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RESEARCH ARTICLE

COMMUNITY CLINIC IN BANGLADESH: EMPOWERING WOMEN THROUGH UTILIZATION AND PARTICIPATION

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ABSTRACT

BACKGROUND

Community Clinics (CC) has been established to provide basic healthcare services at the doorstep of the community people in Bangladesh. Besides health care, government has taken a development program through CC to improve maternal health care with an aim to reduce the maternal mortality. This study was an attempt to find out the role of community women in the utilization and participation of CC management.

METHODS

This cross-sectional study was carried out in 32 randomly selected CCs from 16 randomly selected districts. A total of 63 service providers, 2238 service users (patients) and 3285 community members were included as the respondents of this study. For data collection respondents were interviewed face to face by using a pretested questionnaire.

RESULTS

The majority of the service providers of the CC were from the local community, and a higher proportion of them were female (52.4%). The providers provided healthcare services both in CC and at community level. A total of 2238 patients visited the 32 studied CCs per day for getting treatment and significantly a higher proportion of them were female (71.2%). Most of the patients (83.0%) expressed satisfaction with the services provided in the CCs and most of them were female (83.8%). Of the total 3285 respondents, 60.3% were the women from the catchment communities. The activities of the CC were known by all of them (98.3%) and they participated in the management of CC.

CONCLUSIONS

The study revealed that because of utilization and participation in the management of CC, the women became an imperative person in the community, thus empowering them in healthcare development.

KEYWORDS

Community Clinic, Community Development, Community Participation, PHC, Service Providers, Women Empowerment, Bangladesh

INTRODUCTION

Women empowerment is an important factor for the development of a country, particularly in developing countries.[1] Empowering women is the control of women over their own lives, develop self-reliance and can take decisions and influence in the society, that uplift them in home and community and in the country's development.[1-3] Women empowerment enable women for participation in various activities at different levels in the society and community development and the participation empower them to establish their right.[1,3] Fifty years ago, Easter Boserup pointed out the importance of the role of women in the economic development and that initiated the momentum of participation of women in the development of a country.[4,5] Women empowerment became a feature of economic development and ultimately the overall development of the country, especially the social and political development. Now worldwide women empowerment is a popular agenda for a sustainable development of a country, especially in developing countries.[3,5-7] The MDG-3 (Millennium Development Goal) is to promote gender equality and empower women, thus influences the countries and international agencies to undertake gender related several programs.[7] In SDG (Sustainable Development Goal) much emphasis has been given to ensure the women in achieving their full potential and rights for participation in the achievement of SDGs. SDG-5 is mainly to achieve gender equality and empower all women and girls.[8]

Bangladesh is a thickly populated country; half of its population is female. But women in Bangladesh are in vulnerable position in the society; they need more social protection, particularly in a rural area. Once in Bangladesh, the women were neglected in the society and their contribution in the family and in the society was not valued. Males both in the family and in the community dominated the women. The position of the women in the society was secondary, like a subordinate. Women's life cycle was influenced by the patriarchal, patrilineal, and patrilocal social system of the society. Women were only considered as the homemaker and most of their life passed in the home under the directives of the male. They had restricted mobility and could not do any work outside; not allowed to get treatment of their own and could not take any decision. They had no or little economic opportunities, though some women worked in the agriculture or in industry, but that was not considered as an economic contribution. However, the attitude of the society towards women has been changed, because of increased female education and the socioeconomic development in the recent decades. The women are now regarded as an important contributor to economic development. [9,10]

Government has formulated goals and strategic objectives in relation to women empowerment and rights; and has adopted the underlying principles for the women's involvement in the mainstream of the overall developmental process. Several Social Protection Programs (SPPs) for the overall development in the community and the development of Community Clinic (CC) has been undertaken. The Revitalization of Community Healthcare Initiative is a program under the Social Protection Schemes. In the National Development Policy 2011 government identified CC for the improved health care of the women all over the country with an aim to reduce the maternal mortality by ensuring proper management of the pregnant mother. [9,11] Establishment of the CCs in the rural areas to provide basic healthcare services in the community is a revolutionary initiative of the government. Besides, basic health care, CCs has brought the family planning and preventive health services to doorsteps of the population. CC has access to 6000 rural people and within half an hour walking distance.

