Voices in Development: Discussing the Need for User-End Input in the Public Health System in West Bengal, India

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The government subsidized public health care system in West Bengal has faced much criticism in recent years about the quality of its services.[1] Since only those who cannot afford more expensive forms of health care access the system, many issues do not come under public scrutiny unless things malfunction at an obvious level or until the people affected are those higher on the socio-economic scale than the poorest of the poor. This, as with many other issues, comes down to the difference between voice and voicelessness. Those who have the wherewithal to speak do, and their experiences are reported. For example, both the articles cited above are about socio-economically middle class people for whom the medical system malfunctioned in rather spectacular ways.

As the idea of development shifts from the traditional modernist paradigm,[2] with an emphasis on greater industrialization to one of overall human development,[3] it becomes increasingly important for those who work in the area to pay attention to individual human beings who are being impacted by the processes of development. With the population count standing at 1,027,015,247 as of March 2001,[4] population control is a significant part of development efforts in India. This paper advocates that development planners in the state of West Bengal, India pay attention to and/or conduct qualitative, semi-structured interviewing to assess services offered in family planning contexts. It draws on qualitative, interviewee-oriented research to show the implications for a health system that does not adequately address the concerns of its predominantly female poorer clients. As much of the work that informs policy is demographically- or quantitatively-oriented,[5] an argument for qualitative, user-end evaluations is one that needs to be made in the context under discussion.

The Mother and Child Health (MCH) program of the Government of West Bengal is a part of the public healthcare system under the Department of Health and Family Welfare, Government of West Bengal. The public healthcare system is heavily subsidized by the government, and hence draws clientele who cannot afford more expensive private care. However, there is also another kind of quasi-medical care available to the clientele of these clinics, provided by semi-qualified or unqualified *daktar*s and pharmacists usually attached to small private clinics.[6] Called 'quacks' by staff within the public medical system,

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these local doctors are the target of much anger from within the government subsidized medical system. In interviews, doctors and other personnel talked about how many of these so called *daktar*s were not qualified to give medical advice, prescribe medication, or perform abortions, but women visited them because they were local and inexpensive. Additionally, medical advice provided by such practitioners is frequently problematic and leads to health complications, prompting women to turn to the public healthcare system. According to staff interviewed, this was a particular problem for women who tended to have less money and time for healthcare than men. The public healthcare system therefore needs to provide women with the services they require in ways that make them comfortable, so that women will make the extra effort necessary to access it. For this to happen, policymakers need to pay attention to the specific problems women face when accessing these clinics.

The poverty and disempowerment experienced by many of these women made it necessary to use interviewing techniques that gave them the liberty to converse about their lives as opposed to being interviewed with a format of set questions in a pre-determined order.

METHODOLOGY

The research for this paper was conducted in government subsidized family planning clinics in West Bengal, a state in eastern India bordering Bangladesh. Women using the services of three clinics across the state were interviewed about their experiences with family planning technology and services over a period of nine months. These health centers are called PP (post partum) clinics in West Bengal, and in addition to family planning also offer gynecological, immunization, and ante and post natal care. The particular clinics in this study were M. R. Bangur Hospital located in Kolkata (formerly Calcutta), an urban center; Diamond Harbor Subdivisional Hospital (DHSDH), a sub-urban center; and Mogra Haat II, a rural area. Interviews took place in the waiting rooms of the first two centers, and I traveled to women's homes with family planning field workers in the third center which did not have a PP clinic located within the grounds of the health center. Interviews were conducted in Bengali. Interviews were also conducted with staff, doctors, and administrative personnel within the health system, in order to better understand the contexts in which women receive care in these clinics.

I approached individual women waiting to use the health services offered by the clinic. Interestingly, individual interviews sometimes evolved into group discussions. These are very community-rich situations, and relatives accompanying the primary interviewees would frequently be invited into discussions by the interviewee, which would then become a focus group of sorts. This also happened in interviews that took place in people's homes, as friends and neighbors would come by and be invited to talk with the interviewer. It was evident to me that these women formed close communities with those who lived around them, and this was especially clear in those interviews that expanded outward and became spontaneous mini focus group discussions.

