



# Equality or equity in health care access: a qualitative study of doctors' explanations to a longer doctor's delay among female TB patients in Vietnam

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## Abstract

Earlier studies from Vietnam have highlighted the importance of studying gender aspects of health-seeking and diagnosis of potential tuberculosis patients. A longer doctor's delay to diagnosis among female TB patients has been shown. The objective of the present study was to explore doctors' views about and explanations for the longer doctor's delay. Five focus group discussions and three in-depth interviews were performed in a rural province in Vietnam. Thematic content analysis was used to interpret the data. The doctors suggest that women are lost or delayed within the health care-seeking chain, mainly because of barriers associated with the female gender. These barriers are identified, but yet the patient–doctor encounter seems to be steered by an equality principle. This results in gender blindness since equal treatment is suggested despite needs being different. We argue that gender equity should be the guiding principle for the tuberculosis patient–doctor encounter. An equity principle emphasises that needs vary with factors like gender or context. We suggest more research into the health care-seeking chain in order to identify the specific steps where TB diagnosis of men and women may be delayed. Interventions are needed in order to reduce delay to TB diagnosis especially for women and the current TB control strategy, (DOTS), needs to be examined from an equity perspective.

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## 1. Background

Vietnam is one of the high-burden TB countries in the world. During 2000, the notification rate of all TB cases was 115/100,000 [1]. Similar to case notifications from most low-income countries about

two-thirds of the reported new cases in Vietnam are male and one third female. The National TB programme (NTP) in Vietnam reports 80% case detection and 92% cure rate of new smear-positive cases [1]. However, still problems remain, the notification rates have increased during the last 10 years. Even though a well-working TB programme may be part of an explanation, an actual incidence increase could not be ruled out [1,2]. Since the true incidence of TB in Vietnam is not known, estimates of case detection are based

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on extrapolations from available reported data. In an earlier study from our group, we estimated case detection of pulmonary TB of the National TB programme in a rural district in northern Vietnam. We found case detection in this district to be much lower than the national reported ratio, and significantly so for women [3].

Our earlier qualitative and quantitative studies have mainly concentrated on the TB patient's perspective. These have shown that health-seeking behaviour differs between men and women, with women more often using providers outside the national health care system, and also spending less than male patients [4,5]. Perception of and attitudes to TB were found to be different between men and women in Vietnam. Female TB patients were more likely to perceive stigma and severe social consequences of the disease, whereas men with TB had more financial concerns [6,7]. Long et al. [8] have also showed that self-reported symptoms among male and female TB patients differed. Sputum production and hemoptysis were less common among female TB patients, two characteristic key-symptoms of TB that would raise suspicion of TB in a high prevalent country.

In a study on delay to TB diagnosis in Vietnam, Long et al. [9] reported that women with new sputum-smear positive pulmonary TB had 1.6 weeks longer delay from first contact with a licensed medical doctor to TB diagnosis than men (Table 1). The time from first symptom to first contact with a doctor was similar between men and women. This study finding indicates a longer hereafter called "doctor's delay" for female TB patients. A study from Thailand shows a similar finding with the risk of a long (more than 7 days) health care provider delay being higher among women. [10]. A doctor's delay could be cre-

Table 1

Doctor's delay (time from first contact with a qualified physician to the diagnosis of TB) and total delay (time from first symptom to TB diagnosis) for men and women

Delays mean (weeks)	Doctor's delay	Total delay
Men	3.8	11.4
Women	5.4	13.3
<i>P</i> -value <sup>a</sup>	0.003	0.02

From Long et al. [9].

<sup>a</sup> For the difference in means between men and women.

ated on several levels in the health care-seeking chain. Even though the patient has contacted a licensed doctor, both the patient and the doctor in addition to organisational routines may be involved in the mechanism creating the delay. Thus, we know from the above findings that the doctor's delay seems to be longer for female TB patients in the above contexts, but we know very little about possible underlying reasons.

The importance of the patient–doctor encounter, not only for patient satisfaction and compliance, but also for a successful health outcome has been established in modern medicine. Within this research area, the gender of both the patient and the doctor has been used as an analytical tool in relation to the success of the encounter [11,12]. In our earlier interview, studies with health care providers in Vietnam male doctors mentioned that female TB patients are more difficult to diagnose, whereas female doctors did not perceive any gender related problems in diagnosing TB [13].

