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Original Article

# Client's Satisfaction With Disability care Services Available in a Selected District in Bangladesh

**Md. Ahsan Habib[1], Kh. Shafiur Rahaman[2*], Mainul Alam Chaklader[3]**

[1]Department of Public Health, School of Health Sciences, State University of Bangladesh, Dhaka, Bangladesh
[2]School of Public Health, International Campus, Tehran University of Medical Sciences, Tehran, Iran
[3]Assistant Professor, School of Health Sciences, State University of Bangladesh, Dhaka, Bangladesh

***Corresponding Author:**
Kh. Shafiur Rahaman
Address: BSL Residential Complex, Flat: #B804, Mirpur-13, Dhaka 1216.
Email: rajib_pt@yahoo.com

## Abstract

**Background and aims:** Increasing prevalence of disability in Bangladesh indicates the need of special attention to disability care services within the healthcare setting. Our study aims to identify the level of satisfaction of clients using disability services as well as their opinions to improve those facilities.

**Methods:** We have conducted a cross-sectional study in six disability service centers from Kurigram district of Bangladesh. We have chosen our study participants conveniently during each visit to the service centers. Using a structured questionnaire, the interview process was done. We excluded mentally impaired participants from the study. We have used descriptive analysis of data using appropriate statistical technique.

**Results:** We have interviewed a total of 384 individuals. Respondents mean ± standard deviation (SD) age was 38.35 ± 16.01 years with a range of 12 to 65 years. Most of our participants were physically disabled (63%). Participants were found to be moderately satisfied with the service providers, but marked dissatisfaction were observed among the participants regarding available services and 61.7% participants were dissatisfied with the overall services. The service was not easily accessible reported by the respondents. Lack of physician was the most common complaint. Despite of indicating positive aspects, they recommended employing at least 1 physician for medical treatments and improving positive attitude towards disabled persons.

**Conclusion:** Poor level of satisfaction towards overall disability services were observed in this surveyed community. Policy makers should initiate appropriate measures to ensure easy access and better quality of services based on the results and guidelines discussed in this study.

**Keywords:** Disability, Services, Client's, Satisfaction, Rehabilitation, Healthcare.

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## Introduction

Client is always in the priority of whole process of service delivery. A bad service delivery to the disabled people may lead to harm in several ways. Because of this, it is imperative to assess and evaluate client's satisfaction within the health care setting to make an effort in improving the quality of the health care system.[1] Moreover, client's involvement has always been the cornerstone of health care service utilization process.[2] It is also important for the health caregivers to monitor and assess client's demand and perception regarding available services.[3] The concept of disability varies among different professionals. Disability is complex but common condition. Everyone will suffer from disability or impairment temporarily or permanently during the span of life. According to the World Health Organization's (WHO's) estimation, 15% of the people are disabled around the globe and 70% to 80% of them are residing in low-middle income countries.[4] Nearly 975 million (19.4%) people of 15 years and older are suffering from different kinds of disability around the world and among them 3.8% (190 million) of the people have severe disability (quadriplegia, severe depression, or blindness) estimated by Global Burden of Disease.[5] Global Burden of Disease also estimated that the number of disabled children (0 to 14 years) is 95 million (5.1%).[5] These figures are increasing with the passage of time due to several risk factors such as increasing number of older population and increasing prevalence of chronic diseases that lead to impairment.[4]

Disability is often considered as a curse and embarrassment to a family. It is also believed that disability is the problem of poor people. World Health Survey also indicated higher prevalence of disability in lower income countries, particularly among women,

older people and the poorest wealth quintile.[6] The prevalence of disability in Bangladesh is 9.1% which is considered to be similar to the WHO estimation indicating a higher prevalence[7] but there is no evidence of conducting regular national disability prevalence survey.[8] Common reasons for higher prevalence of disability in Bangladesh might include overpopulation, poverty, illiteracy, lack of awareness and insufficient healthcare services.[8] Disabled person experiences poor health status compared to general people and are vulnerable to deficiencies in healthcare facility and rehabilitation services.[4] Report from neighboring country also indicates that, 2 reasons for not using healthcare services by disabled persons are cost and unavailability of services.[9] Most of the people with disability live in rural areas; therefore, economic inequality persists among the disabled persons in Bangladesh.[10] Moreover, uncoordinated services, lack of skilled personnel and lack of staff affect the quality, availability and acceptability of services for disabled persons.[4] Compared to others, people with disability report nearly three times more denial of health care need, four times more bad treatment and two times more lack of skilled personnel according to their needs.[6]

