Primary Health Care in Rural Bangladesh: "A Sociological Analysis of Two Villages of Bangladesh"

Thesis

By

ABUL KALAM
Department of Sociology
University of Dhaka

Research Supervisor
Dr. NEHAL KARIM
Professor of Sociology
University of Dhaka
Dhaka, Bangladesh

Submitted To
University of Dhaka
In fulfillment of the Requirements for the Degree of
MASTER OF PHILOSOPHY (M.Phil) in Sociology

M.

DECLEARATION

I, Abul Kalam, S/o Kasem Ali Hereby declare that no part of work presented by me for this thesis, entitled ***Primary Health Care in Rural Bangladesh: "A Sociological Analysis of Two Villages of Bangladesh"*** being submitted to University of Dhaka, has been plagiarized from anywhere. Proper references are cited wherever necessary.

I further declare that this work was carried out entirely by me and that it has not, either wholly or in part, been submitted for any other degree.

Abul Kalam

Abul Kalam
Candidate for the Degree of M.Phil
Department of Sociology
University of Dhaka
Bangladesh
Date: 08.12.2012

CERTIFICATE

It is my pleasure to certify that the dissertation entitled "***Primary Health Care in Rural Bangladesh: A Sociological Analysis of Two Villages of Bangladesh***" submitted by Abul Kalam to the Department of Sociology, University of Dhaka, Bangladesh, for the degree of Master of Philosophy in Sociology is an original piece of research done under my supervision. To the best of my knowledge, this dissertation was not previously submitted for any diploma/ degree/ fellowship to any other university/ institute. The materials obtained from other sources have been duly acknowledged in the thesis.

This dissertation is recommended and forwarded to University of Dhaka, through the Department of Sociology, for necessary formalities leading to its acceptance in partial fulfillment of the requirements for the degree of Master of Philosophy (M. Phil) in Sociology.

Dr. Nehal Karim
Research Supervisor
Professor of Sociology
University of Dhaka
Date: 08.12.2012

Certificate of Approval

This is to certify that Mr.Abul Kalam has successfully completed his dissertation in Sociology titled "***Primary Health Care in Rural Bangladesh: A Sociological Analysis of Two Villages of Bangladesh***" The research is found acceptable and approved for submission in fulfillment of the requirement of the degree of Master of Philosophy (M. Phil) in the Department of Sociology.

Dr. Nehal Karim
Research Supervisor
Professor of Sociology
University of Dhaka
Date: 08.12.2012

ACKNOWLEDGEMENT

This Research has done for M.Phil degree. It would not have been possible without the valuable contributions of many individuals. It is indeed my pleasure to express my gratitude for their support, guidance and encouragement. First of all, I would like to acknowledge my gratitude to my honorable thesis supervisor, Dr. Nehal Karim, Professor of Sociology, University of Dhaka. I could not have completed this work without the amazing support and guidance, which I received from him who was with me from the very beginning of this work. Further, I would like to thanks those community people who generously helped me very much in collecting data from the study area.

I am heartily thankful to the field workers Abul Foyaz, Reyad Hossain, Tania Akhter and others whose persistent support from the beginning and to the end of field work enabled me to collect the data which were the heart of a empirical study . Special thanks are also due to the respondents who participated in the sample survey and case study. I am also greatly indebted to the female family planning workers of the concerned areas who helped me braving the unfavorable reality of the study area, especially, helped me to continue my field work among the female respondents. My gratitude is due in particular to my elder brother Abu Taher for his sincerity and monitory and supervision help during fieldwork. In addition, I owe a great debt to my family members, friends and well-wishers who have supported me along every step of this voyage of discovery. I would like to thanks to my all course teachers of M. Phil courses University of Dhaka, and like to acknowledge the role of technology that has made my research work a lot of easier and accessible for those in developing countries like Bangladesh.

At last, I would like to thanks my colleagues at the Department of Economics, Bangladesh University of Business and Technology (BUBT), who provided me valuable technical support to be published my M.Phil thesis paper.

ABSTRACT

Bangladesh is a small country but population is very large. Health care sector in Bangladesh is very essential sector because health is a basic requirement to improve the quality of our life. National economic and social developments depend on the development of health care sector. The large number of people in Bangladesh particularly in rural area remained little access to health care facilities. The lack of participation in health care service is a problematic from different dimensions and complexities. The present health policy in Bangladesh is not people oriented. It is emphasizing on the construction of Thana Health Complex (THC) and Union Health and Family Welfare Centre's (UHFWC) without giving much attention to their utilizations. The study reveals that health seeking behavior and practices are very much helpful to ensure the expectations and the reality of actual health care services among the village people. The donors in providing preventive care with respect to child health care and family planning mainly support this. However, there are serious problem related to both access and quality of curative care. 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. The study is based on facilities and household-based data collected during mid May to mid June 2012 in Jossor Union, Shibpur Upazila at Narsingdi district. The main findings of the research are local health providers who are not accountable to local government, as effective channels do not exist. Therefore poor citizens/clients are neither aware of their rights nor are capable of expressing their needs.

TABLE OF CONTENTS

CHAPTER 4: METH ODOLOGY

CHAPTER 5: FINDINGS OF THE STUDY

LIST OF TABLES

LIST OF FIGURES

ABBREBIATION

ARV	Anti-Retroviral Vaccine
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic Health Survey

BMDC	Bangladesh Medical and Dental Council
BMRC	Bangladesh Medical Research Council
BSS	Behavioral surveillance survey
CBHW	Community-based health worker
CBO	Community based organization
CHV	Community health volunteers
CIDA	Canadian international development agency
CLTS	Community Led Total Sanitation
CST	Care, support and treatment
DALY	Disability Adjusted Life Year
DGFW	Directorate of Family Welfare
DGHS	Directorate of Health Services
DNA	National Water Department
ECG	Electro cardiogram
EHC	Essential Health Care
EMS	Extramarital Sexuality
EP	Primary School
EPC	Combined Primary School
EPI	Extended Programme of Immunization
ESP	Essential Services Package
FHH	Female Headed Household
FP	Family planning
FPW	Family Planning Worker
GAS	Water and Sanitation Forum

GAVI	Global Alliance on Vaccines and Immunization
GHW	Global Health Watch
GK	Gonoshastha Kendro (peoples' health clinic)
Global	Fund Global Fund to fight AIDS, Tuberculosis and Malaria
GPS	Global positioning System
HBM	Health Belief Model
HDI	Human Development Index
HFA	Health for All
HH	House Hold
HPNSDP	Health Population and Nutrition Sector Development Programme
ICDDR, B	International Centre for Diarrhea Disease Research, Bangladesh
ID	Identification Number
IHE	Institute of Health Economics
IMR	Infant Mortality Rate
JMP	Joint Monitoring program
KAP	Knowledge Attitude Practice
LGRDC	Local Government, Rural Development Cooperatives
LSE	Life skills education
MA	Medical Assistant
MBBS	Bachelor of Medicine and Bachelor of Surgery
MDGs	Millennium Development Goals
MHH	Male Headed Household
MICS	Multiple Cluster Indicator Survey
MMR	Maternal Mortality Ratio

MOHFW	Ministry of Health and Family Welfare
MR	Medical Representatives
MHI	Micro Health Insurance
NGO	Non-government Organization
NIE	National Institute of Statistics
NS	Nursing supervisor
PEC	Community Education and promotion
PHC	Primary healthcare
PHEIC	Public health emergency of international concern
PMS	Premarital Sexuality
PPS	probability-proportional-to-size
RMO	Residential medical officer
SPSS	Statistical Package for Social Sciences
SSN	Senior staff nurse
SSR	Same Sex Relation
TBA	Traditional Birth Attendant
UHC	Upazila Health Complex
UHFPO	Upazila health and family planning officer
UHFWC	Union Health and Family Welfare Centre
UNDP	United Nations Development Program
UNICEF	United Nations Children's Emergency Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

CHAPTER.1

INTRODUCTION

This study is about primary health care in rural Bangladesh. Primary health care is essential health care for rural people. Which is based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can come up with the money for to maintain at every stages of their development in the spirit of self-reliance and self-determination. Bangladesh has made significant progress in recent times in many of its social development indicators particularly in health. This country has made important gains in providing primary health care since the Alma-Ata Declaration in 1978. 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. The United Nation International Children's Emergency Fund (UNICEF) and World Health Organization (WHO) sponsored the conference. It forms an integral part both of the countries health system, of which it is the central function and focus, and of the overall social and economic development of the community. 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 what services they expect from Government Health care sectors and actually what they receive.

1.1 Statement of the Problem

Health is essential for human life. There is a well known proverb 'health is wealth' and it is reflected in the words of Novel laureate Amartya Sen , health like education is among the basics capabilities that gives value to human life (Sen,1999). It contributes to both social and economic property. Health in itself is of great value as it enables people to enjoy their potentials as human beings .Therefore, it is important to protect health through healthcare, besides other means such as socio economic

developments. Better health translates into greater and more equitably distributed wealth by building human and social capital and increasing productivity (Bloom et al. 2004, WHO, 2001), though the concept of good health is relative. In the health care context, ethics require that principle of access 'according need' and 'equal access for equal need' is followed (Mooney 1992; Gillstrom 2001). Access being defined as the effortlessness with which health care is obtained or the freedom to use health care. However, health systems are frequently ineffective in reaching the poor, generate less benefit for the poor than the rich, and impose regressive.

Bangladesh has made significant progress in health indicators in recent years in spite of her low level of income. Life expectancy at birth for both males and females has gone up since the 1980s. Infant/child mortality and fertility rates have also declined considerably. The proximate causes behind these successes are interventions in preventive care that has been possible due to the commitment of the state supported by donors, focused policies and certain institutional innovations. Problems, however, remain with respect to curative care in both access and the quality of care for the poor. According to national health policy of Bangladesh, the provision of primary healthcare services is a public responsibility and the government tries to fulfill this role through its own facilities that are geo graphically dispersed. A well-developed rural health infrastructure exists in Bangladesh compared to urban areas but they are in efficiently operated, and there is a trend of declining use of public facilities in recent years (Cockcroft, et al. 2004 and 2007). People rely increasingly for curative care on the private sector that includes different types of actors. Available studies on the problems of the healthcare sector focus on proximate causes such as the absence of doctors, incompetence and indifference of health staff, and corruption related to medical supplies and unofficial fees charge d from patients (Cortez, 2006). The underlying causes of inefficiency are actually rooted in the system that lacks both incentives and accountability.

The formal document on national health policy of Bangladesh was first available in 2000. Prior to that, policies related to health issues were part of development strategies envisaged in Five-Year Plans and implemented through Annual Development Plans. Since 1970s the government, supported by donors, focused on family planning, reproductive healthcare and childcare services to deliver by local

level government facilities dispersed throughout the country. According to the National Health Policy undertaken in 2000 (based on information available on the MOHFW Government of Bangladesh and Public expenditure review and Five-Year Plan), the government accepts the responsibility of primary healthcare delivery as included in ESP with limited curative care. It guarantees the access and quality of care to the population at affordable prices. First of all, services are to be provided through local level health complexes. One of the goals is also to promote pluralism among service providers, and reliance on NGOs for preventive care and promotional activities. The recent health sector reform, Health and Population Sector Program (HPSP) has revealed some progressive components, cited by Public Expenditure Review (2003:67): Unifying the bifurcated health and family planning service delivery structure, shifting to provision of "one stop" service delivery by phasing out the existing. Expanded Programme of Immunization (EPI) outreach and satellite clinics and establishing fixed service points (community clinics). Reorganizing the directorate and the ministry through a re-definition of roles, responsibilities, and accountabilities (especially developing integrated support services focusing on human resource management, development, and training; management information systems; behavior change communication; quality assurance; and procurement. Decentralizing Thana-level health and family planning services. Improving hospital management through delegation and financial authority, Enhancing cost recovery (through fee retention and local fee utilization). Some progress has achieved with respect to directing more resources to primary healthcare, especially for ESP services and targeting the poor, unification of health and family planning services at Upazila level and the adoption of sector-wide programme at the ministerial level. However, inequality in the access to curative remains to be a serious problem (Public Expenditure Review, 2003).

Bangladesh is a signatory to the historic declaration in the International Conference on PHC held at Alma Ata in 1978 where the concept of primary health care (PHC) as the strategy for achieving the goal of Health for All (HFA) by the year 2000 was laid. Bangladesh started with pilot projects in six Upazila's in the year 1979-80 in the lights of which subsequently Primary Health Care (PHC) Program started in Bangladesh in 1980s. The basis of the policy of the government was to provide health care to the un-served and underserved population as far as possible, at their doorsteps,

at a cost that the people can afford. Interventions of operationalizing PHC in Bangladesh were based on three important strategies:

(i) Training of staff on the elements and principles of PHC,

(ii) Provision of basic essential equipments, and

(iii) Ensuring uninterrupted supply to facilitate effective preventive, curative, and rehabilitative services to the vulnerable, the disadvantaged and the poor people.

In Bangladesh the Upazila, Union and Ward levels constitute the operational levels of PHC while the district, divisional and national levels provide managerial support and technical back stopping to the operational levels. According to National health policy, the government has accepted the financier role of the Essential Service Package (ESP) on the ground of market failures and poverty/equity considerations. Bangladesh has two additional components – Firstly behavior change communication and violence against women. Secondly, poverty and nutrition-deficiency related diseases, for example TB, respiratory infections are also very common both mortality and morbidity Thirdly, women especially among the poor households in Bangladesh are more disadvantaged than men in terms of the access to health care while they are subject to violence leading to physical injuries. These problems although have health implications are rooted in the socio-cultural institutions, and have to be tackled through communications and appropriate legal measures.

In 1988, the government initiated the program known as "Intensified PHC Program" which started in two Upazila's in two districts and by present gradually extended to cover 237 Upazila's in 20 districts, which is approximately half of all Upazila's in the country. The Intensified PHC program has demonstrated success in developing useful working mechanism, at Upazila level and below by adopting functional integration of health and family planning services under the package of PHC, Community mobilization through the involvement of Village Health Volunteers (VHB) and TBAs, inter-sectoral action through "action committees" at different levels and strengthening of project management at union Upazila and district levels. The constitutional commitment of the Government of Bangladesh is to provide basic health and medical requirements to all people in the society. The Constitution of the People's Republic of Bangladesh ensured that "Health is the basic right of every citizen of the Republic" as health is fundamental to human development. Since independence, the government

has been pursuing a policy of health development that ensures provision of basic services to the entire population particularly population in rural areas. The successive health plans of the country emphasize Primary Health Care (PHC) as the key approach for improving health status of the people.

The government as a national goal has accepted the goal of "Health for All" by the year 2000.Bangladesh has experienced improvements in the health status of her population in the past decade. It is now widely recognized that investments in the social sector, particularly in health and education, contribute to improved performance of the national economy. Adequate access to primary health care is also important for poverty alleviation. It is directly related to the well-being of individuals and it contributes to human capital accumulation and enhances productivity of workers. Some of these improvements may be partly attributed to the performance of the health sector for example fertility decline has been possible due to extensive family planning services, mortality decline is due to increased immunization coverage, better identification of TB among the poor and treatment of diarrheal diseases with oral rehydration therapy.

The delivery of primary health care in Bangladesh has been taking a remarkably new shape through establishment of 18,000 community clinics, one for every 6,000 rural populations. Since the taking of oath of the current government on January 06, 2009, the Ministry of Health and Family Welfare initiated steps to start the community clinics, of which operation was closed by the previous government. Re-opening of the community clinics were one of the election promises of the ruling party in the 2008 National Election. Of the 18,000 planned community clinics, 9,722 have already been started as of June 2010. The existing union and Upazila level health facilities will also provide community clinic service. Therefore, the government will have to build the additional community clinics to fulfill the 18,000 targets. The government has approved a 5-year long new project called "***Revitalization of Community Health Care Initiatives in Bangladesh***" to further develop the community clinics and strengthen their operations. The estimated budget of the project is 26,774.90 million taka. From the project source of Community Clinics, it has been learnt that beginning from 2009 until June 2010, the community clinics provided services to about 15 million patients. Thus, it is imperatives to find out the primary health care

practices in rural Bangladesh. In this context, this study is a modest endeavor to explore the health seeking behavior of the rural people, facilities they actually receive from public hospital and their expected services from public hospitals. This study would be specifically considered a theoretical framework generally used to explain health-related behavior.

1.2 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:

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

1.3 Research Questions

a. What are the major sources of Primary Health Care Services in your area?
b. What types of Primary Health Care Services does the hospital provide?
c. Do the NGOs provide Primary Health Care service?
d. What are the facilities provided by the NGO's?
e. How much satisfy with the services provided by the government hospital?
f. How much satisfy with the services provided by the non-government organizations?
g. Are the existing health services sufficient?
h. What are the health services you expect for hospitals?
i. What is your history of illness in the last year?
j. What types of treatment did you take?

1.4 Rationale of the Study

Health is a basic requirement to improve the quality of life. A national economic and social development depends on the state of health. A large number of Bangladesh's people, particularly in rural areas, remained with no or little access to primary health care facilities. The lack of participation in health service is a problem that has many dimensions and complexities. Most of the time, the rural people do not get the expected health care facilities because the health care system in rural Bangladesh is mostly centralized –Upazila and union based. Since the primary health care facilities provided by the state, remains far way of the rural local poor people. As a result, government's million-dollar project of health sector ever and anon fails to reach the target. Problem of centralized health service operation system, ceiling and glass ceiling from administration, service provider, information seeking behavior of the participants, social awareness of the participants are the major barriers to receive the primary health care services by the rural people of Bangladesh.

