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Quality of Counselling Services for Pregnant Women in Community Clinics

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ABSTRACT

Maternal health service had a potentially critical role in the improvement of reproductive health. This descriptive study was carried out in Tangail district, from 1st January to 31st December, 2019 to find out the quality of counselling of services for pregnant women in community clinics during pregnancy period. Data were collected among 289 respondents by face to face interview who had delivered within last 24 months and respondents were selected purposively. The majority (97.6%) of the respondents were housewife and maximum (72%) of the respondent were below SSC in this study monthly family income mean was taka 16124.00± 10065.480. Majority of the respondents (99.2%) had received antenatal check-up from different health care facilities and highest (87.2%) had received from the community clinic other hands (6.0%) pregnant women got antenatal care from non-government hospital among 250 respondents (94.0%) pregnant women received ANC from CHCP also (4%) pregnant women received ANC from HA. Out of 250 pregnant women (70%) of the respondents were problem suffer during pregnancy. Here majority (59.6%) pregnant women were suffer from nausea and vomiting and only (6.3%) were suffering from constipation. Majority (89.2%) of the respondents had preparation about danger sign during pregnancy. Most 245 (98%) of the respondents of pregnant women had information about ANC and most (85.7%) got information from CHCF on other hand ride got information (2.9%) from neighbour. half (4.8%) of the respondents choice of conduct delivery at upazila health complex followed by (48.8%) only choice of conduct clinics. Most (98%) of the respondents had received TT vaccine and maximum (95.1%) of the respondents had completed TT vaccine. Enough skilled manpower for patient care (98.4%). Health care provider perform ANC check-up (96.8%). Health care provider counselling during pregnancy (96.4%) physical examination (98.0%) explanation of health. (99.2%) health care provider give any advice before departure (70.4%). Continue to follow-up health status over phone (99.2%). Service providers in health care shows that 33.3% was BSc/BA, 42.9% of service providers were masters and above their professional training more than one third (38.1%) of the providers has basic training, 47.6% had basic & CSBA and rest 14.3% had ECT and nutritional training. Majority 100% of the provider's designation had CHCP, number of staff in two health care had more than half (57.1%) providers.

Facilities in the community clinic (89.6%) citizen charter displayed, (96.4%) fixed waiting place (84.8%). Among them 100% of modem logistics functioning followed by 94.4%, 88.9%, 94.4% were electricity, laptop, electric fan and 55.6% were available display board. Majority (81%) of the providers no EOC services and most (90.5%) of the providers were provided FP counselling after delivery. Maximum (85.7%) of the providers were vaccination services for women aged between 15-49 years. Facilities meeting quality standards will ultimately receive accreditation, thereby generating greater community demand for their services. Ongoing in-service training and replication of this initiative will ensure sustainability and long-term results.

KEYWORDS: Quality, counselling, services, pregnant women, community clinics.

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INTRODUCTION

Maternal mortality remains a public health challenge worldwide, and the global maternal mortality ratio of 342, 900/100,000 live births annually is still unacceptably high. Similarly, maternal mortality is a serious public health problem in Bangladesh. It is estimated that there are676 maternal deaths per 100,000 live births in Bangladesh. The commonest danger signs during the postpartum period include severe bleeding following childbirth, loss of consciousness after childbirth, and fever [1].

Counseling during antenatal care (ANC) visits on danger signs of pregnancy complications is important because it can raise the awareness of expecting mothers in recognizing danger signs. However, improving ANC clients' knowledge of danger signs of pregnancy complications depends not only on the amount of counseling provided but also on its electiveness and on whether the information communicated by the provider can be easily understood and retained by the expecting mother. This study explores the level of knowledge and counseling on danger signs of pregnancy complications during ANC visits at health facilities in Haiti, Malawi, and Senegal. The outcome of interest is the number of danger signs women knew after their ANC visit. The main variable of interest is counseling on danger signs of pregnancy complications [2].

Globally, every minute, at least one woman dies from complications related to pregnancy or childbirth – that means 529 000 women a year. In addition, for every woman who dies in childbirth, around 20 more suffer injury, infection or disease – approximately 10 million women each year [3]. WHO recommends that health services work with women, their families and the broader community so that they have appropriate and comprehensible information on the danger signs during pregnancy, as any woman can develop complications, and to ensure that all are aware of where to seek care in the case of an emergency. Explore with women what they know about danger signs and make sure they know them all. Some danger signs are more difficult than others to recognize such as edema. When counseling women about danger signs you need to explore with them what is normal, what is unusual and what is a danger sign. The next important step is to help the woman and her family plan where they will go and how they will reach the skilled attendant if they have any of these signs. Refer to as much of this information should already have been discussed and drafted into a birth and emergency plan [4].

