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Original Article

Study of Utilization of Health Care Services in Upazilla Health Complex, Keraniganj, Dhaka

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Abstract

Background: Utilization of health care services is an important public health and policy issue in developing countries. However, the level of health care services and its utilization rate is not satisfactory in many countries of the world**.**

Objectives: The objective of the present study was to assess utilization of healthcare services of Upazilla Health Complex, Keranigang, Dhaka.

Methods: This is a descriptive type of cross sectional study, which was conducted in Keraniganj Upazilla Health Complex, Dhaka during the period of march to August 2021. Total 140 data were collected purposively by face to face interview using a semi structured questionnaire.

Results: Among all the respondents, maximum 67 (47.85%) was with equal or more than 40 years of age and minimum 13 (9.28%) was with less than 20 years of age respectively. Majority 86 (61.42%) were female and 54 (38.57%) were male. Almost 95 (67.85%) were Islam, 43 (30.71%) were Hindu and only 2 (1.42%) were Christian. Majority 59 (42.14%) was illiterate. Half of the respondents 54 (38.57%) were housewife and minimum 4 (2.85%) were driver. Maximum 68 (48.57%) had monthly income 10,000-20,000 Taka and minimum 9 (6.42%) had monthly income equal or more than 30,000 Taka. Majority 74 (52.85%) had family member equal or more than 5, 66 (47.14%) had family member less than 5. 140 (100%) respondents had knowledge about outdoor services from this health complex among them majority 76 (54.28%) respondents observed 200-300 outdoor patients attended daily, 73(52.14%) respondents took emergency care daily and 83 (59.28%) respondents respond <15 patients took indoor service daily. UHC is very important to improve accessibility to the health care service.

Conclusion: The first referral hospital in primary level of health care delivery system of Bangladesh is UHC. Information exchange on supervisory and monitoring reports as well as increase manpower fascilities found essential to improve population satisfaction & its better utilization.

Key words: Upazila health complex, Health care services, and utilization of services.

Introduction

Planning and implementing healthcare strategies should be based on country's morbidity and mortality data[1] that reflects the health status of people in a nation. Accurate population-based morbidity data are largely deficient or absent in many developing countries, like Bangladesh.[2] There are nearly 125 million people inhabited in this country.[3] and is divided into 507 administrative units called Upazila (subdistrict), with an average population of ~200,000 in each subdistrict.[4] In Bangladesh there are more than 80% of the people live in rural areas.[5] Globally Bangladesh is among the most densely populated countries with a builtin population momentum resulting from a large proportion of young people. The country is going through significant social and demographic changes. Population growth in urban areas is 2.5%, compared to the national population growth rate of less than 1.4%.[6] Health has been declared a fundamental human right.[7] This implies that the state has a responsibility towards the health of its people. All over the world Governments are striving to expand and improve their health care services. Health is on one hand a highly personal responsibility and on the other hand a major public concern. It thus involves the joint effort of the whole social community and the state to protect and promote health.[8] Health is no longer accepted as charity or privilege of the few but demanded as a right for all. There is a presence of good public health infrastructure network in Bangladesh. The country's health care delivery system consists of three tier network of health care facilities. First tiers are Upazila Health Complexes (UHC) and Union Health and Family Welfare Centers (UH&FWC). These are outpatient facilities for both health and family planning services. The UHCs provide treatment to the cases referred

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from union level and also refer them to the district/medical college hospitals when necessary. Second tier is District hospitals. Third tier is tertiary level hospitals like specialized hospitals, institutes and medical college hospitals are equipped with specialized manpower and modern equipment to provide specialized care and treatment of referred cases from the district hospitals and health facilities of the country.[9] At the upazila level, the Upazila Health and Family Planning Officer (UHFPO) is responsible for the health and family planning services. Each UHC generally consist of eight doctors, one dental surgeon, two pharmacist, two laboratory technicians, one radiographer, one dental technician, five nurses, one mechanic and various auxiliary personnel. The UHFPO is also assisted by the health inspector, sanitary inspector and other staff. Of course many posts remain vacant. At this level domiciliary health and family planning service is provided which comprises of counseling on family planning services, preventive, promotive health care and treatment of minor ailments.[10] The Government provides healthcare services to its rural people through health facilities called Upazila Health Complex (UHC) at the upazila level and through union subcentres at the union level (smallest administrative unit). Many non-governmental organizations (NGOs) also provide healthcare services through community clinics and similar other establishments.[11,12] In addition, the informal sectors provide healthcare services at the village level.[13] In the government healthcare-delivery systems at the upazila level, there are 460 UHCs-each with 31 beds-to provide inpatient care to its population. It also provides outpatient care, primary healthcare, family-planning services, and other preventive healthcare services to its population.[14] The study findings will contribute to identification of accessibility to health care services of UHC and accordingly will help to improve the quality and utilization of health care services of the UHC throughout the country.