However, a large number of populations particularly in the rural areas have a little access to healthcare facilities. It may seem to be that access to health care services for the insolvents or poor people is a dream. Bangladesh is a small country of 1, 47,570 sq kilometers with a vast population of nearly 150 million (unofficial & unconfirmed report of census 2011) Half of the population is under 15 years and nearly 38 per cent of the population live below poverty line. Health and population statistics show that over the last forty-five years infant mortality, maternal mortality rate has gradually declined in Bangladesh, and life expectancy has risen gradually. The percentage of people having access to safe drinking water and sanitation facilities has improved. There are remarkable increases in EPI coverage of children under one year of age between 1990 and now (2012) and also decrease of death rate due to diarrhea during last one and half decades. On the other hand the population of Bangladesh has increasing from 44 million in 1941 and 71 million in 1974 to nearly 150 million now 2012 (unconfirmed census report-2011).Malnutrition is persist in all age group, injury and death from accidents and all kinds of violence are also the causes of serious health problems including mortality. In majority of cases, the poor are the victims. Only about 40 per cent of the population receives some kind of state medical care.

Private sectors in recent decades are providing health care for the poor people in Bangladesh. Most astonishing fact is that the Upazila (Thana) Health Complexes established for about 2 laces population. All these things the physical, mental, and social health's of the people in this country are attributable largely to over population. There is no doubt that the present medical facility either in public or in private sector cannot satisfactorily deal with the requirements of patients belonging to poor people of society. Now private sector medical service has expanded. All these growth and advancement large number of population of the country have no access to minimum secondary and tertiary level medical services because of their poverty. On the other hand senior government officials, various professionals, top political leaders, ministers with family members of above mentioned persons have been going to abroad each year for treatment and check up. This trend is regrettable because of a manifestation of people's no confidence in the local medical services. It is alleged quite frequently in Bangladesh that doctors, nurses and technicians are not sincere in discharging their duties. It may be said that healthcare in Bangladesh is in a shambles. The poor have to struggle with low quality health services that are often out of reach. The conditions of Upazila Health Complexes established to take health services to the poor rural people are in a pathetic condition. Absence of doctors, insufficient supply of medicines and dressing, unsuitable and rusted medical equipment and unserviceable machines has turned most of them into isolated places. More people die from lack of treatment than those who had treatment in those rural centers. On the other hand, specialized hospitals and institutions with super specialties both in public and private sectors are being established exclusively in metropolis cities.

Primary health care and mother & childcare reproductive healthcare is neglected in the rural areas though advancement in the highly institutionalized city and urban areas. The good infrastructures with adequate skilled human resources are available in the shape of Upazila (Thana) Health Complex Hospitals and union health care centers. An MBBS doctor presently includes One third of the union health care centers. The government has created more than 4000 posts for MBBS doctor. Once recruited these doctor have been posted to the available union health centers. Unfortunately the health care facilities in the rural and Upazila level remain very much underutilized due to absence and negligence of doctors and their private practice during and after office hours lack of referrals due to lack of proper

communications and insufficient ambulance, supply of medicines facilities etc. it is no wonder that more than 70 per cent deliveries are done at home. But there are many positive developments of health sectors in Bangladesh. These developments are evident such as the total fertility rate (TFR), contraceptive prevalence rate (CPR), average longevity rate, doctor and population ratio are also significantly positive change. During 2001, the number of hospital beds stood at 45607 while the number of hospital beds in 2012 has risen 82,199. From these figures, an improvement in the health sector is perceivable. Thus, it is imperatives to find out the primary health care practices in rural Bangladesh. In this context, this study is a modest endeavor to explore the health seeking behavior of the rural people, facilities they actually receive from public hospital and their expected services from public hospitals.

1.5 Operational Definitions

1.5.1 Traditional Beliefs

Traditional beliefs are that Traditional Medicine is most of the medical practices that fall outside the realm of 'scientific' medicine. Thus, Kabiraj, totka, herbalists, practitioners of 'Folk Medicine' and faith healers (per. fakir etc) Another traditional belief is that there is a male god and he is called Jehovaha further traditional belief was that a Great Cosmic Mother Goddess gave birth to the world, but that tradition was pretty much trampled on and mostly stamped out through violent means like torturing and burning believers at the stake.

1.5.2 Traditional Medicine

Traditional Medicine is most of the medical practices that fall outside the realm of 'scientific' medicine. Thus, Kabiraj, totka, herbalists, practitioners of 'Folk Medicine' and faith healers Herbal medicines include herbs, herbal materials, herbal preparations, and finished herbal products that contain parts of plants or other plant materials. Traditional medicine is the sum total of knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures

According to Patwardhan (2005), "historically, terms alternative, complementary or traditional medicine all referred to a genre of health care practices or services that got

bound together as a class through the logic of reductio-ad-absurdum, defined by a criteria of absence from the mainframe of what has come to be known as modern medicine."

In Ayurvedic, there are different specialty areas such as *kaya cikitsa* (general medicine), *bala cikitsa* (pediatrics), *graha cikitsa* (psychiatry), *urdhvanga cikitsa* (ENT and eye), *salya cikitsa* (surgery), *damstra cikitsa* (toxicology), *jara cikitsa* (rejuvenation) and *vajikarana cikitsa* (sexual and reproductive health) each with unique taxonomy of health and disease.

1.5.3 Folk Medicine

The folk knowledge traditions which are mostly orally transmitted, are more diverse, ecosystem and ethnic community specific with household level health practices (home remedies for primary health care, food recipes, rituals, customs), specialized healing traditions like bone setting, poison healers, birth attendants, veterinary healers, general healers etc. Hence, countries with similar ecosystems are often found to nurture similar health practices indicating the strong linkages between environment and health. These are also known as indigenous medicine, ethno medicine, bush medicine, little traditions etc. it largely remains in the non-codified folk knowledge form. Diversity, collective ownership guided by customary laws, adaptability to changing contexts and oral transmission are some of the prominent characteristics of this knowledge. While knowledge generation and transmission might vary with cultures, there are several similarities in the value systems and modes of transmission of knowledge among communities.

1.5.4 Kabiraj / *Totka*

Ayurvedic system of medicine based on diet, herbs and exercises; sometimes also combine allopathic medicine such as antibiotics etc. ***Totka*** combines ayurvedic, unani (Muslim system of medicine originating from Greek and faith healing.

1.5.5 Health Seeking Behavior

Health seeking Behavior refers to the sequence of medical actions that individuals undertake to rectify perceived ill health. It is initiated with symptom definition, whereupon a strategy for treatment action is devised.

1.5.6 Para-professionals

Semi-qualified healthcare providers comprised of medical assistants, mid-wives, village doctors and community health workers. They have some kind of institutional training of varying length in preventive and basic curative healthcare services. They work at the village and union level.

1.5.7 Pro-poor Health System

Health system with access irrespective of the ability or willingness to pay, and responsive to the needs and priorities of the poor and the other disadvantaged populations.

1.5.8 Self-Care

Self-Care is any treatment or therapy used without a physician's prescription or direct recommendation by a health care professionals. It involves self-diagnosis by nothing symptoms and treatment actions based on the association of symptoms with successful treatment outcomes in the past. It also using common remedies available within the household for what are perceived to be recurring, illness, experimenting with medicines recommended by a relative or friend.

1.5.9 Unqualified Health Provider

Health care providers in rural Bangladesh who do not have any institutional training in diagnosing and treating illness. Comprises both allopathic practitioners such as drug vendors drug retailers and untrained practitioners of traditional medicine e.g., *Kabiraj / totka, Hakim* and faith healers.

1.5.10 Comprehensive PHC

Comprehensive Primary Health Care has been defined as a package or set of activities that Contains, if not more, a minimum of eight core activities mentioned in the Alma Ata declarations are as follows:

a. Education concerning prevailing health problems and the methods of preventing and controlling them

b. Promotion of food supply and proper nutrition

c. An adequate supply of safe water and basic sanitation

d. Maternal and child health care, including family planning

e. Immunization against the major infectious diseases

f. Prevention and control of locally endemic diseases

g. Appropriate treatment of common diseases and injuries

h. Provision of essential drugs

1.5.11 Health for All

Health for All (HFA) is a social goal. HFA aims at providing the highest possible level of health to all people so that they are able to live a socially and economically productive life. HFA can be defined as: a stage of health development whereby everyone has access to quality health care or will practice self-care protected by financial security so that no individual or family experiences catastrophic expenditure that may bring about impoverishment.

Health for All (HFA) is a social goal. HFA aims at providing the highest possible level of health to all people so that they are able to live a socially and economically productive life. HFA can be defined as: a stage of health development whereby everyone has access to quality health care or will practice self-care protected by financial security so that no individual or family experiences catastrophic expenditure that may bring about impoverishment.1 HFA is a process leading to progressive improvement in the health of the people.

1.5.12 Upazila

The Upazila is the lowest level of administrative structure in Bangladesh. In 1983, the Local Government Ordinance of 1982 was amended to re-designate and upgrade the existing Thana's as Upazila's. Thus, a few Upazila's (sub-districts) comprise a district and an Upazila is consisting of a few unions.

1.5.13 Ultra-Poor

The poorest section among the population with few or no asset, highly vulnerable to any shock e.g., natural disaster, death of the main income earner, female headed household, physically disable family member etc.

1.6 Scope of the Study

This research is descriptive type of research. This study has been conducted on the people on two selected village area of Jossor Union, Shibpur Upazila at Narsingdi district of Bangladesh. The male and female age ranged were 20-55 years old have been interviewed for collecting primary/raw 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.

1.7 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.

The constitution of Bangladesh 18(a) clearly said that common people Nutrition level improve & Public Health Facilities improvement is constitutional commitment of Government. Another illegal drugs use control such as Gaza champagne, heroine etc control is responsible of Government. After liberation of Bangladesh, 38 years have passed but these constitutional rights should ensure by our government or not it is matter of knowing. At past time, rural people use Traditional Medicine such as

Kabiraj, totka, herbalists, practitioners. Now Traditional Medicine is most of the medical practices that fall outside the realm of modern scientific medicine. As a result, improve health care facilities and decrease health risk such as polio, Pneumonia, Cholera, chicken pox Diarrhea etc.

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 programmes that could have helped to improve the value of the research.

CHAPTER.2

LITERATURE REVIEW

Introduction

A Review of literature is an important component in any research process. "Literature reviews provide... with a handy guide of a particular topic (Afolabi 1992)". In any case, the review of literature is basically a critical review of the exiting knowledge on the subject .The researcher has reviewed a couple of English literatures, newspapers, and various national and international reports from multi disciplines in order to get an overall insight about the present research subject. In this chapter, an attempt will be taken to examine and review those specific issues, which help the researcher to understand the underlying issues of vaccination and children's health among childbearing mothers.

2.1 Primary Health Care Services in Bangladesh; Structural Overview

The history of health services in Bangladesh can be traced back to the early 17th century when the East India Company came to rule over the Indian sub-continent and governed it as a police state from England (Rashid and Hyder, 1995). The early efforts of health administration were directed to the alleviation of sufferings due to sickness, catering mostly to the needs of the urban elite class. Subsequently, some facilities were extended to small towns in the form of hospitals with few beds.

In 1943, near the end of the British rule, a Health Survey and Development Committee were formed under the chairman of Sir Joseph Bhore (hence, was popularly known as 'Bhore Committee'). It recommended, inter alia, the integration of curative and preventive services, the production of 'basic doctors' for rural institutions and the establishment of rural health centers. The British rule ended in 1947 and the sub-continent was divided into two sovereign countries, India and Pakistan. Bangladesh was the eastern zone of Pakistan and emerged as an independent nation in 1971. Bangladesh, inherited a non-federal state with its capital based in Dhaka and a general administrative network. The health network consisted of a) Eight medical colleges and hospitals at the national or regional level, b) 14 District hospitals, c) 43 Sub-divisional hospitals, d) 150 Rural Health Centers at the Thana level, and e) A few sub-centers at the union level. There also was one dental college and a national level institute to function as public health production, testing and research laboratory. Such as ICDDRB, Cholera centre, TV, Malaria etc.

WHO had identified eight components of health programs, which is also applicable for Bangladesh the code words "Primary Health Care" (PHC) were selected to describe the following eight components in combination:

- Education about common health problems and what can be done to prevent and control them;
- Maternal and child health care, including family planning;
- Promotion of proper nutrition;
- Immunization against major infectious diseases;
- An adequate supply of safe water;
- Basic sanitation;
- Prevention and control of locally endemic diseases; and

- Appropriate treatment for common diseases and injuries

In 1974, the National Institute of Preventive and Social Medicine (NIPSOM) were established to serve as the national focal point for higher education in public health (see NIPSOM, 1998). In 1976, the number of Thana hospital beds was raised to 31. So was the number of sub-centers under each Thana, which was raised to 4 or 5, depending on the size and population of a Thana (Rashid and Hyder, 1995). Bangladesh signed the Norman Up off (cited in Khan,1993, p. 111) identified four main kinds of participation, which are distinct but interrelated: a) Participation in decision making in identifying problems, formulating alternative planning activities, allocating resources etc; b) Participation in implementation in carrying out activities, managing and operating programs; c) Participation in economic, social, political or other benefits individually or collectively, and d) Participation in evaluation of the activity and its outcomes for feedback purposes.

Alma-Ata Declaration of 1978 and expressed its commitment with the world community to render minimum health care services for its people through what was called a primary health care (PHC) approach. Subsequently, when the World Health Organization (WHO) called upon the member countries to formulate individual National Strategies and a Plan of Action for attaining Health For All (HFA) by the year 2000, Bangladesh responded by preparing a country paper in 1980. The year 1982, may be regarded as the first turning point for a public health movement in the country. In this year, the 1980 country paper prepared was critically reviewed and updated. In subsequent years, the PHC received highest priority in the national 5-year plans as directed in the updated country paper. Four major areas (the improvement of health status, the development of health care delivery system, the improvement of quality of life, and the extension of coverage and accessibility) were identified in formulating national HFA strategies. The pattern of Bangladesh's public health service delivery system is hierarchically structured from the national level to the village level. The structure is based on a top-down approach. All the decisions regarding health policy formulation, service delivery mechanisms, allocation and utilization of resources are taken at the central level, while the lower level organizations carry out the decisions. Different levels of health institutions, hospitals, health centers provide different public health care services to the beneficiaries.

2.1.1 Central / National Level

The supervisory structure of Bangladesh Health Services begins with the Ministry of Health and Family Welfare (MOHFW), headed by a Minister. Two directorates, the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP) operate under the ministry. The ministry is responsible for policy formulation and decision making, whereas the directorates have the responsibility for planning and implementation of programs and projects. Both directorates provide necessary professional and technical guidance to the Ministry. Besides the MOHFW, the Planning Section in the Planning Commission under the Ministry of Planning acts as a technical body with regard to the development plan of the health sector. There also is a Mother and Child Health (MCH) committee, which takes decisions related to the promotion of mother and child health services throughout the country.

2.1.2 Regional or Divisional Level

Within Bangladesh, Seven divisions (Bibhags), there are twenty-one Government Medical College Hospitals, which provide tertiary Health Care across the nation. A wider range of specialists and better laboratory facilities are available here for the treatment of difficult and complicated cases. Because of lengthy administrative and horrible political culture such as DAB, SACHIP (***Sadinata Chicksok Porishad***). Government Medical College Hospitals have also been working as referral institutions for the districts. These are all teaching hospitals, which have bed capacities varying from 250-1050, of which a maximum number of beds are free. The divisional health authority is the functional unit at the divisional level headed by a divisional health director.

2.1.3 District (*Zila*) Level

Secondary health care facilities are available at the districts level hospitals. At present there are 36 hospitals with bed capacity of 50 each, 21 hospitals have 100 beds each, two have 150 each and one hospital in Narsingdi has 200 bed capacities. All hospitals deal with referred cases of the Thana's for further improved treatment. However, these hospitals have limited specialist, diagnostic and laboratory services. District

hospitals provide door and out-door services. Eighty percent beds of these hospitals are free of cost. Apart from these hospitals there are 24 school health clinics, 44 tuberculosis (TB) clinics and 72 urban dispensaries at district level which provide only out-door services (see Rahman, 1999). At the district level, the Civil Surgeon (CS) acts as the district health manager, who also functions as the superintendent of the district hospital. The civil surgeon is responsible for all kind of development and administration of health service in the district. Each district hospital has about seventeen health centers. A civil surgeon's office has 26-41 staff members, depending on the category of the district. Important personnel of this office include Medical Officer, Medical Assistant, Health Education Officer, EPI Supervisor, Sanitary inspector, Superintendent of drugs etc. In the district, hospitals there are about eleven doctors, three technicians, three pharmacists, thirteen nurses, and one record keeper. These numbers vary according to the bed capacity of the hospital. At the district level, there are several committees, which take care of different development and management issues concerning health service. There are also various committees, like a district population committee, a Mother and Child Health (MCH) committee, a Water Supply and Sanitation committee, etc. These committees work to implement the Government's different health strategies.

2.1.4 Thana or Upazila Level

The primary care in the public sector organized around the Upazila Health Complex (UHC), which works as a health-care hub. Many UHC Units have a package service called "comprehensive emergency obstetric care services" (EOC) available. Bangladesh has currently 482 Upazila and 599 administrative Thana's. The Upazila's are the lowest level of administrative government in Bangladesh. As mentioned above, Thana health authority headed by the Thana Health and Family Planning Officer (THFPO). The THFPO also acts as the coordinator and supervisor of the activities of local health centre's and domiciliary field workers. The Thana Health Complex (THC) is a union of Health and Family Welfare Cent res (HFWCs), each covering a population of about 20,000. HFWCs may be of two types: union sub centre (USC) and Family Welfare Centre (FWC), and a union may possess either of these. The Directorate General of Health Services (DGHS) owns the USC, staffed by a medical officer, a medical assistant, a pharmacist, and a medicine carrier. On the

other hand, the Directorate General of Family Planning (DGFP) owns the FWC, staffed by a medical officer, a female family welfare visitor, and a subordinate staff.

The delivery of Primary Health Care (PHC) services to the rural masses is the main target of the Government's present health policy. The Thana Health Complex (THC) is working as the essential unit of PHC system. There are 390 THCs all over the country with a bed capacity of about 31 each. Of these, six beds are reserved for maternal health care. According to the change of political regime, a Thana Health Complex (THC) renamed as an Upazila Health Complex (UHC) from time to time. Like the THCs, the UHCs provide PHC services.