The main causes of maternal mortality in Bangladesh are Bleeding and post-partum hemorrhage (29%), Eclampsia (24%), Obstructed labor (10%), Abortion (5%) [5]. The government of Bangladesh has been pursuing the strategy through establishment of family welfare centers (FWCs), maternal and child health (MCH) units and Maternal & Child Welfare Centers (MCWCs) in the context of a primary health care (PHC) in Bangladesh to reduce maternal mortality. Bangladesh Govt. provided antenatal services to the potential clients in the community through this project but the coverage of population with antenatal care is not satisfactory. 'There are several factors responsible for the underutilization of these facilities. The perceptions of health and health care by the beneficiaries i.e. the mothers, families and community leaders are factors that may influence the utilization of services. In this study, therefore, the researcher has tried to find out the women's perception of problem during pregnancy and delivery, and utilization: antenatal care facilities in a rural community of Bangladesh. The proper utilization of antenatal care of pregnant mothers is believed to greatly reduce neonatal mortality and maternal mortality in our country, particularly in rural communities. We focus here on the quality of antenatal care at community clinic in Tangail district, Bangladesh, with respect to provider counseling of pregnancy danger signs. Furthermore, this research allowed for the care seeking for danger signs of mother regarding reproductive health care services of women in tertiary level hospital in Bangladesh

RESEARCH QUESTION

What is the quality of counseling services for pregnant women in community clinics?

OBJECTIVES:

1. **GENERAL OBJECTIVE**
   To assess the quality of counseling of services for pregnant women in community clinics.2
2. **SPECIFIC OBJECTIVES**
   - To assess the awareness for antenatal care among pregnant women;
   - To assess the aspect for counseling according to need;
   - To assess the quality of counseling for pregnant women seeking antenatal care in community care;
   - To determine available facility in community clinic
   - To determine the socio-demographic characteristics of the respondents;
   - To identify the problems faced by the service providers and their suggestion for improvement.

LIMITATIONS OF THE STUDY

- The study was geographically limited and may not reflect the true picture of the whole situation of the community.
- Sampling technique was purposive sampling. So, there was increase chance of bias.
- This study may not reflect the whole quality of counseling develop for pregnant.
- The study was limited to only three Upazila in the district and this reduces the general inability of the

results to the entire community clinic of urban district area.

- Since the study is cross sectional it may not be strong to demonstrate direct relationship between dependent and independent variables.

MATERIALS AND METHODS

Study design

The study design was a descriptive type of cross-sectional study.

Study place

Study will be conducted at Community Clinic in Tangail district.

Study period

The study was conducted from 1st January to 31st December, 2019.

Study population

Child bearing mothers age between 15-49 years.

Selection Criteria

Inclusion criteria

- Women residing in the study area who delivered within last 24 months.
- Respondents willing to give informed written consent.
- Aged 18 years or above.

Exclusion criteria

- Woman below and above reproductive age group.
- Respondents not willing to give informed written consent.
- Severely ill or mentally handicapped persons.

Sample size

To determine the sample size for cross-sectional study the formula is:

$n= z^2 Pq / d^2$

Here, n = the desired sample size which would help to measure the different indicators z = standard normal deviation. Usually set at 1.96 at 5% level which corresponds to 95% confidence level. p= it is the assumed target proportion to have a particular characteristic =22.6% (Currently married women in rural India 2014. The prevalence of high fever 22.6,). = 0.226 q = 1-p [here p=0.226] =0.774 d = is the degree of accuracy level considered as 50% Therefore, the calculated sample size was n= z2 Pq / d2 = (1.96)2 x 0.226 x 0.774 / (0.05)2 = 368.99. But due to time constraint and non-availability of participant we included 289 Women's.

Sampling technique

Purposive sampling technique was used.

Data collection technique

Face to face interview of participant mothers were conducted to collect data.

Research instrument

Questionnaire was prepared for obtaining required information based on status of care seeking during postpartum danger signs and factor related to care seeking behavior during postpartum period. The questionnaire also includes socio-demographic information. Questionnaire was translated into Bangla. The completed questionnaire was pre-tested on 10 postpartum danger signs develop mothers from Dhaka Medical Collage Hospital, those were not included in the study. The questionnaire was finalized after necessary modifications.

Data management and analysis

At the end of each day of data collection, individual questionnaire was edited through checking and rechecking to see whether it was filled completely and consistently. The data entry was started immediately after completion of data collection. Then data processing and analysis were done by using appropriate method of Statistical Package for Social Sciences (SPSS) Version 20. Data were analyzed according to the objectives of the study. The test statistics used to analyze the data were descriptive statistics, Chi square (x^2). Level of significance was set at 0.05. The results were presented in the form of tables, graphs and statistical inference.

