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Healthcare Service Utilization and Awareness of Community Clinics among Ever-Married Women of Reproductive Age in Bangladesh

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Abstract. *The Government of Bangladesh is establishing community clinics to provide essential healthcare services on the doorstep of the citizens of the country. In Bangladesh, women are the most vulnerable group in case of morbidity and mortality, especially in rural areas. They are unaware and underutilize the health care services provided by community clinics. The objective of the present study was to investigate the association of socio-economic and demographic variables with awareness of community clinics and also with the usage of services for health care from these clinics among the ever-wedded women of childbearing age. Bangladesh Demographic and Health Survey (BDHS), 2017-18 data were used in this research study. The study findings reveal that 56% of women who were ever-married were aware of healthcare services provided by community clinics situated in their residential area and 15.6% of women utilized such community clinic services in the 90 days preceding the survey. In this study, by applying bivariate chi-squared (χ2) test, some demographic, social, and economic variables are identified closely associated with consciousness about community clinics and usage of healthcare services from such clinics among women who were aged 15-49 and ever-married. The variables are marital status, educational qualification, working status, type of place of residence, administrative division, the economic condition of the household, ownership of mobile, number of members in the family, and husband's educational qualification. The government and policymakers should take necessary initiatives to increase the public awareness and utilization of community clinic services. Community clinics should introduce special healthcare facilities for specific groups such as pregnant women or adolescents to increase the utilization of community clinic services.*

Keywords: *Community Clinic, Ever-married Women, Healthcare Services, Bangladesh*

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INTRODUCTION

Community clinics have been established by Bangladesh Government with a view to provide essential health care facilities on the doorstep of the citizen living in the country. During period 1996-2001, the concerned authority of Bangladesh intended to establish 18,000 Community based Clinics throughout the entire country, out of which

10,723 were constructed during that period but the construction of new community clinics was stopped till 2009 (Sarker et al., 2015). The Bangladesh government again took the initiative in 2009 to setting up 14,000 Community Clinics under a project named "Revitalization of Community Health Care Initiatives in Bangladesh" (RCHCIB). (Yaya et al., 2017; Siddiqi et al., 2021). According to a recent estimate, currently, there are 13,907 Community clinics are functioning all over the country (MoHFW), Bangladesh, 2019). The Government of Bangladesh have been implemented five layers of institutions in the sector of health (Rumi et al., 2021) and community clinics are the first level in the delivery of essential medical services to rural people. People from different classes and levels receive different types of essential health care services from community clinics including maternity care, newborn and child health care, immunization, supplementation of micronutrient and nutritive education, contraception and family planning, reproductive health care, counselling and health education, remedy for mild sickness, first-aid, infectious disease control, emergency and complex instances, and referral to higher-degree health facilities (Karim et al., 2016; Siddiqi et al., 2021).

A large proportion of population in Bangladesh is living in rural areas. There exists a huge disparity in the availability of medical and health facilities across rural and urban or city areas. (Rumi et al., 2021). Population living in rural areas cannot get essential health facilities as urban population get, sometimes the cost of healthcare is not affordable for the rural poor population. Therefore, the invention of the community clinics emerged from the idea of delivering essential services for healthcare to those without access to healthcare through full community participation within the national healthcare system. (Siddiqi et al., 2021). Community clinics are now playing a very important role in delivering quality healthcare services to rural population especially disadvantaged population and have become the reliable health care centers for them. A study in a remote area of Bangladesh reported that 68.9% people were satisfied with the healthcare received from community clinics (Muyeed & Siddiqi, 2020). So, the idea of setting up community clinics has proved to be a landmark step in the healthcare system of Bangladesh.

In order to deliver universal, equitable, and cost-effective healthcare services globally, community health services (CHS) are a critical component. (Wu et al., 2016). Community Clinics are the primary level health care service providing institutions that are built and operated by the authority of government with the help of the participation of people living in a specific area where the institution is situated (Riaz et al., 2020). Due to the involvement of the community, the Community clinic setup is a unique example of a public-private collaboration (Hanifi et al., 2020).

