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PRIMARY HEALTH CARE EXPECTATIONS AND REALITY OF BANGLADESH: A SOCIOLOGICAL ANALYSIS OF THE SELECTED TWO RURAL AREAS

Abul Kalam (Corresponding author)
Assistant Professor of Sociology, Department of Economics,
Bangladesh University of Business and Technology (BUBT), Mirpur-2, Dhaka 1216

Shahanaz Parvin
Lecturer in Sociology, Department of Economics,
Bangladesh University of Business and Technology (BUBT), Mirpur-2, Dhaka 1216

ABSTRACT: *Health care sector in Bangladesh is very essential sector. Health is wealth without health care development the quality of our life style is impossible. Our national economic and social development depends on health care sector. There are large amount of people living at the rural area. But they have little access to health care services. Health care service in Bangladesh is problematic and complex into different dimensions. Most of the people are increasingly impatient with the inability of health services to deliver national coverage that meet stated demands and changing needs, failure to provide services that correspond to their expectations. Some people disagree with health care system need to respond better faster to the challenges of new changing. This research deals with the expectations and reality of primary health care in Bangladesh and focuses on different Government and NGOs health care situation in rural areas.*

KEYWORDS: Health care, Traditional Medicine, Rural treatment, Religious Beliefs, Self-efficacy

INTRODUCTION

This study is about primary health care services in rural Bangladesh. Most of the social development indicators Bangladesh have made significant progress in recent time. After the Alma-Ata declaration in 1978 Bangladesh has significant gains to providing primary health care services. The strategy for achieving the goal of "Health for All" Introduce in 1978 an historical conference in Alma-Ata in the former Soviet Union. The government as a national goal has accepted the goal "Health for All" by the year 2000. In order to explain the health behavior of the concerned respondents, this study would consider a socio-psychological model called RDM as its theoretical background. This research work would elucidate the existing health care services of the study areas and actually what they expect from Government and actually what they received.

Objectives of the study

General objective of the proposed study is to explore the expectations of the rural people of Bangladesh regarding primary health care services and the services they actually receive.

Specific objectives

- To explore the primary health care facilities in rural Bangladesh.
- To explore the expectations regarding primary health care by the rural people.
- To assess the primary health care practices (health seeking behavior) enjoyed by the rural people in Bangladesh.

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Research questions

- What are the major sources of primary health care services in your area?
- What types of primary health care services does the hospital provide?
- Do the NGOs provide primary health care service?
- What are the facilities provided by the NGO`s?

Scope of the Study

This is descriptive type of research. This study has been conducted on the people on a rural area of *Aribaria Union porishod* under *Hossainpur Upazila* at *Kishorgonj* District and Jossor Union, Shibpur Upazila at Narsingdi district of Bangladesh. The male and female age ranged 15-45 years old have been interviewed for collecting primary data. This study does not involve any sort of longitudinal design; rather cross-sectional design has been used. Dynamics of rural primary health care services related expectations and practices of the concerned respondents would be explained using quantitative data. For this, some research questions are formulated reviewing related literatures and deducing from few theoretical frameworks. Therefore the findings of this study would be helpful not only to academicians but to the policy planners and development workers.

Limitations of the study

Despite all positive initiatives taken to conduct this study properly, several biases are common in this kind of interview survey based research. First, a major portion of data in this study is reliant on respondent's self-reports and may not be free from unintentional/intentional response biases or deliberate concealment. Interviewer bias may occur when certain characteristics such as experience and knowledge base of the interviewers, and interviewer-respondent interaction influence responses. However, to reduce these limitations, several strategies were adopted. These include, recruitment of experienced interviewers from the concerned study area, extensive training on the study instruments, probing techniques and strategies to establish rapport neutrality essential to complete and accurate data collection for inter-observer variation and interviewer bias. In addition, because of the survey's nature and the extensive techniques taken by interviewers to ensure privacy and confidentiality, it is unlikely that respondents provided socially desirable answers.

It is generally accepted that every researcher is dogged by money, manpower and time (Blalock, 1985). Survey research requires a handsome amount of money. This is a student research project with limited resources that compelled the researcher to curtail many of the programmers that could have helped to improve the value of the research.

REVIEW OF LITERATURE

According to Osman 2004 health care service in Bangladesh is mostly elite-biased, urban focused and curative care oriented. In 1971 there were only 8 medical colleges, 1 post graduate institute, 37 T.B. clinics, 151 rural health centers and 91 maternity and child welfare centers spreading over the country. The new government of Bangladesh took the public health issue as one of the priority concern and in 1972 approved the Thana Health Complex Scheme, with mission to establish a health care network consisted of comprehensive preventive and pro motive health care services in rural areas (GOB 1973). In 1976 government revised the program and planned to build 356 THCs one in each Thana and 1068 sub-centers at the union level (Khan 1988).

According to BIDS survey in 1987, the mortality rate declined from 17.4 per thousand to 14.3 per thousand and the morbidity rate defined as percentage of current sickness to total

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population declined from 16.2 in 1984 to 12.8 in 1987. According to the later survey, deaths under age 5 constituted 48 percent of all deaths, representing a high infant and child mortality (Khan, 1997).

The quality of health care service now an emerging area of research and policy concern in the developing countries like Bangladesh. In the 1990s, more than 70 peer-reviewed publications documented serious quality shortcomings in the American health care system (Institute of Medicine, 2001, p.3). Though little research is available on the quality of health services in Bangladesh, some studies since the 1990s have touched upon the quality of health services (Chowdhury, 1990; Paul, 1999; Andaleeb, 2000; Chaudhury & Hammer, 2004; Sohail, 2005; Andaleeb, Siddiqui, & Khandakar, 2007; Mahdy, 2009; Anwar, Kalim, & Koblinsky, 2009). Sen and Acharya (1997) note the poor quality of health services is a persistent concern in Bangladesh (as cited in Andaleeb, 2000). have touched on the issues of the quality of health care but they conducted survey method in the context of the urban wealthy population.