UHCs provide both in-door and out-door services. UHCs also act as referral for Union sub-centers (USC) and Union Health and Family Welfare Center (UHFWC). At the Upazila level, the Upazila Health and Family Planning Officer (UHFPO) is responsible for the health and family planning services of the Thana/Upazila. 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 health inspector, sanitary inspector and other staffs also assist the UHFPO. 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; promote health care and treatment of minor ailments. Health volunteer and trained traditional birth attendants assist domiciliary workers (Hashem, 2006). There are a number of committees at the Thana/Upazila level in respect of MCH services, water supply and sanitation, health and family planning activities, etc. These committees work to implement the Government's program "Health for All". The UHFPO coordinates with these committees and takes care of all activities regarding health and family planning services of the Thana/Upazila.

2.1.5 Union Level

At a lower tier, the Union Health and Family Welfare Centre (UHFWC) are operational, constituted with two or three sub centers of field-based functionaries. Recently some of the female HAs and FWAs have been trained as birth attendants

(Skilled Birth Attendants SBAs). A Health Inspector (HI) supervises the Health Assistants and Family Welfare Assistants and a Family Planning Inspector (FPI) respectively, posted at the union level. Medical Assistant (MA/SACMO) and mid-wife (Family Welfare Visitor).A common tendency is observed in terms of utilization a stark imbalance in service utilization at public health facilities. At this level, health care services are de livery through both USC and UHFWC. This is the smallest and most peripheral healthcare service unit having sub-center, which provides outpatient services for injuries, wounds and ailments and with no diagnostic, surgical or bed facilities. These health centers provide first static health care facilities. There were 1362 USCs and 2794 UHFWCs in operation by the end of 1996. About fifteen health and family planning personnel are managing the static health care facility and are rendering domiciliary services at the union level (see Hashem (2006), p. 79). A USC is managed by one medical officer, one medical assistant, one pharmacist and other support staff while FWC is managed by one medical assistant, one family welfare visitor, one pharmacist and other support staff. The field supervisory personnel of the health and family planning sector at the union level are to attend the monthly meetings of the union council and discuss problems and issues concerning the delivery of health and family planning services.

2.1.6 Village Level

At the village level, there are community clinics; satellite clinics as most peripheral level health services facilities with a view to provide minimum care. Another village level private sector there is traditional healers (Kabiraj, totka, and faith healers like pir / fakirs), homeopathic practitioners and village doctors Rural Medical Practitioners (RMPs/ Palli Chikitsoks-PCs) retail drugstores that sell allopathic medicine on demand. In addition to dispensing medicine, sellers at these mostly unlicensed and unregulated retail outlets also diagnose and treat illnesses despite having no formal professional training. To this is added at village level an emerging cadre of semi-qualified community health workers / volunteers, who are formally trained by the NGOs (such as BRAC, Gonoshasthya Kendra etc); their numbers have been increasing since the 1990's with the expansion of PHC infrastructure in the country. Traditional Medicine is most of the medical practices that fall outside the realm of 'scientific' medicine. Thus, Kabiraj, totka, herbalists, practitioners of 'Folk Medicine'

and faith healers (pir, fakir etc.) of different shades fall under this broad umbrella. Many of these healers (faith healers) provide a much narrower range of services for a more limited set of conditions. From time to time, this health services are delivered (say once a month). The patients are motivated to go and take services there like EPI, Oral Re-hydration Therapy (ORT) services, awareness rising about health, sanitation, nutrition communicable diseases etc. The staffing pattern of the clinic is one health assistant, one family welfare visitor, and one assistant health inspector.

The Finance Minister quoting Bangladesh Demographic and Health Survey 2011 said, under-5 mortality rate has been reduced to 53 from 65 per 1000 over the past four years. To ensure healthcare for all, he said, 2,091 community clinics would 'hopefully be set up and made operational' by 2012-13 fiscal. The government in its first budget in 2009-10 had committed to establish 13,500 community clinics, a priority of its election manifesto. As of now, 11,409 clinics have been commissioned. The finance minister said as many as 75 million people have taken services from these clinics in the last three years. He said the government was working on updating population policy. *"Dhaka, June 7 (bdnews24.com).*

2.2 Health Problems and Health Care Needs in Bangladesh

In Bangladesh, communicable diseases are responsible for high mortality and constitute major health concerns. They include (1) infectious diseases like, cholera and diarrhea, typhoid, tuberculosis, leprosy, tetanus, diphtheria, whooping cough, measles, rabies, venereal diseases and (2) parasitic diseases like, malaria, filaria and worm infestations. Malnutrition and infections are very common among children, pregnant and lactating mothers usually suffer from various forms of malnutrition and vitamin/iron deficiency. Sanitation and health education are extremely poor among rural population and urban slum dwellers. Among the non-communicable diseases, diabetes, paralysis, blood pressure, heart diseases, respiratory and gastrointestinal disease account for increasing proportions of death tolls. Most of the communicable diseases can be greatly controlled through immunization programs, health education and better management of the diseases. Even in the face of general sub-nutritional level of the majority of the population, mortality and morbidity rates in Bangladesh are declining. There has now been full eradication of small pox, while communicable

diseases like tuberculosis, malaria, diarrhea and cholera are now being controlled in increasing proportions.

According to two surveys conducted by the Bangladesh Institute of Development Studies (BIDS), the mortality rate declined from 17.4 per thousand to 14.3 per thousand in 1987 and the morbidity rate – defined as percentage of current sickness to total 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).

2.2.1 Financial Allocation in Health Care Sector

Public health services programs and the operation maintenance of health facilities financed through the budget every year. The five-year plan specially designed to finance health programs. It is observed that in every fiscal year, allocation for health sector has gradually increased. However, this increase is not sufficient. Until date the health sector did not get proper attention of the Government. In the year, 1985-86, the allocation for health and family planning sector was 3.6 percent, while in 1989-90 it was 4.11 percent of the budget (see Hashem, 2006, p. 85). The financial allocation in 1987/ 88 for health and family planning was tk. 567.92 crore (health tk. 361.21 crore, family planning tk. 197.22 crore, and unallocated block provision tk. 9.4 crore). Now traditional medicine is most of the medical practices that fall outside the realm of modern scientific medicine. As a result, improve health care facilities and decrease health risk is necessary such as polio, Pneumonia, Cholera, chicken pox Diarrhea etc. According to UNDP Human, development Index 2010, The average population growth rate in Bangladesh is 1.30 percent expected average lifetime is 66.9. The budget of Health sector is 23.9 percent of total budget FY2010 /11. Registered one doctors against for 3353 peoples.

The total allocation for health and family planning in 1987/88 represents approximately 1.2 percent of Gross National Product (GNP) or 5.6 percent of the total public expenditure allocation that year. In that year in addition to health and family planning, the allocation for public health engineering was tk. 11.84 crore. It is estimated that NGOs spend about tk. 389.00 crore per year to health, family planning

and nutrition. The services performed by the Government and NGOs are mostly offered free to the public. The households also spend a considerable amount of money in the purchase of drugs, payment of consultation fees to private practitioners and for private visits to government employed doctors, as fees to private hospitals/clinics, pathological tests / x-rays, special food, transport etc. It is estimated that such costs amount to tk. 168 per person per year or a total of tk. 1,763 crore per year, see Khan (1997), pp. 16-17.

In the fiscal year 2002-03 budget, the allocate ion has increased 5 percent. But it is noticeable that in the current budget, highest priority has been given on education and technology sector for which the allocation is 6 percent. The ratio for defense is 13 percent, public administration 8 percent, communication 6 percent, and agriculture 5 percent. In order to provide improved health service to the people, the Government decreased the import tax from 15 percent to 7.5 percent on diagnostic reagent; syringe, needless, catheter etc. (see Hashem, 2006, p. 85).

Bangladesh Finance Minister A M A Muhith has proposed Tk 93.55 billion for the health and family welfare sector for 2012-13 fiscal which is Tk 0.10 billion more than the current financial year *"Dhaka, June 7, 2012 (bdnews24.com).* However, in terms of percentage of the total budget, the allocation for the next fiscal is less than what was proposed for the current fiscal. In 2011-12, it was 5.4 percent of the total budget while it is 4.9 percent of the total budget proposed for 2012-13. "One of our election pledges is to ensure quality health services for all," Muhith said while presenting the national budget in the parliament.

World Health Organization also spent a sum of tk. 13 crore per year outside the ADP allocation on health. The total cost of health care spent by the government, donor agencies, NGOs and individuals thus amount to nearly tk. 2750 crore. The total cost of health care in Bangladesh in 1987 /88 was close to tk. 3000 crore or 6 percent of GNP (Khan, 1997, pp. 16-17).

2.2.2 Health Care Financing by NGOs

Health care services in Bangladesh are deeply related to human life. So it is very much interest of people about health care facilities. Health related huge research

doing now days by various GO-NGO. Not-for-profit non-governmental development organizations (NGOs) are one of the major players in the field of health service provision especially at the grassroots (ILO 2008). These NGOs provide health services through Micro Health Insurance (MHI) as well as payment-for-services basis. Development partners and share of NGO's own expenditure on health as a percent of mainly finance the NGO health budget total health expenditure (national) ranges from 1-2% only. Their modus operandi varies from NGO to NGO: BRAC charges only the cost of medicine and other services through community health workers, while Marie Stops charges at a flat rate of tk 5 to 10 per visit and covers the cost of medicine as well. Marie Stopes and Dhaka Community hospital also provide services through Health Card-based MHI to selected groups such as garments workers. Any higher level care is provided free or at a heavily subsidized cost. Vulnerable groups like poor and ultra-poor receive free treatment from all. However, a comparative assessment of the different NGO financed health care showed that they were lacking in equitable health care financing through cross-subsidy. Only GK succeeded in implementing progressive premium and co-payment scheme through its pioneering MHI scheme. Experiences show that MHI requires different expertise and experience than managing microcredit and that poor are not good candidate for MHI. These need to overcome before success of MHI can be convincingly demonstrated.

2.2.3 Government Strategies Regarding General HealthCare Services

The man objectives of the government health service are eradication of communicable and non-communicable diseases through both curative and preventive interventions. In this perspective, the Government devised some strategies aiming at providing health for all citizens. One of the strategies is the Primary Health Care (PHC) approach, which includes the following major applications:

The Government's health policy primarily aims at providing free medical care to the disadvantaged people of the society, especially to those in rural areas. To ensure effective implementation of its policy, the Government adopted the policy of posting medical graduates in rural areas for at least two years in order to ensure the availability of an adequate number of doctors in rural health centers. The Government also adopted the Private Clinics and Laboratory Ordinance in 1982 to regulate and improve the quality of private facilities and services.

2.3 Health Care Services in Bangladesh; Reality for the Rural People

The constitution of Bangladesh 18(a) clearly said that common people Nutrition level improve & public health facilities improvement is constitutional commitment of government. Another illegal drugs use control such as Gaza champagne, heroyine etc control is responsible of government. After liberation of Bangladesh, 38 years have passed but these constitutional rights should ensure by our government or not it is matter of knowing. At past time, rural people use Traditional Medicine such as Kabiraj, totka, herbalists, practitioners. Now Traditional Medicine is most of the medical practices that fall outside the realm of modern scientific medicine.

The quality of health service is now an emerging area of research and policy concern in both the developing and developed 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). Paul (1999) and 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). The Government of Bangladesh (Gov) has established an extensive health care infrastructure in line with its policy goal of "health for all" (Chowdhury, 1990; Perry, 2000). A key objective of the health policy has been to ensure high quality health services for rural people, women and the poor. Government has

established rural health centre, called Upazila Health Complexes (UHCs) in almost every sub-district, sub-centers and community clinics at the village level throughout the country. These UHCs and sub-centers provide ante-natal and post-natal care, family planning, child health care and curative care, referral service, safe delivery care, diagnosis, health education and medicines (Kabir, 2006).

But Less than 40 % of the total population has access to modern primary health care services beyond immunizations and family planning (Abedin, 1997 cited in Perry, 1999). Only 25% of pregnant women receive antenatal care, and someone with formal training (BBS, 1997c, cited in Perry, 1999) attends only 14% of births. Malnutrition in Bangladesh is among the highest in the world. The extent of stunting and underweight are 45% and 48% respectively for children under five years of age, while anaemia is prevalent among 53% of pregnant women (CPD, 2003). In spite of the progress made, Bangladesh has identified as one of the 57 countries with a critical shortage of the health workforce (doctors, nurses and midwives number below 2.28 per 1000 population). The nurses to population ratio of 0.14 per 1000 and nurses to doctors' ratio of 1:1.85 are among the lowest in the world (WHO, 2007).

The health care system in Bangladesh is a mix of public and private initiative. In terms of physical infrastructure, public sector is stronger than the private sector although in terms of coverage, the health care system of the country should be termed as a privatized one. Besides the private sector, there are some NGOs, which also play a significant role in providing health services. All these institutions are managed and controlled under the policy guidelines of the government (Osman, 2004).

The government's efforts to provide health facilities at the various levels, though free of cost and managed by trained professionals, has however, not lead to desired level of use of the services. Primary health care services are greatly underutilized, despite repeated efforts by the government to improve these services (Jahan and Salehin, 2006).

The latest Report of the Bangladesh Health Watch (BHW) raised serious quality issues (BWH, 2009). Consistent with Andaleeb (2000), the BHW report

shows that the quality of health care services is more likely compromised at the government health facilities than at non-government health facilities (BHW, 2009). The perceptions of poor quality and unreliable health services in public hospitals partly explain why many wealthy people seek health care abroad (Andaleeb, 2000). Andaleeb's (2000) 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. Sohail's (2005) 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 (Sohail, 2005). 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.

This research shows that health education was delivered in a non-participatory and callous way, many providers were absent and there was a lack of supervision and motivation of health workers (Chowdhury, 1990). Against this backdrop, understanding the patient perspectives of rural health service quality is critical to address the quality shortcomings. This is because quality improvement must begin with listening to patients or users of services (Lloyd, 2004). This article is based on a larger study aimed at understanding the influences of professional power on the quality of primary health services in rural Bangladesh (Hasan, 2011). One of the objectives of the study was to understand the quality concerns of rural health service users. This article focuses on the key emerging themes related to the quality of the rural health services from the perspectives of service users.

Hasan (2012) indicates that unavailability and absenteeism of providers, lack of diagnostic facilities, essential drugs, and poor hygiene are important structure-related quality issues. In addition, duration of consultations, timeliness of services, provider behaviour, referral and emergency health services were the process-related concerns of the patients. Lastly, the study indicates that both the structures and processes of services influence the outcomes of the services in terms of patient satisfaction and effectiveness of care. Consistent with Andaleeb's (2000) research in urban Bangladesh, this study 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.

The findings of this research and Andaleeb (2000) are different from the Vietnamese case where public health services are of better quality than that of the private services (Tuan, Dung, Neu & Dibley, 2005). However, the poorer rural people and low-income groups, who form the majority of the rural population, are not being able to take the advantage of the better quality private health services in the study areas. This is consistent with Alubo's (1987) research in Nigeria that showed that the poorer and the less powerful people receive poorer quality health services. This paper demonstrates that the absenteeism and unavailability of providers at the right time plague the rural health services. These findings are consistent with many other studies in different parts of the developing world, including Bangladesh (Justice, 1987; Chowdhury, 1990; Lewis, 1996; Chaudhury & Hammer, 2004).

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 (Chowdhury, 1990). This research provides support in favour of Chowdhury's (1990) research, indicating doctors' unavailability and absenteeism. The results further indicate that there are fewer numbers of doctors to provide adequate services to the rural masses. The Upazila I conducted this research has a large population which is about four times higher than the average population in a sub-district in Bangladesh. The shortage of doctors supports the argument that there is a manpower shortage in rural Bangladesh plaguing the obstetric reproductive health

care services (Anwar, Kalim & Koblinsky, 2009). This must, however, be emphasised 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.

Apart from the weak structure of the rural health institution, this study suggests that the processes of health services at the UHC tend to influence the quality of health services. This means that provider-centric consultation, poor provider behaviour, demand for bribe, harassment, lack of motivations among providers, inadequate consultation time, faulty referral procedures cause patient dissatisfaction and result in ineffectiveness of care. Zaman (2005, pp.123-134, 155-176) and Andaleeb (2000) suggested that doctors and support staff such as ward boys, cleaners and gatekeepers misbehave with patients in the context of the urban health systems. Chowdhury (1990) suggested a lack of commitment, cordiality and motivation among rural health workers in Bangladesh. This study provides support in favour of these study findings in the UHC context.

This research indicates that people avoid the lower tiers of the rural health system. This provides support 76 Hasan / OIDA International Journal of Sustainable Development 03:08 (2012) in favour of Paul's (1999) findings. Paul (1999) had suggested that people tend to by-pass the national health care system due to perceived low quality. This research points to the by-passing within the rural health care system. People bypass the Union or village level health tier and seek health care at the Upazila level. Some relatively wealthy ones bypass the Upazila system and seek health care at the city or town levels. The richest seek health services in India. Thus the bypassing of health services occurs at different levels within the Upazila. However, the research does not show that the majority of the rural people bypass the national boundary for better treatment, perhaps because of lower income. The bypassing appears to be connected with higher income and perceived low quality in the government The results further indicate that income,

geographic isolation, and poverty translate into health inequalities in terms of access to quality health services. It appears that low income groups and women find it difficult to access quality health services. Consistent with Zaman (2005, p.104), this study shows that the poorer village people seek health services in low-cost government health centres. The low-income groups cannot afford to pay for privately provided health services, whether provided by the Government appointed doctors or other private providers. Similarly, women face social barriers to access health services.

The World Health Organization (WHO) suggests that health systems need to be designed in such a way that they cater to the needs of the periphery (cited in Newell, 1988). The public level Upazila health system does not fully cater to the needs of the periphery.