To study further the mechanisms creating gender differences in patient detection and doctor's delay it is necessary to involve the health providers. We have chosen in this study to focus on doctors' opinions on delay to TB diagnosis. The specific objectives were to explore doctors' views and explanations for a longer doctor's delay among female TB patients in order to eventually contribute to improved case detection.

## 2. Methods

The principal investigator is a Swedish medical doctor (AT) involved in international public health research, with experience from earlier studies of TB in Vietnam. The co-investigator (EJ) has thorough experience of qualitative research in low-income countries, especially in Vietnam. Both researchers have participated in the study design, data collection and analysis.

### 2.1. The Vietnamese context

Most people in Vietnam have been in contact with TB; it is a well-known disease and notification rates are high [1]. Vietnam has a vertically organised National TB programme, meaning that TB care is organised from the big national referral hospitals in Hanoi

and Ho Chi Minh City via provincial TB hospitals down to district TB units. Local hospitals as well as community health centres and private providers are supposed to refer all suspect cases to the local district TB units. TB is considered a “social disease”, i.e. a threat to public health in Vietnam. Since treatment is in the public interest, TB medication and hospitalisation for smear-positive (contagious) cases are free. Despite this, there are still associated costs involved for the individual patient. Transport to health care facilities, diagnostic investigations and food during the hospital stay as well as secondary costs such as income loss all have to be covered by the patient him- or herself.

## 2.2. Study setting, study participants, data collection and analysis

The study was carried out in Quanh Ninh Province, at one general hospital and at the TB units in two districts in April 2001. Key informants were purposely selected among staff at the general hospital and the two district units. These were all medical doctors from various departments. Since knowledge in this field is scarce and we wanted to explore diverging views, focus group discussions (FGDs) together with in-depth interviews were performed. In order to avoid a focus that may be perceived as criticism of the performance of the individual doctor when discussing delay to diagnosis, FGDs were considered an appropriate method. Gender equality is on the political agenda of Vietnam today. Hence, there might be a risk of only obtaining “politically correct” opinions from FGD members. However, we conclude in retrospect that the methods used did allow for contrasting ideas to emerge.

The themes of the FGDs and in-depth interviews were developed from findings in our previous studies in Vietnam. Long et al. [9] have demonstrated a longer doctor’s delay to diagnosis among female TB patients, though causes and mechanisms for this have not been investigated, especially not from a doctor’s perspective. Johansson [13] has demonstrated the importance of the patient–doctor encounter for prompt diagnosing and successful treatment. In order to introduce the themes and get the discussion started, the participants were shown a table illustrating the longer time span from first contact with a qualified doctor to TB diagnosis among female patients (Table 1). Two case reports were also presented, representing the typ-

ical health-seeking behaviour of a male and female TB patient [4].

Five focus group discussions with seven to eight participants in each were carried out. One group included both men and women (mixed), while the other four groups were either male or female. To validate the data emerging from the FGDs and to enable a deeper probing into certain areas, two physicians (one male, one female) working at TB units and one male physician in a leading position were interviewed in-depth individually. One of the Swedish researchers ran the FGD with the mixed group in English (without translation). The exclusively male or female FGDs were moderated by a Vietnamese researcher. She is a sociologist working independently outside the province, recruited through personal contacts in Hanoi and with experience from working with qualitative methods, including focus groups. The in-depth interviews were performed by the Swedish researcher and interpreted simultaneously by the sociologist. The FGDs were done in a large room at the hospital and lasted for about 1–1.5 h. The in-depth interviews were made in the offices of the respective physician in the various districts. The interviews lasted about 1 h each.

All FGDs and interviews were tape recorded, translated verbally into English by the moderator and transcribed by the research team. The in-depth interviews were transcribed into English together with the interpreter to allow for more thorough interpretations of the answers. All transcripts were cross-checked by the moderator. FGDs and interviews were regularly transcribed the same day or the following morning. The interview process was finished when the team considered that data saturation had been achieved.

Verbal consent was obtained from all participants and they were informed that they could refuse participation or withdraw from the interviews at any time. Research and ethical clearance of the study was obtained from the Ministry of Health and the National Institute of Tuberculosis and Lung Disease in Hanoi, Vietnam and from the Karolinska Institute in Stockholm, Sweden.

A preliminary analysis was performed immediately following each FGD and interview to help focus the next FGD or interview. Open codes were generated and organised manually, and similar codes were grouped into categories. Categories were then organised into emerging themes. Overall, the analyses

followed the procedures for qualitative thematic content analysis [14]. This method was chosen since the translation process did not allow a word-by-word interpretation of data.

