Health Needs of Clients as reported by Medical Practitioners from two Districts of Sindh

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Abstract

Objective: To identify the major health and reproductive health problems for which people consult local medical practitioners.
Methodology: Forty-one practitioners completed a self-administered questionnaire. A startified purposive sample of practitioners was selected by asking the community members from various towns and rural areas to identify practitioners who have most busy practices and are perceived as providing quality care.
Results: Nine of the forty-one practitioners were females. Twenty-two were consulted mainly by women and another seventeen by an equal number of women and men. Practitioners pointed to malnutrition, malaria, gastrointestinal and respiratory tract problems as being the most common ailments. They identified menstrual problems, malnutrition among pregnant women, burning micturition and vaginal discharge as the most common reproductive health problems of their clients. Only 16 medical practitioners said that they diagnosed someone in the last one-month as suffering from sexually transmitted infections.
Conclusion: The survey helped in developing an understanding of health issues from provider perspective. Findings indicate a concordance between what has been revealed by previous population based studies in similar situations and to what health problems practitioners pointed as common. While a comprehensive needsassessment requires surveys and qualitative interviews with communities, consultations with relatively fewer medical practitioners could also provide a quick and fair approximation of priority health problems in the area (JPMA 52: 239; 2002).

Introduction

Medical practitioners make one of the most important components of the health system in Pakistan. In 2000, in Pakistan there were 6.7 physicians for every 10,000 people[1]. A large number of these medical practitioners work in the private sector only; many others in the public sector run private practices as well. Medical practitioners in the public and private sectors are the main providers of care. A large number of people consult them for health problems. On an average every Pakistani makes about 5.4 visits to a health care provider annually. Three out of every five of these visits are made to the private medical practitioners[2]. Many of these private medical practitioners also work in the government sector. Medical practitioners are the providers of care again for those 20% of visits that are made to the public sector. Despite a limiting environment of unavailability of diagnostic aids, referral support and lack of opportunities for continued medical education, medical practitioners in small towns and rural areas are providing essential outpatient care. It is, therefore, essential that in addition to consulting the local people, health services planning for any area include perspective of medical practitioners as they could provide insight into the local health problems and access to care issues.
In year 2000, a health needs assessment research was conducted in two rural districts of Sindh

province in order to gather information for planning and implementing a reproductive health program. The aim of that assessment was to understand from community and from local health care providers the locally prevalent health care problems, knowledge of community members about reproductive health problems, health services utilisation patterns and barriers to access health care. As part of this research, local medical practitioners, in both private and public sectors, were consulted. The objective of the survey with medical practitioners was to identify the health and reproductive health problems for which local people consult them.

Methodology

This study with medical practitioners was part of a reproductive health needs assessment project in these districts that included in-depth interviews with key informants and a community survey as well. This paper informs about method and results of the study with medical practitioners. A total of 41 practitioners, 20 in district Khairpur and 21 in district Naushahro Feroze completed a self-administered questionnaire. These medical practitioners were selected through a purposive sample. While conducting in-depth key informant interviews and a community survey in various areas, local community based organisations and community members were asked to identify the medical practitioners who have most busy practices in those areas and are perceived by the community as providing quality care. Medical practitioners from all major towns and rural areas were asked to participate. There was no refusal. The questionnaire included questions on average number of patients seen, common health and reproductive problems including sexually transmitted infections. Questions were also asked about community's use of services by these medical practitioners for family planning related information and utilities. The study was conducted in June 2000.

Study Site

District Khairpur and the adjoining district Naushahro Feroze of Sindh Province are predominantly rural. From administration perspective, union councils, deh/villages are considered as rural area while town committees and cities are urban. However, many small towns of the district have few civic facilities compared to those available in larger cities of the province such as Karachi, Hyderabad or Sukkur. Total population of districts Khairpur and Naushahro Feroze is 1,515,000 and 1,065,000 people respectively. Together these districts have 12 talukas; medical practitioners from towns and rural areas of each of these talukas participated in the survey. The largest cities in these districts are Khairpur (population 102,000) and Moro (population 59,000). District and taluka headquarters cities have government hospitals. While general medical practitioners are available in rural areas and small towns, all of the specialists work in the district and taluka headquarter public hospitals or in the private hospitals in a fewer relatively larger cities of these districts. The exact number of medical practitioners and specialists in these districts is not known. Medical practitioners in the public sector are appointed at the district and taluka hospitals as well as at the 14 rural health centres -- outpatient and in-patient facilities with about 10 beds and 102 basic health units - out-patient and outreach primary care centres[3].