Ethical implications

The protocol was first reviewed and approved by the Ethical Committee of National Institute of Preventive and Social Medicine. All respondents were informed about the objectives and procedure of the study and ensured the confidentiality of the data. No more than minimal physical, mental or socio-economic risk or harm to the respondents was involved in the research project, as the interview administered questionnaire was applied for data collection. Respondents' participation and contribution are acknowledged with due respect. Informed consent was taken from respective participants before starting the interview and ensured privacy and confidentiality of the information.

THE MAIN FINDINGS AND RESULTS

Table 1. Distribution of the respondents according to demographic information of service receiver (n=250)

Variables	Characteristics	Frequency (n)	Percentage (%)
Age	≤ 20 years	51	20.4
	21-25 years	116	46.4
	26-30 years	62	24.8
	>30 years	21	8.4
	Mean ± SD = 24.42±4.252, Range: 17-40 years		
Respondents educational qualification	Primary level	83	33.2
	Secondary level	97	38.8
	SSC pass	58	23.2
	HSC and above.	12	4.8
Respondents husband's educational qualification	Primary level	73	29.2
	Secondary level	78	31.2
	Up to SSC	56	22.4
	Up to HSC	36	14.4
	Graduation and above	7	2.8
Types of family	Extent family	142	56.8
	Nuclear family	108	43.2
Monthly family income	Taka ≤10000	72	28.8
	Taka 10001-15000	85	34.0
	Taka 15001-20000	53	21.2
	Taka 20001-25000	13	5.2
	Taka >25000	27	10.8
Getting information about ANC	Yes	245	98
	No	5	2
Person provided information about ANC	CHCP	210	85.7
	FWA	10	4.1
	Doctor	10	4.1
	Neighbour	8	3.3
	Health worker	7	2.9
Husband knew about ANC	Yes	240	96.0
	No	10	4.0

Table 1 shows that 20.4% of the respondents was ≤ 20 years old followed by about half 45.4% of the respondents were 21-25 years old. As regards 24.8% of the respondents were fall in 26-30 years age group and rest of total 8.4% were fall in more than >30 years age groups. The mean age of the respondents was 24.2 years (Range 17-40). Above on third 33.2% of the respondents were primary level educated according to 38.8% were secondary, 23.2% were SSC pass and rest 4.8% of the respondents were Higher secondary and above. One third (29.2%) of the respondents' husband was primary education level followed by 31.2% were secondary level, 22.4% were up to SSC, 14.4% were up to HSC. As regards rest of total (2.8%) respondents husband were graduation and above respectively. More than half 56.8% of the respondents families were extent family followed by 43.2% were nuclear family. In terms of monthly family income, 34% had income Taka 10001-15000, 21.2%, 5.2% were Taka 15001-2000 & Taka 20001-25000, only 10.8% of the respondents monthly family income more than Taka 250000. Highest 98% of the respondent's get information about antenatal care during pregnancy only 2% were did not. Maximum 85.7% of the respondents get information from CHCP followed by 4.1% are same value by FWA and Doctor, 3.3% were neighbour and rest 2.9% were health workers provided with the information. Of the respondent's most 66% husband knew about ANC. whereas only 4% husband did not know about this.

Table 2. Distribution of the pregnant women by seeking ANC (Antenatal Care) (n=250)

Variables	Characteristics	Frequency (n)	Percentage (%)
Received ANC	Yes	248	99.2
	No	2	0.8
Getting ANC	After one month	246	98.4
	After 2 months	2	0.8
	After 3 months	2	0.8
Health care of ANC	Non govt. hospital	15	6.0
	Community clinic	218	87.2
	Union sub center	5	2.0
	NGO clinic	2	0.8
	Satellite clinic	8	3.2
	Others	2	0.8
From received ANC	CHCP	235	94.0
	FWA	10	4.0
	HA	1	0.4
	Others	4	1.6
Problem suffering during pregnancy	Yes		30%
	No		70%
Perception about danger sign	Yes	223	89.2
	No	27	10.8
Received treatment	Yes	222	88.8
	No	28	11.2
Conduct delivery	CHCP	94	37.6
	FWA	3	1.2
	Doctors	143	57.2
	Registered nurse/midwife	10	4.0
Choice of health care	Community clinic	72	28.8
	Union sub-centre	4	1.6
	Upazila health complex	122	48.8
	District hospital	37	14.8
	Home	15	6.0
Transport available	Yes	198	79.2
	No	52	20.8
Adequate financial support	Yes	205	82
	No	45	18
Arranging any blood donor	Yes	161	64.4
	No	84	35.6