In Bangladesh there is common mistrust of the public health services (Mahdy, 2009) and wealthy patients tend to bypass the national health care system and seek treatment abroad (Andaleeb, 2000). Research suggests that the quality of health services is more likely to be compromised in the public health care institutions than in the private ones in the country (Paul, 1999).

Bangladesh has established an extensive health care infrastructure in line with its policy goal of health for all (Chowdhury, 1990; Perry, 2000). The key objectives of health care policy have ensured higher quality health service for rural people. The rural health centre called upazila health complexes (UHCs) have almost every sub district, sub centers and community clinics at the village level throughout the country. These upazila health complexes provide ante-natal and post-natal care, family planning, child health care and curative care, safe delivery care, diagnosis, health education and medicines (Kabir, 2006).

Government efforts to provide health care facilities at the various levels though free of cost and managed by trained professionals.

According to Bangladesh Health Watch report, 2009 shows that the quality of health care services is more likely compromised at the government health care facilities than non-government health care facilities. The perceptions of poor quality and unreliable health services in public hospitals partly explain why many wealthy people seek health care abroad (Andaleeb, 2000). The quantitative study assumes certain predetermined elements of the quality of health services such as confidence of patients in services, clarity of communication between staff and patients, and discipline, and thus missed the perspectives of service users and providers. According to Sohail's 2005 shows that macro level quantitative study looked at the process and structure aspects of quality of PHC and suggests that the majority of the users of the 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 in-patient food. Mahdy (2009) claims that the health care system has not been reformed since the independence of Bangladesh in 1971, and dissatisfied patients seek health services in foreign countries such as India, Thailand, Singapore and in cases, the UK and the USA. This phenomenon known as health tourism (Mahdy 2009), Chowdhury (1990), in a study of the rural health care system, paints a dismal picture of health care service delivery.

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According to Hasan 2011 shows that poor people suffer primary health care service for the unavailability and absenteeism of service providers, lack of diagnostic facilities and essential drugs are important structure-related quality issues. It indicates that both structures and processes of services influence the outcomes of the services in terms of patient satisfaction and effective care. Andaleeb's (2000) research in urban Bangladesh suggests that the private health services are perceived to be of better quality in the rural counterpart. This is because of the longer duration of consultation, less crowding, less harassment, provider responsiveness and the use of diagnostic tools.

In the case of the Bangladesh health care system, the absenteeism and a lack of motivation was documented in a seminal research on rural health workers. This research provides support in favour of Chowdhury's (1990) research, indicating doctors' unavailability and absenteeism. The shortage of doctors in rural Bangladesh plaguing the obstetric reproductive health care services (Anwar, Kalim & Koblinsky, 2009). This must, however, be emphasized that the shortage or unavailability of doctors or other health staff in the UHC is not merely due to absolute manpower shortages. The doctors remain busy with private practice at their home-cum chambers, private clinics and local pharmacies. These forms of private practice contradicts Mahdy's (2009) claim that there is no opportunity for private practice in rural areas in Bangladesh. In contrast, this research provides support for Chaudhury and Hammer's (2004) metaphor of "ghost doctors" who remain frequently absent from their work stations. According to Jahan and Salehin, 2006 in their studies shows that poor people in Bangladesh brings higher health risks and suffer the burden of excess mortality and morbidity.

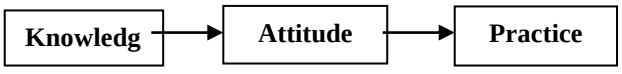
THEORITICAL FRAMEWORK OF THE STUDY

Rational Decision Making Model(RDM)

Human behavior has been predicted and explained using various socio psychological theories, particularly the behavior related to health issues in social science investigations for last five decades. Among them, the social science researchers have extensively used rational decision making model. These theoretical models predict health related behavior, which fall within two major paradigms:-

- One group looks at the role of fear in motivating behavioral change.
- Another group is concerned with cognitive mediating effects of fear arousal on behavior change.

Rational Decision Making (RDM) models which is included with the health Belief Models (HBM) and Theory of Reasoned Action (TRA) models. Human behavior is like purposive, rational and intentional rather than mindless pathological deviant (Amanullah.2002). These paradigms emerged from psychological view. Psychologists thought of these paradigms since 1950s whereas sociologists until 1960s-70s were not concerned with such paradigms. Rational decision making paradigms involve various models, which try to conceptualize how persons behave, why persons behave likely, or not, what factors affect person's behavior etc. By explaining human behavior, theorists of RDM paradigms assume that human behavior rationally and animal behaves irrationally. They also believed that human behavior influenced by imposed knowledge. Their analysis may reflect by the following flow chart;



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KAP model implies that knowledge helps persons to make decision rationally regarding any health behavior, which results in consequently the changes in attitude and practices. KAP implies knowledge about benefits of primary health care services. Rural people will change their attitude toward health seeking behavior. KAP model is no longer sufficient to predict behavior knowledge about AIDS transmission or the fear that AIDS inspires directly leads to preventive behavior (Paicher 1999). The strength of KAP emerged intending to establish a direct and rational connection between knowledge and practices when an individual feels truly concerned by a health risk.