In Bangladesh, governmental and non-governmental organizations are working hand to hand to provide comprehensive healthcare to the people with disability. Community based rehabilitation program has been introduced in some areas with limited resources. But lack of evidence persists in the delivery of healthcare to the disabled persons. Needs and priorities of the people with disabilities remained undiagnosed. Client satisfaction is the factor for any services, particularly for deprived and excluded people particularly people with disability. For dissatisfaction with services, these people may be more isolated and reserve towards seeking health services. Though, healthcare services expanded from tertiary level to community level for disabled people with the improvement of health sector in Bangladesh, their effectiveness towards the target group remains to be revealed. Therefore, our study aims to identify the characteristics of clients, level of satisfaction with disability services nearly available, any reasons for dissatisfaction that are notable, and the ways to improve existing services in a selected district of Bangladesh to provide necessary information to the stakeholders for better service delivery for the disabled population.

## Methods

To answer the key research question we have designed our study in cross-sectional manner. The study was conducted in selected district of Bangladesh, namely Kurigram district. We chose this area because of easy accessibility of data collection. In addition to this, urban areas assumed to provide better service due to high living standard, but service centers in rural area can give us a clear picture of client's satisfaction in rural setting where resource is limited. The study was conducted from May 2016 to October 2016 with a duration of 6 months. There are 64 districts in Bangladesh and we have selected Kurigram district purposively. We have determined our sample size using appropriate formula (Fisher equation) and we got our sample size to choose study subjects which was about 384. There are 6 facilities (rehabilitation center, therapy center, disable schools etc) available in Kurigram district which are providing disability services among their enlisted 783 different type of disabled people. From 783 disabled people, we have selected 384 samples conveniently during the regular visit. We have conducted the interview in those 6 selected centers. We have visited each selected center once a week during the service providing time (from early morning to afternoon). The interview was taken after clients have received the service for the day. Each interview took approximately 30 minutes. Disabled persons with mental impairment who were unable to provide proper information and participation during the interview, were excluded from the study.

### Data Collection and Analysis

We have collected our data by using an interviewer administered structured questionnaire comprising both open-ended and closed-ended questions. The questionnaire was pretested for its completeness and correctness before the final data collection process. Data was collected by trained personnel in disability. During the interview we have asked the disabled people and their caregivers the questionnaires to obtain information easily. In case of persons with impaired speaking, we have conducted the interview session with the caregivers in front of them. Five-point Likert scale was used to measure the level of satisfaction among the study participants. After data collection we have entered and analyzed our data using SPSS version 20. For analysis, we have used descriptive analysis by frequency distribution, percentage, mean and other appropriate statistical tools.

## Results

By employing appropriate sampling technique mentioned above, we have selected a total number of 384 participants from the 6 disability service center in Kurigram district of Bangladesh. The mean ±

standard deviation (SD) age of the respondents was 38.35 ± 16.01 years. The minimum age was 12 years while the maximum age of the participants was 65 years. Our data also reveals that 22.4% (n = 86) of the total participants were between the age group of 41 to 50 years while 20.8% (n = 80) were between 11 to 20 years. About 60% (n = 230) of our participants were male and rest of them (40%) were female. Nearly 54% of the participants were unmarried and 80% of the total participants were Muslim by religion (Table 1). The most common form of disability reported among the participants was physical disability (63%) while only 2.9% were suffering from mental disability (Table 2).