In Bangladesh, women are the most vulnerable group in case of minor to severe illnesses and deaths, especially in areas where health facilities are insufficient. The women are unaware of the healthcare services that are available for their use, and sometimes underutilizing these services could increase maternal morbidity and mortality (Yaya et al., 2017). Women of all ages must therefore have sufficient knowledge and understanding of community healthcare (Sarker et al., 2015). Therefore, to increase the knowledge and understanding of healthcare services and improve the overall health situation, and help the policymakers, it is important to understand which factors are associated with the understanding and usage of services from community clinics by women. Thus, the main objective of this study is to examine the associationof demographic, economic and social factors with awareness and utilization of healthcare

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services from community clinics among ever-married women of childbearing age using a most recent nationwide survey in Bangladesh.

METHODS

The data of this study were extracted from the 2017-18 Bangladesh Demographic and Health Survey (BDHS), which is a population-based cross-sectional survey and which is the eighth survey of this kind of national survey. The BDHS 2017-18 was operated under the administration of NIPORT (National Institute of Population Research and Training), Medical Education and Family Welfare Division, Ministry of Health and Family Welfare, Bangladesh, and the survey was executed by Mitra and Associates, a Bangladeshi private research agency (NIPORT and ICF International, 2020). A nationwide representative sample was selected for this survey. A number of questionnaires were used to collect information about personal, demographic, socio-economic, and health-related issues from the respondents. A total of 20,160 households were chosen for this survey and from these households 20,376 ever-wedded women of reproductive age were eligible for interview and finally, 20,127 women were interviewed (NIPORT and ICF International, 2020). Data and information about the background characteristics of these ever-married women and data about understanding, visitation, and usage of different services for healthcare from community clinics located in their locality are used in this study.

Data of this study were analyzed with the help of a statistical software named SPSS developed by IBM Corporation. IBM SPSS Statistics version 25.0 is used in this study. Univariate descriptive analysis was employed to measure the descriptive variables such as the number in each category along with the percentage. In this study, the chi-square ($\chi 2$) test was performed to determine the association of social, economic, and demographic variables of the ever-wedded women of childbearing age with awareness about community clinics in their locality and also with the usage of services for health care from these clinics.

RESULTS AND DISCUSSION

The findings of the study reveal that 56% of ever-wedded women were aware of community clinics in the place where they live among these women who were conscious about community clinic, 15.61% of women were reported (table 2) to be visited their nearest community clinics before 3 months of BDHS 2017-18. The awareness among ever-wedded women about community clinics has increased in Bangladesh. Using the 2014 BDHS data of Bangladesh, a previous study reported that about 37% of ever-married women were conscious about community clinics (Yaya et al., 2017). By analyzing 2011 BDHS data, Sarkeret al., (2015) observed in a study that, only 18% of women were aware about community clinics.

In this study, the awareness about community clinic were found high among ever-married women aged between 20-34 who were currently married (table 1), the percentages of receiving healthcare services from community clinics were also high among these groups. Educational qualification of ever-married women has found to be close association with aware of community clinic and utilization of health services, women with primary and secondary education were more aware (table 1) and utilize more health services (table 2) from community clinics than those with no education and higher education. Working status of ever-married women is also found an important variable which is associated with awareness and visiting of community clinics. Compared to urban ever-married women, women living in rural areas were found less aware about

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community clinics and they also visited their nearby community clinics more than their counterparts. In this study, regional variations were found in case of consciousness and visitation of community clinics among ever-wedded women of child bearing age.

Table 1. Awareness of community clinics among ever-married women of age 15-49 by demographic, economic, and social variables

Demographic, economic, and social variables	Number and Percentage of women between the ages 15-49, who were found aware of community clinics in their locality.			χ^2 value	p-value
	NO (%)	Yes (%)	Total		
Age of the respondent					
<20	880 (9.9)	1071 (9.5)	1951 (9.7)		
20-34	4637 (52.4)	5911 (52.4)	10548 (52.4)	1.133	0.567
35 or above	3339 (37.7)	4289 (38.1)	7628 (37.9)		
Marital Status of respondent					
Married	8252 (93.2)	10643(94.4)	18895 (93.9)		
Widowed	318 (3.6)	345 (3.1)	663 (3.3)	15.125	0.002***
Divorced	162 (1.8)	172 (1.5)	334 (1.7)		
Separated	124 (1.4)	111 (1.0)	235 (1.2)		
Educational Qualification					
No Education	1378 (15.6)	1824 (16.2)	3202 (15.9)		
Primary	2644 (29.9)	3696 (32.8)	6340 (31.5)	136.21	<0.001***
Secondary	3309 (37.4)	4455 (39.5)	7764 (38.6)		
Higher	1525 (17.2)	1296 (11.5)	2821 (14)		
Respondent's Current working status					
Currently not working	5357 (60.5)	5138 (45.6)	10495 (52.1)	441.45	<0.001***
working	3499 (39.5)	6133 (54.4)	9632 (47.9)		
Type of place of residence					
Rural	5372 (60.7)	2002 (17.8)	7374 (36.6)	3931.13	<0.001***
Urban	3484 (39.3)	9269 (82.2)	12753 (63.4)		
Administrative Division					
Dhaka	1764 (19.9)	1210 (10.7)	2974 (14.8)		
Chittagong	1372 (15.5)	1533 (13.6)	2905 (14.4)		
Rajshahi	963 (10.9)	1613 (14.3)	2576 (12.8)	566.94	<0.001***
Sylhet	1084 (12.2)	1145 (10.2)	2229 (11.1)		
Barisal	923 (10.4)	1231 (10.9)	2154 (10.7)		
Khulna	1080 (12.2)	1550 (13.8)	2630 (13.1)		
Rangpur	752 (8.5)	1740 (15.4)	2492 (12.4)		
Mymensingh	918 (10.4)	1249 (11.1)	2167 (10.8)		