Health Belief Model (HBM)

The Health Belief Model (HBM) was a social cognitive model developed in the 1950s by the U.S Public Health service. This was often used to explain and predict health related behaviors (Stretcher and Rosenstock 1997). This model was often used to predict a variety of preventive health behavior such as dental checkups, dieting, driving under the influence, and sexual risk behavior. The basic components of Health Belief Model were derived from a well establish body of psychological and behavioral theory mainly upon two variables;

1) The value placed by an individual on a particular goal
2) The individual's estimate of the likelihood that a given action will achieve that goal

In the Context of health related behavior, these correspondences are:

1) The desire to avoid illness (or if ill, to get well)
2) The belief that a specific health action will prevent illness.

A final variable completes the original Health Belief Model-the presence of an internal or external stimulus, or "Cues to action" that triggers the individual's health behavior. An internal cue may include symptoms of illness, when as external cues include media companies about health promotion or interpersonal interaction, such as learning that a friend has been affected by a health problem. In this regard, rural people will likely to or trigger action influence either by seeing any physical symptoms of disease and so on or by knowing message from media campaign or interpersonal interaction.

More recently the concept of self-efficacy" has been added to some version of the HBM- Rosen stock suggests that self efficacy was not explicitly incorporated into early version of the Health belief Model (HBM) because the original was on circumscribed preventive actions, such as receiving an immunization or accepting screening test (Rosen stock 1990). He proposes that self-efficacy is more useful in understanding behaviors, such as those related to chronic illness care, which occur over a period and require lifelong changes in behaviors. Since the behavior of interest in this study was a circumscribed action, the concept of self-efficiency was not felt to add explanatory power and thus was not included in the model

Theory of Reasoned Action (TRA)

The theory of reasoned actions integrates social norms and pressures and makes a distinction between intention and action (Fishbein and ajzen 1975; cited Paicher 1999). The roots of the Reasoned Action Theory (TRA) come from the field of

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social psychology. Social psychologists attempts to explain how and why attitude influences behavior, how and why people's beliefs change the way they act. The TRA first developed in late 1960s by Martin Fishbein, later revised and expanded by Fishbein and Ajzen (1967) that focuses person's intention to behave in a certain way. It states that individual behavior is most effectively predicted by the person's intention to engage in a particular action (Loxeley; 1995 cited in Amanullah). An individual will usually act rationally in accordance with his/ her behavioral intention (Fishbein & Ajzen 1980).The TRA suggests that there are two main determinants of intention :

- Attitude toward the behavior
- Subjective Norms

On the one hand, Attitude are made up of the beliefs that a person accumulates over his life time (Ibid)

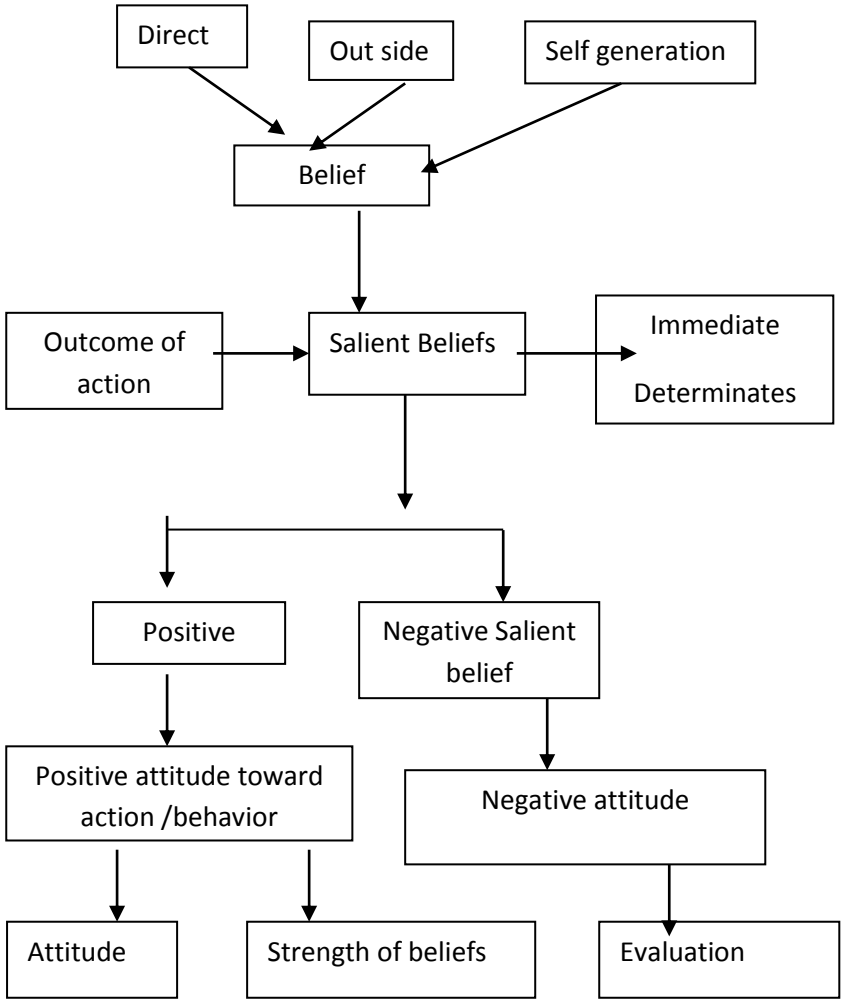

Fig-3: Formation of Attitude

On the contrary, Subjective norms are belief about what others will think about the behavior. They are perceptions about how family and friends will perceive

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the outcome of the behavior (normative beliefs) and the degree to which this influence whether the behavior is carried out (motivation to comply).

((Fishbein & Ajzen 1980).