Table 02 finds the distribution of the respondents by seeking ANC during pregnancy period. Most 99.2% of the respondents received ANC during pregnancy. Only 0.8% of the respondents not received ANC. Majority 98.4% of the respondents had get ANC after one month, 0.8% were getting after 2 and 3 months. Maximum 87.2% of the respondents had received ANC during pregnancy place at community clinic followed by 6.0%, 2%, 3.2%, .8% had received from non govt. hospital, union sub center, NGO clinic, Satellite clinic and only 0.8% ANC received from others providers. Highest 94% of the respondents had received ANC during pregnancy by person from CHCP, according to 4% from received ANC FWA, 0.4% from received from health assistant and rest 1.6% ANC received from others providers. Pregnant women 30% were suffer problem during pregnancy. Majority 89.2% of the respondents was perception about danger sign during pregnancy but only 10.8% did not perception about this. Most 88.8% of the respondents had received treatment during pregnancy whereas only 11.2% respondents had no received treatment during pregnancy. Highest 57.2% of the respondents want to conduct with doctors during delivery next highest 37.6% conduct CHCP, 1.2% & 4% of the respondents want to conduct with FWA & registered nurse/midwife respectively. About half 48.8% of the respondents said their choice of health to conducted delivery at Upazila health complex followed by 28.8%, 1.6%, 14.8%

of the respondents said community clinic, union sub-centre, district hospital and only 6% said their delivery want to place at home. Majority 79.2% of the respondents have transportation availability other hand 20.8% of the respondents have no transportation availability. Maximum 82% of the respondents had adequate financial support but 18% did not adequate financial support. Whereas more than two third 64.4% of the respondents arranged blood donor but 35.6% could not arranged blood donor.

Figure 01 finds that About two third 59.6% of the respondents were suffering from nausea & vomiting, according to 9%, 14.4%, 4.5%, 3.6% & 6.3% were suffering from UTI, Anemia, Epigastria pain Under nutrition & Constipation and only 2.7% were suffering from others type of problem.

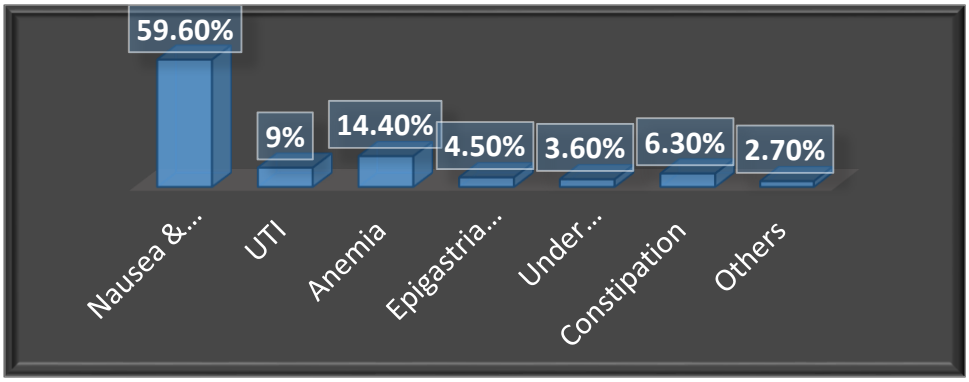

FIGURE 1. Distribution of the respondents by type of problem suffering during pregnancy (n=101)

Table 3. Distribution of the respondents by aspect for counselling to need (pregnancy complication, treatment and dietary habit) (n=250)

Variables	Characteristics	Frequency (n)	Percentage (%)
Any pregnancy complication	Yes	25	10.0
	No	225	90.0
Treatment of complication (n=25)	CHCP	12	48.0
	Doctor	13	52.0
Received TT vaccine	Yes	245	98
	No	05	2.0
Complete TT vaccination (n=245)	Yes	233	95.1
	No	12	4.9
Knowledge about dietary practice	Yes	212	84.8
	No	38	15.2
Diet per day	3-4 times	14	5.6
	4-5 times	8	3.2
	5 times	228	91.2
Intake of adequate amount of food	Yes	232	92.8
	No	18	7.2
Knowledge on rest	Yes	236	94.4
	No	14	5.6
Getting enough rest	Yes	233	93.2
	No	17	6.8
Habituated with tobacco	Yes	55	22
	No	195	78
Type of tobacco consumption	Smoking	6	10.9
	Smokeless tobacco	49	89.1

Table 03 reveals of the respondents by aspect for counselling to need. Of the respondents only 10% were pregnancy complication. Maximum 52% of the respondents told their pregnancy complication want to treatment by doctors and 48% told by CHCP respectively. Most 98% of the respondents had received TT vaccine only 2% did not received TT vaccine. Majority 95.1% of the respondents had completed TT vaccination doses only 4.9% had no completed

