A Study On The Utilization and Health Services Provision by Community Clinics of Jashore, Bangladesh

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ABSTRACT

Background: As Bangladesh has gained the reputation of improving the health sectors, much health related sites still require improvements. Community clinic services (CCS) may contribute to this sector with its foremost importance. So this study was conducted to investigate the utilization and health services provision by community clinics (CCs) in rural area.
Methods: A descriptive longitudinal study was conducted among three community clinics of Jashore and a structured questionnaire was developed on which most of the questions were developed to find out the contributions of these community clinics. Here for data analysis we used SPSS version 25.0 software.
Results: Here we analyzed health service related data from three randomly selected community clinics (CCs). We found an average of 15 patients got antenatal care every month by the Komlapur CC throughout the year. About 140 patients received health services per month from Dogachiya CC. About 634 children were benefited by Saziyali CC throughout the year. By this study we came to know that average 67-75 patients were provided iron supplementations each month by Saziyali CC. All of the CCs had active referral system and online reporting system.
Conclusion: From our study we came to know that majority % of rural people are now dependent on community health care services. But most of the community clinics have many limitations regarding infrastructure, training, medicines, financial etc. So the government should take necessary steps regarding this.

Key words: Community clinic, Ante natal care, Post natal care

INTRODUCTION

Usually the determinants of health are the health system which is the societal response of it. The value of human life is the fundamental of health system. It is the principle commitment of the government of Bangladesh is to supply the basic medical requirement and improve the public health and nutritional status of the people [1]. Since independence many development in health and social areas has been achieved by Bangladesh. Our life expectancy is increased from 45 years to 65 years by 2005. Our infant mortality rate is also decreased from 153 per 1000 live births to 52 per 1000 live births by 2006 [2]. In rural, urban, slum and tribal areas the

prevalence of diarrhoea among the children are 7.1, 7.4 , 11.2 and 5.1 respectively in Bangladesh [3]. Over the last 48 years of independence a lot of improvement in health sectors has been made by Bangladesh which includes medical colleges, medical universities, private clinics and hospitals, community clinics etc. The awareness regarding health issues among general public has also been increased during this period [4]. We know that the economic development of a country is largely dependent on the health status of its population. The vicious cycle of poverty and ill health can be broken up by setting up effective and quality full healthcare system [5]. In order to provide primary health care facilities to door to door to people all over the country the government of Bangladesh started community clinics in 1996. WHO has declared Bangladesh as one of the 58 crisis countries facing crisis on acute human resources for health (HRH). In 2009 a project called "Revitalization of Community Health Care Initiatives in Bangladesh" had been taken up by the government of Bangladesh. The vital purpose of community clinics is to give health educations, medicines, higher health care facilities as like in union health care centres [6]. The key to establish access to care is the universal health coverage (UHC). A regional UHC strategy has been promoted by the WHO South East Asian Region in which the community based health care system is centred [7]. In Bangladesh 14000 community clinics has been established since 2009 for every 6000 population throughout the country in order to bring the health care facilities at the doorstep of the community [8]. Usually in community clinics there are many health workers who deliver the health care services . Community health workers refer to those people who deliver health services, who has training experiences and who does have any kind of professional degree in tertiary education. The association between community and the health system is established by the community health workers (CHWs) [9]. In any society the vital tool for functional health care services is the primary health care system. To maintain the health care services community clinics (CC) has been developed. Bangladesh has 65% people who live in rural area. So in rural areas the CCs provide health care especially those who are at risk such as vulnerable women [10]. Though many challenges such as gender equality, women's education, natural disasters, low national GDP and high poverty; over the four decades Bangladesh has gained tremendous success in health care. But in the areas of maternal and child malnutrition and primary health care (PHC) more success is still required [11]. In Bangladesh about seven million children has been suffering from stunting and under nutrition and as a result their mental and physical potentials has not been developed properly [12]. Inadequate utilization of community clinic services is another factor which is belonging to this sector. Many reasons are responsible for this under utilization some are distance of the facility from home, lack of awareness, poor quality of care etc [10]. Only the association between the community and health system is not enough to improve the performance of the health system but also timely decision making and action based on available information is also required. To follow up the progress of planned activities Community based health information system is essential [13]. The availability and accessibility of services in which people are able to understand, accept and utilize it, only then the effectiveness of the health system will be ensured [14]. The main objective of our study is to determine the utilization and health services provision by community clinics in rural areas of Bangladesh.