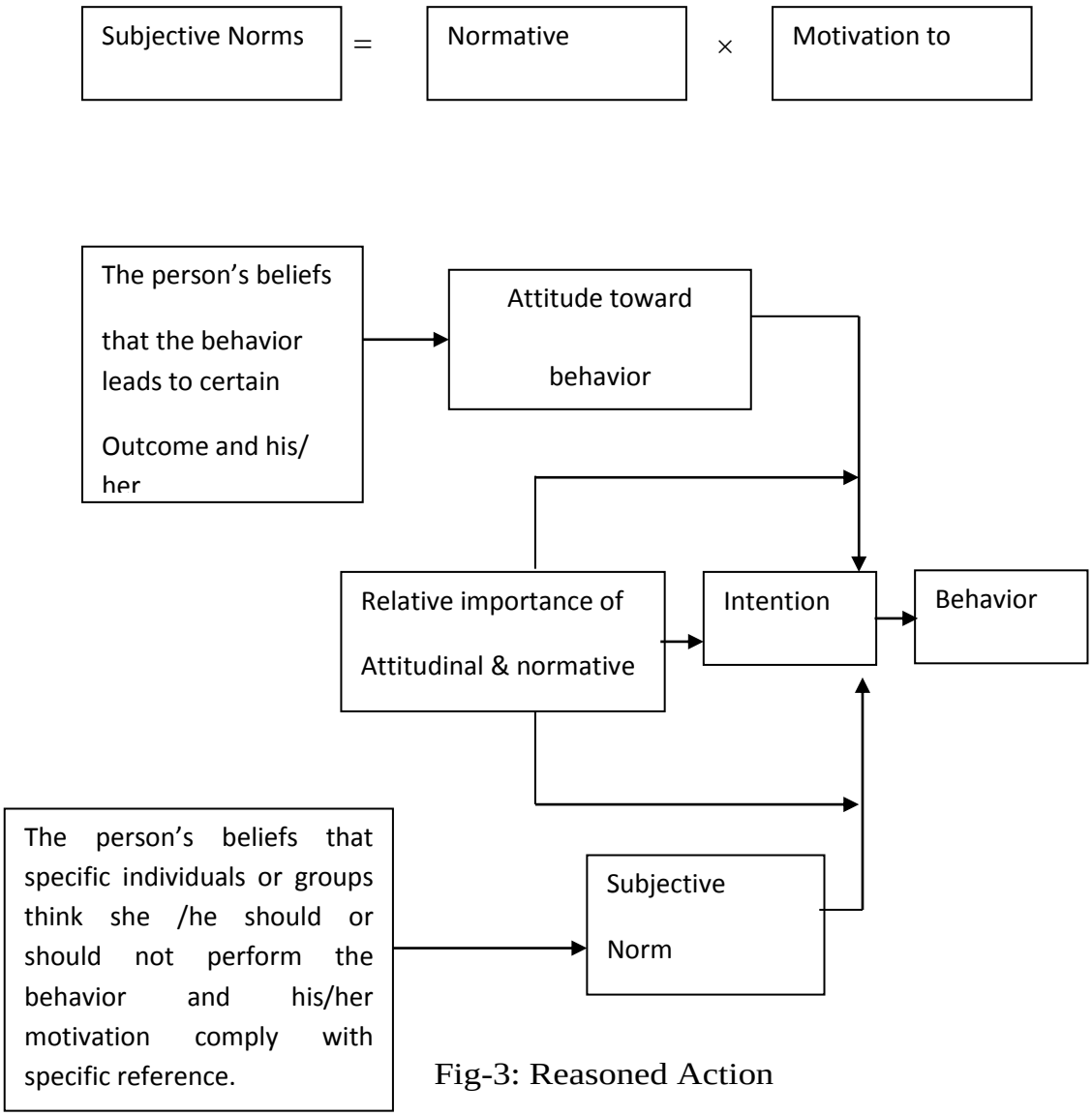

Fig-3: Reasoned Action

METHODOLOGY

Methodology is an important part of social Science research. A successful research depends on rational research methodology. Here we used quantitative and qualitative analysis including observation and case study method. Since data collection of this study was dominantly quantitative through survey, probability sampling were use to draw sampling unit. Random sampling was selected because of sample were random. It is possible to calculate how representative the sample in a wider population to collect the target sample. The age limits of respondents were 20-55 years and total selected sample were 280

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respondents drawn from total target populations at the selected study site. The sample was drawn with help of random sampling through lottery.

General Discursions

The Demographic Profile of the Respondents

The studies were conducted among the people of rural areas in Bangladesh located in two districts one is Kishorgonj and another one is Narsingdi district. Here sample size 280 from total target population 60000 selected by using random sampling techniques. Where 150 respondents selected from Kishorgonj district and 130 respondents from Narsingdi district ranging from age 20 to 55 years were interviewed. Here 51.3 percent was male and 48.7 percent was female whereas married 61.6 percent unmarried 31.3 percent and other 6.4 percent. The maximum age was 55 years and minimum age was 20 years with average 37.5 years and standard deviation 7.

The figure 5.1.1 reveals the demographic profiles of the respondents N=280

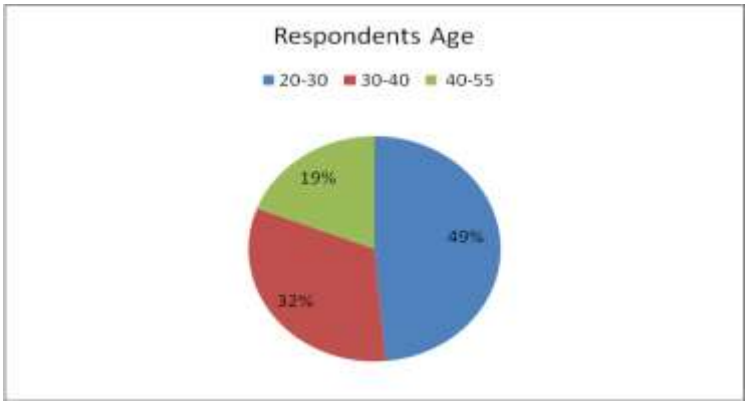

Figure-5.1 Respondents Age (N=280)

The figure 5.1.1 shows that the majority of the respondents 48.7 percent are 20-30 years old; On the contrary, a considerable number of respondents 32.3 percent are 30-40 years old another 19.2 percent respondents were 40-55 years old.