Materials and Methods

This descriptive type of cross-sectional study was conducted in UHC of Keranigonj District and lasted for 6 months from March to August 2021 with a sample size of 140 using an predesigned pretested semi-structured questionnaire to assess Utilization of Healthcare services of Upazilla Health Complex. The questionnaire comprised of socio-demographic factors (sex, age, education, occupation), Services provided in UHC (Indoor service, Outdoor service, Emergency service, Laboratory service). The data collection method was non-probability type of purposive sampling.

Results

Table 1: Variables related to socio-demographic characteristics of respondents (n=140)

Characteristics	Categories	Respondent	
		Frequency	Percentage
Age group (years)	<20	13	9.28
	20-30	27	19.28
	30-40	33	23.57
	≥40	67	47.85
Sex	Male	86	61.42
	Female	54	38.57
Education	Illiterate	59	42.14
	Primary	5	3.57
	Secondary	8	5.71
	SSC	38	27.14
	HSC	17	12.14
	Others	11	9.27
Religion	Muslim	95	67.85
	Hindu	43	30.71
	Christian	2	1.42
Occupation	Housewife	54	38.57
	Maid servent	27	19.28
	Rickshawpuller	22	15.71
	Student	11	7.85
	Day labor	9	6.42
	Agricultural worker	7	5
	Service	6	4.28
	Driver	4	2.85

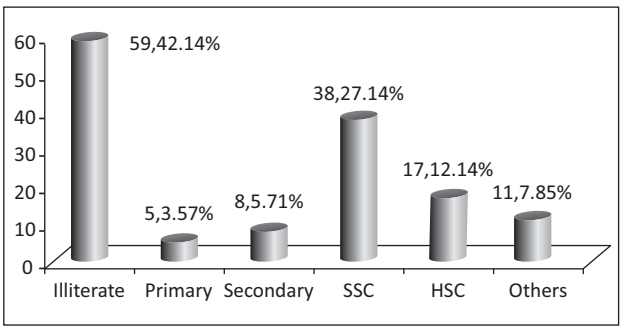

Figure 1: Distribution of respondents according to levels of education (n=140)

Table 2: Distribution of respondents according to knowledge regarding health care service in UHC (n=140)

Characteristics	Frequency	Percentage
Visited outdoor patient daily		
<200	30	21.42
200-300	76	54.28
≥300	34	24.28
Visited emergency patients daily		
<100	21	15.00
100-200	46	32.85
≥200	73	52.14
Visited indoor patient daily		
<15	83	59.28
≥15	57	40.71
Surgical service daily		
<10	9	60.00
≥10	6	40.00
Laboratory fascilities		
Blood test	76	54.28
Urin test	28	20.00
X-ray	18	12.85
USG	8	5.71
Stool test	7	5.00
ECG	3	2.14

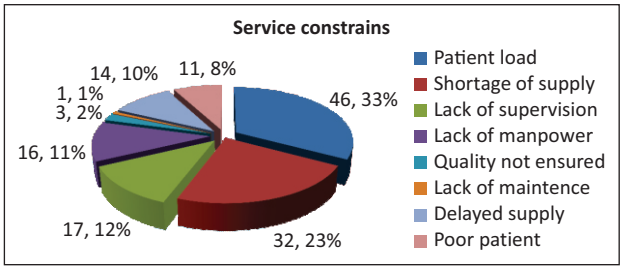

Figure 2: Distribution of respondent according response of service constrains

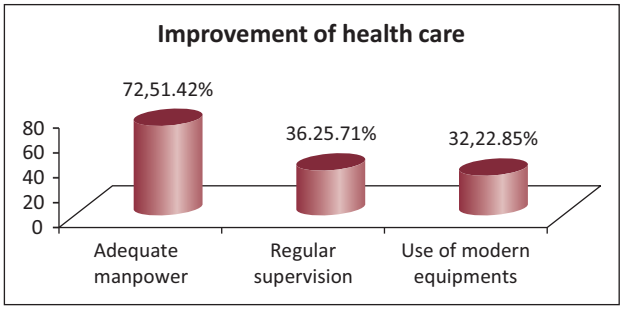

Fig 3: Distribution of respondents opinion regarding improvement of health care

Discussion

Upazila Health Complex (UHC) is the first referral health facility at primary level of health care delivery system in the country. Rural people attend the UHCs to meet their health care needs and demands. The analysis of the data of the current study shows 61.42% respondents were males and 38.57% were females. A Study conducted by Islam MZ showed, out of the 305 respondents, majoroty 55.40% were male and 44.60% were female.[15] It seems that, females are getting poor access to health services than their counterpart males. This finding is close to the finding of census 2011 conducted by the Bangladesh Bureau of Statistics (BBS), where males are slightly higher in proportion to get better access to health facilities in comparison to their counterpart females and it is also the national scenario of the country.[16]

