

Effectiveness of Community Clinic in Urban Area: A Cross Sectional Study

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ABSTRACT

The Community Clinic is great because it is an opportunity to have complimentary therapies at an affordable price. Establishment of Community Clinic (CC) in 1998 was a significant sector-wide reform in the Health Sector of Bangladesh. The sector was revitalized in 2009 with a vision to provide primary health care service to 6000 population per CC. The proposed number of Community Clinics is 18,000 of which 13,500 were constructed and to remain 4,500 established in the existing Union and Upazila level health and family planning facilities. The aim of the study was to find out the effectiveness of community clinics in selected area of Dhaka city. Among the total respondents, the majority (50%) were housewives with age of 15-24 from service receiver group. Maximum (40%) respondents got information from mass media like Television, Radio, Newspaper, then from husband. Majority of respondents on average of both clinics (80%) said that they were satisfied with the quality of service. But they have a complaint of waiting time and distance of the health center from their residence. According to the service provider, Majority has the specific training in their individual service. But some of them have no training or little training. Only a few Nogarshastho clinics provide regular delivery facilities, but majority clinic does not provide such type of service if all the services related to mother and child will available in these health centers more people will benefited.

Key words: Primary health care, Antenatal Care, Postnatal Care, Essential Services Package

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INTRODUCTION

Health service delivery is an intimidating challenge for Bangladesh's health service systems. Many people face hazardous health conditions because of poverty and backwardness. Bangladesh has made huge progress over the past four decades in breaking the cycle of poverty and underprivileged health through its set of connections of affordable health-care.

Community Clinic is a tiny clinic at the grass root level including the remotest and hard to reach the area. It is important for health education (on health, nutrition & FP), health promotion, and treatment of minor ailments, first aid, and identification of emergency and complicated cases. In Bangladesh, community clinics are managed by Community Groups that consist of 9 to 11 members from local elites including land donors, teachers, women's groups, and landless peasants. These community groups focus on accumulating resources for the clinics on mobilizing health care at the society level. They provide training, technical support and advocacy for these Community Groups to ensure that health service delivery is reaching the most vulnerable, particularly the deprived. The primary aim of the community clinic is to provide a package of integrated health and family planning services, the ESP, in a helpful and financially sustainable way. The delivery of ESP was organized at different levels in a way that meets the needs of the local population on a cost-effective basis and in a manner easy to manage and convenient for the clients. Service delivery from fixed facilities may lead to disadvantages of longer travel time, limiting access/usages/coverage especially for poor and women. To offset these potential disadvantage strategies were undertaken to increase scope and quality of services to encourage community participation in health sector.

It is planned that Family Welfare Visitors (FWV) and Assistant Health Inspectors (AHI) from Union Health and Family Welfare Centre (UHFWC) should visit CCs each week to provide additional services that HA and FWA are unable to provide. Each CC will remain under the direct supervision of an MBBS doctor posted either at urban, union or upazila level. However, treatments available at Community Clinics are primary health and family planning services and it will screen and refer patients to higher levels health centers.

LITERATURE REVIEW

Cost burdens of healthcare may deter or delay utilization or promote use of less effective healthcare sources or practices, particularly by the poor, proving the 'inverse care law'. Thus, enhancing poor people's ability to access acceptable level of health care at low-cost has a potential poverty-alleviating effect. Bangladeshi NGO realizes the potential high impact that health services can have in reducing the vulnerability of the poor households. (Charles Normand, 2002)

In a study, among 113 Health workers all were aware of the activities of Community Clinics and 95.6% were aware of the types of medicines available in community clinics. Majority of them (74.3%) knew that there is a community health center for every 6000 people. All community hospitals are in running condition; this statement has been agreed to by 92.9% of health employees. Only 5.4% of workers had received satisfactory training whereas 94.7% did not have sufficient training. Most of the workers were not able to operate MS Office program on the computer; only 5.4% were able to work this. Out of 113 respondents, 70.3% stated that the supply of medicine in the community clinic is adequate. Sixty-four percent respondents agree that the methods of temporary family planning are available in community health centers. Most of the health workers (93.6%) were able to identify critically ill patients and took necessary steps for further care of such patients. Based on the needs of patients 98.2% health workers referred the patients to secondary or tertiary level hospitals. The study revealed that health employees were fully aware of the activities of community health centers. The numbers of community clinic are less; health workers' training is insufficient. There is scarcity of manpower, unavailability of electricity and medicine, communication problem, inadequate facilities for health employees. It has been suggested by the health workers that proper training of health employees, recruitment of more manpower, increasing the facilities of health workers may facilitate the enhancement of the effective and efficient activities of community clinic. (Millat MH, 2011)

