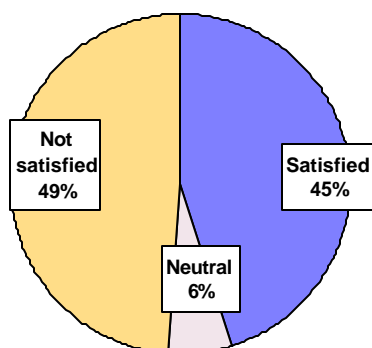


Figure 22. Overall satisfaction among indoor patients interviewed in hospitals

Less than half (45%; 134/295) the indoor patients interviewed said they were satisfied overall with the indoor patient service from the hospital. Figure 22 shows overall satisfaction of indoor patients with the service. There was some variation between hospitals, with highest levels of overall satisfaction among indoor patients in Sylhet district hospital and lowest levels in Maulavibazar hospital (see Table 32, Annex 3).

Cleanliness

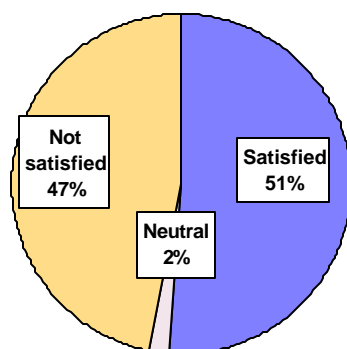


Figure 23. Satisfaction with cleanliness among indoor patients interviewed.

Only about one third of household respondents who reported on hospital admissions were satisfied with the cleanliness of the wards. About half of indoor patients interviewed in the hospitals were satisfied with the cleanliness of the ward area (Figure 23). Satisfaction of indoor patients with cleanliness was highest in Sylhet district hospital (92%; 43/47) and Hobiganj hospital (77%; 39/51), and lowest in Maulavibazar hospital (25%; 13/52).

Privacy

Despite the obvious lack of arrangements for privacy on the wards, over half (55%; 78/142) the household respondents who reported hospital admissions said they were satisfied with the privacy they had been accorded. Nearly half (44%; 135/305) the indoor patients interviewed in hospital said they were satisfied with the privacy on the ward (Figure 24).

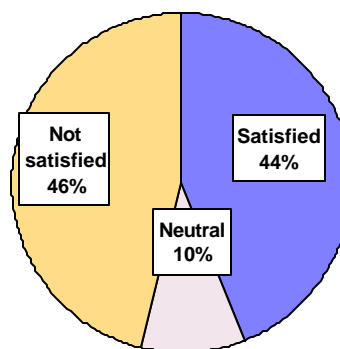


Figure 24. Satisfaction of indoor patients with privacy on the ward.

Behaviour of staff

Satisfaction with staff behaviour

The majority (60-80%) of patients, whether reporting from households or when interviewed in hospital, expressed satisfaction with the behaviour of doctors, nurses and cleaners (see Tables 33, 34 and 35, Annex 3).

Problems noted with staff behaviour

Nearly half of household respondents reporting on hospital admissions cited problems in the way doctors, nurses and cleaners treated them during their stay in the hospital (See Table 36, Annex 3). For doctors the main complaint was of lack of attention (31%; 44/142). This was also a complaint about nurses (19%; 27/142) but with nurses the main complaint was of bad attitude (23%; 33/142). The primary complaint about cleaners was of lack of attention (25%; 35/142). A few household respondents mentioned having to pay extra to staff as a problem.

Indoor patients interviewed in the hospitals had similar complaints about the behaviour of the doctors, nurses and cleaners. But they were rather less likely to have complaints about staff behaviour at all; more than two thirds had no complaints about staff behaviour (Table 37, Annex 3). It is possible that patients might be reluctant to complain about hospital while they are still indoor patients in the hospital, fearing that this could affect their subsequent treatment. The main problems cited included non-attentiveness and bad attitude of the staff.