5.1.2 Respondents Gender (Male female) N=280)

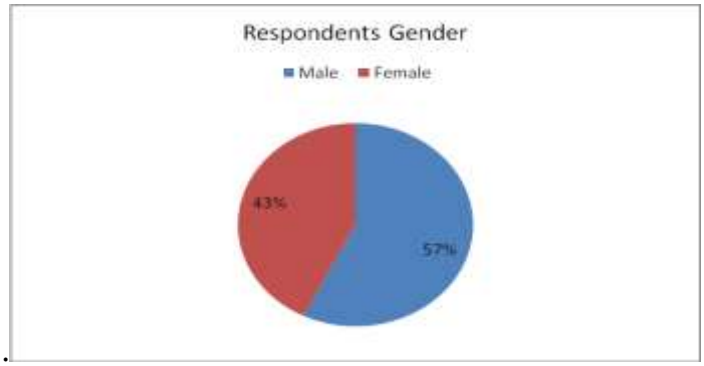

Figure-5.1.2 Respondents Gender (N=280)

Here figure 5.1.2 shows that respondents gender of total 280 samples here male respondents were 57.3 percent and female respondents were 42.7 percent.

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5.1.3 Respondents Marital Status N=280

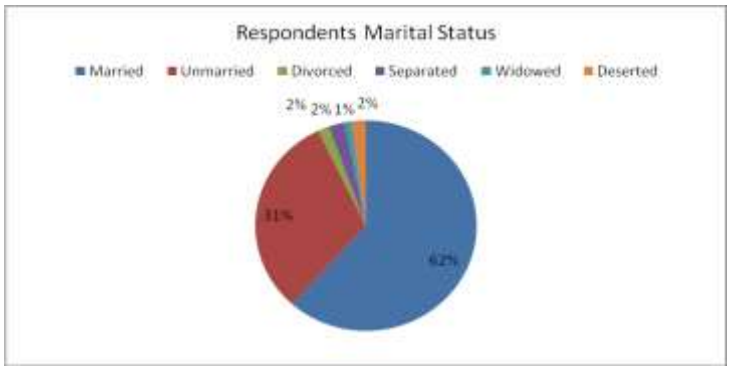

Figure 5.1.3 Respondents Marital Status (N=280)

Here figure 5.1.3 shows that respondents' marital status of the total respondents surveyed, an overwhelming majority of the respondents 61.6 percent were married. On the other hand, a significant number of respondents 31.3 percent were unmarried while 2.4 percent respondents were finding in the both cases of separated and deserted. In addition, One percent of the respondents were divorced; around 1.6 percent was widow.

5.2 Socio-economic Characteristics of the Respondents

Here respondents Socio-economic characteristics such as respondent's level of education, Occupation, monthly family income are shown graphically in the following;

5.2.1 Respondents Level of education N=280

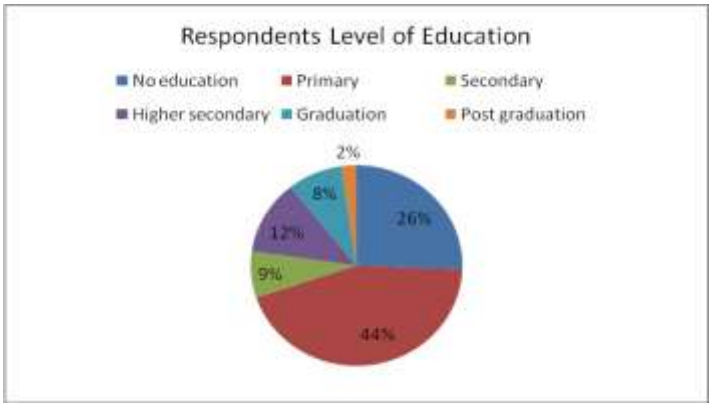

Figure 5.2.1 Respondents Level of education (N=280)

Here figure 5.2.1 shows that the respondent's level of education, most of the respondents 44.2 percent has Primary level of education class five and a significant number of respondents 12.0 percent have passed higher secondary certificate exam (H.S.C). On the contrary, a considerable number of respondents 7.5 percent have completed Secondary certificate exam (S.S.C). Only 8.4 percent respondents has completed graduate and 2.3 percent completed Post graduation degree. Another 25.6 percent respondents were illiterate. The highest class completed was Master and lowest was class one with average class (10) Ten or S.S.C and standard deviation (3.14).

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5.2.2 Respondents Occupational Status (N=280)

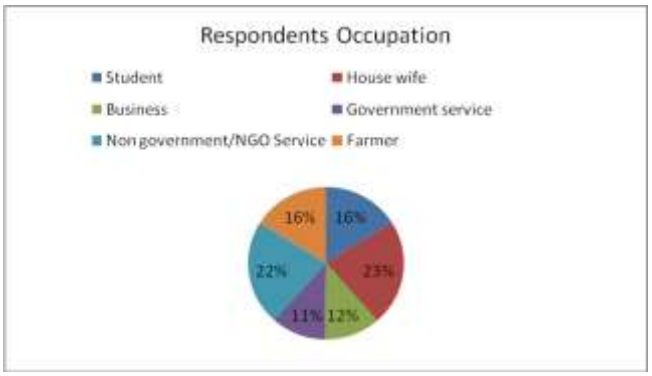

Figure 5.2.2 Respondents Occupation (N=280)

Here figure 5.2.2 shows in terms of respondents' occupations, most of the respondents 21.2 percent are Housewife. On the other hand, 20.2 percent respondents are non-government service holder. In addition, a considerable number of respondents are 15.1 percent are farmers. A considerable number of respondents 15 percent are student. 10.9 percent are Business men.10.7 percent are government services and 6.2 percent are others services.