2.4 Health Care Delivery System in Bangladesh

In Bangladesh health care service structure that was mostly elite-biased, urban-focused and curative-care-oriented. 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 in 1971 (Osman 2004). 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). In brief, the period from 1971 to 1980, in relation to health care service, could be the reorganization and reconstruction phase. The focus of this phase was, mainly, to build the physical infrastructures like hospital and health centers, expansion of beds, procurements of modern equipments etc. all around the country. Along with infrastructural expansion, government initiated some significant attempts to reorganize several service provider agencies. Since the mid 1980s, the government has sought to improve its health services and teaching institutions. The explicit goal was to build one Union Sub centre

(USC) or Health and Family Welfare Centre (HFWC) in every union (4415); one health complex in every Thana (397); and one general hospital or tertiary facility in every district (59). As of 1996, there were 4200 USCs/ HFWCs, 379 health complexes and 59 district hospitals. By 1999, there were 460 Thana health complexes, 1362 Union Sub-Centers and 3315 Community Clinics; there were also 21 government medical colleges and 7 postgraduate/specialized hospitals. There are another 33 private medical and dental colleges. The total number of hospital beds was 43,293 (1999), which has increased to 51, 684 in 2005. In 2005, 3.43 beds per 10,000 populations were available (WHO, 2007).

2.5 Organizational Structure of Health Care Services

Health care services in Bangladesh are delivered by public, private (for profit), non-government organizations and traditional sectors. The public health care system is organized under the overall supervision of the Ministry of Health and Family Welfare. The organization structure of the services is designed in alignment of the administrative set up of the country. The entire area of Bangladesh is divided into 6 administrative divisions. Each division is further divided into districts; there are 64 districts and 460 Upazila's (sub-districts). Upazila's are the lowest administrative unit of the central government. Each Upazila consists, on an average, of 10 unions; and a union consists of 10 villages on an average. An average size of Union, in general, used to have a population of 20,000 – 25,000.

The organizational structure of the public health care system in Bangladesh is highly centralized. At the central level, the Ministry of Health and Family Welfare is the highest government authority headed by a Cabinet Minister, responsible for to implement, manage, coordinate and regulate national health and family planning related all activities, programs and policies. The Secretary is the administrative head of the ministry who assisted by huge number of cadre and non-cadre civil servants. The MOHFW is the second largest ministry, in terms of its manpower, in Bangladesh (Osman 2004). The ministry divided into two wings: Health Wing and Family Planning. Each of the wings is administrative through separate Directorates under the ministry.

The Directorate General of Health Services (DGHS) is the key agency to implement the national health policies and programs. It also provides input to the government for making or changing health related decisions. The directorate is in charge of a wide range of activities from procurement of material and manpower to supervising medical schools. Nine functional Directors assist the DGHS and under each of them, there are several Deputy and Assistant Directors. Until recently, the strength of the DGHS, in total, was 702 (Osman 2004).

Like the DGHS, the Director General of Family Planning has also similar kind of organizational structure that dispersed in a pyramidal fashion from the national level to the grassroots. These two wings have been running separately with their own cadre of workers from top to the grassroots for three decades. In addition to the DGHS, the Directorate of the Nursing Services and Directorate of Drug Administration attached to the Health Wing of MOHFW. These Directorates have their own office, separate workforces and assigned to perform various health care related activities. From the program implementation point of view, the "District" is very important, in fact this is the level from where the health care services in the small district towns and rural areas are controlled, managed and supervised.

The Civil Surgeon is the chief of the district health service. He runs both fixed-site and out-reach health care services in the district. The district health administration is responsible for supervising and coordinating, on average, 17 Upazila Health Complexes – a 30-bed primary care hospital with a very limited secondary level health services. The Upazila Health and Family Planning Officer administer the Upazila health complex. At present, there are 406 Upazila Health Complexes in the country. On paper, the Upazila level health and family planning services are integrated. Upazila Health Complex is organized with three functional components – out-patient department, 31 bed in-patient service including 6 bed for maternal and child care and domiciliary health care section staffed with field workers. The Union Health and Family Welfare Centre are at the bottom of the government health care structure. At present, there are 4200 union health centres. Medical Officers administer some of them, about 1300, and Medical Assistants who assisted by 15 health's and family planning personnel in managing the static health facility and rendering domiciliary services (ibid) run rest.

2.6 An Overview of Traditional Medicine Systems in Bangladesh

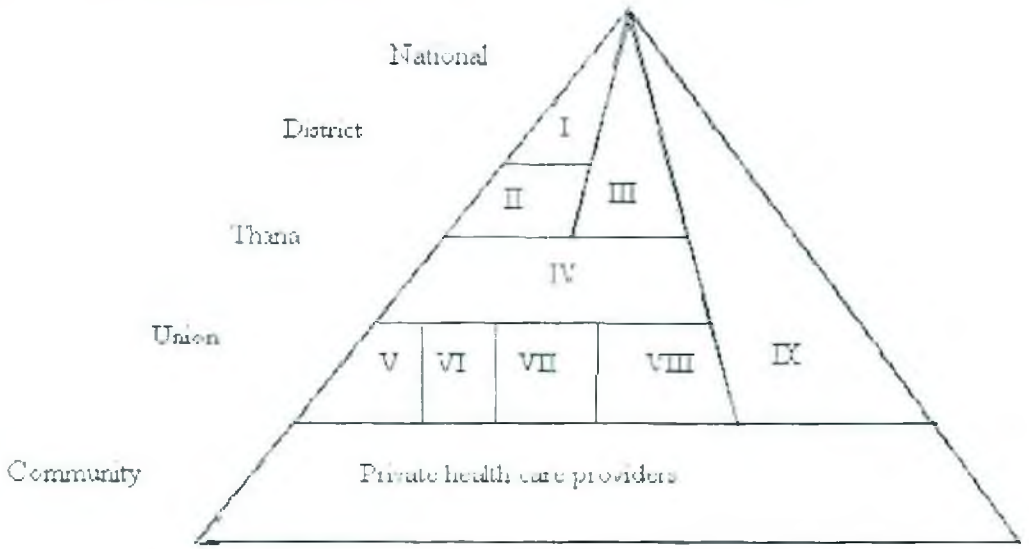
According to World Health Organization (2002), "Traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well being." Further the term complementary and alternative medicine (and sometimes also non-conventional or parallel) are used to refer to a broad set of healthcare practices that are not part of country's own tradition, or not integrated into the dominant healthcare system. As per the context in which it is practiced or the form of knowledge, often it is called in various ways such as traditional medicine, alternative medicine, complementary medicine, natural medicine, herbal medicine, phyto medicine, non-conventional medicine, indigenous medicine, folk medicine, ethno medicine etc. Chinese medicine,

Several classifications have been attempted for defining and classifying traditional medicine. It is pointed that there is no homogenous body of medical thought and practice which can be put under one name (Van dergeest 1997, Patwardhan 2005 p2) WHO strategy (2002: 8) also makes a similar remark that the term alternative refer to large heterogeneous categories defined by what they are not than what they are.

Whereas there is wide diversity at a practical level, a basic philosophical underpinning of all such knowledge systems is their acceptance of a shared world view which is an inherent relationship and sharing of key elements between the macro and micro level, the outside universe and a living being. Few other common dimensions are ecological centeredness, focus on non-material or non-physical dimensions, and a comprehensive approach to health, keeping in mind physical, mental, social, emotional, spiritual, ecological factors in wellbeing. Citing the African traditional medicine situation, Van dergeest et al. (1997) points out some of the key unifying features of any traditional medical knowledge as, popular and public domain knowledge relating to self help; a social character; religious dimension; orientation to prevention; and comprehensive concepts of health and illness than in the Western tradition. Further, one can see broad similarities at the theoretical level of traditional medicines such as their focus on functional aspects of health and diseases; systemic

understanding of health and disease; multi causality approach; a circular method of cause-effect reasoning; subjective, qualitative, individualized and personalized management; preventive focus; attribution of importance to physician's wisdom; etc. Knowledge generation is mostly through subtle observations and experiences within the context i.e. an individual or the nature (Unnikrishnan 2009). Some of these defining features have key policy implications today.

2.7 Hierarchy of Health Care Delivery System in Bangladesh



Source: Islam, 2006

Figure-2: Hierarchy of Health Care Delivery System in Bangladesh.

Notes:

I - Medical College Hospitals (300-500 beds)	V - Dispensary (Outpatient only)
II - District Hospitals (50-200 beds)	VI - Union Family Welfare Center (Outpatient only)
III - Specialized Hospitals	VII - Other health centers
IV - Upazila Health Complex (31 beds)	VII - Maternal and Child Welfare Center (2-10 beds)
	IX - Other hospitals

2.8 Access to Health Care Services in Bangladesh

Most of the people in Bangladesh live below poverty line. As a result, they are very much depriving for their necessary health care facilities. In Bangladesh food, cloth,

shelter, health care, education, social security is the fundamental rights of people. After food, cloth and shelter health rights are worldwide, recognize for mass people. The United Nations Universal declaration of human rights given priority in this Health care rights issues. Access to health services depends on the availability of service (i.e. the availability of physicians, health centers, and hospitals) to the actual as well as potential users.

In Bangladesh, health facilities in both public and private sector are distributed in an unjust way, which makes the services unreachable to low income and rural people. Along with such unjustified distribution of services between urban and rural areas, delivery of services also varied depending on the level of income (rich and poor), which is evident in discriminatory access to services.

The poor in Bangladesh bear higher health risks and suffer the burden of excess mortality and morbidity. The poor in general are more prone to illness and diseases than the non-poor. The poorest households are likely to use health care services and are less willing to pay for improved services compared to other socio-economic groups (Jahan and Salehin, 2006). The scenario of Health care services improved overall very well but rural primary Health care services is not sufficient for people it is also a matter of questions. Total populations 76.61 percent live in rural area and most of them are use traditional Medicine. It is necessary to know about rural primary Health care situation in Bangladesh. As a result, I select this topic of my research title.

CHAPTER.3

THEORETICAL FRAMEWORK OF THE STUDY

Introduction

Health system "consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health". This study would concentrate on rural primary health care behavior. Rationally Health Care behavior as a human behavior is also driven by reason. Although human being is rational, they do not always act rationally. Rational Decision Making paradigm (RDM) has significant background to explain such health related behavior. This chapter would explain primary health care behavior in the light of RDM.

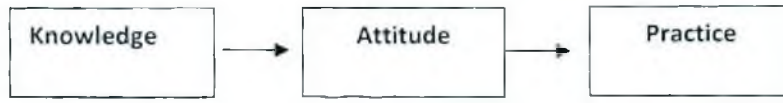
3. 1 RDM (Rational Decision Making Paradigm)

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 paradigms recently. These theoretical models to predict health related behavior, which fall within two major paradigms:-

- One group looks at the role of fear in motivating behavior change.
- Another group is concerned with cognitive mediating effects of fear arousal on behavior change, commonly referred to a Rational Decision Making (RDM) models.

Rational Decision Making models (RDM), which include with the health Belief Model (HBM) and Theory of Reasoned Action (TRA) models that are conceptualize human (in the case of health) behavior as purposive, rational and intentional rather than mindless pathological and /or deviant (Loxeley1995; Cited

in 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:



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. When applied to health seeking behavior. The KAP implies that having knowledge about sources, and 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 "Neither Knowledge about AIDS transmission or the fear that AIDS inspires directly leads to preventive behavior (Paicher 1999)". It seems that people have good knowledge about how the virus spread but numerous KABP (Knowledge, Attitude, Beliefs and Practices) studies have established no direct link between information and action (Peruga and Celentano 1993). To give strength of KAP, HBM emerged intending to establish a direct and rational connection between knowledge and practices when an individual feels truly concerned by a health threat.

3.2 The Health Belief Model (HBM) and Rural Primary Health Care Behavior

Of the various model in health psychology that are used to explain health behavior, the HBM provides the most appropriate theoretical framework in which to examine how mothers/ Parents think about vaccination and diseases. The Health Belief Model (HBM) is a social cognitive model

developed in the 1950s by the U.S Public Health service (Mullen, Heresy, and Inversion 1987), which is often used to explain and predict health related behaviors (Stretcher and Rosenstock1997). This model has 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 are derived from a well-establish body of psychological and behavioral theory whose various models depends mainly upon two variables:

i) The value placed by an individual on a particular goal
ii) 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

For example, if a person's goal is to avoid a health problem, the individual must feel personally vulnerable (Perceived susceptibility) to a problem judged to be potentially serious (perceived severity), and he/she must estimate that specific action will be beneficial in reducing the health threat (Perceived benefit) and will not involve overcoming obstacles (Perceived barriers). Thus, as Rosenstock notes in describing this model, "The combined levels of susceptibility and severity provided the energy or force to act and the perception of benefits (less barriers) provided a preferred path of action (Rosenstock 1966)".

When applied to parents as well as mother's vaccination behavior, the HBM suggests that simply having knowledge and awareness about infections disease will not necessarily result in increased visits to a hospital for vaccination or likely to get vaccinate their children. Instead, the model specifies four related elements that must be present for knowledge about diseases to be translate into preventive action (Onta 1998; Cited in Matsuda 2002).

First: An individual must perceive that he or she is susceptible to an infectious disease; and **second,** that person must also perceived that the disease in a serious condition; **Third**, he/she must believe that there are benefits to taking preventive action; **Finally**, the individual must also perceive that any potential berries to taking preventive actions are outweighed by potential benefits. Based on this Model, Perceived susceptibility, perceived severely, and perceived benefits are likely to be positively related to vaccination behavior, while barriers to taking action are likely to be negatively related to it.

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 model. Rosentock 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 (Rosenstock 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 .A diagram of HBM is presented below in the following figure

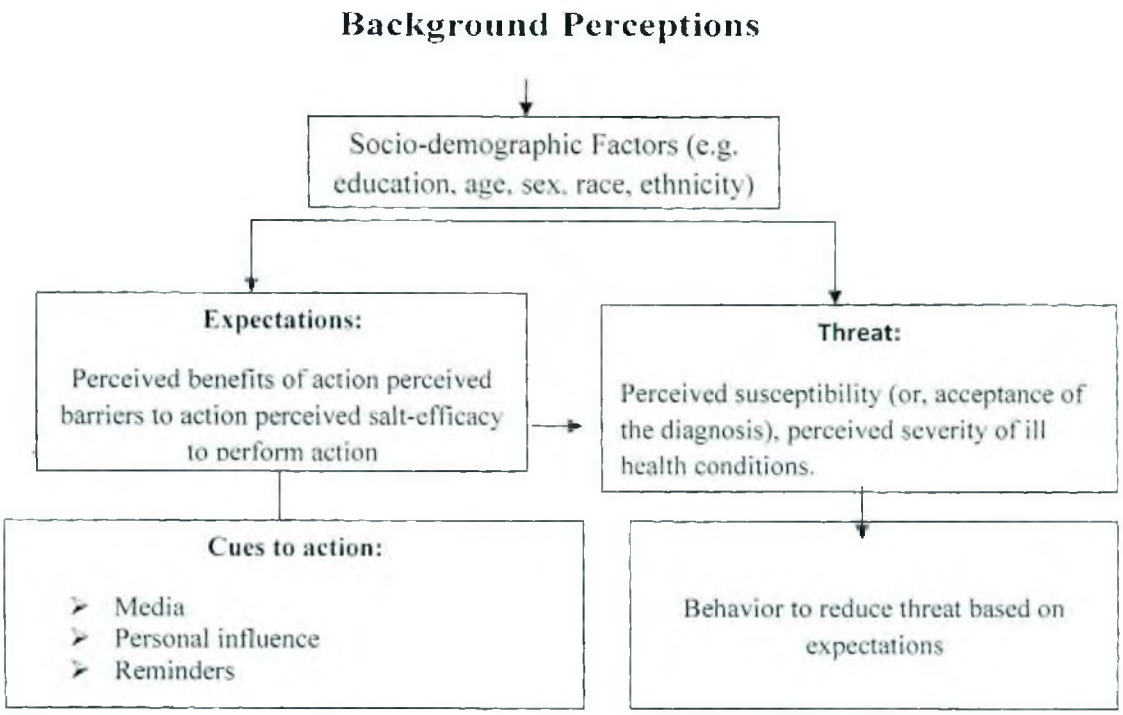


Figure3.1: A schematic outline of the HBM proposed by (Rosenstock et al.1990)

3. 3 Theory of Reasoned Action (TRA) and Rural Primary Health Care Behavior

The theory of reasoned action 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 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)

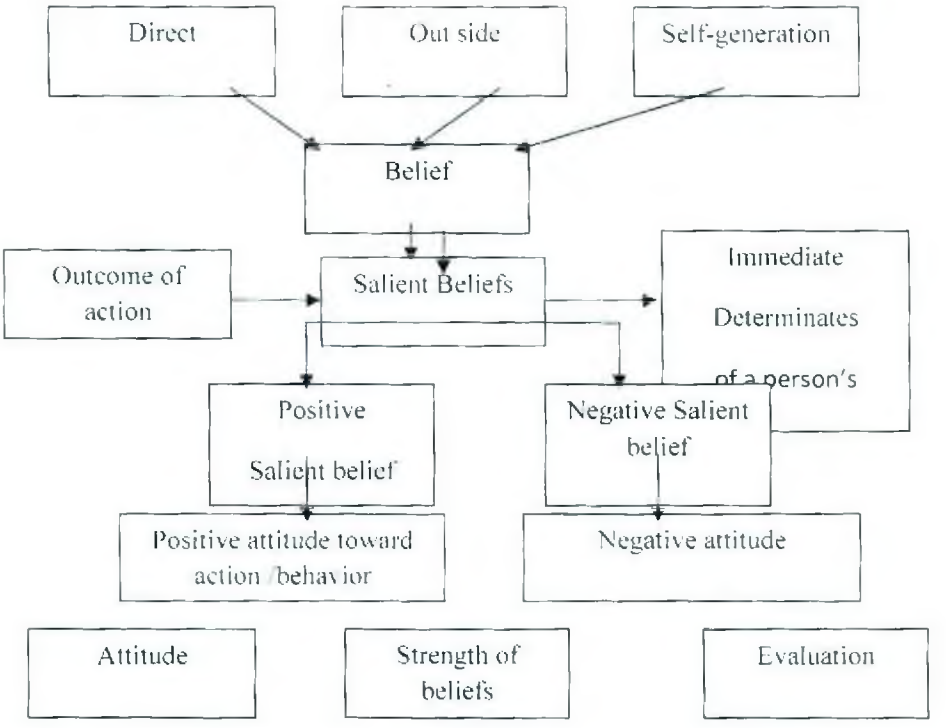


Figure 3.2: Formation of Attitude

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 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).