The poverty and disempowerment experienced by many of these women made it necessary to use interviewing techniques that gave them the liberty to converse about their lives as opposed to being interviewed with a format of set questions in a pre-determined order.[7] These interviews ranged from semi-structured to unstructured, and women had the freedom to talk in ways they felt most comfortable about concerns when accessing and using fertility control products and services. An interview usually began with questions about basic information (age,

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occupation, years married, number and age of children, and so on). After the preliminaries were completed, the interviewer's role was restricted to introducing certain topics (for instance, children, contraception, quality of care at the clinic) into the conversation at points that seemed appropriate so as not to cut into or otherwise disturb the flow of the conversation, which was primarily directed by the interviewee. In these interviewing situations, women decided on which topics they wanted to focus and also determined the length of time they wished to discuss the areas on which they chose to concentrate.

It is, however, necessary to make a qualification at this point. These women were aware that as individuals their power in this situation was limited, and were afraid that if rendered visible as sources of complaint they might lose even those services currently available. The role of research such as this, therefore, emerged as particularly important, because it allowed women to express their discontent in relative anonymity. The assurance of anonymity was essential if many of these women were to feel comfortable discussing their issues with the public health system. In addition to anonymity, it was seen during this project that long, informal interviews made women comfortable and allowed them to introduce and discuss concerns they felt were important in the conversation. Several issues discussed in this paper were first introduced to the interviewer by the interviewees. Almost all of these issues were brought into the conversation toward the later part of the discussion, after the woman or women felt comfortable in the interview situation. For example, most women initially expressed hesitation when asked about their experiences with doctors and other staff, but became increasingly comfortable and forthcoming as the interview became more conversational and therefore informal.

What were the issues, then, that emerged during this research? Broadly, women using the public health system in these contexts (a) felt disrespected and mistreated by staff at the clinics, (b) would like more interaction time with doctors, (c) would like the clinic to be operational during the times it was supposed to be, (d) would like more access to health information related to their conditions in forms that they understood, and (e) would like more government subsidization of medication.

SOCIAL DIFFERENTIALS TO POWER DIFFERENTIALS

Women relate their treatment by staff directly to the difference they perceive between themselves and those women who are nurses and other healthcare workers in these clinics. One woman at M. R. Bangur said,

> They [the staff] always treat us badly. It is because they feel that we do not understand them and what they say, and because they have jobs here.

There is more than one line of difference being referred to here. There are educational and socio-economic gaps, and the consequent defining of those gaps by behavior on the part of staff. Staff at these clinics were better educated and visibly better dressed than most clients. This line of difference was reinforced by other, more obvious markers. For example, I saw that staff frequently discussed their attitudes toward clients with each other. Because clinics are small and clients frequently crowd around the doors leading in, they are often within earshot of these discussions. These conversations between staff, it was observed, were usually about clients' inability to understand basic directions, or their unwillingness to follow them. In several instances while I was an observer at a clinic, members of staff also shouted at clients for various reasons.

"I have been here for the whole morning and my children must be hungry at home. I need to go back and cook. So I am now leaving. I will ask my local pharmacist to read this for me and explain it."

While it is true that the staff do tend to behave badly with the patients coming to the clinics, it emerged from observation that staff members at these clinics were not uncaring towards clients or unaware of their needs. They just felt overworked and under-compensated for the amount of work they had to complete because of the large number of patients they saw on a daily basis. Several members of staff at the clinics said they recognize that their behavior could be misunderstood, but that they essentially felt themselves to be without choice in this matter. One ANM (Auxiliary Nurse Midwife) interviewed at DHSDH said:

> When I shout at them to stop crowding around the door I feel bad sometimes. I know that they want to ask questions, or they don't know what's happening with their sickness. But when they crowd around me and I am trying to help them, it irritates me sometimes. There are so many of them, and we have so much work.

On the part of women patients, however, this is perceived as a power issue and that staff behave this way because they can. One woman at Bangur said:

> It [staff behavior] is because I don't have money. If I had money I would not be coming here. I would go to a big doctor, and [he] would not treat me like this...

Another at DHSDH said:

> If I had been allowed to study beyond class three, I would get a job here. But I was not allowed by my family, so I have to come here and they treat us like this.

Yet another talked of a specific experience when she asked a member of the staff for information about her particular problem:

> I did not understand what the doctor said so I asked her [a member of the staff] and she said she did not have the time, and ...sent me to another person. But that person is not here [in the clinic] and I cannot wait any more. I have been here for the whole morning and my children must be hungry at home. I need to go back and cook. So I am now leaving. I will ask my local pharmacist to read this for me and explain it.

This sort of situation is obviously problematic if the goal of the health system is to attract women and keep them away from quacks. But while staff behavior and response was difficult for women, it was compounded by the experiences women had with doctors.