### 3. Results

#### 3.1. Gender and structural factors, implications for health care

In all our interviews and FGDs gender in relation to TB was never discussed in isolation. Inevitably, poverty and socio-economic inequities were mentioned at the same time.

Where resources are scarce, the allocation of funding for women's illnesses is even less than the small amount available for men. In rural areas in Vietnam, married women often live with their husband's family, the in-laws. The wife's status in the family is inferior to both that of her husband and the in-laws. The following description by a female doctor illustrates how these conditions affect daily life as well as personal health:

The TB patients usually come from very poor families, and they usually live under poor conditions. Popular rules state that the man should get treatment before the woman since he is the pillar of the household. In the rural areas, the status of women is lower than that of men. When men get TB, all family resources may be spent, but that is not done for women. So first of all the woman hides her illness and then maybe the family does not support her financially so she has more difficulties. (Female Dr. FG3)

In general, women were described as shy and hesitant, which was thought to have a negative effect on their health-seeking behaviour and their interaction with the doctor. They were perceived as delaying seeking medical care, and when finally seeing the doctor, being reluctant to and ashamed of talking about their symptoms. Compared to men, they were said to have a greater fear of TB-associated stigma. Women were also thought to have low self-esteem and limited knowledge in health care-seeking matters. Women often do not follow their doctor's prescriptions, mainly because of a need to double-check these with their hus-

band, family and neighbours before following them. Women were thus perceived to perform sanctioned actions as opposed to men, who were said to even "push the doctor" in order to get the proper diagnostic investigations done. The care-taking role of women was emphasised as one of the factors limiting women's access to time. Overall resources for women in terms of time and money were considered scarce, due to their inferior position in the household as well as the fact that they were busy taking care of their family and children.

Informants painted a completely different picture of the male gender role. In contrast to women, men in Vietnam were described as daring and open, even in contact with a medical doctor. Men were seen as willing to follow directions and prescriptions and, being the primary breadwinners, also to have more access to money and to have a decision-making power of their own, independently of the rest of the family.

The following quotes show how men and women are described and perceived as acting in accordance with their expected gender roles.

Vietnamese women are very shy, they have a character of their own. You know they are afraid when they make contact. They consult me about their health, and after examining them I propose an investigation. After some 5 days they will come back with the result and I ask "what took you so long?" They say that they were very busy taking care of the children and the family. Maybe this is how the TB diagnosis gets delayed. (Male Dr. FG1)

When a woman is advised to take a test, she first thinks about money. She may be responsible for spending within the household, but she does not think of herself. Children and family come first. If a woman comes together with her husband and he has to take some tests, she decides quickly that they should spend the money on him. There's a difference if she is the sick one. (Female Dr. FG5)

TB is a very common disease in the rural areas. When somebody gets TB it is easier if it's a man, he can bike to the hospital. Women have to ask their husbands or children to be transported to the hospital. Not every woman can go by herself. So men can supply the [sputum] test during 3 subsequent days

if the doctor asks for it, but women cannot. (Male Dr. FG2)

The characterisation of the female gender role not only comprised the weak female person, but also included another dimension. At the same time as women in general were described as shy, soft, hesitant and in need of support, women were also perceived as being able to wait for proper care without any problem, and as having the capacity to run a home despite being ill. She has to perform her daily duties and take responsibility for the welfare of the family, despite other emerging needs of her own.

When men get sick they get support from all family members like the in-laws and others. He gets support all the time from the family, they take care of him. But if the woman gets sick, as long as she can move she still has to do everything herself. (Female Dr. FG3)

Women are always busy with something so they don't think about themselves, they think about others. Men are quicker than women to seek care and find out about the disease. Women are busy with the family and may think it is of no importance, they always come late. (Male TB Dr.)

The following quote illustrates the expectations of men and women as being unchangeable and static. By accepting and emphasising that it is women who are responsible for the family and the home, a stereotypical female gender role is recreated.

The woman is always busier with work at home than the man is. Who will take care of the family if the woman has to stay at the TB unit? (Male Dr. FG4)

The doctor's views on female and male gender roles in Vietnam seemed relevant to the issue of how health-seeking behaviour and delay to TB diagnosis may differ between men and women. These interpretations were similar in the different FGDs and interviews, irrespective of the sex of the doctors and their positions in the health care hierarchy. Viewed as a whole, gender characteristics were generally considered as being able to cause a longer delay among women in following the doctor's prescribed investigations such as X-ray examinations or sputum smear testing.