5.2.3 Respondents Family Income

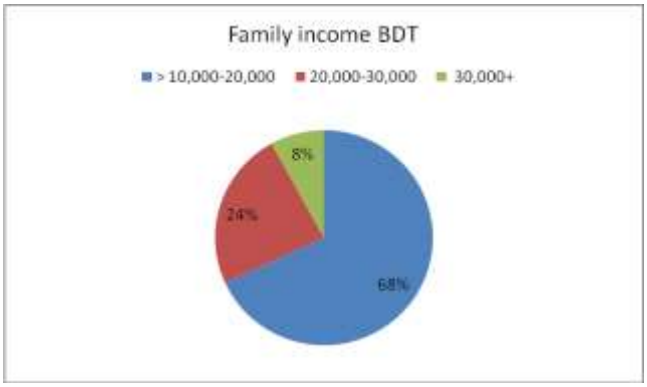

Figure 5.2.3 Respondents Family Income (N=280)

Here figure 5.2.3 shows in terms of respondent's total monthly income, the majority of the respondents 68.1 percent family income ranges between less than Tk.10, 000-Tk to 20, 000 per month. On the contrary, a significant number of respondents 23.9 percent monthly family income is between Tk.20, 000-Tk. to 30, 000. It is reported that a considerable number of respondents 8 percent monthly family income is more than Tk.30, 000. The highest and lowest income was 10,000 Tk. and 2000 TK. with average income was 13,623 TK and standard deviation 11, 814 TK.

5.2.4 Respondents History of Illness:

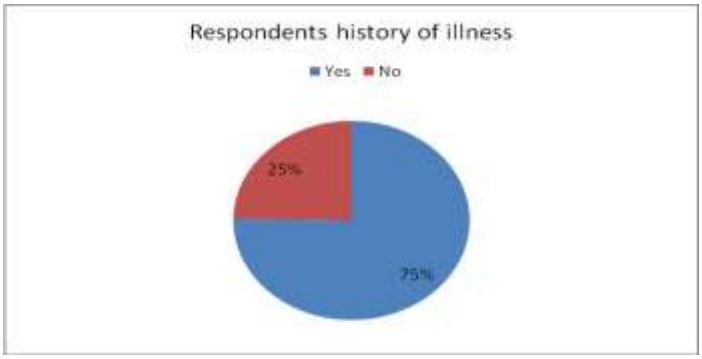

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Figure 5.2.4 Respondents History of Illness (N=280)

Figure 5.2.4 shows that the respondents history of illness last one year. A significant number of respondents 82.8 percent said that they were facing into different kinds of illness. As a result, they went to hospital and other health care services for cure. On the other hand, 27.2 percent said that they were not facing any kinds of major illness accept catch cold and fiber.

5.2.5 Level of Satisfaction of Traditional Treatment

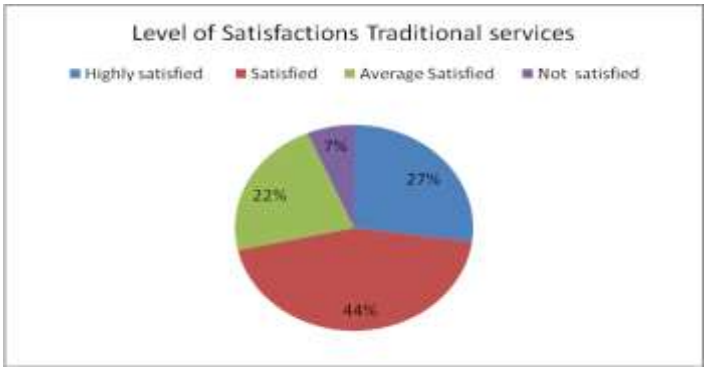

Figure 5.2.5 Level of Satisfaction of Traditional Treatment (N=280)

Figure 5.2.5 Shows that the respondents level of satisfaction with the traditional methods of treatment a significant number of respondent 44.3 percent of total respondent are satisfied about traditional methods of treatment, 27.2 percent are highly satisfied about traditional methods of treatment, 22.1 percent are Average Satisfied and 6.4 percent respondents are not satisfied about traditional methods of treatment.

5.2.6 Doctors are available in government hospital or not

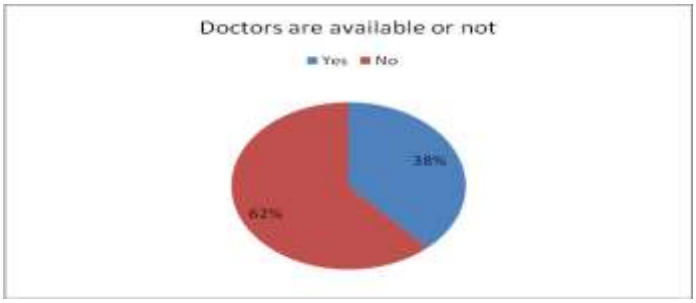

Figure 5.2.6 Doctors are available in government hospital or not (N=280)

Figure 5.2.6 shows that the respondents regarding whether the doctors are available in government hospital or not most of the respondents 61.8 percent said that doctors are not available in the government hospital as a result most of the peasant are sufferer about illness. Another 38.2 percent said that doctors are available in the government hospital. However, real scenarios of government hospitals are true doctor's absenteeism.