METHODS

It was a descriptive longitudinal study.The study population in this survey included people who were usually received primary health care services from Community Clinics situated in Jashore district of Bangladesh. We selected three community clinics which were named as Komlapur community clinic, Saziyali community clinic and Dogachiya community clinic. The community clinics were selected by randomize sampling process from the total community clinics situated in Jashore district. We selected those community clinics because all of these three community clinics were situated in mostly underdeveloped and vulnerable areas. People who did not receive healthcare services from the above mentioned community clinics were excluded from the survey. We collected last one year data from each community clinic regarding different category of patients who received health services by the above mentioned community clinics from September 2018 to August 2019. Actually everyday patient's data were recorded by the Community Health Care Provider (CHCP), Health Assistant (HA) and Family Welfare Assistant (FWA). They collected data through face to face interview of the patients and the face to face interviews were taken in the CCs. Each week on Saturday we went to the CCs and collected the weekly data from the community clinics. We classified our patients as children, Ante natal care of patients and post natal care of patients. From the recorded data of the CHCP, HA and FWA we only collected data about iron, calcium and folic acid supplementation of anti natal, post natal and other patients. We also collected data about the number of children got health care services by the CCs as well as we collected information about nutritional counselling, training facilities of the community health care providers (CHCPs), educational background of the CHCPs and the referral system of those community clinics. Many health services were given to ante natal and post natal care including health and nutrition education, basic knowledge about their diet and iron, folic acid, calcium supplementation. Each week on Saturday night we inputted all the collected weekly data in SPSS software so that no data manipulation could

be occurred. Data were compiled, tabulated and analyzed using SPSS according to the objectives of the study. Actually we analyzed the frequency distribution of data based on % among various variables. After getting the frequency distribution (%) chart we represented the data on bar charts.

RESULTS

From the descriptive longitudinal study of Komlapur, Dogachiya and Saziyali community clinics it was identified that a total number 1833, 1660 and 1502 beneficiaries received different types of health services throughout the year. From these three community clinics we came to know that each community clinic has specific area range to give health services. On the basis of their range about 6500, 7800 and 6600 people were under the direct health coverage services of Komlapur, Dogachiya and Saziyali community clinic respectively. An average of 148 and 42 patients received ante natal and post natal care respectively throughout the year from Komlapur community clinic. The figure 1 showed how many patients got ante natal and postnatal care throughout the year by Komlapur community clinic and we found that approximately an average of 15 and 4 patients got ante natal and post natal care on monthly basis throughout the year. The figures 2 and 3 showed that how many patients were facilitated per month by Komlapur and Saziyali community clinic respectively. A compare of health services between Komlapur and Saziyali community clinic was established and we found that more patients were benefited by Komlapur community clinic than Saziyali community clinic. From the figure 2 an average of about 150 patients were given health facility per month by Komlapur community clinic and on the other hand from figure 3 an average of 125 patients per month were benefited by Saziyali community clinic. The figure 4 showed the health service situation of children by Saziyali community clinic .From that figure we came to know that about approximately 40-50 children got health service on monthly basis by the Saziyali community clinic. This survey identified that a total of 634 children were benefited from Saziyali community clinic throughout the year. The figure 5 demonstrated the iron supplementation throughout the year by Saziyali community clinic. A total of 868 patients got iron supplementation in 1 year from Saziyali community clinic. We noticed that about 67-75 patients got iron supplementation service monthly throughout the year by Saziyali community clinic. From figure 6 we wanted to demonstrate how many patients got health services from Dogachiya community clinic per month. We surprisingly found that approximately an average of 140 patients got health services per month on regular basis. During data collection we also got some verbal information from the community clinics regarding referral system, qualification of the CHCPs, disease types, training system, online reporting systems and the nutritional counselling situation. We found that all of the three community clinics had an active referral system and they referred the patients mostly to sadar hospital Jashore. About 3% patients were referred each month by these community clinics. The entire CHCPs of the CCs had master's degree from different field and all of them obtained their masters degree from M.M College Jashore. All of the CHCPs got 3 month basic training regarding health services from the