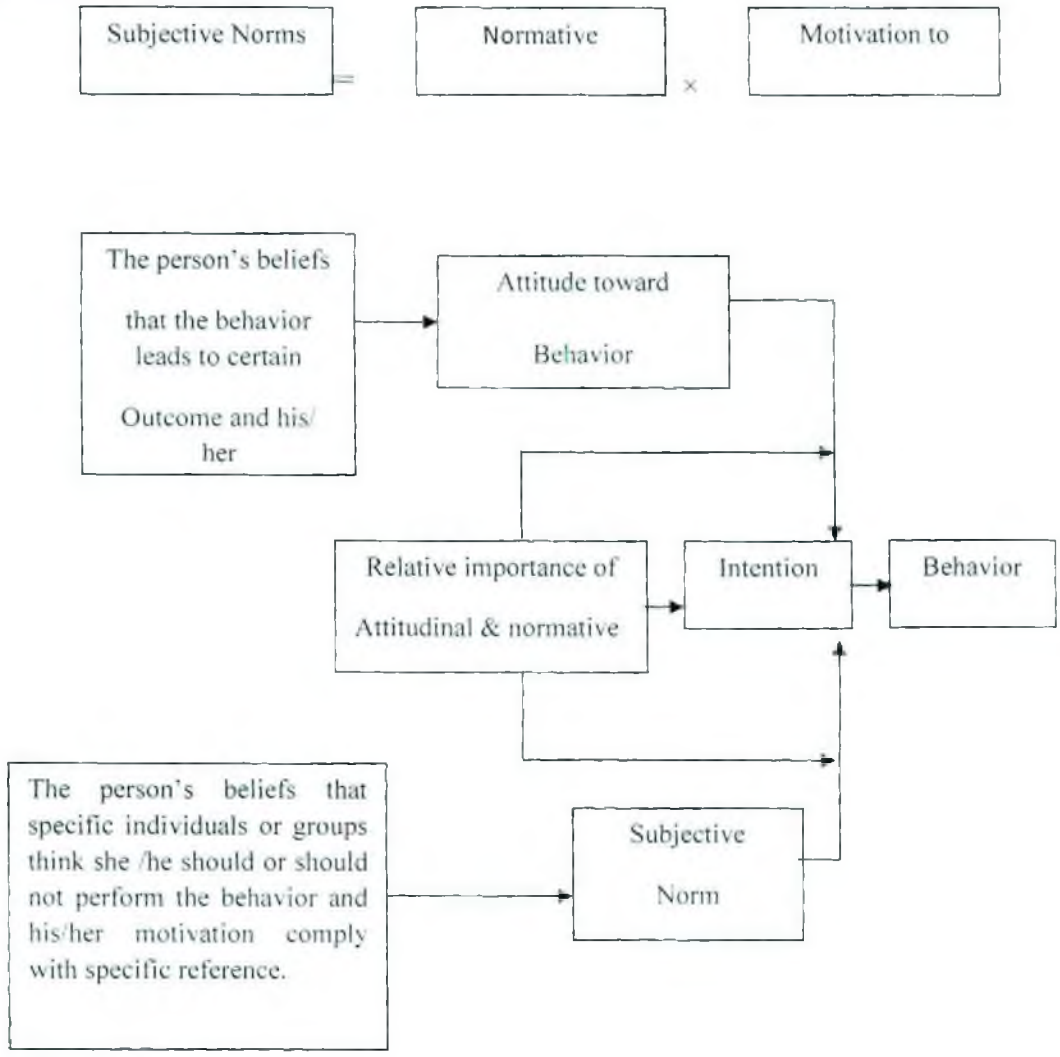


Figure-3.3: Reasoned Action Model by (Aizen and Fishbein, 1975)

3. 4 Theory of Planned Behavior (TPB) and Rural Health Care Behavior

The theory of reasoned action (TRA) works most successfully when applied to behaviors that are under a person's volitional control. If behaviors are not fully under volitional control, she/he may not actually perform the behavior due to intervening environmental conditions. However, Ajzen, and Fishbein (1980) formulated by TRA which they stated that behavior appeared to be 100% voluntary and under control that resulted in perceived behavior control'' from which emerged

"The theory of planned Behavior (TPB)"

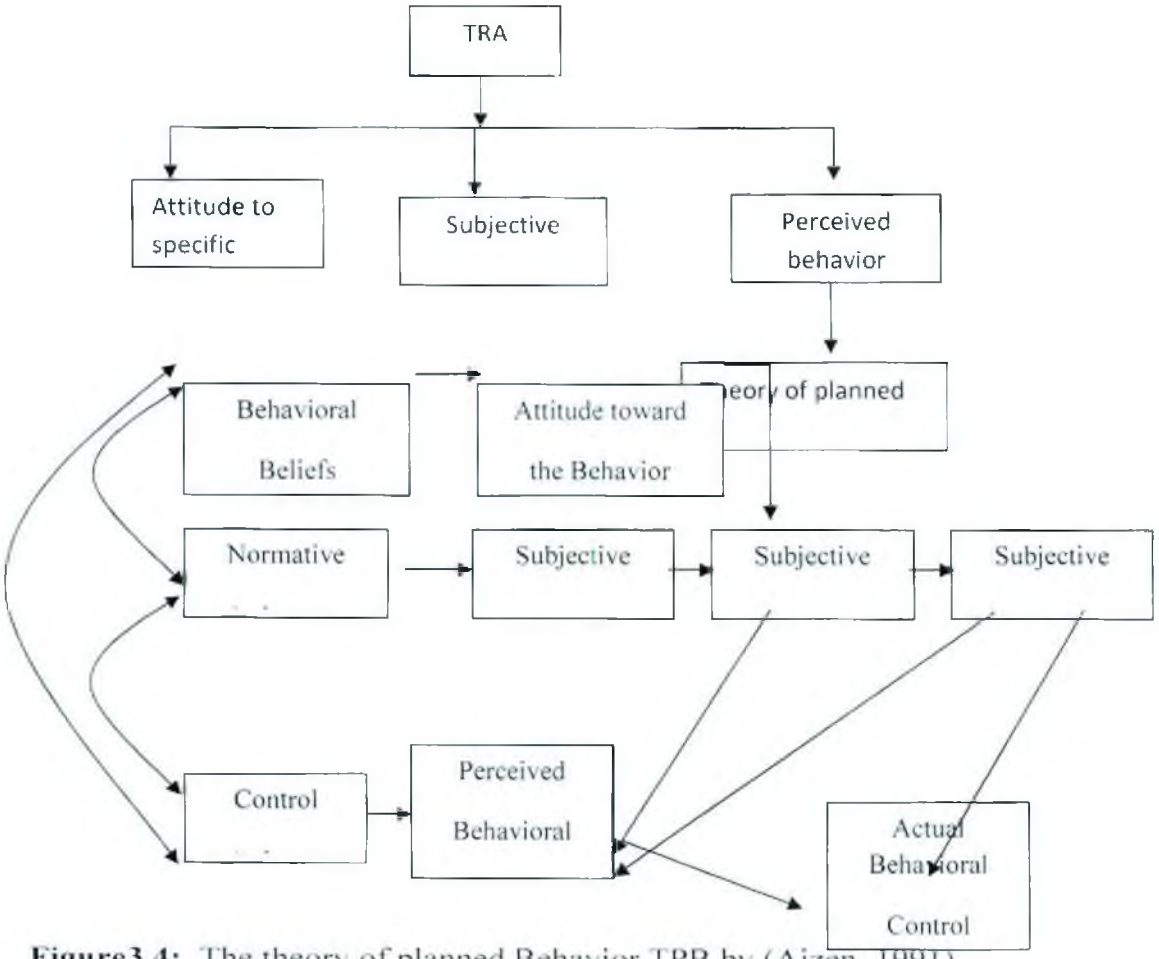


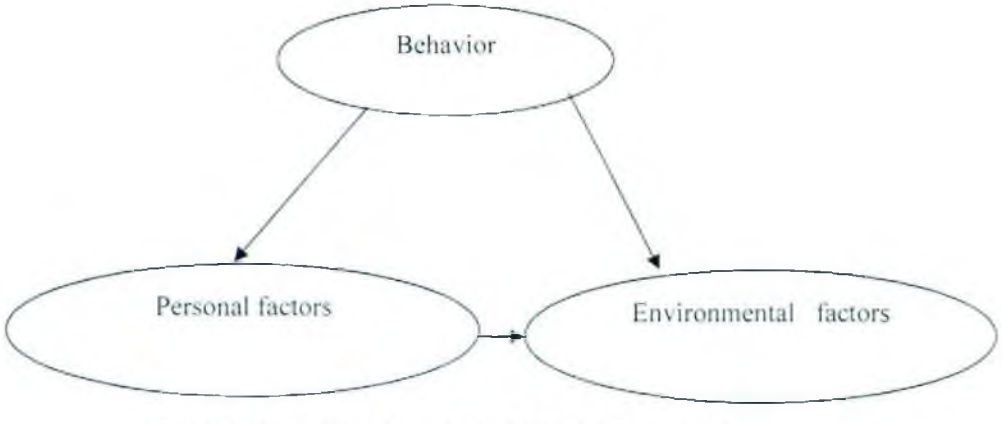
Figure3.4: The theory of planned Behavior TPB by (Ajzen, 1991)

The perceived behavioral control consists of "control belief" and "perceived power".' In this regard, perceived behavioral control indicates that a persons' motivation or intention were influenced by how difficult the behaviors are perceived to be, as well as the perception of how successfully the individual can, or cannot, perform the activity. If a person holds strong control beliefs about the existence of factors that will facilitate a behavior, then the individual will have high-perceived control over a behavior. Conversely, the person will have a long perception of control if she holds strong control beliefs that impede the behavior. This perception can reflect post experiences, anticipation of upcoming circumstances, and the attitudes of the influential norms or that surround the individual.

In the application of primary health related behavior, Marlow, Waller & Wardle (2007) found that the intention to take action for illness was associated with age, sex and region of residence of the respondent, household compositions, uptake of childhood vaccination, awareness and knowledge of HPV, belief that someone the respondent knew would get cervical cancer, overall attitudes toward vaccines and HPV vaccine, subjective norms, perceived behavioral control of the decision to get vaccine and perceived influence of vaccination and sexual behavior. Cultural background, education, religious affiliation and sole of religious beliefs in daily decisions were not associated with intention to take action for illness.

3. 5 Social Cognitive Theory or Theory of Self-Efficacy and Rural Primary Health Care Behavior

Bandura provided his concept of "Self-efficacy" in 1977 in his ***Social learning theory*** rejecting traditional learning theory, the social cognitive theory is related to heath behavior or communication. It deals with cognitive, emotional aspects of behavior for understanding behavioral change. In addition to the HBM, TRA and TPB, Bandura cautions that to achieve self-directed change, people need to be given not only reasons to alter risky habits but also the behavioral means, resources and social supports to do so. It will require certain skills in self-motivation and self-guidance (Bandura, 1995).



(Cognitive, affective and biological events)

Figure 3.5 Conceptual Model of Self efficacy by (Pajares 2002).

Self-efficacy and social modeling are two elements of Bandura's theory. Self-efficacy refers to a personal belief in his/her personal ability to affect change, which determines what course of action that person will choose, how long it will be sustained in the face of resist fence, and his/her resiliency to bounce back following setbacks.

Social modeling is based on the principles that people learn vicariously by observing the actions of others. If people see models similar to them solving problems successfully, they will develop a stronger belief in their abilities. These ties in with self- efficacy, they can act effectively, since only if actors are confident in their ability to act.

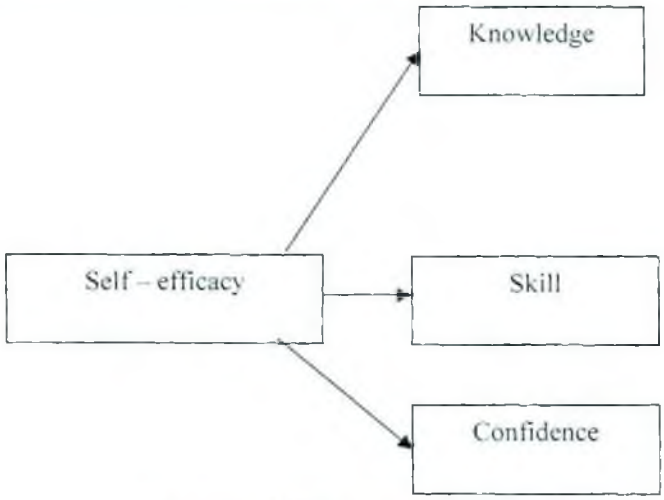


Figure3.6 Elements of self-efficacy

Witte (1992) found that people are unlikely to undertake a risk control measure unless they feel that they can effectively control the risk (i.e., response-and self-efficacy) and it is personally relevant and serious. In supporting of social modeling regarding mother's vaccination behavior, Mapatano et al. (2008) found that mothers with family member who had suffered from any EPI- Preventable diseases where likely to have their children completely immunized. Topuzolu et al. (2006) also found that although it was not wide spread opinions, there were also mothers who believed that vaccination was not essential, A mother who was not

vaccinated and stayed healthy believed that vaccination was not a need for her children. He also found that Knowing or witnessing childhood deaths and disability from these diseases might have caused a sick perception and a motivation for immunization among mothers (Ibid).

All studies above mentioned proves that self-efficacy- ability to affect change behavior (Confidence) comes from experience how other people are successful practicing certain behavior, when mother see some children have become victim of diseases and prevailed by vaccine. They keep strong belief and start to practice certain behavior. In this regard, Kennedy, Brown, & Gust (2005) studied on the parents who oppose and support compulsory vaccination, found that the opposed parents are not confident and only somewhat confident in the safety of childhood vaccines respectively 28 percent and 15 percent.

3. 6 Rational Decision Making (RDM) and Rural Primary Health Care Behavior; A Critical Analysis

Rational Decision making models was taken for granted that human beings are rational and they act rationally. Thereby, RDM paradigms were successful tools to explain and predict the human behavior. But recently many studies have proved that due to rational being, people act many irrational actions because these individualistic as well as psychological and preconceived models that impose knowledge to change human behavior are unable to change human behavior, for that why, these avoid the socio- cultural considerations. There by, the most risk prevention models, i.e. Rational Decision making (RDM) models are insufficient to produce the comprehensive changes necessary to reduce high-risk public health behavior. Knowledge or education alone does not change behavior and neither does the teaching of necessary skills alone (Becker 1998). Vaccine related behavior is not still only a medical issue but also concerned with multicultural issues.

In this section, I will examine the utilities of RDM regarding prediction and explanation of human behavior. There has been trenchant criticism of RDM models, much of it, as will be described below, focused around the difficulty of trying to explain behavior such as sexual (as well vaccine related behavior) which is embedded in cultural values, myths and assumptions, through cognition (Doughlas 1994). The assumption of implicit links between knowledge and behavior is not correct (Douglas 1994). For example, education was once believed to be key effective intervention, but research has indicated that education or knowledge alone is rarely successful (Shop and Davidson 1994). Chin and Hibbs (1998, 2002) stated that Decision-making is complex, a few highly educated mothers who make a deliberate decisions not to vaccinate.

Although the health belief model has been used extensively in studies of health behaviors, critics of the model have pointed out a variety of limitations. There has been a lack of uniformity in testing the model, especially in the way variables are operationalized (Champion1984). Tools used to measure HBM component have not been refined or standardized .In addition, the model does not apply numeric coefficient to the concepts of susceptibility, severity, benefits and barriers, nor does it delineate the specific nature of the relationships among the variables (Rosenstock 1990).Most studies, however, have treated the model as additive and have tested only direct relationships between the variables and the health related behavior of interest.

Another problem with the HBM is a lack of consistency in the use and testing of the model. That is, not all variables have been included in all studies. For example, identifying and measuring the concept of cues to action has been problematic .Cues can be diverse in nature, may occur in fleeting manner, and an individual may or may not consciously remember events that trigger action. In retrospective studies, the nature and importance of cues is more difficult to evaluate because research participants are asked about behaviors performed in the past. For these and other reasons, the variables "cues" has not been included in many studies

based on the HBM (Harrison, 1992). Because the HBM is a psychological model ,it accounts for only as much of the variance in health behaviors as can be explained by attitudes and beliefs that are obvious to and consciously evaluate by individuals (Janz1984). Other factors related to the individuals, such as demographic variables, personality factors, social supports, or previous health experiences may play a role in influencing behavior, but they are not an explicit part of this model. Instead, they are thought to influence the major variables in the model. In addition , Concepts reflective of the larger social structure , such as institutional or public policy ,and social isolation that may affect access to health care , are not included in the HBM, however .this criticism could also be directed at most other psychological models.

In spite of the criticisms the HBM has been used successfully for over thirty years to understand health behaviors in a variety of circumstances .As kirscht wrote in his analysis of the model, it is "complex and variable in its history, yet surprisingly robust and useful" (Kirscht 1988).Thus, it is a very useful method for explaining health behavior –one that should provide substantial power in predicting the perceptions that underlie vaccination behavior in mothers.

Several studies have already provided evidence supporting the utility of the HBM in understanding the factors associated with parents' vaccination behaviors. A 1996 study of parents in a rural Cameroonian village analyze factors associated with caregiver compliance to appropriate vaccination time lines (Tuma 1996). Another study conducted among mothers and primary caregivers in Indianapolis ,Indiana(USA) also showed that perceived severity and susceptibility were two components of the HBM that were significantly related to greater likelihood of immunization(Zimet 1995).

While these studies suggest that perceived threats (susceptibility and severity of disease) are the most significant predictors of parents' vaccination behaviors, other studies have challenged this conclusion. In

particular, an epidemiological study conducted among young adults in Denmark found that perceived benefits and, more importantly, perceived barriers were significantly related to immunization rates in both parents and their children (Nexoe 1997). Moreover, several additional studies have indicated perceived barriers to be the component of the model that is most related to childhood vaccination behavior among parents (Janz1984; cited in Henderson1999).