Results

Medical practitioners, forty-one, with at least MBBS (Bachelor of Medicine and Bachelor of Surgery) degree were included in this study. All of them had private practices. Seven of these practitioners, all female, identified obstetrics as their expertise. Two male practitioners identified themselves as surgeons. Ten of the forty-one practitioners were females. This is reflective of the

general situation in these districts as female medical practitioners are relatively few in numbers, particularly in rural areas.

Years of practice in the area

Out of 41 practitioners 31 were practising in those areas for more than five years. Seventeen practitioners were those who had their practice there for more than ten years.

Clients: Gender Mix

Twenty-two medical practitioners said that women constitute a majority of their clients. Another seventeen medical practitioners said that an equal number of male and female clients consult them. Only two practitioners reported that majority of their clients are male. Considering that only ten of these practitioners are women, the situation suggests that women do visit male medical practitioners. It might be indicative of the fact, that women suffer from high morbidity; or that men either use hospitals or alternative health providers.

Major health problems in these districts

The medical practitioners pointed to malnutrition, gastrointestinal, respiratory tract infections and diseases, and malaria as the major health problems in these areas. A few of these medical practitioners also pointed to the unavailability of diagnostic aids such as x-rays and ultrasound as some of the main problems. Eight out of ten females practitioners considered poverty and lack of education as a major problem; only one out of thirty one male prctitioners identified these issues (Table 1).

Table 1. Major health problems identified by medical practitioners.

Major health problem in the area	Female medical practitioners (n=10)	Male medical practitioners (n=31)*
Poverty and Lack of Education**	8	1
Malnutrition	2	8
Inadequate diagnostic aids	2	4
Gastrointestinal problems	0	12
Malaria	0	11
Respiratory Tract Problems	0	8
Tuberculosis	0	4

*Numbers do not add as each medical practitioner pointed to more than one problem.

**P<0.0001 Fishers' $\chi 2$ test.

Reproductive health problems

Medical practitioners were asked to point out the three most common reproductive health problems for which clients consult them.

Table 2. Three most common reproductive health problems of the clients identified by medical practitioners (n=41).

Reproductive Health Problems	Practitioners who considered the problem as of highest prevalence	Practitioners who considered the problem as 2nd highest prevalence	Practitioners who considered the problem as 3rd highest prevalence
Abnormal/irregular menstruation	25	2	3
Malnutrition among pregnant women	7	9	8
Burning micturition	4	12	2
Infertility	3	1	3
Domestic violence	1	1	1
Vaginal Discharge	0	5	11
Hypertension among pregnant women	0	3	5
Sexually transmitted infections	0	2	2

sTable 2 shows the number of practitioners who considered a particular reproductive health issue as of highest, 2nd highest, or 3rd highest in terms of number of cases diagnosed.

There was some difference between female and male practitioners in terms of what reproductive health problems they considered most common (Table 3).

Table 3. Reproductive health problems considered most common by female and male medical practitioners (n=41).

Reproductive Health Problems	Female practitioners who considered the problem as one of three most prevalent RH problems* (n=10)	Male practitioners who considered the problem as one of the three most prevalent RH problems (n=31)
Abnormal/irregular menstruation	8	22
Malnutrition among pregnant women	7	17
Burning micturition	0	18
Vaginal Discharge**	7	9
Hypertension among pregnant women	1	7
Infertility	4	3
Sexually transmitted infections	0	4
Domestic violence	0	3

* Numbers of responses do not tally as practitioners were asked to point to three most prevalent problems.

** $P<0.05$ Fisher's χ^2 test.

However, this difference is statistically significant only for vaginal discharge and infertility both of which were reported by more female practitioners as common conditions.

Consulting medical practitioners for family planning related care

The practitioners pointed out that only a few clients consult them on family planning. Fifteen out of forty one practitioners said that only occasionally someone asks for information on family planning. Another sixteen said that on any given day, no more than two patients consult them on family planning. Twenty-one practitioners said that during the last one month at least one but not more than five persons consulted them for side effects of contraceptive methods.

Sexually Transmitted Infections

Out of 41, sixteen practitioners said that they diagnosed someone in the last one month prior to the survey as suffering from sexually transmitted infections (STI). Seven Óf these seventeen practitioners said that they diagnosed more than five people with STIs in the last one month. When asked which sexually transmitted infections are common among men and women whom they have provided care, medical practitioners pointed to gonorrhoea among men and trichomonas and

'leucorrhoea' among women. Two practitioners said that sexually transmitted hepatitis B was most common among patients whom they diagnosed as STIs. These practitioners reported common symptoms for these STIs as vaginal discharge and burning micturition among women patients and purulent urethral discharge and burning micturition among men.