The overall educational status of our participants was poor. The majority of our participants have completed their education up to primary level (72.4%, n = 278), 3.6% (n = 14) were illiterate and only 4.2% (n = 16) were graduated. In our study, business was the mostly reported occupation of our participants (30.75%, n = 118) followed by farmers (27.86%, n = 107). More than 25% of the participants were unemployed and nearly 3% of them were beggars. Regarding housing condition, we found that the majority of our participants (30.7%, n = 118) were living in pit with grass roof while only 6.8% (n = 26) and 12.5% (n = 48) were living in semi-pukka (Semi solid dwellings) and pukka (Solid dwellings) houses respectively. About 60% (n = 230) of our participants were belonged to a nuclear family. The minimum number of family member of our participants was 3 while the maximum was 11. Around 35% (n = 133) of participants had family members between 4 to 6 persons, while around 20% (n = 76) had family members between 10 to 12 persons. We have also asked our participants about their family income. The finding showed that around 60% (n = 226) of participants reported having family income between $126 to $250 (Table 3).

The level of satisfaction varies among the clients in respectfulness of service providers. Overall, 60% of our participants were moderately satisfied with the service provided by counsellors and 61.7% of the participants also reported their moderate satisfaction

**Table 1.** Demographic Characteristics of Study Participants (n = 384)

| Characteristics | Number | Percent |
|---|---|---|
| Age group (y) | | |
| 11-20 | 80 | 20.8 |
| 21-30 | 47 | 12.2 |
| 31-40 | 66 | 17.2 |
| 41-50 | 86 | 22.4 |
| 51-60 | 74 | 19.3 |
| >60 | 31 | 8.1 |
| Gender | | |
| Male | 230 | 59.9 |
| Female | 154 | 40.1 |
| Marital status | | |
| Unmarried | 206 | 53.65 |
| Married | 178 | 46.35 |
| Religion | | |
| Muslim | 307 | 80 |
| Hindu | 77 | 20 |

**Table 2.** Disability Characteristics of Study Participants (n = 384)

| Disability Type | Number | Percent |
|---|---|---|
| Physical | 242 | 63.0 |
| Intellectual | 36 | 9.4 |
| Sensory | 97 | 25.3 |
| Mental | 9 | 2.3 |

**Table 3.** Socioeconomic Characteristics of Study Participants (n = 384)

| Characteristics | Number | Percent |
|---|---|---|
| Educational status | | |
| Illiterate | 14 | 3.6 |
| Primary level | 278 | 72.4 |
| Secondary level | 43 | 10.12 |
| Higher secondary level | 33 | 8.6 |
| Graduated | 16 | 4.2 |
| Occupation | | |
| Unemployed | 94 | 24.43 |
| Homemaker | 38 | 9.77 |
| Business | 118 | 30.75 |
| Farmer | 107 | 27.86 |
| Service holder | 17 | 4.55 |
| Beggar | 10 | 2.58 |
| Housing condition | | |
| Pukka | 48 | 12.5 |
| Semi-pukka | 26 | 6.8 |
| Full tin shade | 98 | 25.5 |
| Tin shade and pit | 94 | 24.5 |
| Pit with grass roof | 118 | 30.7 |
| Family type | | |
| Joint | 154 | 40.0 |
| Nuclear | 230 | 60.0 |
| Number of family member | | |
| Up to 3 | 77 | 20.1 |
| 4 to 6 | 133 | 34.6 |
| 7 to 9 | 98 | 25.5 |
| 10 to 12 | 76 | 19.8 |
| Family income ($) | | |
| Up to $125 | 135 | 35.2 |
| $126 to $250 | 226 | 58.9 |
| $251 to $375 | 23 | 6.0 |