9. Perceived problems and suggestions about hospital services: views of service users

Respondents in the households as well as the outdoor and indoor patients interviewed were asked for their views about are the main problems with the services of the hospitals and what they would recommend in terms of improvement. Household respondents were also asked specifically about how much they would be willing to pay as an official fee for an outdoor patient visit and as an indoor patient daily fee. The issue of increased user fees was discussed in focus groups. Focus groups also discussed privacy in hospitals and complaints systems.

Main problems with the services

Householders' views

Very few households (4%; (20/441) for Sylhet medical college and 8% (67/704) for district hospitals) did not cite any problems with the services of these hospitals. The most commonly cited problems were **lack of medicines, generally bad service** and **bad attitude of staff** (see table 38, Annex 3).

Views from the outdoor patient interviews

The opinions were not very different from those of householders though a higher proportion stated that they did not have any problem with the services they received from the hospital (15%; 14/92 for medical college hospital and 13%; 26/194 for district hospitals). Table 39 in Annex 3 summarizes the main problems expressed by outdoor patients in the two settings. Again **non-availability of medicines** emerges as a major problem. **Overcrowding** was identified as the second most common problem for the medical college hospital, whereas **staff attitude** was the most common problem cited for district hospitals.

Views from the indoor patient interviews

The main problems identified by indoor patients are similar to those noted by households and outdoor patients (see Table 40, Annex 3). Indoor patients also note **lack of beds** (for the medical college hospital) and **bad food**. Again **lack of medicines** is the most commonly cited problem.

Views from focus groups (See Annex 4)

Focus groups discussed some of the perceived problems with hospital services. They were asked why hospital staff might have a bad attitude towards patients. Many groups (especially of men) said that staff want patients to pay them money and behave badly if they do not get these payments. Other suggestions included that bad behaviour was mainly towards poor people, with rich or well-connected people treated better. Some groups appreciated that staff were overworked and got irritated by the many attendants and constant requests from patients.

Rich patients get special attention. Doctors take care of them all the time. Male focus group, Sylhet

Privacy in hospitals

Serious lack of privacy was reported by outdoor and indoor patients and noted by the team undertaking the institutional reviews. Yet not all patients were dissatisfied with privacy: more than half of outdoor patients said they were satisfied with the privacy arrangements, and more than a third of indoor patients said they were satisfied with privacy. It may be that expectations of privacy are not high and this was explored with focus groups.

When I went to the district hospital the doctor did not use the screen. When I asked he said that if I could visit him in his private clinic he would examine me properly. So I came back without examination.
Female focus group, Sunamganj town

Many female groups felt that there was a system for privacy but it was not used, while male groups thought there was no system for privacy. Problems of male doctors examining female patients were raised by many groups in relation to privacy.

My son's wife and nephew got wounded. We took them to the district hospital. The staff put both of them in the same bed. We could not tolerate that so we took our daughter in law to a private clinic.
Female focus group, Sylhet town.

Most of the focus groups felt that a screen should be used during examinations, a female health worker should examine female patients (and a male worker male patients), and that there should be separate rooms for female and male patients in the outdoor patient facility.

Complaining about hospital services and staff

Well-functioning complaints systems are one way of helping to ensure continuing improvement in quality of services. Yet formal complaining is not commonplace in Bangladesh, even if people are unhappy with the service they receive. Most focus groups said they would do 'nothing' if they had a bad experience at the hospital. They noted that those who could afford it would go to a private facility. Some people (mostly men) said they would complain. Reasons given for not complaining were not knowing who to complain to, feeling there is no benefit to complaining as nothing changes, and a perception that staff become more rude if patients complain.

If we make a complaint it goes against us as they become more rude and sometimes the patient is discharged without treatment.
Male focus group, Sunamganj

More constructively, some people talked about setting up complaint centers, with a remit to take action on the issues raised.

A complaint centre should be organised where hospital authorities, public representatives and an officer from the Thana police station should attend.
Female focus group, Sylhet town

Suggestions for improvement of hospital services

Householders' suggestions

Almost all the households felt that there was a need for improving various aspects of the services of district and medical college hospitals. The suggestions made by the householders essentially relate to the problems they identified. Thus when asked what would they recommend in terms of improvement the most common suggestion was to improve the **availability of medicines**. Other common suggestions included **better service, attentive staff with good attitude, free or less expensive services, more/good doctors, better management** and a **clean facility** (see Table 41, Annex 3).

