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Reproductive Health Care Services for Women at Community Clinic in Rajshahi City: A Cross Sectional Study

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Abstract

In Bangladesh has achieved remarkable successes in improving the health of the population, some health indicators remain poor. One factor contributing to this situation is low use of primary and community health services. The aim of the study was to assess the general knowledge community clinic and its reproductive health services. A cross sectional descriptive study was carried out for a view to assess knowledge about reproductive health care services for women at community clinic in Rajshahi. The sample size was 307. Study showed that (53.7%) were in the age group of 21-30 years, monthly family income (87.6%) was taka 6001-10000, education level 54.1% was class VI-XII, among them (79.2%) were housewife, 99.0% of the respondents heard about CC, (97.1%) of the respondents received services from the CHCP. It was found that majority (98.7%) of the respondents knew about the health care services provided by CC, majority (99.3%) of the respondents knew about the services provided for MCH, majority (99.3%) of the respondents knew about services provided for family planning by CC, majority (95.8%) of the respondents knew about the services provided for health education, majority (97.7%) did not know about the services provided for EOC, majority (83.1%) of the respondents knew about services provided for safe motherhood, majority (90.6%) of the respondents knew about the services provided for referral to UHC. The relationship between educational status of the respondents and going to CC, types of care was found statistically non-significant (p>0.01). The relationship between occupation of the respondents and by whom the service was provided, type of care was found statistically significant (p<0.01). It was found that 98.70% of the respondents were Muslim, 94.46% of the respondents were married and 52.44% of the respondents were from joint family. This study provided some important information which might help the concerned authority to take appropriate measures to improve the health status of the women in Rajshahi district.

Keywords: Awareness, Reproductive health, community health services and Rajshahi City.

AMS Classification: 62P10.

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1. Introduction

The present Government during its previous tenure in 1998 planned to establish 13,500 Community Clinics. During 1998-2001 period 10,723 Community Clinics were constructed and 8,000 started functioning. Due to change of govt. in 2001 Community Clinics were closed and remained as such till 2008. Govt. in 2009 has taken initiative for revitalization of Community Clinic as priority program & is being implemented through RCHCIB under MoHFW (Salahuddin et al. 1988). In Bangladesh has achieved remarkable successes in improving the health of the population, some health indicators remain poor. One factor contributing to this situation is low use of primary and community health services. Reasons for not using community health services include cultural and social belief systems, discrimination against the poor, distance of the facility from home, lack of information on sources of care, lack of awareness on the value of services, perceived poor quality of care, and high access costs. To improve this situation, especially access, use and equity, the Ministry of Health and Family Welfare (MOHFW) has built nearly 13,500 community clinics (Potter-Perry 2005) through the 'Revitalization of Community Health Care Initiative in Bangladesh (RCHCIB) - Community Clinic Project' aimed at providing an essential service package for women, children and the poor. However, most community clinics (CCs) are yet to become fully functional due to rational use of drugs, trained providers, system wise referral mechanisms and favorable opening hours. One unique approach taken by the Government at that time was to construct these community clinics in lands which would be donated by the community, to be managed by a community based committee, formed by the local people and to be chaired by a representative of the local government bodies, i.e., union perished, as per a manual prepared by the Ministry of Health & Family Welfare, Government of Bangladesh. Land donor is a mandated member of the committee. The member secretary of the committee is CHCP. The committee has to have at least three women as members and one third of the committees to be chaired by female representatives of the union porishod (WHO: Mother Baby Package 1994). The word clinic means a center for physical examination and treatment of ambulant patients who are not hospitalized (Long et al., 1993). The terms of reference of the committee was also given in the manual by the Ministry back in 1998, which was modified later. All these clinics were constructed over a piece of land of 3 to 5 decimals, a prototype structure with 2 rooms and a waiting space. Each clinic has a sanitary latrine and a tube well. As a condition the piece of donated land required to be in at least at street level and not a ditch or low land and should be at a well connected place, transportable and easily accessible (Chowdhury and Mushtaque, 2005). In the late 1990s, the Government of Bangladesh, with support from the World Health Organization (WHO), decided to establish one community clinic for every 6000 population, within half-an-hour walking distance, or within ¹/₂ km distance from one rural residency to bring health care to the doorsteps of the community. Here community is defined within 6000 people for improvement of better health services on primary health care. These clinics were intended as one-stop service centers to meet community primary health care needs (Anantha, 2000).Community clinic is the lowest tire the primary level health facilities established in rural areas all over Bangladesh including very hard to reach, remote and isolated areas. It is the first to contact and one point service outlet for health. At present 13,320 (96% of the target 13,861) are on board and soon 200 more will be added in the list. For providing services 13,822 CHCP, a new category of health care service providers one for each CC have been recruited, provided basic and refresher training. They have also been provided training from other programmes. They have been provided services to the rural people particularly the poor and