Theory of Reasoned Action is active when behavior is under volitional control of individual. That is, the theory only applies to behavior that is consciously thought out before hand. Emotional decisions, habitual actions or any behavior that is not consciously considered can't be explained by this theory. For example, Ajzen, Timk, and white (1982) found that people who are prone to vary their behavior depending on what situation they are in (high self monitors) are not explained by the TRA. A high self-monitor does not always act on the intentions he has.

Ingham et al. (1992 ;cited in Amanullah 2002) described seven impediments to rational behaviors including perceived invulnerability, positive reasons for non-rationality such as preserving reputations or relationships, external and internal pressures which suggest that the behavior is often not under personal control, the mystique of serial behavior, negotiation and Joint decision making.

They concluded that the social content in which the behavior was enacted was a far more powerful influence on behavior than the cognition of the individual enacting the behavior. Without understanding social content, it would be difficult to develop an adequate explanation of the behavior. Knowledge, attitude, intentions and practice or behavior is not always correlated that is proved by study of Feyisetan, Asa, & Ebigbola (1997), they found that there is a big difference between the percentage of women who knew the correct cause of measles 4.4 percent and the percentage who suggested modern medical curative measures (73.0%) that reinforces our earlier contention that levels of adequacy of knowledge about disease

who knew the correct cause of measles 4.4 percent and the percentage who suggested modern medical curative measures (73.0%) that reinforces our earlier contention that levels of adequacy of knowledge about disease causation may be irrelevant in the choice of curative measures when appropriate preventive and curative measures are available at low cost.

The theory of planned behavior (TPB) based on the assumption that human beings are rational and make systematic decisions based on available information. Unconscious motives are not considered. Factors such as personality and demographic variables are not taken into consideration. There is a much ambiguity, regarding how to define perceived behavioral control and this creates embankment problems.The assumption of TPB is that Perceived behavioral control predicts actual behavior control; this may not always be the case. However, these models totally ignore the socio-structural variables that are also considered significant in affecting personal behavior like sexual risks, vaccinations behavior, dieting, risk practices while performing occupations practices etc.

3. 7 Conceptual Framework of the Study

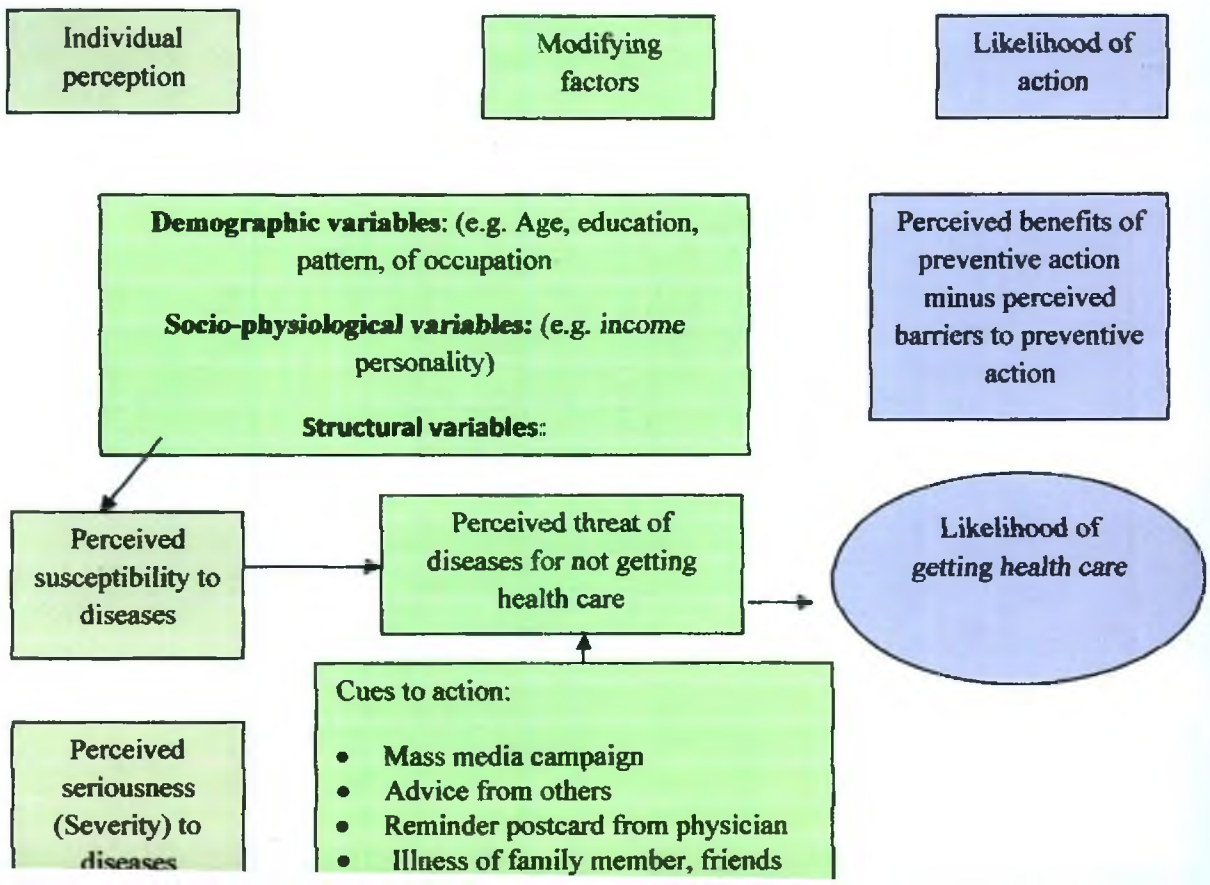


Figure3.7 Conceptual framework of the study

Conclusion:

The theoretical framework and conceptual framework discussed above would direct the subsequent the whole work in order to measure the applicability of the model in analyzing primary health care behavior of the rural, statistical findings related to the various components of HBM as well as RDM & Vaccine Acceptance Model & their analysis will be presented in the subsequent chapters.

CHAPTER.4

METHODOLOGY

Introduction

Research methodology is a way to study the various steps that generally adopted by a researcher in studying his research problem systematically along with the logic assumptions and rational behind them (Islam, 2008). Research Methodology is important part of research. A successful research depends on rational research methodology. Therefore, it is very important for scientific and social science research. It depends on types of research and nature of research. While it directs how a researcher will go about studying any phenomena or problem after well addressing the problem, in this chapter, detailed design of the study including sample size, study population, process of instrument development of data collection and data analysis will be explain to gain an insight about the whole procedure of this research work.

4.1 Why Quantitative Methodology?

One chooses research method based on what one is seeking to uncover, be data and information in the form of members or meanings (Brayton 1997). There has been widespread debate in recent years within many of the social sciences regarding the relative merits and demerits of quantitative and qualitative method, for research method, both methods may appears to be apposite derived from different philosophies. Each approach has its own set of philosophical assumptions and principles and its own stance on how to do research (Neumann 1997: 60). Yet, both are legitimate way of conducting research and supplement to each other, providing alternative insights into human behavior.

In spite of having strength and weakness within both methods, some sociologists often prefer to quantitative approach between two research methods quantitative and qualitative, presenting the data numerically in terms of means, percentage, or frequency counts. In another word, it is a mode of inquiry that attempt to systematically measure and predict phenomena a world of numbers, percentage, and therefore tangible analysis. Such data (as often referred to, "measurement" data) measures the amount of extent of some behavior regarding beliefs, trait, feelings and opinions about the target population. Numerical scores can often properly state the extent of different variables and appropriate quantitative information on each of variables conducting statistical tests that would reveal the strength or absence of the relationship.

Whereas there are several draw backs to qualitative approach of inquiry (Murray 1998). Firstly, the results are always subject the personal biases. A person, who interviewed, for example, is stating their version of the truth. Personal perspectives invariably affect what the individual believes and understands. Similarly, the results reported by the researcher conducting a naturalistic observation will be attaining by that researcher's individual interpretation of the events. Further, while case studies are rich

sources of information about individuals, it is risky to assume that the information can generalized to the rest of the population.

Furthermore, analyzing the data from qualitative research can be difficult, since open ended questions and naturalistic observations leave room for so much variability between individuals that comparisons are difficult Finally, although it may be tempting for researchers to infer cause and effect relationship from the results of naturalistic observations, interviews , archival data and case studies, this would be irresponsible. Qualitative methods rarely attempt to control any of the factors that affect situations. So although one factor may appear to have caused an event, its influence cannot be confirmed without conducting more investigations that are precise. There is thus tradeoff between flexibility and precision. Regarding these reasons, the quantitative approach has applied.

Additionally, deciding approach also depend on the nature and objectives of the study. The aim of quantitative research (Hopkins 1998) is to determine how one thing (a variable) affect another in a population, Quantitative research design are either descriptive (subjects measured once) or experimental (subjects measured before and after a treatment). A descriptive study establishes only associations between variables, which need a sample of hundreds or even thousands of subjects for an accurate estimate of the relationship between variables. Under Hopkin's circumstances, this study is descriptive because no attempt was, here, made to change (or intervene) health care behavior or conditions, rather measured as they were. The major objective of this study was to show association between primary health care and their health behavior and to show how their health beliefs affect on their practices. There was also to show significant association of rural primary health care expectations of people and the actual reality of rural people. Under these rationales, the quantitative approach was applied to conduct this research.

4.2 Research or Study Area

This research was conducted into two selected village under Narsingdi District, Shibpur Upazila at Jassor Union. This is far from Dhaka Capital city only about 60 km. The estimated population of study area (Jassor Union) were 34542 (UP report 2011) spread over an area of 25.18 Km. There are literacy rate approximately 66 %, there are 4146 population of Sotabond Village and 5783 population of Sharifpur village (Thana Health Complex report 2011). The study area selected of two villages Sotabond and Sharifpur under Jossor Union purpose of considering the study objective because of underprivileged area of Shibpur Thana in terms of socio-economic and demographic characteristics. The scenario of Health care services improved overall very well but Rural Primary Health Care services is not sufficient for people it is also a matter of questions. Total population of Bangladesh 76.61 % live in rural area and most of them use traditional Medicine. It is necessary to know about Rural Primary Health Care situation in Bangladesh. As a result, I was select two villages of my research area. It is also predict that how their socio cultural beliefs (Traditional Health Beliefs) affect their Primary Health Care behavior and health awareness of people that's why two rural village area like Sotabond and Sharifpur village was selected as study site, although, according to THC, this village is recognized as high performing regarding primary health care coverage.

4.3 Study Population: Sampling and Sample Size

The male and female age ranged is 20-55 years old and study populations of this study are living in the selected two villages. Sampling is a statistical procedure of drawing a small number of elements from a population (also called universe) and drawing conclusion regarding the population (Islam, 2008:99). Since data collection of this study was dominantly quantitative through survey, probability sampling were use to draw sampling unit. If a sample selected according to the rules of probability, it is a probability sample or random sample (Ibid). Random sampling was selected because if a sample is random, then it is possible to calculate how representative the sample is of the wider population from which the sample was

drawn. During mid May to mid June 2012, a simple random sample of **280** respondents was drawn at study site. The sample was drawn with help of random sampling through lottery.

4.4 Study Instrument

The study instrument was predominately quantitative; however, qualitative data collected through open-ended questions and as well as close ended questions. Thereby, a semi structured questionnaire as well as interview schedule was use. Instead of mail questionnaire & self-administered questionnaire, interview schedule was used because using, for example, self-administer questionnaire as the data collection instrument often becomes problematic, like respondents more likely to stop participation mid-way through the survey, if again, respondent cannot ask for clarification and there would be no interviewer intervention available for probing or explaining. Low response rate could a great problem of using questionnaire. On the country, interviewing respondents have advantages like fewer misunderstood questions and inappropriate responses, higher response rates, greater control over the environment that the survey is administered in. Thus, the data were collect with interview schedule.

The survey instrument as well as interview schedule including 36 questions was divided in various section entailing demographic characteristics , knowledge and attitude toward Primary Health Care and also Maternal & Child Health Care, four components of HBM (perceived susceptibility, perceived severity, perceived benefits, perceived barriers,); socio-cultural beliefs about primary health care and also maternal & child health care. Expose to primary health worker (FWC), mass media, NGO health worker & motivation of health awareness.

4. 5 Pre-Testing and Finalization of Interview Schedule

Pre-testing and finalization of Interview schedule to the following procedure:

- I designed the draft questionnaire and completed pre-testing.

- Based on pre-test findings I checked the translation, consistency and integrity of the questionnaire. I finalized the questionnaire and showed it to my supervisor for final approval.
- After approval of the Bengali questionnaire, I then printed the Bengali questionnaire and translated it later into English.

During Pre-Testing of the survey instruments, the following issues were considered:

- The probing techniques
- The language necessary to address specific cultural beliefs
- The sequencing of questions
- The technique/method/options for documenting responses
- Providing appropriate skips in the questionnaire

4. 6 Techniques of Data Collection

Survey techniques generally used to collect Social Sciences and statistical primary data. It is the most appropriate way of collection information from this large number of respondent (population universe). Surveys are flexible in the sense that a wide range of information can be collect. Basic benefit for using this data collection technique is to use the statistical techniques with certain validity, reliability, and statistical significance. Because of standardized format of data collection, Survey is free from several types of errors, relatively easy to administer and an economic way of data collection due to the focus provided by standardized questions. Several researchers used this method to study, attitude, values, beliefs and behaviors.

4. 7 Data Collection Procedures

Data collection was accomplished into four-week time during mid May to mid June 2012. The researchers himself along with other two interviewers administered the survey to respondents according the sampling plan discussed above. There were three personnel including the researcher,

responsible for data collection from study area. The two-field interviewers were recruited from the study area where one was female another was male comprising a primary school teacher and a NGO (BRAC) field level health worker. They have experience of field data collection as well as conducting interview.

One female field interviewers was recruited because of some target population of this study area were female regarding it gender communication & negotiation are more affordable or easier. Besides, they were trained on the data collection mechanism, the art of data collection, briefing on the questionnaire etc. After the training, these personnel went to the field and conducted the required number of interview schedule according to sampling frame systematic random sampling procedure, desired respondents were selected priory. Thereby, Once potential respondents had agreed to participate, an interview venue (yard of house) was agreed upon, the respondents were instructed that the interview would take about 30 minutes, that their names would not be recorded, and that their responses would be treated as anonymous data, they were also instructed of the purpose of this study. The respondents were interviewed in generally, surrounding of their household main house, kitchen, garden of home yard of house etc.

4.8 Data Processing and Analysis

Quantitative data processing involved the following steps:

- Questionnaire registration and editing
- Edit verification
- Listing of open-ended responses and classification
- Coding and code transfer
- Verification of coding and code transfer
- Development of data entry structure
- Data entry and entry verification
- Entering data as per questionnaire structure in SPSS 17.0 version
- Verifying the logic and accuracy of the data as per filled up questionnaire

- Keeping and maintaining data back-ups
- Tabulating as per objective and requirement in Quantum (an upgraded version of SPSS), also tabulating data in SPSS 17.0 version
- Development of analysis plan
- Program development as per the analysis plan
- Program running and report generation.

4.9 Key Variable Measurements

4.9.1 Demographic Characteristics

Level of Education: Levels of completed formal education among the respondents were assessed using a 5-point scale, with "1" = no education, "2"= Primary education, "3" = Secondary education, "4" = Higher secondary and "5" = tertiary (grade > 12). Also, the age of each respondent was elicited in an open-ended format, and information about occupation was also obtained, using seven categories: "1" =farming labor, "2" = Small business woman, "3" = Student,"4"=Housewife,"5"= Government service,"6"= Non-Government service,"7"= House servant

Monthly Income: In order to account for other salient variables, particularly social class, average income per month was elicited and coded using the following scale: "1" = less than Tk. 5000, "2" = Tk. 5000-10000, "3" = Tk. 10,000-15,000, "4" = 15,000-20,000,"5"= 20000-25000.

Marital status: of mothers was assessed using 5categories:"1"= Married,"2"= Divorced,"3"= Separated,"4"=Widow,"5"=Abandoned.

4.9.2 Media Exposure

Media exposure of mothers were assesses "Do you listen radio (as well watch TV?) Coded as "1" = "yes", 2 = "no", 3 = "do not know". And their level of radio listening and watching TV" How frequently you listen radio (as well watch TV), coded as;"1"= every day,"2"= at least a term in a week, "3"= less than a term in a week.

4.10 Reliability and Validity of the Study

"Reliability and validity are tools of an essentially positivist epistemology (Watling, as cited is winter, 2000:7)". Reliability is the ability of an instrument to produce consistent results when it is repeated under similar condition. The extent to which results are consistent over time and accurate representation of the total population under study referred to as reliability and if the results of a study can be reproducing under a similar methodology, then the research instrument is considered reliable (Joppe 2000, cited in Golafshani 2003).

On the contrary, validity means the ability to produce finding that are in an agreement with theoretical or conceptual values. Validity is the strength of our conclusions, inferences or propositions. More formally, (Cook and Campbell 1979) define it as the "Validity is the best available approximation to the truth or falsity of a given inference, proposition or conclusion." Validity determines whether the research truly measures that which it was intended to measure of how truthful the research results are. In other words, does the research instrument allow you to hit ''the bull's eye'' of your research object? Researchers generally determine validity asking a series of questions, and will often look for the answers in the research of others (Joppe 2000:1)

In this study, to verify reliability and validity of the survey data, cross checking of completed interview schedules with field workers and verification by randomized spot checks with the respondents was done. That is to say, to assess the reliability of survey data, administration of interview schedule or portions of the interview schedule were conducted to the same respondents at different times or under different circumstances in order to assess how stable the answers were. On the contrary, to asses validity of survey data, corroboration audit observation were conducted –i.e. the finding of this study were compared with different sources and nature.

Interviewed through inter personal communication, the mothers whose responses seemed 'out of line' with information provided by other similar respondents.

- * The findings of this study were verified with recorded data or information by Thana health complex.