How frequent watch TV					
Not ever	2556 (28.9)	4815 (42.7)	7371 (36.6)		
Fewer than once per week	677 (7.6)	1085 (9.6)	1762 (8.8)	510.143	<0.001***
At best once in a week	5623 (63.5)	5371 (47.7)	10994 (54.6)		
Owns a mobile phone					
No	3139 (35.4)	4839 (42.9)	7978 (39.6)	116.228	<0.001***
Yes	5717 (64.6)	6432 (57.1)	12149(60.4)		
Index of wealth					
Poorest	1253 (14.1)	2573 (22.8)	3826 (19.0)		
Poorer	1119 (12.6)	2714 (24.1)	3833 (19.0)	1837.35	<0.001***
Middle	1344 (15.2)	2539 (22.5)	3883 (19.3)		
Richer	2061 (23.3)	2027 (18.0)	4088 (20.3)		
Richest	3079 (34.8)	1418 (12.6)	4497 (22.3)		
Gender of the head of household					
Female	1231 (13.9)	1623 (14.4)	2854 (14.2)	1.017	0.313
Male	7625 (86.1)	9648 (85.6)	17273(85.8)		
Number of household member in the family					
<5	3936 (44.4)	4837 (42.9)	8773 (43.6)	10.122	0.006***
5-9	4301 (48.6)	5716 (50.7)	10017 (49.8)		
10 or above 10	619 (7)	718 (6.4)	1337 (6.6)		
Husband's Educational Qualification					
Illiterate	1552 (18.8)	2424 (22.8)	3976 (19.8)		
Primary	2381 (28.9)	3542 (33.3)	5923 (29.4)		
Secondary	2471 (29.9)	3108 (29.2)	5579 (27.7)	216.133	<0.001***
Higher	1820 (22.1)	1553 (14.6)	3373 (16.8)		
No idea	27 (0.3)	16 (0.2)	43 (0.2%)		
Missing or have no husband	-	-	1233 (6.1)		
Total	**8856 (44%)**	**11271 (56%)**	**20127**		

Note: *** Significant at p value is less than 0.01, ** Significant at p value is lesss than 0.05,

* Significant at p value is less than 0.10

This study reported that women who were ever-wedded and watched television fewer than once per week were more aware and received health care services from community clinics in their locality. Similar results were also found for respondents who owned mobile phones were more conscious and aware of community clinics and receiving more healthcare services from community clinics. The economic condition of the household has been found to be a close statistical association both with awareness of

community clinics and utilization of healthcare services from it. Surprisingly, the study results of this study showed that ever-married women from high economic status were more aware of community clinics in their locality (table 1) but in table 2, it is observed that ever-married women from lower economic status utilized the services from community clinics more. The study findings from the $\chi 2$ test also show in table 1 and 2 that, the number of household members in the family and the husband's educational qualification of ever-married women of reproductive ages have a close statistical association with awareness of community clinic and healthcare service utilization from community clinics.

Table 2. Visitation of community clinics by women who were ever-married and reported that they were conscious of community clinics according to different demographic, economic, and social variables.