FIGURE 1. Ante natal and post natal care situation in Komlapur community clinic

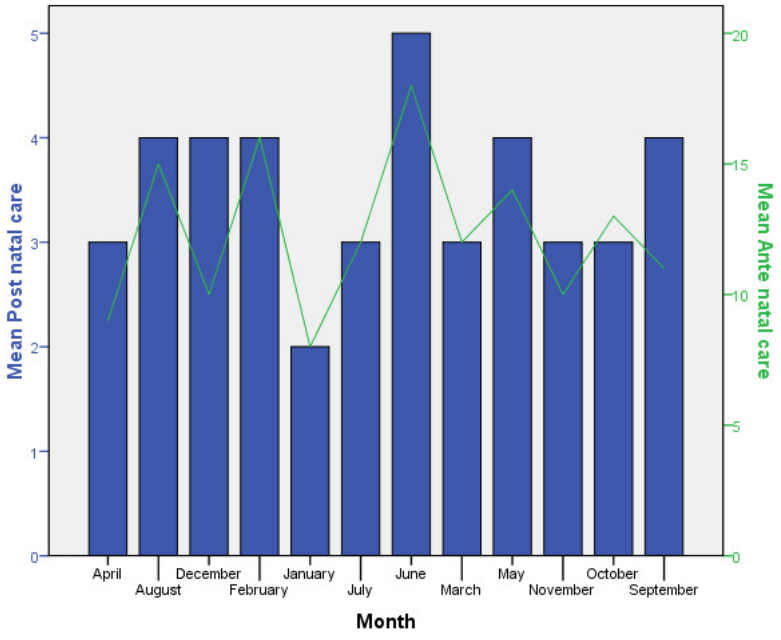


FIGURE 2.Total patients per month in Komlapur community clinic

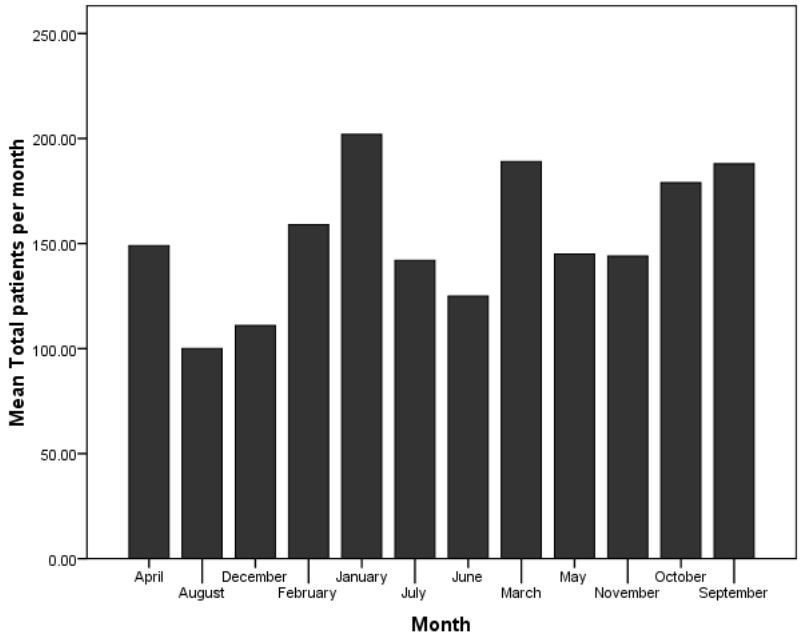
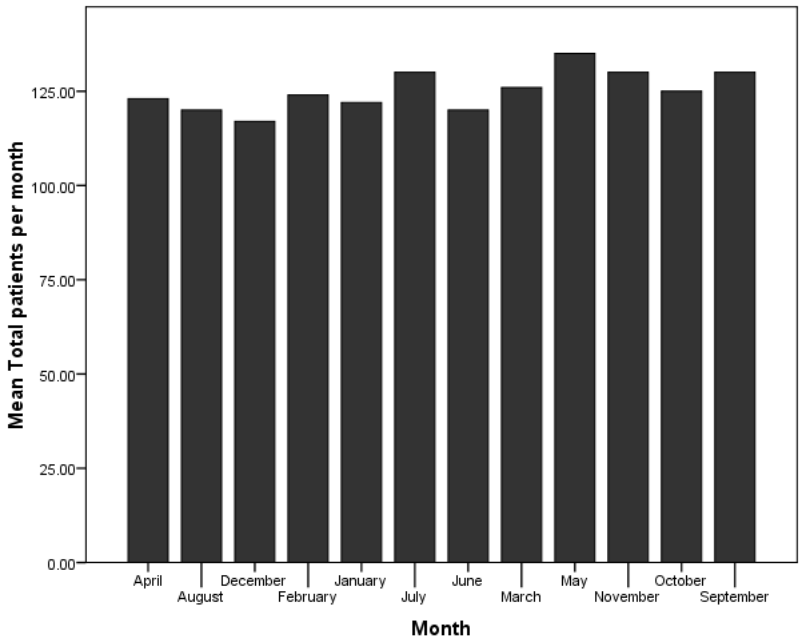