TT vaccine doses. Most 84.8% of the respondents had knowledge about dietary practice during pregnancy but 15.2% did not know. Maximum 91.2% of the respondents were opinion five times frequency of consumption of diet per day, 5.6% opinion 3-4 times and only 3.2% of the respondent's opinion 4-5 times of diet per day. Most 92.8% of the respondents told adequate amount of food and fluid need to take per day only 7.2% did not adequate. Majority 94.4% of the respondents had knowledge about requirement of rest during pregnancy only 5.6% did not know. Majority 78% of the respondents did not habituated with tobacco consumption but 22% of the respondents habituated with tobacco consumption. Of the respondents 89.1% were taking smokeless tobacco and 10.9% were smoking.

Figure 2 represents that out of 25 respondents were different complications in pregnancy. Among them more than one third 36.1% respondents were blurring of vision followed by 13.9%, 22.2%, 13.9% were Lower abdominal pain, Excessive PV bleeding, Swelling of face and hand and 13.9% of the respondents were others complication during pregnancy.

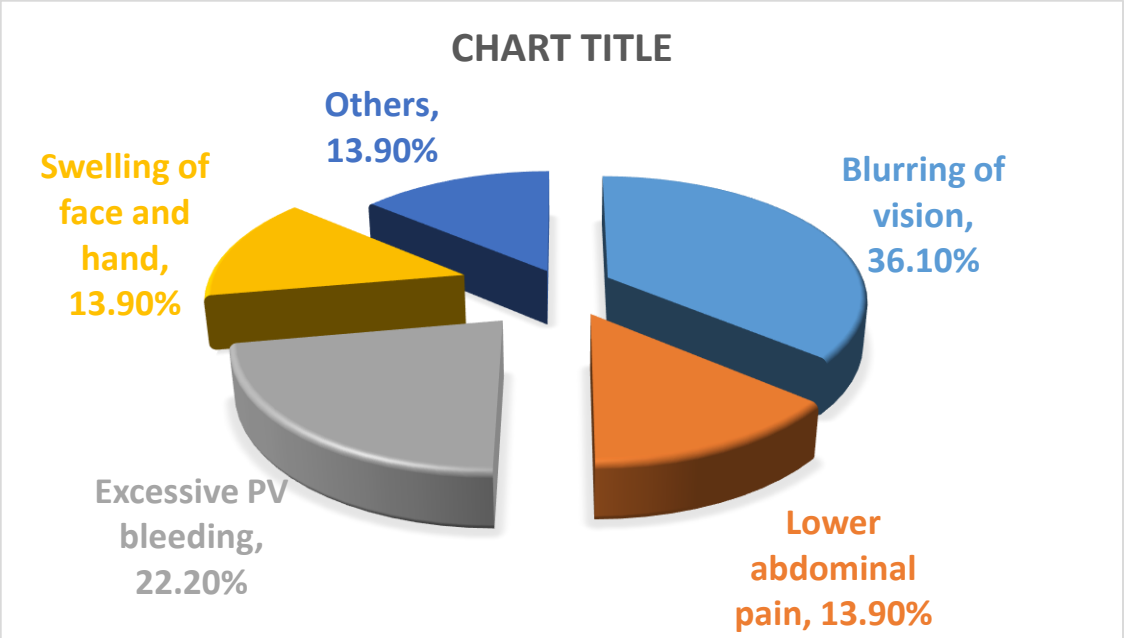

FIGURE 2. Distribution of the respondents by type of problem suffering during pregnancy (n=25)

Table 4. Distribution of the respondents according to information of ANC facilities of service receiver (n=250)

Variables	Characteristics	Frequency (n)	Percentage (%)
Operate Community clinic between 9 am to 3 pm	Yes	244	97.6
	No	6	2.4
Suitable transport to reach the community clinic	Yes	230	92.0
	No	20	8.0
Waiting time for health care	<10 minutes	87	34.8
	10-20 minutes	111	44.4
	20-30 minutes	42	16.8
	>30 minutes	10	4.0
Place of refer	UHC	178	71.2
	District hospital	67	26.8
	Medical College	5	2.0

Table 4 Distribution of the respondents according to information of ANC facilities of service receiver. Most (97.6%) of the respondents told community clinic operate between 9 am to 3 pm. Majority (92%) of the respondents said having suitable transport to reach the community clinic. But only 8% of the respondents not having suitable transport to reach the community clinic. of the respondents 34.8% told <10 minutes wait before visiting the health care providers according to 44.4% were 10-20 minutes, 16.8% were 20-30 minutes and rest 4% were more than 30 minutes wait before visiting for the health care providers. The majority (71.2%) of the respondents said their refer to UHC, 26.8% were district hospital and 2% were medical college.