**Table 4.** Respectfulness of Service Providers Towards Their Clients (n = 384)

| Services/Service Providers | Very Dissatisfied No. (%) | Dissatisfied No. (%) | Moderately Satisfied No. (%) | Satisfied No. (%) | Very Satisfied No. (%) |
|---|---|---|---|---|---|
| Counseling services by counselor | N/A[a] | N/A | 230 (60) | 154 (40) | N/A |
| Rehabilitation professional | N/A | 9 (2.3) | 237 (61.7) | 138(35.9) | N/A |
| Paramedic | N/A | 76 (20) | 154 (40) | 154 (40) | N/A |
| Receptionist | N/A | 76 (20) | 76 (20) | 230 (60) | N/A |
| Helper | 76 (20) | 230 (60) | N/A | 76 (20) | N/A |
| Verbal assessment of health care providers | N/A | N/A | 269 (70) | 76 (20) | 39 (10) |
| Easy accessibility of services | N/A | 308 (80) | 76 (20) | N/A | N/A |
| Satisfaction with interpretive services | 141 (36.8) | 243 (63.2) | N/A | N/A | N/A |
| Satisfaction with waiting time before service | 150 (39) | 131 (33.9) | N/A | 103 (27.1) | N/A |
| Satisfaction with information of follow-up care | 96 (25.1) | 131 (33.9) | 36(9.6) | 121 (31.4) | N/A |
| Satisfaction with counseling received | 132 (34.4) | 101 (26.4) | N/A | 151 (39.2) | N/A |
| Satisfaction with way of communication of service providers | 48 (12.2) | 50 (13.2) | 210 (54.6) | 76 (20) | N/A |
| Satisfaction with maintained privacy | 78 (20.3) | 141 (36.7) | N/A | 165 (43) | N/A |
| Overall satisfaction | N/A | 237 (61.7) | 9 (2.3) | 138 (35.9) | N/A |

[a] Not answered.

of services from rehabilitation professional. The majority of participants (60%) were dissatisfied with the service from the helper and 20% were dissatisfied with the service from receptionist. Most of our participants were moderately satisfied with the verbal assessment of health care providers in those centers. Dissatisfaction level was very high among the participants on easy accessibility of services and interpretive services. Nearly 40% of the participants were very dissatisfied with interpretive services. Most of our participants were very dissatisfied on waiting time before services while only 27.1% of them reported satisfied. Dissatisfaction level was also reported markedly on information of follow-up care by the respondents. Nearly 40% respondents reported satisfied with the counselling services received, but the level of dissatifaction was also remarkable. Our participants were also moderately satisfied with the ways communication of service providers. Satisfaction level of participants were very poor with regard to the maintenance of privacy which is a great concern. In a nutshell, the majority of our participants have reported being dissatisfied with the overall services of those selected centers (Table 4).

All of the respondents reported that they were not informed about the health care planned. It was also reported by all that services were not delivered with proper care and support though counselling services were received by all of the participants. Appropriate information on referral services were not provided according to the opinion of all participants. Cleanliness (20%) and providing free services (80%) were some of the positive aspects reported by our respondents. Our participants also reported not having at least one general physician to treat medical problems as the negative aspect of those service centers, therefore, suggestion was given to provide medical treatment by doctors. Another suggestion was to improve positive attitude towards persons with disabilities (PWDs) given by nearly 70% of the participants.

## Discussion

Quality control, easy access and cost are some of the challenges faced by any health care services. Patient's satisfaction is greatly influenced by those challenges. With the increasing prevalence of disability in Bangladesh, it is imperative for the government to provide quality health care ensuring easy access and cheap cost. Several programs from the government and non-government sector are running across the country to serve the people with disability. Evaluation of those disability care program from client's point of view is rare. Therefore we have conducted the study with the aim to determine the level of satisfaction towards available disability care services among the clients which is the first attempt to the best of our knowledge. Yet this survey can help in improving quality of the disability care if disseminated properly. The findings in our study can also provide necessary information for researchers, policymakers and practitioners who are involved in this sector to improve the quality of care and client's satisfaction with disability care services as well as successful implementation of a health care program targeting

disabled people. Evidence on disability care services is limited in our country context; therefore, it was very difficult to compare our findings.