vulnerable. HA and FWA have also been supporting them at CC. Essential medicines out of which four simple antibiotics and rest OTC products. Temporary contraceptives are supplied to CC. from 2009 to 2016, medicine worth BDT 8,270.50 million with 25 - 30 items of medicines have been supplied to CCs. Up to March 2016 more than 483 million visits have been made to CC services of which more than 11 million emergency and complicated patients have been referred to higher facilities for proper management (Gupte 1996). The immediate supervisors of these clinics are the union level field supervisors, i.e., Assistant Health Inspectors (AHIs) and Family Planning Inspectors (FPIs) from the directorate of health and directorate of family planning respectively. The clinics are also visited on a monthly basis by the union level service providers, e.g., Family Welfare Visitors (FWVs) and Medical Assistants (MAs)/Sub-Assistant Community Medical Officers (SACMOs) from the two directorates respectively. It is expected that medical officers working at the union level might also visit these clinics when an order is passed to this end (Haque et al. 1994).Now people can avail of health, family planning, nutrition, overall antenatal and postnatal care, diarrhoea, pneumonia with other childhood infections reproductive health with consequences of early marriage, and nutrition services under one roof and within half-an-hour walking distance from their homes, even in remote areas. Community clinics are not only providing health, family and nutrition services to the rural people but are also becoming centers for health information and consultation. On average, each clinic receives 40 patients per day. The aim of the study was to assess the general knowledge community clinic and its reproductive health services.

2. Materials and Methods

2.1 Study Design: This was cross-sectional type of descriptive study.

2.2 Study Period: From January 2017 to December 2017.

2.3 Place of the study: Department of Community Medicine, Rajshahi Medical College.

2.4 Area of the study: Jagirpara and Kukhondi Community Clinic in Rajshahi district, Rajshahi.

3.5 Study population: All the patients attending Jagirpara and Kukhondi Community Clinic, Rajshahi during the study period constituted the study population.

2.6 Sample size: Sample size were 307.

2.7 Sampling technique: Purposive sampling technique was followed.

2.8 Sample size determination technique: The sample size was determined by using the following formula:

Sample size, $n = (z^2pq)/d^2$, Where, p = Response distribution i.e., proportion of factor in the population or the expected frequency value, q = 1-p, d = Margin of error is the amount of error that one would tolerate. Z = Area under normal curve corresponding to the desired confidence level (CI) and it is the amount of uncertainty that one can tolerate. Now for the present study, Z = 1.96 at 9.5% CI, p = 0.6 (Rate of utilization of health care services by the women), q = 0.4 and d = 0.05, $n = [(1.96)^2 (0.6) (0.4)] / (0.05)^2 = 368$. Total sample size taken for this study was 307 (Unavailability of the respondents).

2.9 Research instruments: A structured questionnaire was used to collect data from the respondents.

2.10 Data collection procedure: The researcher himself collected data from the women attending Community Clinic, Rajshahi by face to face interview through a partially structured questionnaire. All efforts were made to collect data accurately.

2.11 Data analysis procedure: All data was entered and analyzed through SPSS 21.0. Mean and standard deviation will be used for continuous data while frequency and percentage will be calculated for categorical data. Statistical significance was found by applying relevant statistical tests at appropriate probability level (p = 0.05 or p = 0.01).

3. Results

Regarding age distribution of the respondents it was found that out of 307 respondents majority(53.7%) were in the age group of 21-30 years, 25.1% were 31-40 years, 15.6% were 10-20 years, 3.9% were 41-50 years and only 1.6% were in the age group of 51-60 years. The mean age of the respondents was 29.23 \pm 11.35 years (Table No. 1). Regarding monthly family income it was revealed that out of 307 respondents majority (87.6%) had taka 6001-10000 taka as monthly family income, 9.1% had 10001+ taka and 3.3% had 3000-6000 taka as monthly family income. The mean monthly family income was 6333.47 \pm 1329.71 Taka (Table No.2). Regarding educational status it was observed that 54.1%, 33.2%, 12.4% and 0.3% of the respondents had education level of class VI-XII, class I-V, illiterate and graduate plus respectively. (Table no. 03).Table no. 4 showed that most (79.2%) of the respondents' were housewife, 10.7% were others, 7.5% were in service, 2.0% were day labour and 0.7% were in business (Table No. 4)

From the table no 5, it was found that 99.0% of the respondents informed about Community Clinic and 1.0% did not inform about it (Table No. 5). Regarding knowledge on Community Clinic it was observed that most (99.3%) of the respondents knew about it and only 0.7% did not know about it (Table No. 6). Above table showed that most (96.4%) of the respondents were attending to CC and 3.6% did not attend to CC (Table No. 7).