### 3.2. Immediate reactions to the possibility of a doctor's delay

After showing the physicians the results of our previous studies, it became very clear that the doctors were very reluctant to accept the fact that there might be any kind of doctor's delay at all. They expressed surprise and disbelief in the findings we presented. Even when classified as cases of doctor's delay, the physicians interviewed explained that these cases must be caused by patient behaviour, primarily non-compliance.

### 3.3. A shift of responsibility away from oneself

In line with the immediate denial of any doctor's delay was the tendency to shift the responsibility for delays or inadequate health-seeking behaviour away from oneself and onto a different division such as the TB unit or onto the patient him- or herself. The quote below illustrates how there seems to be a well-known problem with inadequate adherence to the referral system, especially by women, but how the responsibility of the patients is shifted towards the TB unit.

If a patient with long duration of cough comes to see us, we will send them to chest X-ray. After that we can conclude if they have got TB. Then, we refer the patients to the TB unit. It is easier to refer the male patients, since women still have an important role in the family and they need to calculate their resources. In our hospital, we only have the responsibility of carrying out the chest X-ray, the rest is done at the TB unit. The main part of the delay starts after the X-ray is conducted. (Male Dr. FG2)

The delay mentioned here was interpreted as being caused by the patient delaying these investigations by simply not attending to them immediately. Further, this was explained by references to gender characteristics such as shyness among women, causing them to avoid medical investigations, or lack of decision-making power leading to a need to ask for permission before investigations could be performed. Time and time again, our informants stated as fact that doctors in Vietnam give men and women the same treatment without any gender bias. Yet, when discussing they offered conflicting views. The doctors at times recognise that gender-specific needs might vary.

However, they still argued that the patient–doctor encounter should be based on an equality principle, i.e. identical treatment of men and women. The following quote from a male doctor in focus group 1 (FG1) summarises the general view quite well.

I think we examine all patients equally, without any difference between men and women. In my opinion, the delay only depends on the attitude of the patient. (Male Dr. FG1)

Although the male doctor quoted below perceives that getting to the hospital might be difficult for women, he states that men and women have the same opportunities of getting to healthcare.

I would like yet again to emphasise the problem for women with transportation from their home to the hospital. And I am very well aware that in any Vietnamese family if there is one sick person, the man and woman have the same chances of getting treatment. Nobody says that the man has the right to go to hospital and the woman does not, nobody can say that. It might happen, but in very few families. (Male Dr. FG2)

### 3.4. Gender related needs in the patient–doctor encounter

Some physicians thought the success of the patient–doctor encounter was dependent on sex and much easier if doctor and patient were of the same sex, whereas others said communication was just as easy regardless. There were no evident gender differences among the doctors representing the different opinions, rather the opinions seemed steered by the doctor's individual personality. The respondents seemed also to see current societal gender roles creating different needs and expectations during the doctor–patient encounter.

There is a difference between female and male doctors. If I'm a woman, I may say more to a female doctor and then I'll get the diagnosis sooner. I think there are more male doctors in TB management. . . Women, they may know about the symptoms of TB, they may know before coming to the doctor but they are very shy about that so they don't say much to the doctor. That's why the doctor does not pay much attention to them. . . Women don't want to talk about

all their symptoms, they do not want to be informed about the disease. If we have a good communication she will say more about her symptoms. In the beginning, we don't get to know about TB suspected symptoms, but later on we may. (Female Dr. FG1)

I explain more to women. I inform them that TB is a curable disease. I inform that it's better if treatment is started sooner, it is easier to cure. With women we have to talk softly, not directly. We spend more time with the female patient. (Female Dr. FG5)

I don't discriminate against any patients, male or female, it is the same for me. I have the same attitude towards all patients. I usually encourage them to follow the treatment and advise them that TB is a curable disease. During the encounter, I can make them feel the same, I can ask them about their lives and about previous contacts with TB patients and their economy so I get to know them. (Male TB Dr. FG7)

I would like to emphasise that the understanding between doctor and patient depends a lot on the sex of the doctor. If the doctor is male and the patient is male they have an easy understanding. (Male Dr. FG2).