Demographic, economic, and social variables	Ever-married women visited community clinics and were reported aware of community clinics in their locality			χ^2 value	p-value
	NO (%)	Yes (%)	Total		
Age of the respondent					
<20	928 (9.8)	143 (8.1)	1071 (9.5)	32.434	<0.001***
20-34	4879 (51.3)	1032 (58.7)	5911 (52.4)		
35 or above	3705 (39.0)	584 (33.2)	4289 (38.1)		
Marital Status of respondent					
Married	8953 (94.1)	1690 (96.1)	10643 (94.4)	12.592	0.006***
Widowed	301 (3.2)	44 (2.5)	345 (3.1)		
Divorced	157 (1.7)	15 (0.9)	172 (1.5)		
Separated	101 (1.1)	10 (0.6)	111 (1.0)		
Educational Qualification					
No Education	1595 (16.8)	229 (13.0)	1824 (16.2)		
Primary	3079 (32.4)	617 (35.1)	3696 (32.8)	26.742	<0.001***
Secondary	3711 (39.0)	744 (42.3)	4455 (39.5)		
Higher	1127 (11.8)	169 (9.6)	1296 (11.5)		
Respondent's Current working status					
Currently not working	4368 (45.8)	770 (43.8)	5138 (45.6)	2.756	0.097*
working	5144 (54.1)	989 (56.2)	6133 (54.4)		
Place of residence					
Rural	1745 (18.3)	257 (14.6)	2002 (17.8)	14.175	<0.001***
Urban	7767 (81.7)	1502 (85.4)	9269 (82.2)		
Administrative Division					
Dhaka	1098 (11.5)	112 (6.4)	1210 (10.7)		
Chittagong	1261 (13.3)	272 (15.6)	1533 (13.6)		
Rajshahi	1342 (14.1)	271 (15.4)	1613 (14.3)	81.581	<0.001***
Sylhet	944 (9.9)	201 (11.4)	1145 (10.2)		
Barisal	1079 (11.3)	152 (8.6)	1231 (10.9)		
Khulna	1243 (13.1)	307 (17.5)	1550 (13.8)		
Rangpur	1467 (15.4)	273 (15.5)	1740 (15.4)		

Mymensingh	1078 (11.3)	171 (9.7)	1249 (11.1)		
How frequent watch TV					
Not ever	4063 (42.7)	752 (42.8)	4815 (42.7)	1.371	0.504
Fewer than once per week	903 (9.5)	182 (10.3)	1085 (9.6)		
At best once in a week	4546 (47.8)	825 (46.9)	5371 (47.7)		
Owns a mobile phone					
No	4023 (42.3)	816 (46.4)	4839 (42.9)	10.166	0.001***
Yes	5489 (57.7)	943 (53.6)	6432 (57.1)		
Index of wealth					
Poorest	2127 (22.4)	446 (25.4)	2573 (22.8)		
Poorer	2220 (23.3)	494 (28.1)	2714 (24.1)		
Middle	2124 (22.3)	415 (23.6)	2539 (22.5)	70.825	<0.001***
Richer	1755 (18.5)	272 (15.6)	2027 (18.0)		
Richest	1286 (13.5)	132 (7.5)	1418 (12.6)		
Gender of the head of household				9.318	0.002***
Female	1411 (14.8)	212 (12.1)	1623 (14.4)		
Male	8101 (85.2)	1547(87.9)	9648 (85.6)		
Number of household member in the family					
<5	4061 (42.7)	776 (44.1)	4837 (42.9)	11.029	0.004***
5-9	4814 (50.6)	902 (51.3)	5716 (50.7)		
10 or above 10	619 (7)	718 (6.4)	718 (6.4)		
Husband's Educational Qualification					
Illiterate	2036 (22.7)	388 (23.0)	2424 (21.5)	31.021	<0.001***
Primary	2902 (32.4)	640 (37.9)	3542 (31.4)		
Secondary	2635 (29.4)	473 (28.0)	3108 (27.6)		
Higher	1366 (15.3)	187 (11.1)	1553 (13.8)		
No idea	14 (0.2)	2 (0.1)	16 (0.1%)		
Missing or have no husband	-	-	628 (5.6)		
Total	**9512 (84.39%)**	**1759 (15.61%)**	**11271**		

*Note: *** Significant at p value is less than 0.01, ** Significant at p value is lesss than 0.05, * Significant at p value is less than 0.10.*