The CC is in a built structure and commonly has two service rooms, one lavatory and a waiting space. The services provided in the CC by the Community Health Care Providers (CHCP) as main provider and other providers are Health Assistant (HA) and Family Welfare Assistant (FWA). To supervise and to support the CC services, there is a community group (CG) and three community support groups (CSG). The members of the community group are selected mainly from the community to ensure the community participation and to own the CC. The CC is the best example of Public Private Partnership (PPP) as the CCs are constructed on the lands donated by community; construction, medicine and necessary logistics and service providers are from government, but the management is done by the CG and CSG. [12-15] The present study examines the pattern of community participation and the service utilization from the CC with emphasis to assess the status of women involvement and their responsibilities as a member.

METHODS

This was a cross-sectional study carried out to assess the women's participation and utilization in the activities and management of CC. The study was conducted in 32 CCs and in the catchment communities of the CCs. From each division two districts were selected randomly, and a total of 16 districts were included in the study. Similarly, from each selected district 2 CCs thus, 32 CCs were selected randomly. A total of 63 service providers, 2238 service users and 3285 community people were included as respondents of this study. Community Health Care Providers (CHCPs), Health Assistants (HAs) and Family Welfare Assistants (FWAs) who were available during the data collection period were included as respondents to service providers. Patients and other health care users who came into CCs on data collection days were also included as respondents for service users. From the community, a member of the household aged ≥18 years irrespective of sex was selected randomly as a respondent, and the particular household was selected by systematic random sampling using the GR (geographic reconnaissance) number of the households. Data were collected through face-to-face interview of the respondents by using a pretested questionnaire.

After collection, the data were cleaned and cross-checked for inconsistencies, as well as for any unusual findings. Frequency, percentage, mean and standard deviation were undertaken for descriptive statistics. Chi-square was performed for inferential statistics, to find out associations between qualitative variables. The p-value <0.05 was considered as the level of significance.

The ethical clearance for the study was obtained from Bangladesh Medical Research Council (BMRC). There was no risk for the study participants and there was no hazardous procedure involved in the study and had no physical invasive procedure with the participants. All the participants were informed about the purpose of the study and informed consent was obtained from each of them before interviewing.

RESULTS

Of the 63 service provider respondents from 32 CCs, 29 were CHCPs, 19 were HAs and 15 were FWAs. Overall female (52.4%) respondents had a significantly ($\chi 2$=18.165; p<.001) higher proportion than males (47.6%). Majority (60.3%) of the respondents had a graduate or higher level of education. The mean age was 35.2±10.03 years and the majority (58.7%) of them were aged 25 to 34 years. (Table-1). Almost all the service provider respondents (95.2%) were found to offer CC based health care services in addition to providing services in the community. Two-thirds of the respondents worked 6 days a week in CC and over 90% worked for 5 to 6 hours per day. The most common services provided at the doorstep were EPI (Expanded Program on Immunization) vaccination and family planning services. (Table-2)

TABLE-1 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF SERVICE PROVIDERS

CHARACTERISTICS	SERVICE PROVIDERS			TOTAL	SIGNIFICANCE
	CHCP (n=29)	HA (n=19)	FWA (n=15)		
Sex					
Male	19 (65.5)	11(57.9)	0 (0.0)	30 (47.6)	χ^2= 18.165; df= 2; p <.001
Female	10 (34.5)	8 (43.1)	15 (100.0)	33(52.4)	
Education					
Up to HSC	9 (31.0)	11 (57.9)	5 (33.3)	25 (39.7)	χ^2=3.782; df= 2; p >.05
≥Graduate	20 (69.0)	8 (42.1)	10 (66.7)	38 (60.3)	
Age (years) Mean±SD35.2±10.03					
25 – 34	22 (75.9)	8 (42.1)	7 (46.7)	37 (58.7)	Fisher's Exact =8.105; df=4;p>.05
35 – 44	5 (17.2)	5 26.3)	3 (20.0)	13 (20.6)	
45 – 54	2 (6.9)	6 (31.6)	5 (33.3)	13 (20.6)	

TABLE-2 WORKLOAD OF THE SERVICE PROVIDERS

SERVICES	FREQUENCY	PERCENTAGE
Attend CC every week		
Yes	60	95.2
No	3	4.8
Duration of work per day		
3-4 hours	06	09.5
5-6 hours	57	90.5
Number of working days per week		
6 days	42	66.7
2-3 days	21	33.3
Home visit per week		
<2 days	4	6.3
2-3 days	26	41.3
>3 days	5	7.9
Nil	28	44.4
Service(s) provided by home visit		
DOTS (TB)	12	19.0
FP (Contraceptive) services	21	33.3
EPI (Vaccination) services	30	47.6