Over the last two decades, the health and family planning programme of Bangladesh has achieved considerable progress in reducing infant mortality, under-five mortality, maternal mortality and morbidity. To extend the reach the health care facilities from door to the doorstep and to improve overall health situation of the country through ensuring comprehensive primary health care service to the people of rural area of Bangladesh. (Nargis M, 2010)

It is noted that the highest number of problems (22%) in health sector are related to inadequate number of physicians, wrong treatment. There are also negligence towards patients, absence from duty and unwillingness of doctors to stay in rural areas and small towns. The other problems were related to supplies, equipment, beds (21%). Some other major problems often discussed also include lack of ambulance services as well as proper referral services. (National Health Accounts, 2003)

Community Clinics (CC) were to provide services for around 6000 people, and it was envisaged that their location would make them accessible for 80% of the population within less than 30 minutes walking distance. The design was to be simple – two rooms with drinking water and lavatory facilities, and a covered waiting area. Funds for building the clinics were provided centrally, but communities had to donate land. This was designed to increase the feeling of ownership of the developments. In a similar way each community was required to set up a group to support and assist with the management of the CC, although the staff and supplies were provided by the government. Each clinic should have two staff, one health assistant and one family welfare assistant. There is a specified allocation of equipment and a range of drugs necessary to deliver the ESP services. Staff from the CCs would continue to provide a limited range of outreach services, especially in the early period after opening, and staff from higher levels in the system would visit on a regular basis to provide additional services and to supervise the CC staff. The development included a training program for CC staff. (Directorate General of Health Services, 2011)

OBJECTIVES

General:-

- To assess the access, utilization, and quality of care provider and service receiver with their satisfaction with community clinic in Dhaka city

Specific: - In addition, the study aimed to:

- Assess the location and physical facilities of these clinics against standards outlined in the government plan;
- Identify the factors that constrain CCs from meeting the health care needs of users, as well as the satisfaction of clients on the quality of care provided by these health facilities;

METHODOLOGY

A cross sectional study was done to find out the effectiveness of community clinic in two clinics in Dhaka city. The study used a range of quantitative and qualitative methods. We have used semi structural questionnaires to conduct this study. In this research we tried to focus on service availability, access to care, quality of care and patient satisfaction. A number of methods were used to collect data. These were (i) Document analysis (including Literature review) (ii) direct observation, and (iii) key informants interviews.

COMMUNITY CLINIC IN BANGLADESH

Establishment of Community Clinic (CC) in 1998 was a significant sector-wide reform in the Health Sector of Bangladesh. That was revitalized in 2009 with a vision to provide primary health care service to 6000 population per CC. The proposed number of Community Clinics is 18,000 of which 13,500 were constructed and to remain 4,500 to be established in the existing Union and Upazila level health and family planning facilities.

In Bangladesh, interest in health-sector reform is widespread. One of the reform agenda adopted in Bangladesh National Health and Family Planning Programme is the shift from the home-based to a static centre-based service-delivery system. The five-year plan (1998-2003) of the Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh (Gob), is aimed at providing a range of essential health and family planning services i.e. The Essential Services Packages (ESP), especially to the vulnerable groups, i.e., women, children, and the poor. The HPSP has delineated three vital features for delivery of the ESP: client-oriented services, unified management, and one-stop service. To meet the strategy at the community level, fixed-site clinics featuring a one-stop service centre, referred to as Community Clinic (CC). Under the supervision of a unified management, will gradually replace the existing home-visit approach. Given the substantial changes suggested in the HPSP, the implementation of ESP delivery, including the close monitoring to derive sufficient information to fine-tune and modify the approach as required. Clinics provide legal help for low-income people and communities with issues that involve basic needs, such as access to housing, health care and education. Available services vary according to each clinic's resources.

Most of the people are poor in Bangladesh. Usually, they do not visit doctors; they visit so-called Quack doctors (Village doctor). As their purchasing capacities are very small, drugs or investigation prescribed by physicians, most of the prescription remain unused. Nutritional status and health awareness of the people are very deprived. Women, children and elderly group are usually away from Medicare facility. So those categories of people suffer from infectious diseases in a high incidence. People do not consult any health personnel in the early period of their diseases. Some people become poorer due to bearing of treatment expenditure. Community clinic plays a vital role on providing services for those poor people.