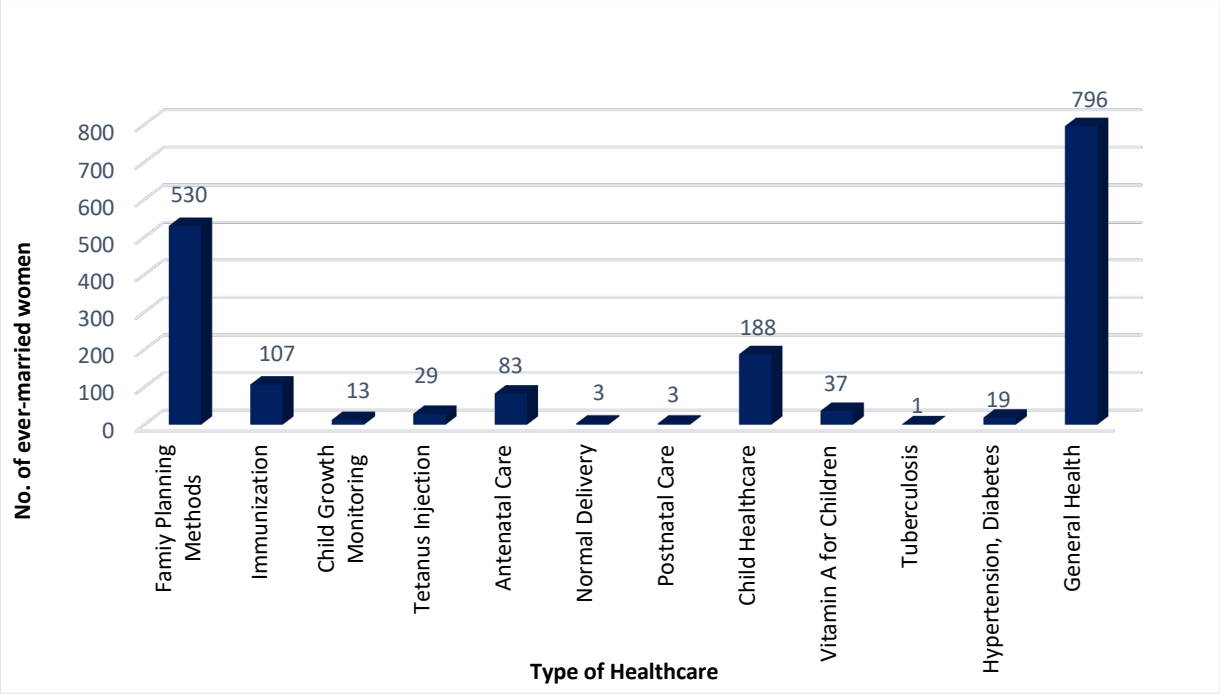

Figure 1. Type of healthcare received by women age between 15-49 and ever-married before three months of 2017-18 BDHS

Figure 1 presents that, Ever-married women who visited community clinics in the 3 months before the survey were receiving different types of healthcare facilities from their nearest community clinics. 30.13% of ever-married women (530) visited community clinics for family planning methods services, 45.25% of ever-married women (796) visited community clinics for general healthcare services, and 10% (188) for child healthcare, and 6.13% (107) for immunization. Most of the healthcare and medical services provided by community clinics are cost-free or low-cost, therefore the number of individuals receiving essential primary healthcare from community clinics is increasing day by day.

CONCLUSION

The establishment of community clinics has a notable role in enhancing the overall condition of health of the citizen living in Bangladesh, especially the population living in rural areas by providing one-stop services for health, nutrition, and family planning focusing on prevention and health promotion. A mentionable number of social, demographic, and economic factors are identified in this study which are closely associated with awareness and usage of healthcare and medical services from community clinics among women who were reported ever-married and aged between 15-49 years. The associate variables are marital status, educational qualification, working status, type of place of residence, administrative division, the economic condition of the household, ownership of a mobile, number of members in the family, and husband's educational qualification, etc. As the idea of establishing community clinics is based on the involvement and participation of the population living in a specific community, the active and full engagement of populations of all walks of life should be ensured for the success of community clinics. The scope of healthcare services in community clinics should be expanded by providing all types of medicine, and providing treatment for complex diseases as the rural poor people who are deprived of general medical facilities can easily receive emergency healthcare. Considering the needs of a particular group of the

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population, Community clinics should introduce special healthcare facilities for pregnant women or adolescents to increase the utilization of community clinic services. The government and stakeholders should take necessary initiatives to create public awareness about community clinics and their service utilization through the different types of public awareness programs using print and electronic mediaedia.

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