It was found that a maximum of 90 patients (service users) visited to one CC per day to receive treatment (78.9%) and FP&MCH (21.1%) services. Among the patients visited, over half (56.7%) were females and one-fourth were children. (Table-3) CCs provided several services, but the common services received by the users were maternal and neonatal services (91.8%), EPI vaccination (86.4%) and treatment of common diseases and first aid (71.8%). (Table-4) A total of 2,238 patients visited the studied 32 CCs in a day, of them 644 (28.8%) were males and a higher proportion (71.2%) were females. Overall, 83.0% of the patients were satisfied with the CC services and female users (83.8%) were found to be significantly ($\chi2=6.778$; $p<.05$) more satisfied than males (81.2%).

The reasons for satisfactions were, prompt service by the providers (85.7%), skilled and qualified service providers (85.6%), and provide adequate advice and health education (84.4%).(Table-5) The respondents also mentioned several reasons to choose CCs for getting treatment and other services. The common reasons were, service was free of cost (97.7%), proper management by the committee (92.8%), less distance and easy communication (79.3%), good behaviour and advice (69.4%), available medicine (67.3%), cleanliness of the premises (63.9%) and less waiting time for getting services (60.0%). (Table-6)

TABLE-3 SERVICES RECEIVED BY THE PATIENTS PER DAY IN A COMMUNITY CLINIC

PATIENTS' CHARACTERISTICS	SERVICES RECEIVED PER DAY					
	Treatment		FP & MCH		Total	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Male	21	30.1	4	21.1	25	27.8
Female	39	54.9	12	63.1	51	56.7
Child	11	15.01	3	15.8	14	25.5
Total	71	78.9	19	21.1	90	100.0

TABLE-4 PATIENTS' KNOWLEDGE REGARDING SERVICES AVAILABLE AT CC [N=2238]

SERVICES AVAILABLE AT THE CC (MULTIPLE RESPONSES)	FREQUENCY	PERCENTAGE
Maternal and Neonatal services	2039	91.8
Integrated management of childhood illness (IMCI)	849	38.2
Reproductive Health services and Family Planning	1205	54.3
EPI (Vaccination) services	1918	86.4
Registration of newly married couple, pregnant mothers, birth and death; preservation of EDD	704	31.7
Nutritional education and micronutrient supplementation	1105	49.8
Health, Nutrition and FP education & counseling	1082	48.7
Treatment of common diseases and problems & first aid for the minor injuries	1595	71.8
Screening of Diabetes, Hypertension, Autism, Club feet and referral to higher facilities	816	36.8
Normal delivery with the availability of trained manpower & other facilities	175	7.9
Identification of emergency and complicated cases with referral to higher facilities	485	21.8
Establishing an effective referral linkage.	348	15.7
Provide Essential Service Package (ESP)	86	3.9

TABLE-5 PATIENTS' SATISFACTION REGARDING SERVICES PROVIDED IN CCS (N=2238)

SEX	LEVEL OF SATISFACTION			TEST OF SIGNIFICANCE
	Satisfied f (%)	Partially satisfied f (%)	Not satisfied f (%)	
Perceived quality of services				
Male	506 (78.7)	125(19.4)	13 (1.9)	$\chi^2 = 2.728$
Female	1298(81.4)	276(17.3)	20(1.3)	df = 2
Total	1805(80.7)	401(17.9)	32(1.4)	p>.05
Availability of medicine				
Male	481(74.7)	147(22.8)	16(2.5)	$\chi^2 = 1.287$
Female	1226(76.9)	330(20.7)	38(2.4)	df = 2
Total	1707(76.3)	477(21.3)	54(2.4)	p>.05
Qualified person provide service				
Male	544(84.5)	80(12.4)	20(3.1)	$\chi^2 = 11.742$
Female	1372(86.1)	205(12.9)	17(1.1)	df = 2
Total	1916(85.6)	285(12.7)	37(1.7)	p<.01
Information obtained from providers				
Male	490(76.1)	139(21.6)	15(2.3)	$\chi^2 = 0.165$
Female	1224(76.8)	336(21.1)	34(2.1)	df = 2
Total	1714(76.6)	475(21.2)	49(2.2)	p>.05
Received prompt service				
Male	546 (84.9)	73(11.3)	25 (3.7)	$\chi^2 = 9.052$
Female	1374(86.2)	192(12.0)	28 (1.8)	df = 2
Total	1919(85.7)	268(12.0)	52 (2.3)	p<.05
Quality health education				
Male	522(81.1)	94(14.6)	28(4.3)	$\chi^2 = 8.229$
Female	1367(85.8)	182(11.4)	45(2.8)	df = 2
Total	1889(84.4)	276(12.3)	73(3.3)	p<.05
Overall				
Male	523 (81.2)	99 (15.4)	22 (3.4)	$\chi2 = 6.778$
Female	1334 (83.8)	232 (14.6)	27 (1.7)	df = 2
Total	1858 (83.0)	331 (14.8)	49 (2.2)	p<.05