- ❖ The findings of this study were compared with the studies, which were conducted in rural Bangladesh.
- ❖ The findings of this study were reviewed by an public's health expert who a was medical officer of THC of study site.

The extent to which reliability and validity must be established and the approaches to use depends upon the nature of the information collected and the uses to which it will be put.

4.11 Ethical Considerations

Social researchers must consider the right of the respondents involved in any study (Baker, 1999). Thus in order to carry out a research project, the researchers must consider the ethical aspects of their studies. In this research, an ethical standard has been maintained in every stage of this research. Researcher ethics is very important because here consider various important ethical decision of the respondent, study area, research instrument etc.

4.11.1 Introduction and Explanation of the Survey's Purpose

It was mandatory that all the investigators introduced themselves and explained the purpose of the study before collecting any information from the respondents. Respondents then had to indicate that their participation was voluntary. Details of the ethical issues are state below.

4.11.2 Confidentiality

The respondents were informed clearly that the information they provided during the interview would be kept strictly confidential. Only the interviewer and the researcher would have access to the questionnaires. The questionnaire would then destroy upon completion of the data analysis and cross-tabulation. The name and address of the respondents was not recorded anywhere in the questionnaire.

4.11.3 Privacy

Furthermore, privacy during the interview process was safe guarded. The interview was hold under conditions wherein the respondent felt most comfortable in responding openly. In addition, their identity was not linked to the study at any point of time or stages of the study. It was at the respondents' discretion to participate in the interview. The study registered oral consent from all interviewees. Any form of coercion of the study subjects was strictly avoided in either getting their consent or interview.

Conclusion

This chapter has presented the overall methodological aspect of the study. In the next chapter; results of the study will be presented and analyze.

CHAPTER.5

FINDINGS OF THE STUDY

5. 1 Demographic Profile of the Respondents

The present study was conducted among the people of a rural area of Bangladesh located in Narsingdi District. In total, 280 respondents ranging from age 20 to 55 years were interviewed. Of them 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.

Table 5.1: Demographic Profile of the Respondents (N=280)

Major Characteristics	Per cent
1. Age (in year)	
20-30	48.7
30-40	32.3
40-55	19.2
Total	**100**
11. Gender	
Male	51.3
Female	48.7
Total	**100**
111. Marital Status	
Married	61.6
Unmarried	31.3
Divorced	1.6
Separated	2.4
Widowed	1.0
Deserted	2.1
Total	**100**

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

The respondents surveyed, an overwhelming majority of the respondents (61.6%) was married. On the other hand, a significant number of respondents (31.3%) are unmarried while 2.4% 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 widowed.

Figure 5.1 Respondents Age (N=280)

The figure 5.1 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.

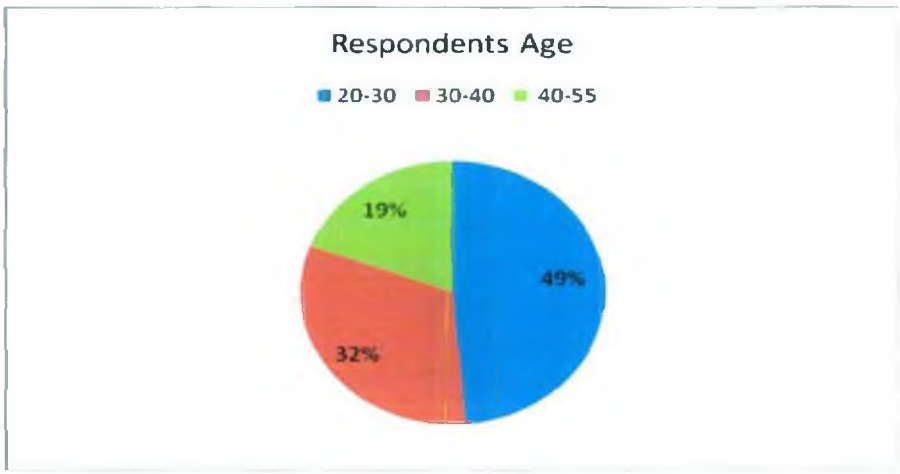


Figure 5.2 Respondents Gender (N=280)

Here figure 5.2 shows that respondents gender of total 280 samples here male respondents were 57.3 percent and female respondents were 42.7 percent.

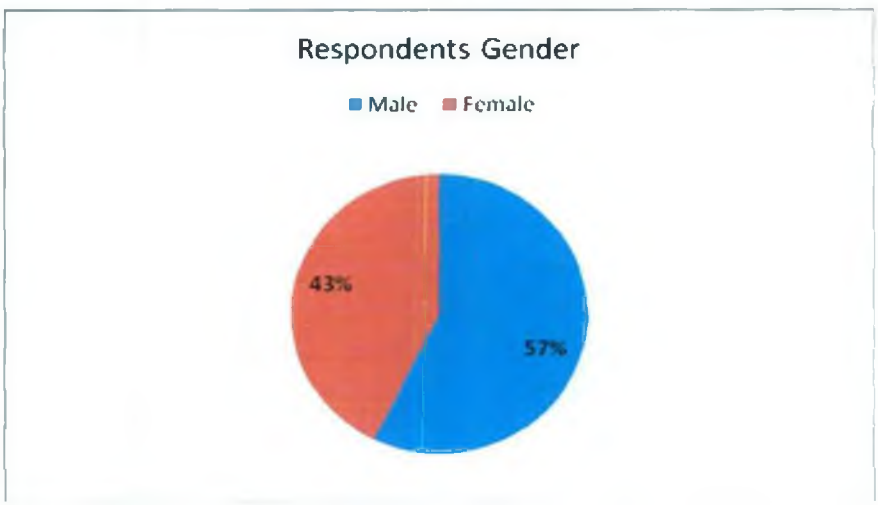
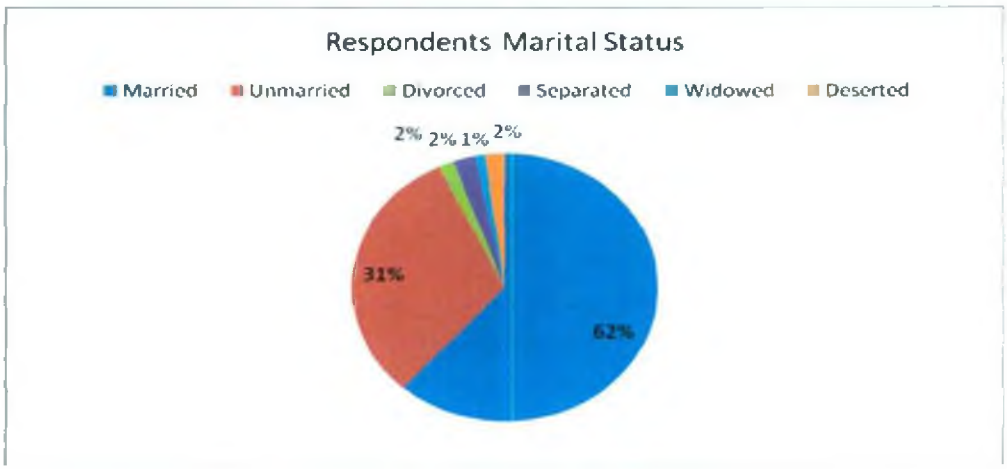


Figure 5.3 Respondents Marital Status (N=280)

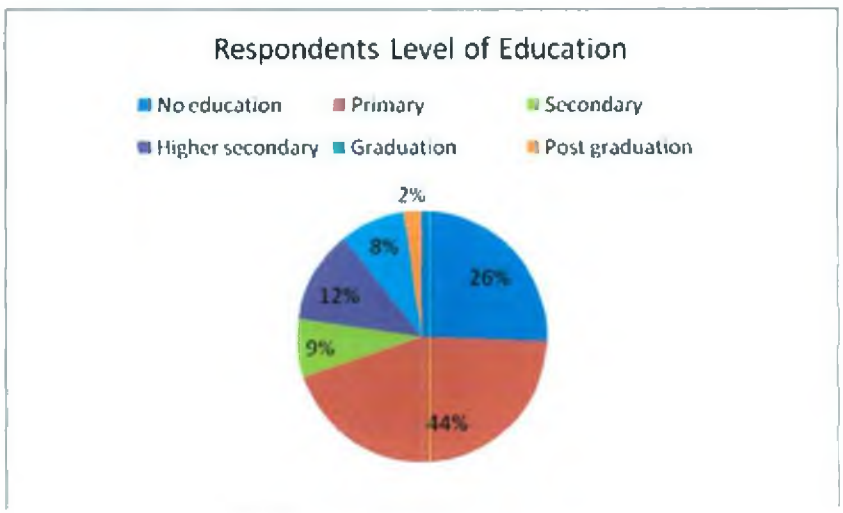
Here figure 5.3 shows that respondents marital status of the total respondents surveyed, an overwhelming majority of the respondents 61.6 percent were married. On the other hand, a significant number of respondents 31.3 percent were unmarried while 2.4 percent respondents were finding in the both cases 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 (N=280)

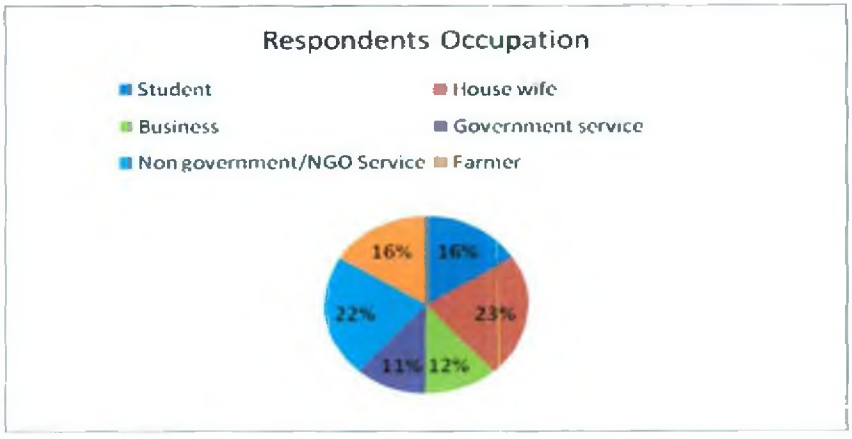
Here respondents Socio-economic characteristics such as respondent's level of education, Occupation, monthly family income are shown graphically in the following;

Figure 5.4 Respondents Level of education (N=280)



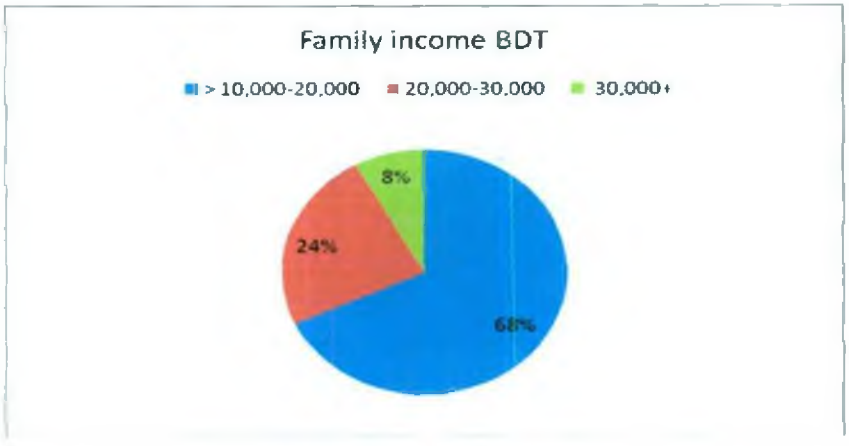
Here figure 5.4 shows that the respondent's level of education, most of the respondents 44.2 percent has Primary level of education class five and a significant number of respondents 12.0 percent have passed higher secondary certificate exam (H.S.C). On the contrary, a considerable number of respondents 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).

Figure 5.5 Respondents Occupation (N=280)



Here figure 5.5 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.

Figure 5.6 Respondents Family Income (N=280)



Here figure 5.6 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.

5.3 Facilities Regarding Primary Health Care Services

Table 5.1 shows that the distribution of the Respondents by the nature of hospitals for medical facilities around 52 percent said that they went to Upazila Hospital for their medical treatment. Another significant number of respondent about 45 percent said that they went to Community clinic for their treatment. However, large number of respondent 38 percent said that they also went to Homeopathic doctor; rest of the respondent went to other medical treatment Dispensary 29 percent, NGO services 33 percent, spiritual medicine 12 percent, peer Hozor 36 percent and other traditional health care services. These percentages add up to more than 100 because of respondents appeared in more than one category.

Table 5.1 Distribution of the Respondents Nature of Hospitals for Medical Facilities (N=280)

Nature of Hospitals	Percent *
Upazila Hospital	52
Union Parishad Hospital	26
Community clinic	45
NGO provided health services	33
Dispensary	29
Local doctor	26
Peer /Hozor	36
Homeopathic doctor	38
Spiritual Doctor(zin pori)	12

*These percentages add up to more than 100 because of respondents appeared in more than one category

Table 5.2 Distribution of the Respondents Health Care Facilities Provided by Hospital (N=280)

Health Care Facilities by Hospital	Percent *
Primary health care	52
Emergency health care	35
Maternity health	45.3
Child care service	38.5
Fertility Health care	17.6
Tuberculosis /TV	6.3
Malaria services	2.5
Road accident services	7.4
Diarrhea/Cholera services	27.6
Others	6.1

*These percentages add up to more than 100 because of respondents appeared in more than one category

Table 5.2 Represent that the distribution of the respondents health care facilities provided by the Hospital. The significant number of respondent 52 percent said that primary health care facilities provided by Hospital. On the other hand, 45.3 percent said about maternity health, 38.5 percent are childcare services, 27.6 percent are Diarrhea / Cholera services and rest of the respondents health care facilities provided by the Hospital is less significant rather than that previous services.

Figure 5.7 Distribution of the Respondents History of Illness (N=280)

Figure 5.7 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.

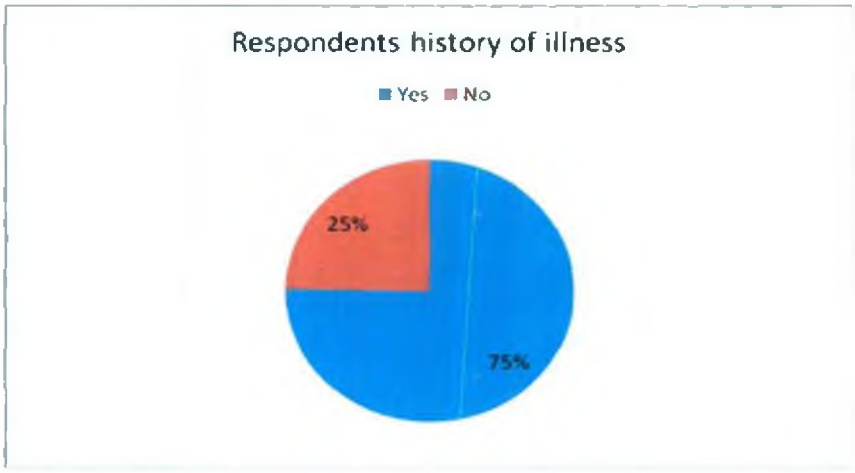


Table 5.4 Distribution of the Respondents by Treatment Seeking Behavior (N=280)

The place where they go for Treatment	Percent
Dispensary	57.5
Community clinic	42
Upazila hospital	31.5
Medical College Hospitals	28
District headquarters' Hospital	36
Homeopathic doctor	45
Private clinic	23
Traditional doctor	37
Peer /Hozor	38
Homeopathic doctor	49
Folk medicine Spiritual Doctor(zin pori)	24

*These percentages add up to more than 100 because of respondents appeared in more than one category

Table 5.3 shows that the distribution of the respondents by treatment seeking behavior. Here most of the respondents 57.5 percent said about dispensary where they go for treatment. Another significant number of respondents 49 percent go Homeopathic doctor for treatment, 42 percent go community clinic for treatment, 36 percent go district headquarters hospitals, 37 percent go traditional doctors and rest of the respondents go another place for treatment. In fact Table 5.6 shows that the overall composition of health care services which is provides various sources of treatment centre.

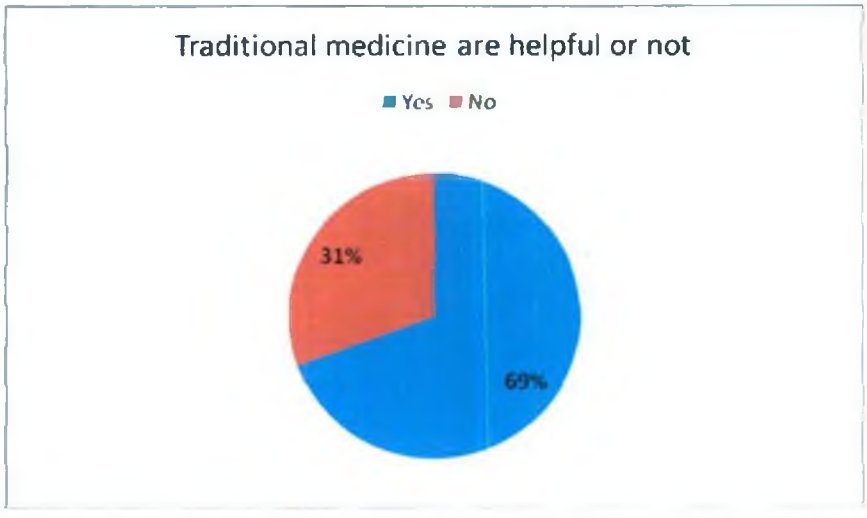
Table 5.5 Distribution of the Respondents by the Nature of Received Traditional Medicine (N=280)

Nature of Traditional Medicine	Percent
Pani para (Holy water)	49
Jar fokh	26.5
Gacer pata and *mul* (leaves and root of trees)	58
Tabij pora	43
*Chal pora (*Rice*)*	16
Folk medicine Spiritual (zin pori)	37
Cover of tree	31
Folkways beliefs	34
Others	10

*These percentages add up to more than 100 because of respondents appeared in more than one category

Table 5.4 indicates that the distribution of the respondents by the nature of received traditional medicine. Here most of the villagers are faith of traditional medicine as a result; they also use various types of traditional medicine as for example, if anyone is betting by the snake then villagers use traditional treatment with sucking snake toxin by hen. In fact, the Table has shown that the significant number of respondents 58 percent uses Gacer *pata and mul* (leaves and root of trees) for treatment. Another 49 percent respondents use *pani pora* (Holy water), 43 percent *gaser pata and mool* (Leaves and root of tree) which is very significant,43 percent use Tabij pora, 34 percent are folkways beliefs and rest of them are use another traditional health care treatment.