Women patients felt that doctors gave them less time than they should because of the enormous gap in socio-economic status. More than one woman said that the doctor did not treat her well because of her poverty and consequent voicelessness. In one interview at Bangur a woman was discussing her gynecological history when she said:

> Doctors don't ask about us the way you are doing now. Now we are sitting here and you are asking me questions. We get one minute with the doctor, and you just tell what your problem is in a rush, and he writes the medicine down. That is all. Sometimes I remember later that I did not tell him something, but it is too late then. My chance is gone. ...I think it is because I am poor.

Another woman said:

> I know she is a good doctor, and I have come a long way to see her, but she gave me only two minutes. I know that there are many people here, but I wish I had more time. ...I don't think she heard everything I said properly. I hope there is no problem with the medicine.

This is a high degree of uncertainty to live with, especially when it is compounded by the feeling that there is a fundamental hierarchical difference that does not permit a woman to ask too many questions. It is true that a large number of women come to the clinic every day. At M. R. Bangur, which is located in the city of Kolkata, this was seen to be as many as thirty for an individual doctor on a day. The clinic was open for only four to five hours every morning, which is why women were rushed in and out of doctors' chambers.

It emerged in interviews that women were aware that doctors within the public healthcare system were better qualified than local quacks, but the quality of interactions made them uncomfortable and therefore tense and hesitant within these situations.

A related issue was one that came up in several conversations. For example, in an interview at her home in a village called Parui under the catchment area of the health center at Mogra Haat II, a woman said:

> I have many questions to ask, but he is a man. I know he is a doctor, but still I don't want to ask certain questions that I cannot ask a man. So I just hear what he says and leave.

In a situation like this, then, the woman voluntarily cuts her interaction time with the doctor for factors other than time constraints. Although there were those who separated the male from the doctor in their minds and did not report feeling uncomfortable, several women said that this was a factor that engendered discomfort in their experiences with the healthcare system. When asked about this, a doctor interviewed at M. R. Bangur said:

> Yes I am aware that this may be a factor, but I try to be careful. I also try to be very matter-of-fact, so the women know that I am only a doctor when I talk to them.

Unfortunately, though, discomfort on the part of several women clients continues to exist, necessitating more sensitivity on the part of male doctors. It emerged in interviews that women were aware that doctors within the public healthcare system were better qualified than local quacks, but the quality of interactions made them uncomfortable and therefore tense and hesitant within these situations. Overall, it was clear that women needed to feel more relaxed and less rushed in interactions with doctors in order to be satisfied with these medical encounters.

DOCTORS AND ACCOUNTABILITY

A second factor that influenced women's interactions with doctors had to do with an operational feature of the medical system. Public health staff indicated that there was no specific doctor assigned to any of these clinics, rather that doctors sat in rotation. This was to ensure that doctors with different kinds of specializations were present in the clinic on various days. Theoretically this seems like a good way to distribute the resources of the system, but there were times when the doctor on duty was very late or did not show up at all. It emerged from interviews with staff and women patients that this happened much less frequently in the city at M. R. Bangur than at DHSDH, which is a sub-urban center and therefore comparatively removed from the administrative hub. However, this was more problematic at DHSDH than at Bangur because women patients usually traveled further to get to the Sub Divisional Hospital, and said that it was more difficult for them to return on other days. In part, this was a matter of distance and method of transportation. The bulk of the clientele in DHSDH came from surrounding villages and had to travel large distances by bus, rickshaw, or train (sometimes all three) to get to the clinic. This demanded a substantial financial and time investment on the part of women who had little of either. Additionally, suburban and rural families tend to be more overtly conservative than urban families,[8] thus making it harder for women in these areas to be out of the home repeatedly and for extensive periods.

Those who make policy decisions in the public healthcare system need to pay attention to the occurrence of such incidents and provide a viable remedy if women are to choose this system over local quacks.

If the doctor did not arrive, that portion of the clinic simply did not operate on that day, and women were asked to return for the next scheduled day. This was problematic for many of these women because it meant that a whole day had been wasted, as waiting periods in these clinics were long. In these situations women who had already waited three to four hours were told that the doctor would not be available to see them on that day. One such woman at DHSDH said:

> I have to see the doctor, and he is not here again. This is the second time this has happened to me. I cannot come here every day; it takes me two hours to get here. I do not know what to do. They [the staff] are telling us to leave, but I think I will wait a little while more and see if some other doctor is available later, so I don't have to come next week... Today, when I was leaving, my mother in law was angry with me for coming out again.