5.2.7 Level of Satisfaction Services by Government Hospital

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Figure 5.2.7 Level of Satisfaction Services by Government Hospital (N=280)

Figure 5.2.7 Represent that the distribution of the respondents level of satisfaction with the services by government hospital. Here large number of respondents 53.4 percent said that they are not satisfied by the services of government hospitals, another 18.7 percent are average satisfied, 17.2 percent are satisfied, 10.7 percent are highly satisfied by the services of government hospitals. Actual situation of the government hospital is that lack of proper treatment and unhealthy environment existing as a result rich and concern people are not satisfied their services.

5.2.8 Primary Health Care Services Received from NGOs

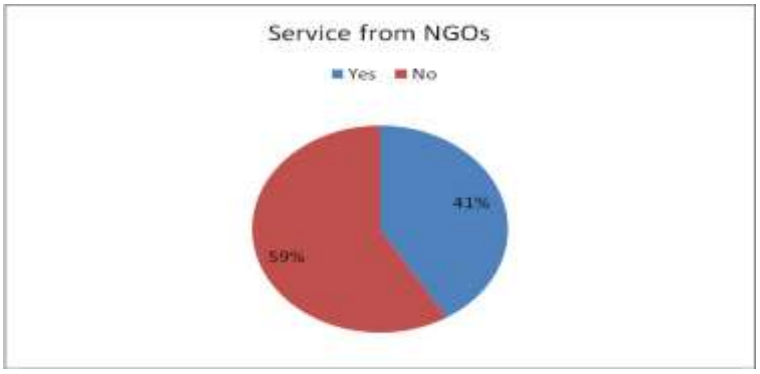

Figure 5.2.8 Primary Health Care Services Received from NGOs (N=280)

Figure 5.2.7 shows that the Primary health care services received by the respondents from NGOs here around half of the respondents 41.7 percent said that they received Primary health care services from different NGOs such as BRAC; Another 58.7 percent respondents are not received Primary health care services from NGOs. It is a matter of question that various types of donor agency provide and funded health sectors by the implementation of different NGO`s.

5.2.9 Respondents by Media Exposure from Radio / Television

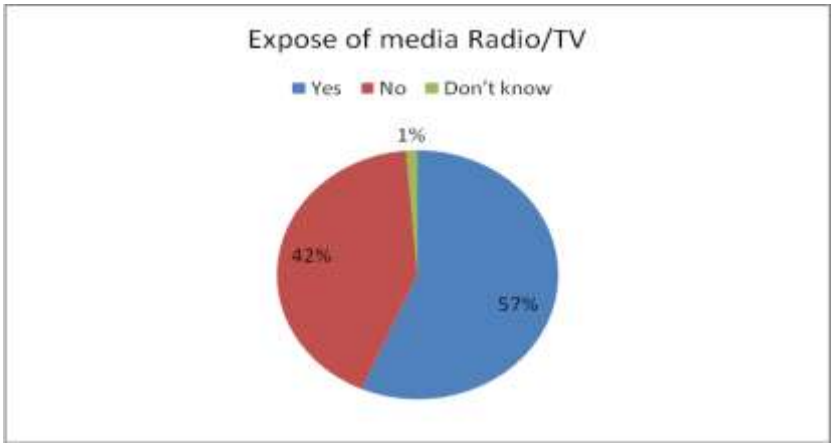

Figure- 5.2.9 Respondents by Media Exposure from Radio / Television (N=280)

Here figure 5.2.8 shows that respondents were asked if they had exposure to media such as radio / Television more than half of the respondents 56.5 percent stated that they listen, watch radio/Television, and while a considerable number of respondents 42.2 percent reported that, they did not listen to the radio. Another 1.3 percent don`t know about health awareness program at listen, watch radio/Television,

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5.2.10 Respondent's Health Care Message from TV

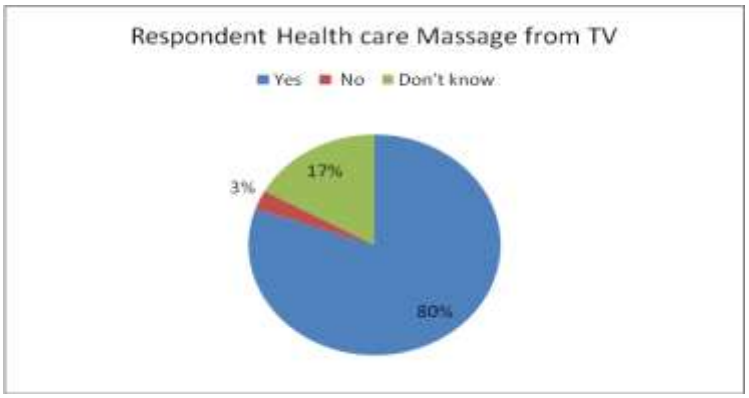

Figure 5.2.10 Respondent's Health Care Message from TV (N=280)

Here figure 5.2.9 shows that respondents were asked are they got message about Health care massage from TV as shows most of the respondents 80.3 percent had reported that they got message about vaccination from TV while a considerable number of respondents 24 percent had reported that they did not get massage.