FIGURE 3.Total patients per month in Saziyali CC



upazila health office and during the three months they got 1.5 month theoretical training and 1.5 month practical training. The CHCPs informed us that all of the patients had lower socio economic condition and most of the patients were women and children. The CHCPs provide nutritional counselling to pregnant woman, lactating mother and children. We also noticed some common types diseases which were handled by these community clinics throughout the year and the diseases were mostly fever, cough, diarrhoea, dysentery, allergy, abdominal pain, common eye diseases, checking of diabetics, immunization to pregnant women etc. We found that all of the community clinics had to report through online daily about their daily health services to patients. Structural Information of Community Clinics was as follows-The Community Clinics had been built on the land given by

FIGURE 4. Health service to children in Saziyali CC

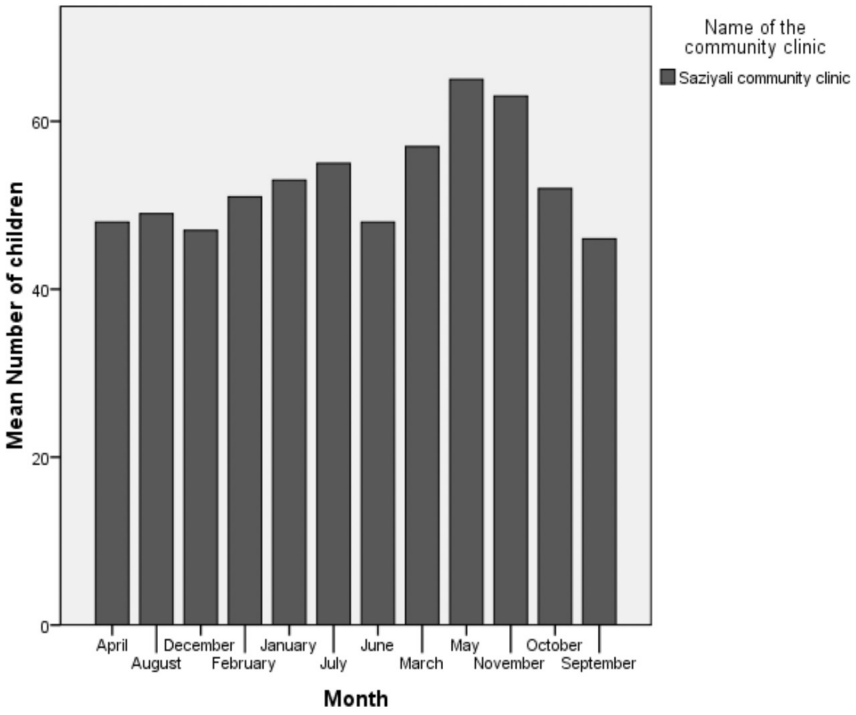
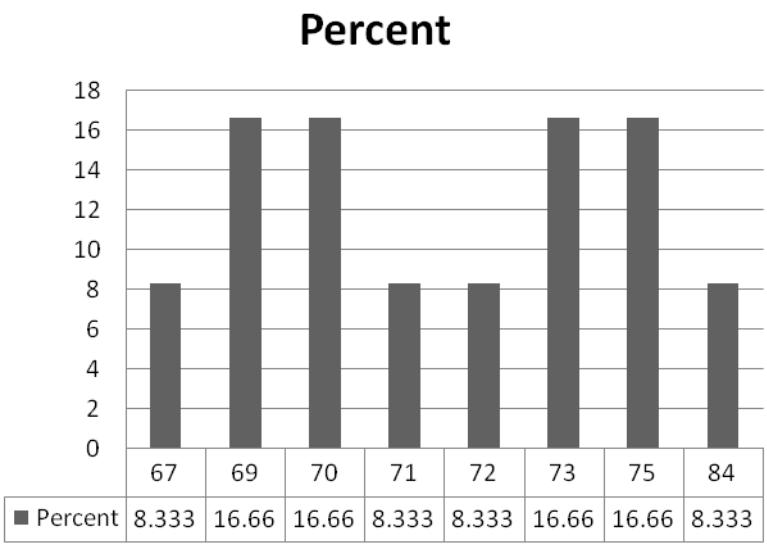