Age in group	No. 307	(100%)
10-20 years	48	15.6
21-30 years	165	53.7
31-40 years	77	25.1
41-50 years	12	3.9
51-60 years	5	1.6
Monthly family income		
Taka 3000-6000	10	3.3
Taka 6001-10000	269	87.6
Taka 10001+	28	9.1
Educational status		
Illiterate	38	12.4
Class I-V	102	33.2
Class VI-XII	166	54.1
Graduate plus	1	0.3

 Table no. 01: Respondents socio economic and demographic profile

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Age in group	No. 307	(100%)	
Occupation			
Housewife	243	79.2	
Service	23	7.5	
Day labour	6	2.0	
Business	2	0.7	
Others	33	10.7	
Informed about CC			
Yes	304	99.0	
No	3	1.0	
Knowledge of CC			
Yes	305	99.3	
No	2	0.7	

Above table showed the relationship between educational status of the respondents and utilization of Community Clinic. Irrespective of educational status 97.1%, went to or attended the CC. But their level of education and service utilization were not statistically significant (p>0.01) [Table no. 2].

Table no. 2: Relationship between educational status and utilization of Community Clinic

Educational	Utilization of Community Clinic		
status	Yes	No	
Illiterate	37 (97.4%)	1 (2.6%)	
Class I-V	99 (97.1%)	3 (2.9%)	
Class VI-XII	159 (95.8%)	7 (4.2%)	
Graduate+	1 (100.0%)	0 (0.0%)	
Total	296 (96.4%)	11 (3.6%)	

 $\chi^2 = 0.451$, df = 3, p> 0.01

Above table showed the relationship between educational status of the respondents and types of care or treatment. About 28.9% of the respondents who were illiterate received MCH care, respondents (50.6%) who had class VI-XII level of education received family planning services and 100.0% of the graduate respondents received MCH care. The relationship between educational status of the respondents and types of care was found statistically non-significant (p>0.01) [Table no. 3].

Table no. 3: Relationship between educational status and types of care or treatment

Educational	Types of care or treatment				
status	Treatmen t for disease	MCH Care	FP Disease	Others	Total
Illiterate	8 (21.1%)	11 (28.9%)	9 (23.7%)	10 (26.3%)	38 (12.4%)
Class I-V	13 (12.7%)	31 (30.4%)	44 (43.1%)	14 (13.7%)	102 (33.2%)
Class VI-XII	26 (15.7%)	41 (24.7%)	84 (50.6%)	15 (9.0%)	166 (54.1%)
Graduate+	0 (0.0%)	1 (100.0%)	0 (0.0%)	0 (0.0%)	1 (0.3%)
Total	47 (15.3%)	84 (27.4%)	137(44.6%)	39 (12.7%)	307 (100.%)

 $\chi^2 = 17.230$, df = 9, p> 0.01

Above table showed the relationship between occupations of the respondents and by service provider. About 97.9% of the respondents who were housewife received service from CHCP, 95.7% of the respondents who were in service received treatment from CHCP, 66.7% of the respondents who were day labour received treatment from the CHCP. The relationship between occupation of the respondents and the service provider was found statistically significant (p<0.01) [Table no. 4].

Occupation -	Service	Totol	
	СНСР	Don't know	Total
Housewife	238 (97.9%)	5 (2.1%)	243 (79.2%)
Service	22 (95.7%)	1 (4.3%)	23 (7.5%)
Day labour	4 (66.7%)	2 (33.3%)	6 (2.0%)
Business	2 (100.0%)	0 (0.0%)	2 (0.7%)
Others	32 (96.1%)	1 (3.1%)	33 (10.4%)
Total	298 (97.1%)	9 (2.9%)	307 (100.%)

Table no. 4: Relationship between occupation and service provider

 $\chi^2 = 20.39$, df = 5, p< 0.01

Above table showed the relationship between occupation of the respondents and type of care. About 44.0% of the respondents who were housewife received family planning care, 26.1% of the respondents who were in service received MCH care, 33.7% of the day labour received treatment for diseases and 100.0% of the businessmen received MCH care. The relationship between occupation of the respondents and type of care was found statistically significant (p<0.01) [Table no.5].