Table 5. Distribution of the respondents according to demographic information of service providers in health care (n=21)

Variables	Characteristics	Frequency (N)	Percentage (%)
Gender	Male	6	28.6
	Female	15	71.4
Educational level	HSC and bellow	5	23.8
	BSc/MBBS/BA	7	33.3
	Masters and above	9	42.9
Professional training	Basic training	8	38.1
	Basic + CSBA	10	47.6
	ECT and nutritional training	3	14.3
Designation *Multiple responses	CHCP	21	100.0
	FWA	4	19.0
	HA	1	4.8
Length of service	≤ 7 years	6	28.6
	8-15 years	13	61.9
Supporting staffs	Guard	2	11.8
	Aya	14	82.3
	Cleaner	1	5.7

Table 5 Distribution of the respondents according to demographic information of service providers in health care. Of the service providers total out 21, among them 71.4% of the providers were female and 28.6% were male. Service providers 23.8% educational level had HSC and bellow, followed by 33.3% had BSc/MMBS/BA and highest 42.9% of service providers were Masters and above respectively. More than one third (38.1%) of the providers had basic training according to 47.6% had Basic & CSBA and rest 14.3% had ECT and nutritional training. Majority (76.2%) of the service provider's designation had CHCP, 19% had FWA and a least number of 4.8% had HA respectively. Two third (61.9%) of the providers were working duration of 8-15 years, 28.6% were 7 or less than seven years and 9.5% were more than 15 years duration of the total length of service in community clinic. Among them (82.3%) of supporting staffs had Aya in local community clinic according to 11.8% had guard and 5.7% had cleaner.

Table 6.Distribution of the respondents (providers) by providing treatment and problem faced (n=21).

Variables	Characteristics	Frequency (n)	Percentage (%)
Treatment for danger sign	Yes	1	4.8
	No	20	95.2
Problem faced	Yes	9	42.9
	No	12	57.1
Type of problem faced (n=09)	Community participant and counselling	3	33.3
	Increase to CHV training and refresh trading	3	33.3
	Increase to publicity of conscious	2	22.2
	Supply short of Electric, Water and Reading	1	11.1
Problem faced by health education	Yes	6	28.6
	No	15	71.4

Table 6 Reveals distribution of the respondents (providers) by providing treatment and problem faced. Most (95.2%) of the providers no providing treatment for danger sign during pregnancy women only 4.8% were treatment. More than half (57.1%) of the providers were no problem faced during proving counselling to the pregnant and 42.9% were problem faced. Out of 21 providers among them 9 providers were problem faced. The same value 33.3% provider Community participant and counselling & Increase to CHV training and refresh trading problem faced during counselling to the pregnant, 22.2% were Increase to publicity of conscious and 11.1% were Supply short of Electric, Water and Reading. Providers 28.6% had problem faced by health education and 71.4% providers had no problem.

Table 7. Distribution of the condition of available logistics (functioning) in 18 community clinic (n=18)

Variables	Characteristics	Frequency (n)	Percentage (%)
Available logistics (functioning)	Electricity	17	94.4
	Laptop	16	88.9
	Modem	18	100.0
	Electric fan	17	94.4
	Display board	10	55.6
Furniture (functioning)	Examination tables	14	77.8
	Steel Almeria	17	94.4
	Black board	13	72.2
	Chairs	17	94.4
	Bench	12	66.7
Instruments for new born care (functioning)	Measuring tape	16	88.9
	Weight machine	18	100.0
	Naso gastric tube (small)	12	66.7
	Penguin sucker	13	72.2
	Umbo bag	13	72.2
	Baby towel	13	72.2
	Sterile tie	14	77.8
	Scissor	13	72.2
	Watch	13	72.2

Table 7 Shows distribution of the condition of available logistics (functioning) in18 community clinic. Out of 18 community clinic among them 100% of modem logistics functioning followed by 94.4%, 88.9%, 94.4% were electricity, laptop, electric fan and 55.6% were available display board. Among them 77.8% were functioning examination table, 94.4% are same value steel Almeria and chairs were functions and 72.2% were functioning black board. Most of respondents had facilities on different aspects for new born care as mentioned in the above table.