A woman at M. R. Bangur said:

> I will not get paid today because I have been here from the morning. The doctor has just arrived [he was an hour and a half late], so I will wait and see if he can see everybody on the list. The day is already wasted, but I don't want to not be paid for another day.

These were also difficult situations for members of the staff, who had to give women the news that the doctor would not be available. On three such occasions at DHSDH, staff shouted at women to leave the clinic and return on another day, as several women were still in the waiting area despite being told that the doctor would not be in. In an interview about such situations a nurse attached to the clinic at DHSDH said:

> What can I do, I have to shout at them. They refuse to leave, even when I have told them that the doctor is not coming. It makes me angry that we have to do this. The doctor just did not come, but we have to tell the women that, and we know that this is a very difficult situation for these women that they may not be able to come back. But what can I do? The doctor did not come.

Grassroots level staff, like this nurse and others who actually work directly with women in these clinics, are aware of the conditions faced by the clients. They expressed resentment at doctors who simply did not turn up, or bureaucrats in the medical system who did not process paperwork fast enough for them to get medical supplies on time. Some form of administrative regulation is needed so that the occurrence of situations like this is kept to a minimum. Those who make policy decisions in the public healthcare system need to pay attention to the occurrence of such incidents and provide a viable remedy if women are to choose this system over local quacks.

The fact that women take scribbled prescriptions to semi-literate sources of information is one that policymakers within the health system urgently need to address.

LANGUAGE AND LITERACY

The fourth issue that makes visits to these clinics problematic for women is that prescriptions are usually written in English, not Bengali, because most doctors in the medical system are educated in English. This is one of the fallouts of the fact that Bengal was politically and administratively colonized by the British for almost two hundred years.[9] It was observed that most women coming to these clinics were functionally illiterate. Many of them could sign their names with some effort in Bengali, but that was about all they could read or write. This meant that most patients could not read either the diagnosis or the medication recommended, which were in English. I was approached by several women who wanted me to read and explain their diagnoses to them, as the doctor had not done so or had said something the woman did not understand. A woman in Bangur approached me with these words:

> I wanted to ask what he meant but he spoke really fast and then called for the next person. So will you look at this and tell me what problem I have?

This needs to be addressed, as it is a serious disincentive to women visiting government health care clinics. Not only is English a language that is unfamiliar to most of these women, in the context of Indian society English is also an indicator of power in various ways.[10] Therefore a prescription written in English is not only a prescription that a woman cannot read, it is also a marker of education and socioeconomic difference in ways that are problematic.

Additionally, situations such as this drive women to approach their local *daktar* or pharmacist to interpret the prescriptions and give them the medications. One woman at DHSDH said:

> Everyone I know who comes here from my area takes it [the prescription] back and shows it to our doctor there. He reads it to us and tells us what medicine to take and how to take it. It takes so long here [in the clinic], and I can't wait for more time for the sister [nurse] to tell me what the doctor wrote. She is busy, see. There are so many women asking her questions...

If the education level of these local sources of health information is open to question, and it seems from the literature[11] and from interviews with staff and doctors that it is, this is a situation that the public health system needs to address. Doctors are famed the world over for their bad handwriting, and prescriptions shown to me demonstrated that doctors in the public health system in West Bengal are not exceptions to this stereotype. The fact that women take scribbled prescriptions to semi-literate sources of information is one that policymakers within the health system urgently need to address.

ACCESS TO MEDICINE

Another issue that came up repeatedly and was of concern to many women was that of prices of medication. Ante-natal vitamins, iron pills, and tetanus injections are provided free to expectant mothers as part of the MCH program.[12] Contraceptive pills are also usually free, unless the clinic runs out of supplies. If a woman develops any other health condition, medication is usually the responsibility of the patient. When a clinic has these other medications available, they are given to those who need them. More often than not, however, women have to buy medication related to their conditions at full price in pharmacies outside the clinic. This is a financial burden for many clients. A woman at M. R. Bangur who developed a thyroid condition after the birth of her first baby said:

> When it was discovered that I had the condition, they told me to go and get the medicine from outside. But I do not have the money to have medicine every day for the rest of my life. I have two children, and sending them to school and buying books and other school things for them is very expensive. So I don't have the medicine… Some days I can't get out of bed. I was told this may happen, but I cannot buy the medicine, so I try not to think about it.