TABLE-6 PATIENTS' OPINION REGARDING CC [N=2238]

OPINION OF THE PATIENTS (MULTIPLE RESPONSES)	FREQUENCY	PERCENTAGE
Less distance (near the village, easy communication)	1775	79.3
Better waiting arrangement	1062	47.5
Less waiting time	1343	60.0
Experienced and qualified provider	1101	49.2
Providers good behavior, give necessary advice	1554	69.4
Cleanliness of the premises	1431	63.9
Availability of drugs	1507	67.3
One stop service (Health, FP & Nutrition)	869	38.8
Services is free of cost	2187	97.7
Convenient clinic hour	573	25.6
Provider is known (from locality)	544	24.3
Proper management by the Community people	2076	92.8

Different committees were involved in the management of CCs, and CG was constituted mainly by community people. From the community, 3285 household members from the catchment areas of 32 CCs were included as the respondents. Among the total 3285 community members, majority were females (60.3%). The mean age of the community members was 35.8±10.02 years and two-thirds (74.3%) of them were 19 to 44 years old. Half of the community members (50.5%) were housewife and next to them agriculture (19.5%) was the occupation. Majority of them had education up to primary (36.2%) and secondary level (32.1%) of education. (Table-7) The management committee had several responsibilities for the proper running of CCs, and the majority of the female community members were involved to serve these responsibilities. It was found that almost all (98.3%) the community members knew the activities and satisfied with the behaviors of the service providers. However, less than one-third of them mentioned some problems which were inadequate supply of medicine, in adequate service providers, financial constraint and lack of treatment of non-communicable disease (NCD). (Table-8)

TABLE-7 SOCIO-DEMOGRAPHIC PROFILE OF THE COMMUNITY MEMBERS OF CC MANAGEMENT [N=3285

ATTRIBUTE	FREQUENCY	PERCENTAGE
Gender		
Male	1305	39.7
Female	1980	60.3
Age (Years)		
19 -44	2445	74.3
45 – 59	626	19.1
≥60	214	6.5
Mean ± SD	35.8±10.02 years	

Occupation		
Business	328	10.0
Agriculture	642	19.5
Service	131	4.0
Housewife	1658	50.5
Student	236	7.2
0thers	290	8.8
Education		
Never gone to school	746	22.7
Primary (1-5 years of education)	1188	36.2
Secondary (6-10 years of education)	1055	32.1
HSC	296	9.0

TABLE-8 KNOWLEDGE OF COMMUNITY MEMBERS IN THE MANAGEMENT OF CCS (N=3287)

ATTRIBUTE	FREQUENCY	PERCENTAGE
Know the activities of CC	3229(98.3)	
know about the CG in the management of CC	1989	60.5
Know about the service Providers	2078	63.3
Status of drug supply in CC	1538	46.8
Know about the clinic hours	2275	69.3
Friendly Behavior of Service Providers	3148	95.8
Problems / Constraints		
Some medicine is not available	1078	32.8
Inadequate service providers	1015	30.9
Lack of treatment of NCDs	995	30.3
Financial constraintto running the CC	1078	32.8
Long distance	354	10.8
Irregular or no electricity	260	7.9
Poor constructed building	100	3.0

DISCUSSION

One of the principles of Primary Health Care (PHC) is community participation and involvement. Theestablishment of community clinic in Bangladesh was

based on this principle of PHC. The community participation of CC had been initiated with the donation of land by the community people. The community people actively took part in the management of CC through involvement in various management committees and by getting services from CC. Without maximum utilization of the human resources, socio-economic development of a country is not possible. In Bangladesh women are half of its population, therefore their utilization of services is essential. [13-16] The result of this study revealed that both male and female were the members of the community group (CG), a management committee for operating CC, and almost all members were from the community. However, significantly a higher proportion of the community group members were women (60.3%) who took part in this study and majority of them were housewives. The women were reported to be actively taken part in monitoring, guiding, attending meetings, and giving an opinion regarding management of CC. The management committee had several responsibilities for the smooth running of CC and the women members were found to carry out these responsibilities properly. The management committee identified the various problems for proper running of the CC and realizing these problems, the women members took active part in solving the problems. Most of these problems were also reported in the previous studies conducted on CC. [13,14]