Table 8. Distribution of the community clinic by providing EOC services (n=21)

Variables	Characteristics	Frequency (n)	Percentage (%)
Providing EOC services	Yes	4	19.0
	No	17	81.0
FP Counselling after delivery	Yes	19	90.5
	No	2	9.5
Provide vaccination services	Yes	18	85.7
	No	3	14.3
Some other finding	Provide health education before pregnancy	250	100.0
	Provide iron and folic acid for pregnant women	250	100.0
	Provide ANC service	250	100.0
	Provided postnatal care	250	100.0

Table 8 Reveals Distribution of the community clinic by providing EOC services. Majority 81% of the providers no EOC services only19% were EOC. Most 90.5% of the providers were provided FP counselling after delivery only 9.5% were no provided FP counselling after delivery. Maximum 85.7% of the providers were vaccination services for women aged between 15-49 years only 14.3% were no vaccine. Some other finding, provide health education before pregnancy 250 100.0%, ANC service 100.0%, iron and folic acid for pregnant women 100% and postnatal care 100.0%.

Table 9. Distribution of the respondents by facilities in the community clinic (n=250)

Variables	Frequency (n)	Percentage (%)
Citizen charter displayed	224	89.6
Fixed waiting place	241	96.4
Separate toilet for male and female	62	24.8
Enough skilled manpower for patient care	212	84.8
Health care provider perform ANC check-up	246	98.4
Health care provider give enough counselling during pregnancy	242	96.8
Physical examination	241	96.4
Explanation of health condition	245	98.0
Health care provider give any advice before departure	248	99.2
Continue to follow up health status over phone	176	70.4
health care provider refer to other health facilities	248	99.2

Table 09 shows that regarding facilities in the community clinic, most of respondents had facilities on different aspects of health care providers as mentioned in the above table.

Table 10. Relationship between socio-demographic characteristics and counselling of service provider.

Variables	Characteristics	Counselling Status		Total (%)	$\chi 2$	P-value
		Yes	No			
		N (%)	N (%)			
Age group	<25 years	163 (97.6)	4 (2.4)	167(100.0)	1.05	0.30
	≥ 25 years	79 (95.2)	4 (4.8)	83 (100.0)		
	Total	242 (96.8)	8 (3.2)	250 (100.0)		
Education of respondents	Bellow SSC	174 (96.7)	6 (3.3)	180 (100.0)	0.37	0.84
	SSC & above	68 (97.1)	2 (2.9)	8 (100.0)		
	Total	242 (96.8)	8 (3.2)	250 (100.0)		
Occupation of respondents	House wife	236 (96.7)	8 (3.3)	244 (100.0)	0.20	0.65
	Others	6 (100.0)	0 (0.0)	6 (100.0)		
	Total	242 (96.8)	8 (3.2)	250 (100.0)		
Monthly family income	Lower income (Tk <20000)	204 (97.1)	6 (2.9)	210 (100.0)	0.49	0.48
	Higher income (Tk >20000)	38 (95.0.0)	2 (5.0)	40 (100.0)		
	Total	242 (96.8)	8 (3.2)	250 (100.0)		

Table 10 shows that association between age of the respondents and following the output of counselling of service provider result. It is observed that 97.6% of the respondents had counselling in less than 25 years old. Whereas 4.8% of the respondents had no counselling in more than 25 years old. There was not statistically significant between age and counselling service provider ($p>0.05$). Relationship between educational status of the respondents and counselling of service provider. The result shows that majority of (97.1%) of the respondents had counselling from service providers of higher education (SSC and above) On the other hand shows that 3.3% of the respondents had no counselling from service providers of lower education (Bellow SSC). There was not statistically significant between educational qualification and counselling of service ($p>0.05$). Relationship between occupation of the respondents and counselling of service provider. Among them (100%) of the respondents had counselling from service providers of others occupation. In case of 3.3% 3.3% of the respondents had no counselling from service providers of housewife. There was not statistically significant between occupation and counselling of service providers ($p>0.05$). Relationship between monthly family income and counselling of service provider. It reveals that 97.1% of the respondents had counselling of service providers of lower income (Tk <20000). Whereas only 5.0% of the respondents had no counselling of service providers of higher monthly income (Tk. 20000). There was not statistically significant between monthly income and counselling of service providers ($p>0.05$).

DISCUSSION

This cross-sectional study was communities based cross sectional study identified quality of counselling factors that

influence about providing for during pregnancy period. Analysis shows that among the mothers, (61%) had no formal education, (21%) had 5 years, (10%) had 6-12 years, and (8%) had 12 or more years of formal schooling. Similarly among the husbands, (41%) had no formal education, (32%) had 5 years, (16%) had 6-12 years, and (11%) had 12 or more years of formal schooling (Table 1). This finds is not consistent with the previous study [6].