In our study, we found that the majority of our participants were not well-educated. Educational level of a patient is necessary because education can contribute to their satisfaction. Moreover, patients have a role to play in the process of service delivery. Educating patients is also important to help them in the self-care process.[11] Research suggests that patient's satisfaction is also influenced by their socioeconomic status.[12] In our study, we have observed that clients were moderately satisfied with services provided by healthcare professionals such as counselors, rehabilitation professionals, and paramedics. In other study, they also found that clients were satisfied with the behavior of healthcare provider.[13] But marked dissatisfaction were reported based on the services of other staff particularly receptionist and helper in our survey. Similarity found with other study where patient's dissatisfaction was influenced by staff discipline in health care setting.[11]

Majority of our participants were moderately satisfied with the way of communication and behavior of service providers but still many of them reported they were dissatisfied. The situation is similar in context of Bangladesh where the majority of healthcare service providers are unwilling to openly communicate with the patients, which is cornerstone of health service delivery.[11] Another study also found that service orientation of healthcare professional has profound effect on patient's satisfaction. Responsibility also goes to the policymakers to build patient-centered healthcare delivery system.[14] Most of the respondents reported their dissatisfaction with waiting time before services. The result is in accordance with other studies where waiting time and less consultation time contributed to patient dissatisfaction.[12,15,16] Maintaining privacy was another influencing factor for respondent's dissatisfaction in this study which is considered as one of the powerful predictor for client's satisfaction reported by experts.[12]

By easy accessibility of services, this present study found that most of our respondents were dissatisfied. On the other hand, a similar previous study found that 55% were dissatisfied on easy accessibility of services.[12] These data showed the contrast between these studies regarding satisfaction with accessibility of service, because of that the current study was conducted among disable persons who were generally deprived from the services whereas previous study was conducted among the general population as well as general hospital which is usually more accessible and friendly services for general population exist. Therefore, our study reveals that existing disability services are neither easily accessible nor friendly for the disabled. Dissatisfaction was also observed in follow-up care practices, which is similar to previous findings. This current study was conducted among those service centers where follow-up mechanism were not maintained, on the other hand, previous study was conducted among those specialized health centers where follow-up mechanism and follow-up flow chart were maintained for ensuring follow-up services.[13] Not having a general practitioner for providing medical treatment was the main complaint by all participants. Lack of trained personnel could also be a reason for patients' dissatisfaction reported by other study in Bangladesh.[16] Most of our respondents suggested that staff should show positive attitude towards PWDs and rest of them suggested that center should provide medical treatment by specialist doctors or consultant.

Practitioners involved in disability care should observe the results revealed in this study as appraisal of their service. They should also remember that patient-driven service standards are important to provide quality care and therefore, to be better understood.[12] It is also essential to identify gaps and influencing factors from the perspective of staffs in providing the proper service delivery. Research should also be focused on the level of satisfaction among service providers working in those facilities because research suggests that satisfaction of employee and clients are inter-related and satisfied employees reinforce client's satisfaction and vice-versa.[17] It is also evident that satisfaction has a profound impact on the interaction between client and service providers and whether the client intends to receive the same facility again.[18,19] Therefore, duty goes to the health care providers again to understand client's demand and act accordingly for their compliance in a service delivery. The main limitation of this study is that we have conducted this study in a rural district of Bangladesh, thus, we cannot generalize our results to other districts or urban settings. Additionally, research must be undertaken which represents the populations of the many districts or regions to compare the results revealed in this study. Broad research in this regard can help to find other relevant factors missed out in this study, it could as well be a useful tool for the planning and implementation of future disability program and service center.

## Conclusion

Most of the respondents were dissatisfied with overall services received from the disability service centers. Dissatisfaction with staff behavior, waiting

time, information on follow-up care and counseling services were observed markedly in our surveyed cohort. Demand of special consultant or doctors for medical treatment were noted. Based on our findings we recommend that disability program and authority of disability service centers to ensure easy accessibility, quality services with positive attitude, respectfulness through developing disability-friendly infrastructure, appropriate professional recruitment, staff development and monitoring. Construction of health care satisfaction index can help to compare services of different disability centers periodically. Authorities should engage the disabled population in their need assessment, development and implementation of disability program for ensuring better services. Further research is a demand to take precise decision as a whole by the policy-makers to improve quality of care and access to these available services. Therefore, it is also necessary to extend infrastructure and follow the pattern of services provided by hospitals in developed countries.