	Type of care				
Occupation	Treatment for disease	МСН	FP	Others	Total
Housewife	38 (13.6%)	73 (30.0%)	107 (44.0%)	30 (12.3%)	243 (79.2%)
Service	4 (17.4%)	6 (26.1%)	13 (56.5%)	0 (0.0%)	23 (7.5%)
Day labour	2 (33.7%)	0 (0.0%)	0 (0.0%)	4 (66.7%)	6 (2.0%)
Business	0 (0.0%)	2 (100.0%)	0 (0.0%)	0 (0.0%)	2 (0.7%)
Others	8 (21.9%)	3 (9.4%)	17 (53.1%)	5 (15.6%)	33 (10.4%)
Total	47 (15.3%)	84 (27.4%)	137 (44.6%)	39 (12.7%)	307 (100.%)

Table no. 5: Relationship between occupation and type of care

 $\chi^2 = 40.49$, df = 15, p< 0.01

4. Discussion

In This study which was carried out with a view to assess knowledge regarding utilization of reproductive health care services by the women of the catchment area of community clinic in Rajshahi. The sample size was 307 which was selected purposively. Regarding age distribution of the respondents it was found that out of 307 respondents majority(53.7%) were in the age group of 21-30 years, 25.1% were 31-40 years, 15.6% were 10-20 years, 3.9% were 41-50 years and only 1.6% were in the age group of 51-60 years. The mean age of the respondents was 29.23 ± 11.35

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years. In another study the mean age was 31-37 years (Webster 1998). Regarding monthly family income it was revealed that out of 307 respondents majority (87.6%) had taka 6001-10000 taka as monthly family income, 9.1% had 10001+ taka and 3.3% had 3000-6000 taka as monthly family income. The mean monthly family income was 6333.47 ± 1329.71 Taka Bangladesh is a low economically developed country (Christman 1980).Regarding educational status it was observed that 54.1%, 33.2%, 12.4% and 0.3% of the respondents had education level of class VI-XII, class I-V, illiterate and graduate plus respectively. Most (79.2%) of the respondents' were housewife, 10.7% were others, 7.5% were in service, 2.0% were day labour and 0.7% were in business. It was found that 99.0% of the respondents hear about Community Clinic and 1.0% did not hear about it. Regarding knowledge on Community Clinic it was observed that most (99.3%) of the respondents knew about it and only 0.7% did not know about it. Most (96.4%) of the respondents were going to CC and 3.6% did not go to CC. It is a service which can avail every one easily at their rural area (Fiedler 2001). Most (84.4%) of the respondents were not 1^{st} time in CC and 15.6% were 1^{st} time in CC. Most (42.0%) of the respondents visited others time in CC, 17.6% visited 4 times, 15.3% visited 3 times, 12.7% visited single time and 12.4% visited 2 times in CC. Rural people got the maximum health support from the community clinic in rural Bangladesh (Paul 1991).It was revealed that most (97.1%) of the respondents knew about the opening date of CC and 2.9% did not know it. It was found that majority (94.5%) of the respondents knew the opening time of CC and 5.5% did not know about it. It was found that majority (97.1%) of the respondents received services from the CHCP and 2.9% did not know about it.

It was a very good initiative by the Govt. and every one would get maximum health support from here (World Bank Health Features in Bangladesh 2001). It was found that majority (98.7%) of the respondents knew about the health care services provided by CC and only 1.3% did not know about it. It was found that majority (99.3%) of the respondents knew about the services provided for the common diseases in CC and only 0.7% did not know about it. It was found that majority (99.3%) of the respondents knew about the services provided for MCH and 0.7% did not know about it. It was found that majority (99.3%) of the respondents knew about services provided for family planning by CC and only 0.7% did not know about it. It was found that majority (95.8%) of the respondents knew about the services provided for health education, 3.3% did not know about it. It was found that majority (96.4%) of the respondents did not know about the services provided for surgery and only 2.3% knew about it. It was found that out of 307 respondents majority (97.7%) did not know about the services provided for EOC and only 0.7% knew about it. Female were now a days very sensitive about their health (Becker et al. 1999). It was found that majority (83.1%) of the respondents knew about services provided for safe motherhood and 4.6% did not know about it. Bangladesh is one among the few countries of the world that provides free medical services at the community level through various public health facilities. It is now evident that, clients' perceived quality of services and their expectations of service standards affect health service utilization to a great extent (Akhter et al. 2000). It was found that majority (90.6%) of the respondents knew about the services provided for referral to UHC and 2.3% did not know about it. It was found that majority (44.6%) of the respondents knew that CC deliver support related with family planning diseases, 27.4% knew MCH care, 15.3% knew about general treatment for disease and 12.7% knew about other types of care. In Bangladesh, rapid advancements in coverage of many health interventions have coincided with impressive reductions in fertility and rates of maternal, infant, and childhood mortality. These advances, which have taken place despite such