Community group members also raise awareness among the community people regarding occurrence and prevention of various diseases, about the maternal and child health care services, and family planning and other services available in the clinic.[14] The current study revealed that most of the patients knew about the services available in the CC. They mentioned about thirteen different services available in CC, of which women and child health services were more common. It was also important that many people from the local community visited CC every day to receive various services. Most (84.4%) of them were satisfied with the services provided by the CC by receiving prompt health care, services provided by a qualified person, and awareness through quality health education. They also expressed satisfaction with less waiting time and proper seating arrangement for receiving services. The service users in another study also expressed their satisfaction regarding the quality of services and services available in the CC, but differed with waiting time and distance.[15]

A few years ago, the women in Bangladesh, particularly the women from rural areas, did not have easy access to get treatment from a healthcare facility because of various reasons, such as long distance from health care facility, negative decision regarding healthcare by male members, poverty.[17,18] The CC had created the opportunity for community women, providing easy access to receive treatment from CC and significantly a higher proportion of them were getting the services from CC. The factors that made for self-reliance of women and favoured them to obtain services as mentioned by them were, CC being near the village, easy communication and could come alone as needed and, services provider were familiar to them, and the community women were in the management community. The community women not only utilizing services from the CC in addition the women CG members also taking part in the management by giving their opinion freely without any hesitation regarding the services and management of the CC.

Most of the service providers in the CC were from the local community and some of them were also a member of the support committees. On an average the service providers were the young adult (35.2±10.03 years) and a higher proportion of them (60.3%) had graduation or higher education level. The service providers worked for 5-6 hours/day, and most of them (55.6%) did the home visits every week. The service users had the opportunity to meet with the service providers both in CC while receiving treatment and at the village when the providers visited them for doorstep services like DOTS (Directly Observed Treatment Short course), FP (Family Planning) and EPI (Expanded Program on Immunization), and by this meeting, the service providers became familiar with the villagers. More than half (52.4%) of the service providers were female and were involved in the functioning of CC by doing their daily workload and being members of the committee.

This study revealed that in the functioning of CC, the service providers, especially the women were playing an important role through active participation in various CC activities. As a result, the women became a vital person in the

community, especially as a healthcare provider. An approach of socio-economic development in the community is the active participation of women, and without active participation of the women, the socio-development will not be fully achieved. [1,16,19] Therefore, the active participation of the community women through CC activities would result in a proper community healthcare development particularly for women.

Sustainable development of a country without women empowerment is said to be impossible. [20,21] For socio-economic development, women's involvement in the mainstream of the developmental process is fundamental in the developing country. [20,22] In Bangladesh, the government has undertaken various programs and activities for women empowerment. In National Women Development Policy 2011, the aim of empowering women, the government has given emphasis to give equal opportunity to women in education, training, science and technology and technical activities to make them self-reliant.[9] Already government achieved considerable progress on women's development, especially in education and political empowerment. According to 'Gender Gap Index Report' in 2016, Bangladesh stood at the 72nd position among 144 nations in the world, and secured consecutively 2nd times as the top country among South Asian countries.[9,23] However, the implementation of CC by the current government is a program for active participation of rural women in healthcare development as well to improve the health care of the women.[9] This study revealed that the community women actively taking part in the healthcare development in the community through their participation in the operation and management of the CC, and by utilizing the services provided in the CC. Thus, the CC has increased the ability of community women to access into a healthcare facility and to get different services, which increases the self-reliance and the ability to overcome their own subordination leading to empowering them to establish their health care rights. [16,20,24]

CONCLUSION

Community Clinic (CC) is a revolutionary initiative by the government to bring basic healthcare services to the community people. Community people are actively involved with the establishment and management of CC. From the clinic, people get treatment and other health care services, and in the village, they are visited by the service providers for various healthcare programs. This study revealed that a higher proportion of the community women participated actively in the operation and management of CC and getting services from the CC and retaining an important role. Thus, the active participation in the functioning of the CC of the community women has given opportunity to empower them and establish their rights to health care.

CONFLICT OF INTEREST

Authors declare that they have no conflict of interest.

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