### 3.5. Doctors' suggestions for improvement

When discussing various aspects of doctor's delay, a few of the discussants brought up problems with the current organisation of TB and medical care and suggested solutions. These surfaced spontaneously, and it was evident that thought had been given to these issues beforehand. General views were that the relationship between higher (general hospital, provincial TB hospital) and lower (community health centres and district hospitals) levels of care needed to be improved. Doctors working at lower levels were considered less knowledgeable about diseases like TB, and more likely to prescribe antibiotics or other medications irrationally and for their own gain. Improved education to these doctors and easier referral to TB diagnostics were mentioned. The vertical character of the National TB programme was also criticised and said to create lack of contact and understanding between the different units.

Most of the solutions that were presented were one-way solutions involving top-down actions on the part of the doctor or, in a broader perspective, by the health care system or state.

We talk a lot about gender equality but I don't think the rural women know anything about this. The women in the rural areas lack knowledge. They could be informed that TB is curable, and that if they reduce the delay less transmission will occur. If you treat them in the community after a short while other people will realise that TB is not dangerous. (Female Dr. FG3)

Suggestions that involved empowerment and more specifically individualising the patient-doctor encounter were only put forward by a couple of the participants. One male doctor expressed his way of improving the patient-doctor encounter in the following way:

When the patients are farmers I try to explain to them and support them because they suffer a lot. They are afraid. But if the patients are workers or teachers they know more because they have more support than farmers. Farmers are very shy and we try to explain because you know they know less than others. (Male Dr. FG1)

The male doctor in a leading position recognised the importance of the patient-doctor encounter. He also brought up lack of empathy leading to stereotypical behaviour and lack of understanding of the individual patient.

I agree they [the doctors] are busy, but they are robots; they use one-way communication. They fulfil their responsibilities with techniques. I have stated the need for a reorientation several times now. (Male Dr. interview)

#### 4. Discussion

The Communist party in Vietnam promotes gender equality. Positive effects of the equal opportunity politics are seen in many areas [15]. Recently, a discussion of equity versus equality has emerged in the public health area. Where gender equality indicates identical treatment or opportunities gender equity implies in-

stead a differentiated treatment when it is needed. An equity principle is thus ruled by the different needs men and women may have in a certain context. Within public health, where biological disease characteristics interact with social determinants to create situations of different needs among men and women, the equity principle is essential [16]. Defined in this way, gender equity in health is equal to the absence of gender bias. For a disease like TB, it is particularly important to ensure that, as Sen et al. [16] put it, "bias does not masquerade as "natural" biological difference". In the case of TB, the possibility of a gender bias could be raised when discussing the gender distribution observed in reported notification rates.

In our findings, the patient-doctor encounter is put in the context of not only traditional views of men and women but also the equality principle, stating that men and women should be treated in the same way. When an equality principle is applied to an encounter, in which positions are unequal to begin with, the result may instead be expressed as gender blindness [16]. Our results demonstrate this in several ways. The discussants reiterate the equal treatment principle but still acknowledge that men and women have different needs. It is clear to the doctor who talks about the problems of rural women with transportation that these are related to women's status and limited access to resources. Yet, he also talks about the equal opportunities to good health care given to men and women in Vietnam. In this light, the equality principle that should steer the patient-doctor encounter is instead expressed as gender blindness, where the basic organising gender principles are prevailing.

The forthcoming message from our results is thus that the longer doctor's delay for female TB patients is not caused by delays in recognising symptoms or proposing investigations, but instead by the fact that women are thought to delay their own diagnostic process. Reasons for this are considered to be both socio-cultural beliefs such as TB-related stigma and social consequences of the disease, and practical concerns like costs, transportation and lack of decision-making power on the part of the individual woman. These factors described should not be regarded in isolation, but rather as inter-linked parts of the structural inequities that exists between men and women in Vietnam. Women's inferior status in the family and the described need to perform sanctioned

actions makes them more vulnerable to the isolation related to TB stigma. Thus, the consequences of TB related stigma are reproducing gender inequities in a similar way to what has been described for HIV/AIDS [17].

The interpretation by the doctors in our study is that the longer delay to TB diagnosis among women is caused by a break in the health-seeking chain, due to factors associated with the female gender role. Not because of any factors to be found within the health care system.

Despite the awareness of these inequities among the doctors, the efforts needed to change the situation are not mobilised. Hence, this may too be described as a form of doctor's delay. This aspect of the doctor's delay has less to do with the individual performance of the doctors than with the societal system and structures that influence the patient–doctor encounter.