5.2.11 Respondent's Knowledge about Malnutrition

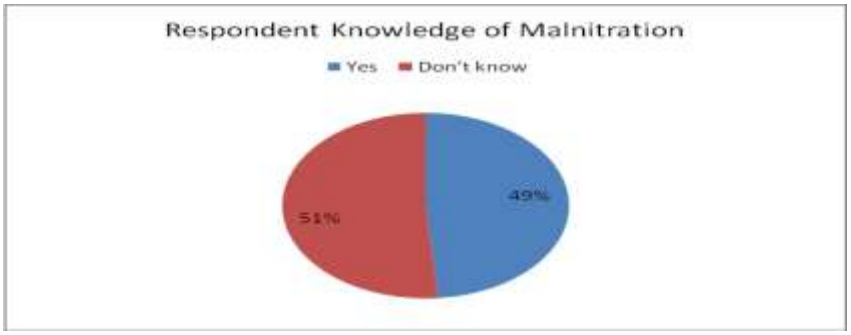

Figure 5.2.11 Respondent's Knowledge about Malnutrition (N=280)

Here figure 5.2.10 shows that respondents were asked to know about malnutrition. 48.6 percent respondents know about malnutrition from various sources like media, NGOs and health worker. However, another most of the respondents 51.4 percent do not know about malnutrition because they are not any idea about Nutrition, which is helpful for our health. It is government health sectors failure to give proper awareness about malnutrition.

5.2.12 Respondent's Knowledge about Breast Feeding

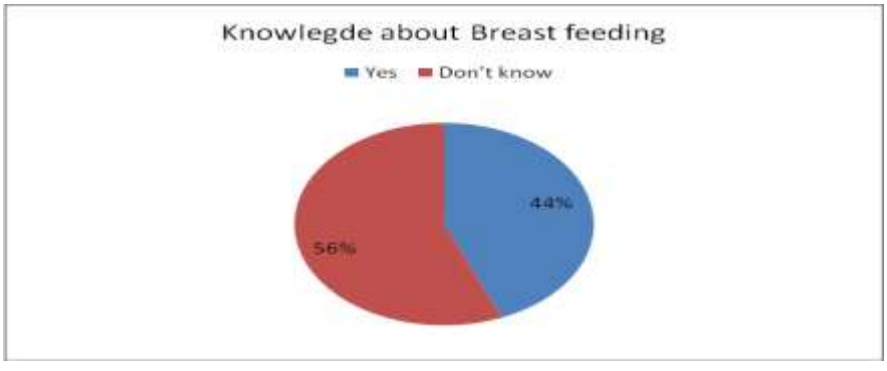

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Figure 5.2.12 Respondent's Knowledge about Breast Feeding (N=280)

Here respondents were asked about to know only breast feeding is necessary for a baby at least six month during six month baby doesn't need to feed another food or cow milk. Figure 5.2.11 shows that 43.7 percent respondents know about only breast-feeding is necessary for baby up to six month. However, another 56.3 percent respondents do not know about breast-feeding.

RECOMMENDATIONS

The following research findings came out from my study;

- Though the National Health Policy is essentially people oriented, my analysis shows that the problem falsehood in the implementation level of policies. So the Government needs to modify its traditional process and be more people oriented.
- Accountability and transparency is an important factor for all sectors. However, the health sector is absence of accountability and transparency. Bureaucratic response is also very important in health care sector. Therefore, the bureaucratic response is positive view to the mass people for ensuring participation in health.
- The Government gives accessibility of community based health service providers in the rural health complex and other Non-Government organizations. Also needs to make sure that the donors view does not negatively influence its policymaking and implementation in the health sector.
- Campaigns of government health programs, such as family planning, safe motherhood and expanded program of immunization (EPI) should be increase. The qualities and the behavior of health employees working helpful to the people in order to improve the participation in rural health service.
- Education, awareness and motivational strategies are important factors for ensuring the people's participation in health services and the success of different health programs. Hence, these strategies should strictly follow on the development programs.
- Financial and technical support is also important for ensuring a high quality of health care but the government allocation does not match the demand. The Government should provide the necessary financial and technical support to the rural health complex.
- Government receives foreign Aid funds for health sector; they are accountable to the foreign donors. However, the Government should also keep in mind national interests. Donor's performance may go against national interests. Therefore, the Government should try to become independent from the donors.
- Viii) Apart from insufficient infrastructure and logistics, the corrupt practices and unwillingness of some government doctors to stay at their posted place makes the government health services inaccessible to the people. Doctors should identify and punished in order to improve the efficiency of health services.
- iix) Regular monitoring and supervision should adopt in government health sector for ensuring participation of people in rural health complex. Seminars and focus group discussions can be arrange to attract the people's information about health services. Television programs, Radio programs, and Newspaper advertisements can be helpful in this regard.

CONCLUSIONS

Health care service is most important factor of human life. So people's participation in health care service is very significant in ensuring health policy of Bangladesh. Health care services

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based on primary health services. Bangladesh has gradually improved health care status of people, especially in rural areas where more than 85 percent of the people are living and underserved and underprivileged groups. The study focused on the degree of people's participation in public health services of Bangladesh including the extent of expectations and how much they actually enjoy or reality. It suggests that the people's participation in health services is not satisfactory.

The Government also tries to motive the people to use the existing health facilities, but most of the people are not willing to use modern health care facilities due to the ignorance and traditional mentality of rural people. The present study revealed that most of the respondent expresses that health education and information is critical for ensuring people's participation in rural health service. But the health education and information is not possible due to the apathy of the Government, and thus, the people's participation and integration of health care services remain poor.

This paper also demonstrates the need to pay urgent attention to the process of service delivery for quality improvement in the rural health system. Usually the focus of health development has been on the structure aspects of quality. To improve the confidence and trust of local people in the public health services, the processes of services may be improved by providing adequate consultation time, delivering services at the right time, motivating the providers to provide care more responsibly, curbing corruption, providing more integrated referral services and avoiding unnecessary referrals. These would contribute to quality improvement of the governmental services through greater access, equity and more service utilization, and thus may help achieve the policy goal of health for all.

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