Suggestions from outdoor patient interviews

The same pattern of suggestions emerged from the interviews with outdoor patients. They also specifically suggested **more seats** in the outdoor patient department and **free medicines** for outdoor patients (see Table 42, Annex 3). Similar suggestions were made both for district as well as medical college hospitals.

Suggestions from indoor patient interviews

As well as suggestions in common with households and outdoor patients, indoor patients specifically suggested provision of **more beds** and **cleaner facilities**. For indoor patients who have to stay some time on the wards the issue of cleanliness becomes more important. Some also requested **better quality food**. (See Table 43, Annex 3).

Views about unofficial payments and user fees

Some people in focus groups thought that extra payments and bribes are inevitable in order to get service.

Nobody can get services in the district hospital without paying bribes.
Male focus group, Maulavibazar

The focus group discussions suggested a difference of understanding between men and women about official and unofficial payments. All ten of

For a woman like me it is not possible to get good service at the hospital as I cannot pay any extra money.
Female focus group, Sunamganj

the women's focus groups said they consider tickets for outdoor patient services to be official charges, whilst the ten focus groups of men said that payments against a receipt are official and payments without a receipt are unofficial.

All the focus groups agreed that unofficial payments to staff or agents are bribery and are bad. Women's focus groups tended to think the payments were bad primarily because people who cannot pay cannot get a good service, while many of the men's focus groups thought unofficial payments were bad because the money does not go to the government.

The focus groups of men and women discussed how they would react to an increase in user charges for hospitals. There was some disagreement, but more than half the groups said they would agree with this but *only* if this led to an improved quality of service from the hospitals (see Annex 4). About half the groups noted that an increase in user fees would make the poor suffer more (unless there was some way to provide free services for those who cannot afford to pay a fee). Some people warned of the difficulty of changing the culture into one where all payments were official.

It's a good proposal as the money would go to the government who could use it to buy medicines and equipment. We would have more facilities, doctors and nurses would be available, more beds in the hospital, no need to buy medicine from outside.
Male focus group, Sylhet town

It's easy to change unofficial payments into official ones in a short time, but changing attitudes is not one day's work. So first change attitudes for improving services, then make the unofficial payments official.
Female focus group, Sylhet town

Community involvement with hospital management

Community focus groups discussed the possibility of future community involvement in management of district hospitals as part of the HII. This idea was well received, with all groups being generally in favour of the proposal. Participants felt it would allow members of the community to communicate their problems and ideas with hospital management more freely. Some people also expressed the view that community involvement should result in improved service quality based on the advice of community representatives.

The proposal is good. It will form a bridge between government and people.
Female focus group, Sunamganj

Suggestions for specific ways the community could be involved included giving advice and opinions, participating in supervision of services, increasing accountability of staff, and establishing a two way system of communication. Many women's groups also suggested the more mundane role of helping to keep the hospital environment clean.

Suggested people from the community to be involved in hospital management included elderly educated people, Parisad council members, religious leaders and school teachers. Most groups felt the community members should be involved in selecting representatives in some way.

10. Perceived problems and suggestions about hospital services: views of service providers

When asked about their opinion about the quality of the services provided by their hospitals, the hospital in-charge in the medical college hospital and the Sylhet and Hobiganj district hospitals regarded the services as good. In Sunamganj and Maulavibazar the in-charge considered them neither good nor bad.

Management at all the hospitals showed a strong concern about the shortage of staff. They demanded that the vacant posts should be immediately filled, especially those of consultants and doctors. At the same time they also suggested increasing the overall number of staff in all categories.

Inadequate supply of materials and equipment especially medicines was an equally important problem identified. This matches with the concerns shown by the patients and respondents at the households. It was suggested that the supplies and medicine should be made available to the hospital in adequate quantity. There should be regular maintenance and replacement of equipment used in the hospitals.