What, then, causes the break in the health care chain and the lack of action to counteract it? According to our informants, the patient–doctor encounter is not seen as a possibility of enacting with patients as individuals. As opposed to what current trends in specifically modern medicine argue [12]. Vietnamese doctors state that the encounter should, in line with the equality principle, preferably be identical for all patients. The doctor's responsibility starts and ends with the patient entering and leaving the room, and what happens in the room is determined by the doctor. Typically one-way communication is described with the doctor informing and suggesting different actions to the patient and one doctor complained about the doctors' tendency to "act like robots".

To avoid gender blindness in the patient–doctor encounter, we argue that the possibility of getting a TB diagnosis should instead be governed by an equity principle. In practice, this means that the patient–doctor encounter has to be a personalised meeting where enough time is allocated for a communication built on trust and empowerment. Studies from other parts of the world have shown how the quality of an encounter increases if more time is spent on communication, explanations, information and other strategies that are thought to empower the patient [18]. For a stigmatising disease like TB, which also requires long and tedious treatment, patient empowerment is of great importance [13]. To override these limiting factors, the diagnostic procedure needs

to be approached from the situation of the individual man or woman with TB suggestive symptoms.

The structure of the National TB programme needs also to be discussed from an equity perspective. The programme is organised according to the WHO promoted DOTS strategy [19]. A "one size fits all" policy, which focuses on contagious cases identified by self-referral. Referral to the NTP could be done both by the individual patient as well as by other health providers. The NTP structure is vertical and according to our results there is a lack of communication between different levels of care. In many rural districts, sputum smear examinations are only performed at the hospitals where the TB unit is situated [4]. In light of our findings, several barriers to the actual TB diagnosis could be found within the structure of the NTP.

Suggestive TB patients have to pay for the initial examinations as well as for transport to the TB unit, which in rural areas often represent a considerable distance [4]. In addition there are socio-cultural factors negatively associated with TB, which could imply a low motivation to follow the referral chain and go for the specific TB examinations [7]. Included in the DOTS strategy is also the concept of direct observed treatment (DOT), meaning that each intake of TB medication should literally be supervised [19]. In Vietnam, the DOT part is often solved by the patient being hospitalised during the initial 2 months of the treatment. Ambulatory treatment exists as well, but then implies that the patient has to be in regular contact with a health care provider. In the case of a stigmatising disease like TB, apart from the practical concerns associated with daily health care contacts, there are additional aspects to consider when analysing the policy from an equity perspective. Fear of being associated with TB may lead to a fear of the DOT regimen where it is more or less obvious to anyone in the neighbourhood that the patient is being treated for TB, and may in turn lead to delays in following the referral chain. Earlier studies have shown gender differences in the health-seeking behaviour among individuals with TB suggestive symptoms [4,5,13]. According to these and the here presented results, a multitude of factors such as stigma, family hierarchy, resource allocation in terms of time and money and also the quality of the patient–doctor encounter are more important to women's health-seeking behaviour than men's.

## 5. Conclusions

In this study, we took a special interest in the longer time from first contact with a doctor to tuberculosis diagnosis found among female TB patients. Despite the fact that this delay has been quantitatively assessed very little is known about underlying reasons [9,20]. Our study contributes with an exploration of this subject from the doctors' perspective.

The delays have to be further examined and we suggest more research into the health care-seeking chain in order to identify the specific steps where TB diagnosis of men and women may be delayed. The current TB control strategy, DOTS, also needs to be examined from an equity perspective to identify possible sources of gender bias.

The doctors suggest that women are lost or delayed within the health care-seeking chain, mainly because of specific barriers associated with the female gender. These barriers are well-known, but yet the patient–doctor encounter seems to be steered by an equality principle without considerations of gender specific needs. We argue therefore that gender equity should be the guiding principle for the tuberculosis patient–doctor encounter, implying that interventions are needed in order to reduce delay to TB diagnosis especially for women. An intervention using house–hold interviews to identify TB cases has been studied in a rural Vietnamese district. The study showed a significant under-diagnosing and a very low case detection ratio of female TB cases in this area [3]. In line with those findings and the here presented results, there seem to be a need of both concrete actions to increase TB case finding together with a general need of increasing awareness of gender inequities among doctors. Johansson [13] has described in her earlier work from Vietnam how a 'broker system' exists where former TB patients in an unofficial way inform potential TB patients about health-seeking and treatment. This system could be formalised and interventions used to address the issues of health-seeking behaviour and under detection of especially female TB cases [21].

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