HEALTH SERVICE IN COMMUNITY CLINIC

Community Clinics (CC) were to provide services for around 6000 people, and it was envisaged that their location would make them accessible for 80% of the population within less than 30 minutes walking distance. The design was to be simple – two rooms with drinking water and lavatory facilities and a covered waiting area. Funds for building the clinics have been provided centrally, but communities had to donate land. In a similar way each community was required to set up a group to support and assist with the management of the CC, although the staff and supplies were provided by the government. Each clinic should have two staff, one health assistant and one family welfare assistant. There is a specified allocation of equipment and a range of drugs necessary to deliver the ESP services. Staff from the CCs would continue to provide a limited range of outreach services, especially in the early period after opening, and staff from higher levels in the system would visit on a regular basis to provide additional services and to supervise the CC staff. The development included a training program for CC staff.

SERVICE DESIGN AND COMMUNITY CLINIC

- For ESP and BCC service delivery, a team comprising of one FWA and one HA (or their equivalents after re-organization) are the core personnel. A FWV provides additional clinical services and supportive supervision and visits each centre at least once a month
- Each team has at least one female (FWA/HA) worker.
- Services are provided from a fixed facility serving a population of approximately 6,000. Services are to be available on every working day. Depending on local arrangement, the Community Clinic may choose other opening times that suit local needs.
- Limited domiciliary services were focused on groups or individuals who are at risk. The most neglected including the extreme poor, drop-outs for family planning and follow-up for specific infectious diseases including Directly Observed Therapies (DOTS). These services are provided in most cases one day per week, by one of the staff, with other maintaining the services at the CC.
- Depending on the service needs of the catchment population, it may be necessary to provide domiciliary or outreach services for an additional half or whole day. But on most days, the two team members will be working together in the CC. The decision on a use of health worker time on focused domiciliary visits has been made by the Upazila Health Manager in consultation with the UHFWC in charge and the community.
- The function of the CC is to provide first-level services of the ESP. Performance and quality standards were based on technical values and norms for ESP interventions.
- Location and timing of the CCs should base on negotiation between the Upazila manager and community members with participation of UHFWC in-charge. The existing satellite clinics and outreach centers are being gradually

reduced. While the one-stop services will focused on providing the ESP and BCC, the existing behavior of the community will require some time to change. The following steps will take for a gradual reduction of the satellite/outreach services. In four weeks, the team will cover different outreach clinics/centers with 6000 population in each. I.e. one for 1,500 people (instead of one for 1,000 as exists now). In a union, therefore, there will be 16 such centers (instead of present 24) in addition to the four clinics. The 16 centers (for four teams) have reduced to 12 based on the experience of the piloting being done in TFIPP area. If there are 12 centers per union, each team will go to 3 outreach clinics (one per month). The remaining one-day per month may be used for attending management meetings at the Upazila. At present each centre is visited by HA/FWA once a month. So, even with this suggested reduction in the number of outreach sites, the number of visits per month will remain the same. There will be community-based non-salaried volunteers who will assist field workers at outreach sites and CCs.

The Specific Functions of CCs are

- Registration of pregnant women
- BCC: hygiene, diet, immunization
- Informing of pregnant women in advance to attend the clinic for FWV services and ensuring that pregnant women come for antenatal services.
- Referral to higher levels
- Providing FP methods: pills and condoms
- EPI: informing families in advance about outreach clinics and ensuring that children are immunized at the correct times.
- Minor treatment: ORS, Vitamin A, anti helminthes, ARI, DOTS for TB, MDT for Leprosy, anti-malaria.

HUMAN RESOURCES MANAGEMENT

Usually, each of the service providers (HA and FWA) rendered services at the clinic for 5 days a week, and undertake selected home-visit once a week. These providers also undertook other field activities outside the clinic, e.g. conducting EPI sessions and SC (if any), Geographical Reconnaissance (GR) updating, participating in NIDs etc. The FWV had been attending the CC twice a month as per schedule.

Supplies and stock: Family-planning commodities were supplied in sufficient quantity for the CCs, and the stocks were satisfactory on the day of assessment. However, supply of some enlisted medicines was either in shortage or totally absent in the facilities. The providers reported that they had a shortage of medicines since the opening of the clinics. Besides, supply and stock of enlisted equipment were also inadequate.