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challenges as widespread poverty, political instability, and frequent natural disasters, warrant careful analysis of Bangladesh's approach to health-service delivery in the past four decades (Chowdhury & Mushtaque, 2005). It was found that majority (97.7%) of the respondents knew about solving health problems and 2.3% did not know it. It was found that majority (42.9%) of the respondents either did not know or like about the services of CC so they did not come to the clinic and 14.3% considered that the service was not good. It was found that majority (99.0%) of the respondents' family member came to CC and 1.0% did not come. Although Bangladesh has achieved tremendous success in health care over the last four decades, it still lagged behind in the areas of maternal and child malnutrition and primary health care (PHC). To increase access to PHC, the Bangladesh government established approximately 18,000 community clinics (CCs). The purpose of this study was to examine the associations of socioeconomic determinants of women aged 12-49 years with the CCs awareness and visitation (Salahuddin et al. 1988). It was found that majority (66.7%) of the respondents did not know why their family member did not come to CC and 33.3% considered that service was not good. It was found that majority (96.1%) of the respondents came to CC for ANC and 3.9% did not come. It was found that majority (53.8%) of the respondents did not know about the services and for this they did not come to CC for ANC and 38.5% considered that service was not good. Research-based evidence is necessary to improve the efficacy and service coverage of community clinics among key population (Elo 1995). The relationship between educational status of the respondents and going to Community Clinic was found statistically non-significant (p>0.01). The relationship between educational status of the respondents and types of care was found statistically non-significant (p>0.01). The relationship between occupation of the respondents and by whom the service was provided was found statistically significant (p < 0.01). The relationship between occupation of the respondents and type of care was found statistically significant (p<0.01). It was found that 98.70% of the respondents were Muslim and 1.30% was from other religion (Fig. no. 01). It was found that 94.46% of the respondents were married and 5.54% were single (Fig. no. 02). It was found that 52.44% of the respondents were from joint family, 43.97% from nuclear family and 3.58% were from extended family.

4.1 Limitations of the study

The present study was conducted in Rajshahi district, thus the findings may not be generalized to a large population. Study population very small, only 307, so the result represents only this district. Most of the respondents were illiterate and female, so the information they gave might not be accurate.

5. Conclusion

In this study to assess knowledge regarding utilization of reproductive health care services by the women of the catchment area of community clinic in Rajshahi. Regarding knowledge on Community Clinic it was observed that most (99.3%) of the respondents knew about it. Most (96.4%) of the respondents were going to CC, (84.4%) of the respondents were not 1st time in CC, most (42.0%) of the respondents visited others time in CC. It was revealed that most (97.1%) of the respondents knew about the opening date of CC and 2.9% did not know it. It was found that majority (94.5%) of the respondents knew the opening time of. It was found that majority (97.1%) of the respondents received services from the CHCP. It was found that majority (98.7%) of the respondents knew about the health care services provided by CC. It was found that majority (99.3%) of the respondents knew about the services provided for the common diseases in CC. It was found that majority (99.3%) of the respondents knew about the services provided for the common diseases in CC.

was found that majority (99.3%) of the respondents knew about the services provided for MCH. It was found that majority (99.3%) of the respondents knew about services provided for family planning by CC. It was found that majority (95.8%) of the respondents knew about the services provided for health education. It was found that majority (96.4%) of the respondents did not know about the services provided for surgery. It was found that majority (83.1%) of the respondents knew about services provided for safe motherhood and 4.6% did not know about it. It was found that majority (90.6%) of the respondents knew about the services provided for referral to UHC. It was found that majority (44.6%) of the respondents knew that CC deliver support related with family planning diseases. It was found that majority (97.7%) of the respondents knew about solving health problems. The Government should be given accessibility of community based health service providers in the rural health complex and other organizations. Campaigns of government health programs, such as-family planning, safe motherhood, expanded program of immunization, should be increased. The qualities and the behavior of health personnel working should be helpful to the people in order to improve the participation in rural health service. Education, awareness and motivational strategies are important factors for ensuring the people's participation in health services and the success of different health programs. Hence, these strategies should be strictly followed on the development programs. Regular monitoring and supervision should be adopted in government health sector for ensuring participation of people in rural health complex.

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