In current study most (98%) of the respondents known about antenatal care during pregnancy. Most (96%) of the respondent's husband knew about ANC. whereas only (4%) husband did not know about this, (99.2%) of the respondents received ANC during pregnancy, (98.4%) of the respondents had gotten ANC after one month maximum (87.2%) of the respondents had received ANC during pregnancy place at community clinic. Analysis shows that women perceive antenatal care as an important aspect of their pregnancy. Majority of them reported that common places for antenatal care were hospitals and health centers [1]. Another study (94%) of the respondents received ANC. About (48%) received ANC 5 or < 5 times, (45%) 6 – 10 times and the rest (7.1%) > 10 times. Over (45%) received the care from private hospital, (28.9%) from public facilities and (18.5%) from NGO clinics. In about (80%) cases, doctors were the service providers followed by paramedics (17.3%) and very few (3.5%) were trained nurses. On the other hand this is consistent with the previous study [7].

This study shows also that out of 18 community clinic among them (100.0%) of modem logistics functioning followed by (94.4%), (88.9%), (94.4%) were electricity, laptop, electric fan and (55.6%) were available display board. The condition of available furniture (functioning). Among them (77.8%) were functioning examination table, (94.4%) are same value steel Almeria and chairs were functions and (72.2%) were functioning black board. (Table-07). Regarding facilities in the community clinic, most of respondents had facilities on different aspects for new born care as mentioned in the above table. Majority (81%) of the providers no EOC services, most (90.5%) of the providers were provided FP counselling after. Maximum (85.7%) of the providers were vaccination services for women aged between 15-49 years.

In this study shows that association between age of the respondents and following the output of counselling of service provider result. It is observed that (97.6%) of the respondents had counselling in less than 25 years old. Whereas (4.8%) of the respondents had no counselling in more than 25 years old. There was not statistically significant between age and counselling service provider ($p>0.05$). The result shows that majority of (97.1%) of the respondents had counselling from service providers of higher education (SSC and above) on the other hand shows that (3.3%) of the respondents had no counselling from service providers of lower education (Bellow SSC). There was not statistically significant between educational qualification and counselling of service ($p>0.05$). Among them (100.0%) of the respondents had counselling from service providers of others occupation. In case of (3.3%) of the respondents had no counselling from service providers of housewives'. There was not statistically significant between occupation and counselling of service providers ($p>0.05$). It reveals that (97.1%) of the respondents had counselling of service providers of lower income (Tk <20000). Whereas only (5.0%) of the respondents had no counselling of service providers of higher monthly income (Tk. 20000). There was not statistically significant between monthly income and counselling of service providers ($p>0.05$). A cross sectional study conducted in Nepal on 719 mothers between the ages of 15-54 years showed similar finding [8]. Father's education is also associated with health care sought during postpartum period in this study. This study is not consisting in another previews study.

CONCLUSIONS

This study addressed the quality of counselling services for pregnant women in community clinics among rural pregnant women. Most of the respondent was housewife and their maximum husband knowledge about antennal care. Most of the respondents had received antenatal care of duration of pregnancy period. About three-third of the respondent health care of ANC during pregnancy at community clinic and treatment received for CHCP. Above two third of the respondents had problem during pregnancy, among them about two third of the respondent develop nausea & vomiting. Study shows also that maximum respondent had no physical and mental stress. Most of the respondents opinion health care providers take give enough counselling during pregnancy, physical examination, any advice before departure and refer to other health facilities, whereas inadequate separate toilet for male and female and citizen charter displayed. The findings of this study suggest that most were well located in terms of access. Community participation is widely seen as a key to the improvement of services. The involvement of community at every stage was inadequate; the problems of staff availability and skills, and the limited availability of services and drugs are really the responsibility of officials at Union and Upazila levels. There is a clearly stated commitment from the Government to human resource development in the health sector, and this is likely to be a priority if the necessary skills for community clinics are to be put in place. There are some shortages of equipment and furnishings. This study revealed that pregnant mothers suffer from many problem which demands awareness, motivation, education and appropriate health care facilities to improve their life.

RECOMMENDATIONS

- One skilled midwife should be posted to provide required services.
- Proper education and training clinical skill birth attendant (CSBA) for all CHCP

- To ensure delivery equipment supply as per need.
- To ensure list of services display board in all community clinic.
- To increase logistic support in community clinic.
- Fill up the manpower health assistant (HA) and family welfare assistant (FWA) all vacant post.
- Where male CHCP posted there should be ensuring at list one CSBA trained female FWA.
- There should be separated toilet facility for male & female.

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Statement of Informed Consent

"Informed consent was obtained from all individual participants included in the study."

Contribution to Authors

All authors involved in protocol preparation, data collection and literature search up to manuscript writing as well as revision of this manuscript

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