The management were of the view that the hospitals should have discretion to use their own budget and revenue. They suggested decentralization of the authority and power for financial management. They also suggested increasing the sources of revenue generation such as increasing the outpatient fee, bed charges, ambulance fee, and fee for clinical investigations such as x-ray, laboratory tests, etc.

The majority of the hospitals suggested the need for an increase in the number of beds and cabins. In some of the hospitals the administration also recommended improving the range of clinical services available such as adding an ultrasound facility, biochemical and pathological tests and advanced radiological investigations. Other individual recommendations included:

- Maintenance and expansion of hospital space and infrastructure including painting the building every six months
- Training of doctors and other technical staff
- Financial incentives to the staff to improve their motivation and commitment for good quality service.
- Increase in the overall hospital budget.

Conclusions and recommendations

This survey has generated useful baseline information against which to evaluate the success of the Hospital Improvement Initiative in terms of the experience and perceptions of patients (see Table).

Main indicators from baseline survey that can be used to assess effects of HII on experience and perceptions of hospital patients.

Indicator	Baseline value*
<i>Household opinion and use of hospital services</i>	
% households with overall opinion of local hospital as good	21% District hospitals 28% Medical College Hospital
% households using government and private outdoor patient facilities in the last year	28% government 71% private
% households using government and private indoor patient facilities in the last year	12% government 2% private
<i>Referral</i>	
% outdoor patients without referral	97% District hospitals 86% Medical College Hospital
% indoor patients without referral	75% District hospitals 63% Medical College Hospital
<i>Costs</i>	
% who borrowed money for OP attendance	25%
% who borrowed money for IP admission	63%
% patients on general wards paying bed charges	12%
<i>Outdoor patient experience</i>	
% able to sit down while waiting to be seen	35%
% doctor/health worker spent >5 minutes on consultation	10%
% doctor/health worker spent >1 minute with them	71%
% with screen used for consultation/examination	26%
% examined physically	27%
% received all prescribed medicines from hospital	16% from household reports 64% from OP interviews
% satisfied overall	45%
% satisfied with cleanliness	82%
% satisfied with privacy	59%
% satisfied with doctor or other health worker	58%
<i>Indoor patient experience</i>	
% admitted as emergency	52%
% used agent/source in hospital to secure admission	30%
% with two or more attendants at time of interview	48%
% given bed on first day of admission	73%
% with screen always used by doctor when examining	15%
% received all prescribed medicines from hospital	7%
% who bought medicines from outside	60%
% satisfied overall	45%
% satisfied with cleanliness	51%
% satisfied with privacy	44%
% satisfied with doctors	65%
% satisfied with nurses	76%

* The values of the indicators vary between individual hospitals.

A repeat survey at the end of the HII is recommended, including repeat measures of these indicators (table), as a way of assessing the impact of the various aspects of the

initiative on the use of government hospital facilities by households and on the experience and perceptions of outdoor and indoor patients.

The present experience of indoor and outdoor patients in the medical college hospital and the four district hospitals falls far short of the ideal in many respects. There are problems with waiting arrangements in the outdoor patient departments and with bed availability in the wards. Arrangements for privacy are rudimentary and not used when present. Many patients are not able to get the medicines they are prescribed from the hospital and have to buy them outside: this seems to be a particular problem for indoor patients. Patients often pay more than the official fee for registration or admission and some patients in general beds are paying a daily bed fee, although officially they should not do so.

It is recommended that the HII programme is considered in the light of this evidence, to ensure that planned activities will address the problem areas. This should help to emphasize a client centred approach and accountability in the programme.

Increasing stakeholder participation is an important aspect of the HII. The process of this survey has itself served to begin the involvement of communities in a dialogue about the services to be provided from the hospitals. The proposal for involvement of communities in hospital management found favour with focus groups. *Discussion of the findings of this baseline survey with hospital management and community representatives is recommended* as a concrete way to move forward with involving communities in planning for improvement of the service they receive from the hospitals.