I heard many such stories during the course of the project. Women did tend to put family and children, particularly children's education, far ahead of their own medical needs. This kind of situation has two implications. First, it tends to make women go to local sources of health that they know and whom they feel comfortable asking for cheaper medicine. Several women in all three centers said that local *daktars* were known to them and they got help with medicine, particularly if the local pharmacist was also attached to the *daktar's* clinic. One woman in a village called Lakhikantopur under the health center at Mogra Haat II said:

> If I go to the big doctor in the government hospital he gives me expensive medicine. He does not know about my life. But if I go to my own *daktar* here, he will give me cheap medicine, and if I buy it from him, he will let me pay over time.

Although some women also told stories about local sources of health providing bad medicine or adding interest to medicine prices that were paid over time, the feeling overall seemed to be that it was simply easier not to go to the government hospital.

The second factor that made the non-subsidization of medicine problematic was that the only medicines and supplements that were consistently free and available were connected with pregnancy. Women received ante-natal vitamins and iron for free, but not medicines that treated (for example) reproductive tract infections. Mala-D, the contraceptive pill provided by the government, was also usually free, but clinics did seem to run out of supplies frequently in the period I was an observer. Therefore, the only health related pills that women could consistently expect to access free were those given to expectant mothers. This is a problem if one considers that so much time, money, and energy in development policy is spent on population control.

If the system prioritizes women only when they are pregnant and not when they are unwell due to other reasons, this may in fact be a disincentive for women to access the system's services for reasons other than pregnancy.

This is certainly not an argument for asking women to pay for supplements when they are expectant mothers. Most women interviewed simply would not be able to afford that. If the system prioritizes women only when they are pregnant and not when they are unwell due to other reasons, this may in fact be a disincentive for women to access the system's services for reasons other than pregnancy. Government subsidization of medicine for women is essential if women are to use these clinics and receive the kind of care they deserve not only as mothers but also as human beings.

CONCLUSION

It is essential for women's voices to be heard in the public health arena. Qualitative, in-depth interviewing seems to be the best way to record these voices, as women need to feel very comfortable within interview situations to discuss experiential issues in such contexts. This paper offers five recommendations based on in-depth interviews at the three centers at which research was conducted.

- Workshops should be designed and conducted for staff to help them better cope with the frustrations they face as go-betweens for the system and patients. These workshops would deal with issues such as anger management and appropriate behavior toward women clients so as not to intimidate them or further emphasize the socio-economic difference between staff and patients.
- Individual interaction time with doctors needs to be increased. The system could do this by assigning more doctors per clinic, or by keeping the clinic open for longer times than it currently is. Either way, doctors need to be sensitized to the issues that female patients deal with in medical encounters.
- A working administrative system needs to monitor the time doctors spend at clinics, and make a note of those days they are absent or late. It is also important that there be a backup system. For instance, if a doctor does not turn up on a particular day, another local doctor should be available to fill that spot so women do not have to return home without having seen a doctor.
- Specific positions need to be created for women who will read and explain prescriptions to clients at the clinic. Nurses on duty are supposed to be doing this, but it was observed that they were usually very busy and unable to fulfill this function. Junior staff positions as readers of prescriptions would solve this problem.
- Government subsidization of medication is essential to drawing women to these clinics. This is a huge structural change and demands a whole different research project (perhaps several more), but the need is felt very deeply and policy attention needs to be paid to this issue.

While it is possible that policymakers may not be entirely blind to these concerns, the acknowledgement policymakers currently offer seems more verbal than anything substantive that translates into a difference in women's lives. For example, the National Population Policy, 2000 says:

> Stabilizing population is an essential requirement for promoting sustainable development with more equitable distribution. However, it is as much a function of making reproductive health accessible for all as of increasing the provision of primary and secondary education ...besides empowering women and enhancing their employment opportunities, and providing transport and communications.[13]

How does a system go about doing this? It can start by listening to what people using the system say about it, and making changes based on the needs of those people. The women interviewed were very clear about the issues that made access to the public health system difficult for them. As discussed in this paper, some of those issues were socio-economic and some were rooted in the organization and priorities of the system. The recommendations offered are grounded in this research and based on what women themselves had to say. Some of the recommendations offered are possible to implement with minor administrative changes and others may take years to work out. It is also possible that the recommendations offered may not be the most appropriate solutions for the problems brought up in interviews. One hopes that much more fieldwork will take place and many more suggestions will be offered that help women use the public health system with facility and ease. In the end, that is the aim of this paper and of the project at large: To point out the fact that there is a problem and to voice that problem in forums that are taken seriously by those who influence and create public health policy. ■

If a doctor does not turn up on a particular day, another local doctor should be available to fill that spot so women do not have to return home without having seen a doctor.

NOTES

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