## Ethical Approval

Our study has been approved by ethical review committee of State University of Bangladesh. Prior to data collection, we have taken permission from the authority of selected 6 disability service centers. We also discussed the purpose of the study with the participants and received informed consent verbally prior to the interview. In case of interviewing children and adolescent clients, the consents were taken from the parents. Any information in this study which might disclose participant's identity was kept confidential.

## Conflict of Interest Disclosures

None.

## References


1. Bara AC, Van den Heuvel WJ, Maarse JA, Van Dijk JP. Users' satisfaction with the Romanian health care system: an evaluation of recent health care reforms. Eur J Public Health. 2002;12(4):39-40.
2. Peprah AA. Determinants of patients' satisfaction at Sunyani regional hospital, Ghana. Int J Bus Soc Res. 2014;4(1):96-108.
3. Mohsin Muhammad B, Ernest Cyril de R. Private healthcare quality: applying a SERVQUAL model.Int J Health Care Qual Assur.2010;23(7):658-73. doi: 10.1108/09526861011071580.
4. World Health Organization. World report on disability. Geneva: WHO; 2011.
5. The global burden of disease: 2004 update. Geneva: WHO; 2008.
6. WHO World Health Survey. http://www.who.int/healthinfo/survey/en/. Accessed December 9, 2009.
7. Strengthening Employment Prospects for Persons with Disabilities in Asia and the Pacific, Disability at a Glance. United Nations ESCAP; 2015.
8. Titumir RA, Hossain J. Disability in Bangladesh: prevalence, knowledge, attitudes and practices. Dhaka: Unnayan Onneshan; 2005.
9. People with disabilities in India: from commitments to outcomes. Washington, DC: World Bank; 2009.
10. Tareque MI, Begum S, Saito Y. Inequality in disability in Bangladesh. PLoS One. 2014;9(7):e103681. doi: 10.1371/journal.pone.0103681.
11. Andaleeb SS. Service quality perceptions and patient satisfaction: a study of hospitals in a developing country. Soc Sci Med. 2001;52(9):1359-70
12. Mendoza Aldana J, Piechulek H, al-Sabir A. Client satisfaction and quality of health care in rural Bangladesh. Bull World Health Organ. 2001;79(6):512-7.
13. Hossain SJ, Ferdousi J, Biswas MK, Mahfuz N, Biswas G. Quality of care: view of patient satisfaction with physiotherapy in government and private settings in Dhaka, Bangladesh. Faridpur Med Coll J. 2013;7(2):71-4. doi: 10.3329/fmcj.v7i2.13502.
14. Khandakar MS. Rural health care system and patients' satisfaction towards medical care in Bangladesh: an empirical Study. J Bus Stud. 2014;35(2);83-102.
15. Rahman MM, Shahidullah M, Shahiduzzaman M, Rashid HA. Quality of health care from patient perspectives. Bangladesh Med Res Counc Bull. 2002;28(3):87-96.
16. Ferdousi MJ. Patient satisfaction with community clinic care: facility and household based survey in a sub-district in Bangladesh. Mediscope. 2015;1(1):6. doi: 10.3329/mediscope.v1i1.21633.
17. Zeithaml VA, Bitner MJ. Services Marketing. New York: McGraw Hill; 2003.
18. Schutt RK, Cruz ER, Woodford ML. Client satisfaction in a breast and cervical cancer early detection program: the influence of ethnicity and language, health, resources, and barriers. Women Health. 2008;48(3):283-302. doi: 10.1080/03630240802463475.
19. Alden DL, Do MH, Bhawuk D. Client satisfaction with reproductive health-care quality: integrating business approaches to modeling and measurement. Soc Sci Med. 2004;59(11):2219-32. doi: 10.1016/j.socscimed.2004.03.026.


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