IEC materials: Information, education, and communication (IEC) materials, such as pictorial posters on family planning, immunization, acute respiratory infection (ARI), diarrhea, nutrition, emergency obstetric care (EOC), tuberculosis-leprosy, and on CCs, were displayed inside the clinic building. Some flip-charts were supplied for demonstration during health-education sessions. Information on clinic hours, name of service providers, and a list of services available at the health center were written on several mounted whiteboards displayed in the middle of the wall of the waiting space in both the clinics. No billboard was seen outside the clinics.

Limited home-visits: The HAs or FWAs alternatively visited the selected homes once a week according to a prefixed work plan in both the clinics. They carried the follow-up and service-delivery registers with them during home-visits. They also follow-up the pregnant mothers, registration of new couples, and registration of births and deaths. Family-planning is a motivational work. They searched for drop-outs, made EPI campaigns, behavior change communication (BCC), and advice for common ailments provided.

EPI sessions: In the CCs, immunization services were held twice a week (every Saturday and Tuesday or, every Sunday and Tuesday). Attendances of clients for immunizations in the locations were quite good.

Management information system (MIS): The FWAs and HAs in the CCs worked on the unified (UMIS) forms and registers. In addition, they were also provided with daily attendance and inspection books, receipt and dispatch books, a CG monthly meeting register, and financial accounts book to keep the record of respective matters.

FINDINGS: SERVICE PROVIDERS AND SERVICE RECEIVERS OF COMMUNITY HEALTH CARE

This study was done in two community clinics in Dhaka city (Surjer Hashi & Nogor Sastho) to find out health services in both health centers. It has found that both health centers provide same types of service, but there is more satisfaction on service receiver in Nogor Sastho clinic. On the basis of the study the distribution of the respondent's socio-demographic condition in case of the service receiver is shown as bellow:

Table-1 Distribution of Socio-Demographic Profile

	Surjer Hashi	%	Nogor Sastho	%
Age Group				
15-24	5	50%	4	40%
24-34	3	30%	5	50%
35-44	2	20%	1	10%
Occupation				
House Wife	4	40%	5	50%
Garments Worker	2	20%	0	
Teacher	1	10%	3	30%
Other	3	30%	2	20%
Total	10		10	

On the basis of the field work majority of respondent's age group is (24-34), and most of them are house wife.

Table- 2 Sources of Information

Sources of Information	Surjer Hashi	%	Nogor Sastho	%
Husband	2	20%	3	30%
Relatives	2	20%	3	30%
Neighbor	2	20%	1	10%
Mass Media	4	40%	3	30%
Other	10		10	

According to the respondents majority, got information from mass media (that is radio, TV and newspaper) and then from husband.

Table-3 Quality of services

Name of the Clinic	Satisfaction	%	Dissatisfaction	%	Total
Shurjer Hashi	7	70%	3	30%	10
Nogorshastho	9	90%	1	10%	10

Majority of respondents (80%) said that they were satisfied with the quality of service.

DISCUSSION

Service Receiver Statement: According to the service receiver, they told that they are satisfied in the service. All essential service is available in both of centers. Maximum service receivers were informed about cc from their husband, relative and mass media. Actually Mass media is playing a massive role to get information of health service about cc. They want more service including ANC, PNC and CS. They faced the problem that is the waiting time and distance of cc from their location.

Service Provider Statement: Majority have the specific training in their individual service. But some of them have no training. Maternal and child care service is common on both centres. But there are lacking of service like-delivery centers, USG, X-ray and pathology test. Only a few Nogorshastho clinics provide usual deliveries, but this kind of centre is limited. In both centre married and unmarried all types of people can get services. Mainly housewife of middle and lower class people receives the service than any other profession.

CONCLUSION

The aim of this study was to assess the development of community clinics, their location, Facilities, staffing, services and management. There are some reasons to be optimistic the developments have put in place facilities of broadly the planned specification in broadly the right locations. Causes for concern are the poor quality of some of the construction, some deficiencies in the facilities, furnishing and equipment and poor maintenance. However, in terms of operation and service development the picture is less encouraging. Many of the problems found in other government health services have appeared here – shortages of drugs and consumables, insufficient skills in some staff, staff not available when needed, and generally services considered to be of a poor standard by users. There are also risks in that some previously successful outreach services are to be replaced, and there is a need to ensure that the benefits of these are retained. It is clear that at present the community clinics are playing at most a limited role in the development of ESP services for those most in need.

RECOMMENDATION

- Service should be more available
- Instrument and lab should maintain appropriately.
- Ambulance service should be provided.
- Number of branches should be an increase.
- Location design should allocate according to patient need.

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