In respect of age of the participants and accessibility to UHC health care service, maximum 67 (47.85%) was with equal or more than 40 years of age, 33 (23.57%) was with 30-40 years of age, 27 (19.28%) was with 20-30 years of age and 13 (9.28%) was with less than 20 years of age accessibility to health care services of the UHC. This finding of the study can be explained by the facts that the middle aged people are the productive and income generating group in the rural community and they were more concerned about their illness and health care utilization for cure, that's why they were in large proportion in comparison to the other age groups. Moreover, middle age group are more conscious about their health for a better health in future.[17] similar findings also observed another study was conducted by Young, JT.[18]

Regarding education it was explored that, majority 59 (42.14%) was illiterate, 5 (3.57%) were Class (I - V), 8 (5.71%) were Class (VI - X) level, 38 (27.14%) were educated SSC, 17 (12.14%) were HSC, 11(9.27%) were others. In this regard, findings related to educational qualification differed as the SVRS of BBS found adult literacy rate 58.8%. This difference may be explained by the logic that this specific study was conducted in selected rural community while the SVRS carried out the survey countrywide.[19] Similar findings were revealed by the study conducted by Sohail, M where the study revealed that less educated rural people had poor accessibility to health care services of UHC while educated people had good accessibility.[20]

In respect of occupation of participants 54 (38.57%) were housewife, 27 (19.28%) were maid servant, 22 (15.71%) were rickshawpuller, 11 (7.85%) were student, 9 (6.42%) were day labor, 7 (5%) were agriculture, 6 (4.28%) were service and 4 (2.85%) were driver had good accessibility to services of UHC. In this regard, the findings of Bangladesh Bureau of Health Education found that 36.1% people with occupation; agriculture, forestry, fisheries and 63.9% with non-agricultural occupations were prevailing in the country and their accessibility to health facilities was not satisfactory.[21]

Majority 76 (54.28%) respondents respond approx 200-300 patients received outdoor service, 73 (52.14%) respondents has been observed more than or equal 200 patient daily taken emergency service daily and 57 (40.71%) respondents respond more than or equal 15 indoor patient visited daily in this health complex and majority 76 (54.28%) respondents respond there is lab facilities is available here as well.

Regarding problems associated with accessibility to UHC services, majority respond patients load, shortage of supply, Lack of supervision, lack of manpower, quality not ensured, lack of maintenance, delayed supply, poor patient were 46.32%, 32(22.85%), 17 (12.14%) 16 (11.42%), 3 (2.14%),1(1%), 14 (10%),11 (7.85%) respectively mentioned referred to another hospital, 18.4% for poor communication and 15.3% mentioned limited treatment facility. A similar study was conducted by Sohail, M which was macro level quantitative study looked at the process and structure aspects of quality of PHC and suggests that the majority of the users of government PHC services were dissatisfied with the existing level of quality of care. In particular, people were most dissatisfied with waiting time, cleanliness, and privacy of treatment and the standard of inpatient food.[22]

To ensure good accessibility at the UHC, these constraints must be considered by the health policy makers and health care managers and accordingly effective measures should be taken. Suggestion regarding improvement to UHC services, majority 72 (51.42%) respondent respond improvement of adequate manpower for 24 hours service, 36 (25.71%) respond improvement of regular supervision of the higher authority in this health complex and 32 (22.85%) respond use modern equipment with regular maintenance in this health complex. A study was conducted by Hasan, MK in respect of quality of health and patients ‟expectation showed that, unavailability of health professionals, shortage of health staff, lack of resources and cleanliness of the UHC, lack of adequate infrastructures at the UHC, lack of adequate diagnostic facilities, power supply and drug supply as the major factors related accessibility to health care.[23] All these factors are still prevailing as major barriers to UHC services throughout the country.

Conclusion

Most of the respondents faced problem shortage of supply of medicine, patients load, and lack of supervision process. This issued can be solved by enhancing manpower as well as arrengement and use of modern equipments. For this, coordination and cooperation between central and local health managers must be improved for well-functioning and accessibility of rural people to UHC.

The active involvement of local government and communities in UHC management can improve service delivery systems. To overcome the problems associated with accessibility specific measures and program interventions should be devised.

Conflict of interest: No

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