FIGURE 5. Iron supplementation throughout the year in Saziyali community clinic

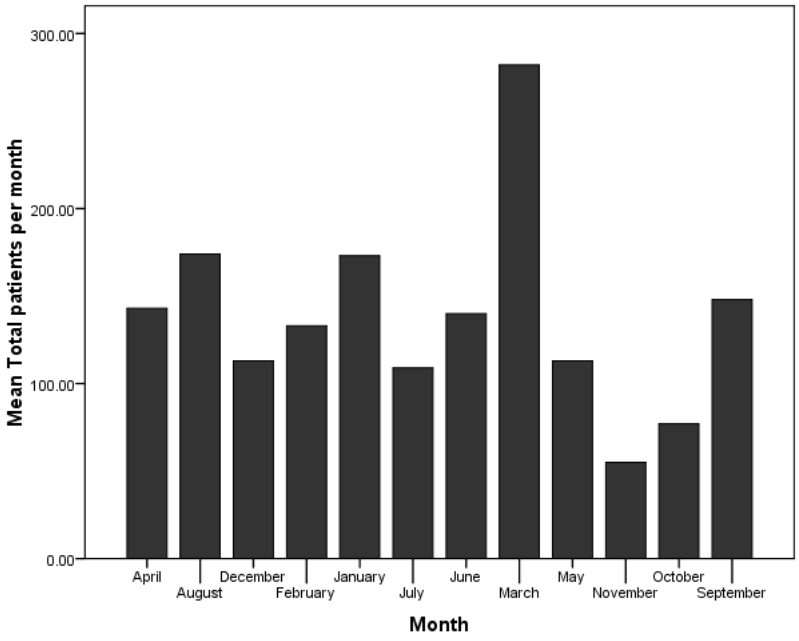


local people with the financial help from government of Bangladesh. Those were mainly one storey building. The community clinics had two rooms excluding the EPI corner and patient waiting room. Two rooms were used for reviewing patients and providing services. The clinics were well ventilated as well as well furnished. But the water supply, toilet and electricity facilities were not sufficient there.

DISCUSSION

The main function of community clinic is to provide basic treatment for all groups of people. Basic treatment is important including first aid services. Another function of community clinic is to provide maternal and child health services. It includes registration of pregnant women and motivates them to attend ante natal care during pregnancy. In 2002, maternal health review stated that in only 20% of

FIGURE 6. Total patients per month in Dogachiya community clinic



cases government maternal health services was received by people. Our study found an improvement in provision of maternal health services.

According to the Barman S et al study about health care services in community clinic of Bangladesh they found active referral system in community clinics which is similar with our study because we also found active referral system to higher level care if the patients cannot be managed in community clinics.

The government policy says that if patients cannot be managed in the community referral should be made to nearby secondary or tertiary government hospitals. This is totally matched with our survey because all of the community clinics within our study referred patients to sadar hospital Jashore which is a government hospital.

It is evident from the report of health system development program states that people in the community expected the establishment of a hospital with availability of MBBS doctors, nurses and necessary logistics for treatment of all types of diseases at grass root level. However, in reality they have got a small clinic with limited health facilities and treatment which are usually provided by undertrained or untrained and unskilled service providers with inadequate supply of drugs and logistics. There is also an issue with attitude and availability of service providers in clinics.

The report from health systems development program states that the reasons why community clinics are not functioning properly could be either due to lack of drugs and medical equipment or limited knowledge of service providers. We also asked the CHCPs about their limitations to provide health services to the community level they also gave us the same information as the health system development program.

Though community clinics have some limitations but it provides great health services to people specially the rural individuals. Most of the rural people have low socio economic condition so they cannot bear the cost of health care services. These community clinics provide cost free health care services to vulnerable group of people specially children, adolescents, mother and old age people. From our study we found that some community clinics provide health care facilities to orphan group which was totally cost free service.

Several recommendations can be made to improve the service in community clinics such as 1) regular visit of community clinics by graduate doctors to ensure service standards; 2) provision of simple diagnostic procedures in community clinics; 3) increase supply of free medicines for rural people; 4) increase awareness among local people by organizing awareness program regarding health services; 5) involvement of community groups to ensure accountability in managing community clinics; 6) regular and long term training facilities for community health care service providers to increase knowledge and competency.

The main strength of our study is the successful representation of actual importance of community clinics in rural areas. From our study we can say that community clinics have great impact on health services provision and utilization around vulnerable areas. In this study we also represent the limitations of these community clinics so that the government of Bangladesh can get an overview of these problems and take appropriate actions regarding these problems.

The study has some limitations such as short duration of the study, number of study population was limited and the study was conducted only in three community clinics which was not sufficient enough to draw any concrete conclusion.

CONCLUSION

Through a one-stop service with particular emphasis on vulnerable and poor people in community the community clinics aim to provide health and family planning services. HPSP (Health and Population Sector Program (1998-2003) has stated that the function of community clinic would be improved with involvement of community groups and adequate and effective service provision by service providers [15]. However in reality the standard of providing health services is inadequate in most of the sectors. Though, there are some limitations in providing health services, community clinic has opened a new era in the health service of Bangladesh.

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Conflict of Interest

None declared

Ethical approval

Not require

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