Discussion

Majority of the medical practitioners in the study area were men. Women generally prefered consulting female health care providers. However, many women consulted both male and female practitioners for various illnesses including menstrual disorders and other reproductive health issues. This reflects on the respect these practitioners command, the lack of female practitioners in the areas, higher morbidity of women and the fact that often it is women who take children to practitioners when children are sick. However, considering the cultural background, this does not mean that women get all the needed care for their reproductive health problems.

Medical practitioners who were interviewed for this survey were running successful practices and that could be the reason that most of them were based there for more than 5 years. Findings of this study suggest that medical practitioners are well aware of local health problems and that consultations with rather a small number of practitioners could contribute positively to the local health planning process. For example, practitioners in our study pointed to malnutrition among pregnant women as a major reproductive health problem. Community based studies have also highlighted that pregnant women in poor areas are chronically malnourished[4]. In the National Reproductive Health Package it is acknowledged that at least 40% women are anaemic[5]. A survey of 738 rural women revealed that 66% women had symptoms consistent with anaemia and authors suggested high parity and low access to food and medical care as major contributing factors[6]. This community based study, which was conducted in rural Sindh, also pointed to reporting of burning sensation while passing urine by no less than 17% women. This information helps understand why 18 practitioners whom we surveyed pointed to burning micturition as one of the most prevalent health problems for which clients consult them.

A common finding between the community survey results and this study is the prevalence of menstrual problem in women. For example, in one such community survey nearly 45% of women reported either heavy bleeding, prolonged bleeding or painful menses[7].

We found resemblance between insights provided by practitioners and what other studies have revealed with regard to family planning services. While only a few clients consulted medical practitioners for advice on family planning, a significant number of community members consulted them for side effects of family planning methods. This finding is consistent with the fact that a majority of users of family planning services do not consult medical practitioners but go to specific family planning clinics. Sajan and Fikree have raised concerns about the quality of these family planning services, as they identified, through a community-based study, that intrauterine contraceptive devices were a significant predictor of pelvic inflammatory disease[7]. Those who suffer from side effects consult medical practitioners as family planning services offer little medical care.

Health care services are not equally accessible to everyone in a community; those who access services might not represent community at large. Therefore, community surveys are necessary. However, consultations with a few practitioners in an area could provide a quick and fair evaluation of common health problems. It is also important to consult both female and male practitioners. Studies have pointed out that physicians' gender does not influence clinical decision-

making[8]. However, it has also been observed that female physicians communicate differently and that is one of the reasons why patient satisfaction is high with them[9]. This could result in greater information exchange between clients and female medical practitioners, thus identifying underlying social factors contributing to illnesses. It is interesting to note, that in our study out often female practitioners, eight assessed poverty or lack of education to be the major problems while only one out of thirtyone male practitioners had a similar opinion. It is an observation that females, who form the larger percentage of clientage, are more comfortable in discussing their social problems with female practitioners. Such differences help understand the need to consult both male and female practitioners for assessment purposes. On the other hand, the results suggest that patients with gastrointestinal problems and malaria consult male practitioners. Interviewing preferably with both male and female practitioners would therefore give a better indication of common local health problems.

Interviewing medical practitioners, to identify and prioritise local problems, was found to be valuable in most issues. There are, however, certain diseases for which people might not consult medical practitioners. Community surveys or clinical studies are required to identify the extent of such problems. Information collection on sexual health problems is a challenge in Pakistan. In our study, besides other reproductive health issues, the medical practitioners were consulted by many, for sexually transmitted infections also. However the number of these consultations was small. This is despite a high demand for sexual health services which is evident from the existence of a large number of unqualified people operating sex health clinics used by a large number of people[10]. People either do not consult medical practitioners with a perception that alternative health care providers are better equipped to deal with those diseases and/or the fear that consulting a mainstream health care provider might infringe confidentiality. In our study out of41 only 16 practitioners said that they diagnosed between 1-5 patients with STI inthe last one month. This is against a reported community prevalence of STIs in Pakistan between 12.3 and 25%11-13. In this case, a truer picture would emerge only through clinical studies that diagnose patients using accepted clinical gold standards.

We belive that the exact extent of local problems could only be ascertained through a comprehensive survey with a sample of the population.This study focussed on identifying health needs by interviewing a small sample of local medical practitioners. In this respect the present study cannot be generalized to a larger population. We suggest that consultations with a few medical practitioners, identified by the community as providing good care to a large number of people in an area, could provide a quick and fair approximation of common health problems in the area. This approach could be very useful in situations where resource and time constraints do not allow population surveys. A comprehensive needs assessment, employing interviews with local medical practitioners, in addition to community surveys, would help in developing an in-depth understanding of local issues from both community and provider perspectives. Additionally, such an approach could provide opportunities for enhanced health care provider-community interaction, at the stage of problem identification and analysis, planning and implementation for improved access and quality of care.

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