Figure 5.8: Distribution of the Respondents by the Response whether Traditional Medicines are helpful or not (N=280)



Here figure 5.8 shows that the respondents whether traditional medicines are helpful or not here significant number of respondents 69.4 percent said that traditional medicine is helpful for their cure as a result they prefer traditional medicine rather than modern medicine. Another 30.6 percent respondents said that traditional medicines are not helpful for treatment for dieses. As a result, they do not use traditional medicine.

Figure 5.9: Distribution of the Respondents by the Level of Satisfaction with the Traditional Methods of Treatment (N=280)

Figure 5.9 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.

5.4 Primary Health Care Services; Expectations and Reality

There are various governments, non-government organizations in Bangladesh provide Health Care for common people, and they said that Health care services huge improve after their services. It is also matter of knowing that Health care services huge improve after their services is really or not. Because statistical data and the real situation are not similar, it is very general about Bangladesh context. Another It is also a matter of knowing that governments and non-government organizations in

Bangladesh provide Health Care for common people is discrepancy real or not I will tray know by this research.

Figure 5.10: Respondents by the responses regarding whether the doctors are available in government hospital or not (N=280)

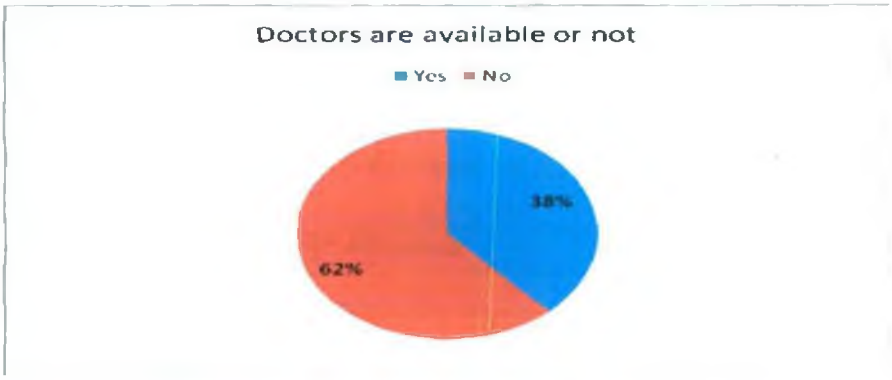


Figure 5.10 shows that the respondents regarding whether the doctors are available in government hospital or not most of the respondents 61.8 percent said that doctors are not available in the government hospital as a result most of the peasant are sufferer about illness. Another 38.2 percent said that doctors are available in the government hospital. However, real scenarios of government hospitals are true doctor's absenteeism.

Table 5.6 Distribution of the Respondents by the Factors of Unavailable of Doctors in Government Hospital (N=280)

Why doctors are not available in Gov Hospitals?	Percent
Private Practice	56
Lower standard of living	34
Own private clinic	28
Lack of facilities	20
Poor salary	41
Posting at remote area	46
Shortage of Doctors	58
Lack of suitable accommodations	17
Fare from residence	13
Others	5

*These percentages add up to more than 100 because of respondents appeared in more than one category

Table 5.5 represent that the distribution of the respondents by the factors of unavailable of doctors in Government hospital most significant number of respondents 58 percent said shortage of doctors, another 56 percent said due to doctors private practice, 46 percent said in order to posting remote area doctors are not available in Government hospital. Another 41 percent of total respondents said poor salary 34 percent lower standard of living and the other hand less significant causes of doctors unavailable in the Government hospital.

Table 5.6 Treatment / Services Provided by the Government Hospital / Doctors (N=280)

Services provided by Gov Hospitals	Percent
Primary treatment	52
Emergency treatment	36
Family planning	53
Health awareness	27
Maternal health services	43.5
Reproductive health services	47
Child care services	39
EPI Services	54
Others	3

*These percentages add up to more than 100 because of respondents appeared in more than one category

Table 5.6 shows that respondent`s about the treatment or services provided by the government hospital/ doctors. Here significant number of respondents 54 percent of total respondents said EPI services,52 percent primary treatment, 47 percent said reproductive health services, 43.5 percent said maternal health services, 39 percent child care services and the rest of them are less important percentages of service provide government hospital or doctors.

Figure 5.11 Distribution of the Respondents by the Level of Satisfaction with the Services by Government Hospital (N=280)

Figure 5.11 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.

Figure 5.12 Distribution of the Respondents by the Responses whether Services of Government Hospitals are Sufficient or not (N=280)

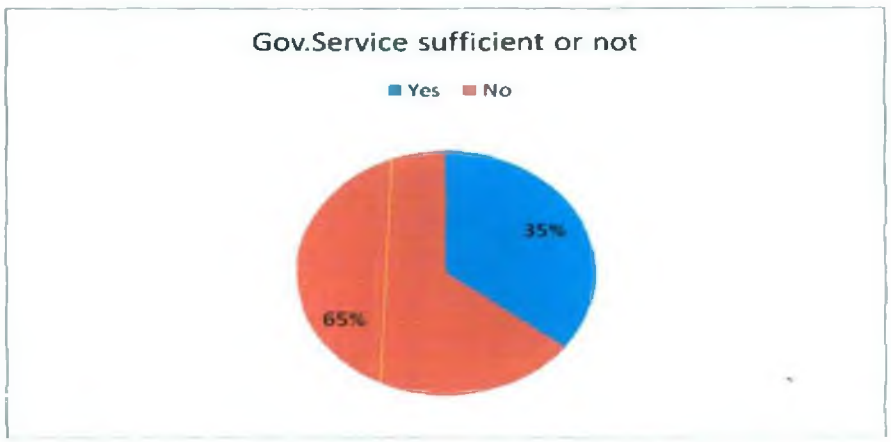


Figure5.12 shows that the respondents by the responses whether services of government hospitals are sufficient or not. Here most of the respondent 64.6 percent said that the services of government hospitals are not sufficient, another 35.4 percent said that the services of government hospitals are sufficient. Because of shortage of doctors, nurse and hospital bed are as usual in Bangladesh.

Table 5.7 Causes of Insufficient Health Services from Government Hospital (N=280)

Causes of Insufficient Services	Percent
Lack of hospital bed	46
Shortage of doctors / nurse	52
Private practice	63
Lack of proper monitoring	47
Influence of private clinic to doctors	43
Corruption of hospital staffs	38
Service for poor people	26
Remote area from divisional city	21
Mental dissatisfaction of doctors	32
Others	5

*These percentages add up to more than 100 because of respondents appeared in more than one category

Table 5.7 shows that the causes of insufficient health services from government hospital most significant number of respondents 63 percent said that doctors private practice at different clinic, 52 percent said shortage of doctors and nurses, 47 percent lack of proper hospital monitoring, 46 percent said lack of hospital bed, 43 percent influence of private clinic, 38 percent said corruption of hospital staffs, 32 percent are mental dissatisfaction of doctors about service at village or remote area. Another cause is less significant than above causes.

Table 5.8 Distribution of the Respondents by the Expected Services from Government Hospitals (N=280)

Expected services	Percent
Free medicine / drugs	53
Free diagnostic service	18
Surgical service with low cost	42
Emergency health care service	56
Special child care	47
Reproductive health service	36
Special maternal health service	26
Special service for burnt patient	38
Post disaster infectious and water born disease	21
Brest cancer related service	13

*These percentages add up to more than 100 because of respondents appeared in more than one category

Table 5.8 shows that the distribution of the respondent by the expected services from government hospital. Here most of the respondents about 56 percent expect from government hospital emergency medical services such as suicide cases drink toxin in that case government hospital not provide emergency health care services. Another 53 percent of total respondents expect free medicine/ drugs. 47 percent of total respondent expect special child care because most of the children in Bangladesh facing various disease, 42 percent are surgical service with low cost, 38 percent are special service for burnt patient, 36 percent reproductive health services, 26 percent are special maternal health services and the rest of the respondents expectations are less important rather than that.

Figure 5.13 Primary Health Care Services Received by the Respondents from NGOs (N=280)

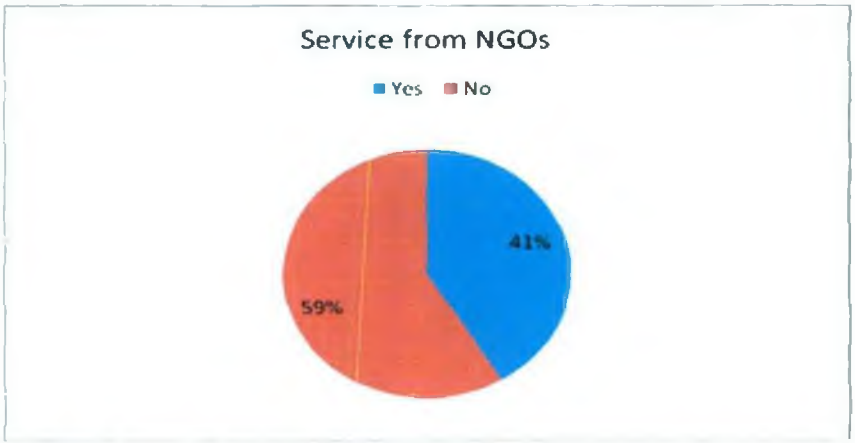


Figure 5.13 shows that the Primary health care services received by the respondents from NGOs here around half of the respondents 41.7 percent said that they received Primary health care services from different NGOs such as BRAC, Another 58.7 percent respondents are not received Primary health care services 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.

Table 5.10 Health Care Services by NGOs Received by the Respondents (N=280)

Health Care Services by NGOs	Percent
Family planning related services	35.2
Free medicine services	21
Awareness about health and water born diseases	45
Maternity health	52
Reproductive health specially for women	29.7
Child care service	42.3
Emergency health care	13
TV Tuberculosis / Malaria care services	5.6
EPI Services	33.8
Others	5.4

*These percentages add up to more than 100 because of respondents appeared in more than one category

The table 5.9 shows that NGO health care services received by the respondents most of the respondent 52 percent said that they received Maternity health care. On the other hand, 45 percent received Awareness about health and water born diseases.42.3 respondent received Childcare service. Another NGO health care service received by the respondents is average significant. So here various types of services received from NGO`s it downer project based health care services which provide various NGO`s.

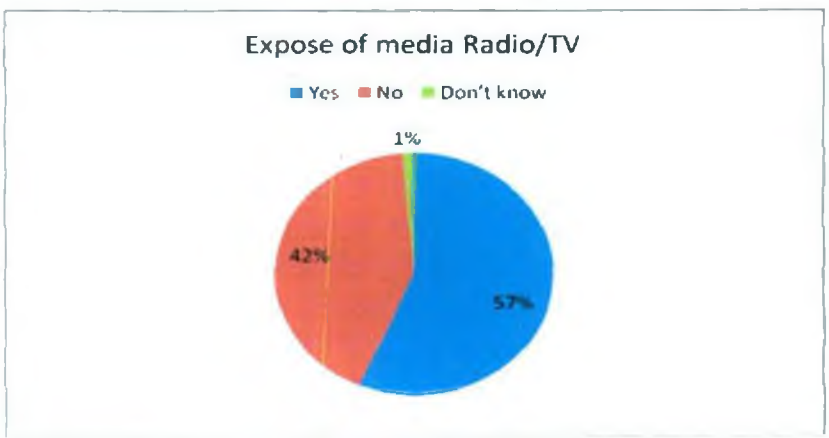
Figure 5.14: Distribution of the Respondents Satisfaction level of Health Care Services by NGOs (N=280)

Here figure 5.14 shows that respondents level of satisfaction about health care services by NGOs. As exposed in table -5.18, while a considerable number of respondents 48.6 percent reported that, they were satisfied. Another 25.3 percent Respondents were average satisfied, 20.5 percent were highly satisfied and an additional 5.6 percent not satisfied about NGOs health care services.

5. 5: Exposure to Mass Media

Mass media is a strong and important information & communication system in the modern world. Most of the cases information thoroughly passes away by the advertisement of electronic and mass media. As a result, common people get massage about health awareness and other social and political issues. So mass media play important role about health awareness.

Figure- 5 15 Distribution of Respondents by Media Exposure from Radio / Television (N=280)



Here figure 5.15 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,

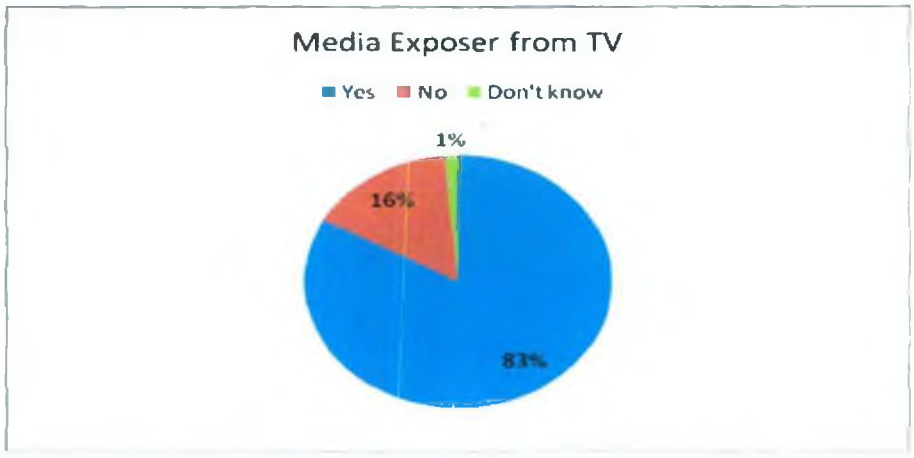
Figure 5.16 Distribution of Respondents in terms of the Level of Listening Radio (N=280)

Here figure 5.16 shows that respondents were asked how they frequently they Listening Radio, most of the respondents 37.3 percent had reported that they Listening Radio regularly but a considerable number of respondents 34.6 percent also Listening Radio At least 4 days in a week . Another 28.1 percent Listening Radio Less than 4 days in a week

Figure 5.17 Distribution of Respondent in terms of Exposure of Health Care Message from Radio (N=280)

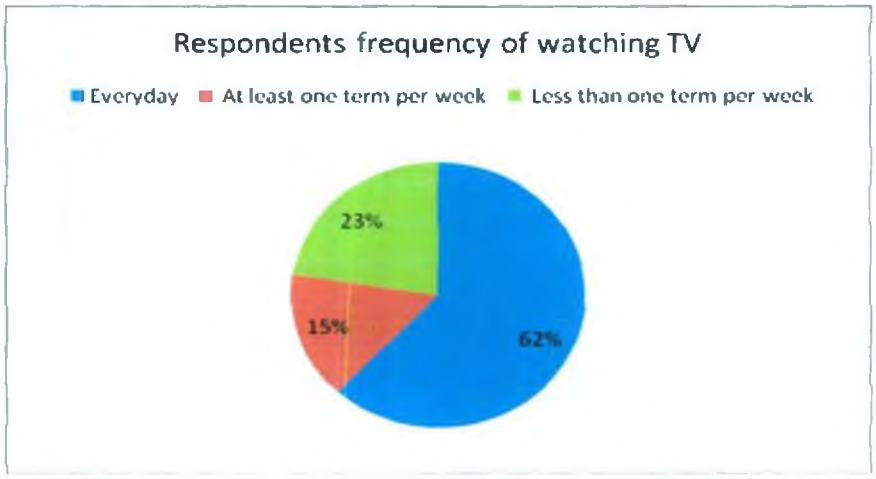
Here figure 5.17 shows that respondents were asked where they got message about Health care most of the respondents 49.3 percent had reported that they got message about health care from Radio while a considerable number of respondents 24.2 percent had reported that they did not get massage. Another 26.5 percent don't know about health care massage advertisement given by Radio.

Figure- 5.18 Distribution of Respondents by Media Exposure from TV (N=280)



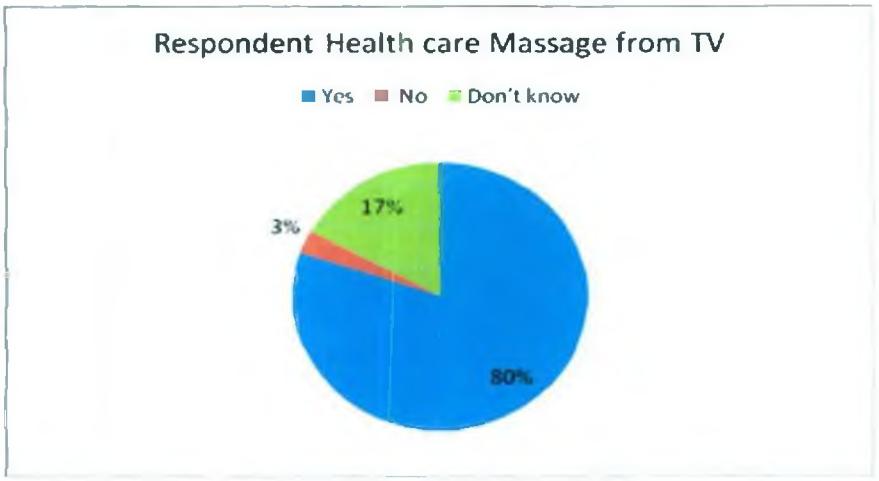
Here figure 5.18 shows that respondents were asked if they had exposure to media such as TV. Most of the respondents 83.1 percent had stated that they watch TV while a small number of respondents had reported that they did not watch TV.

Figure- 5.19 Distribution of Respondents by Frequency of Watching TV (N=280)



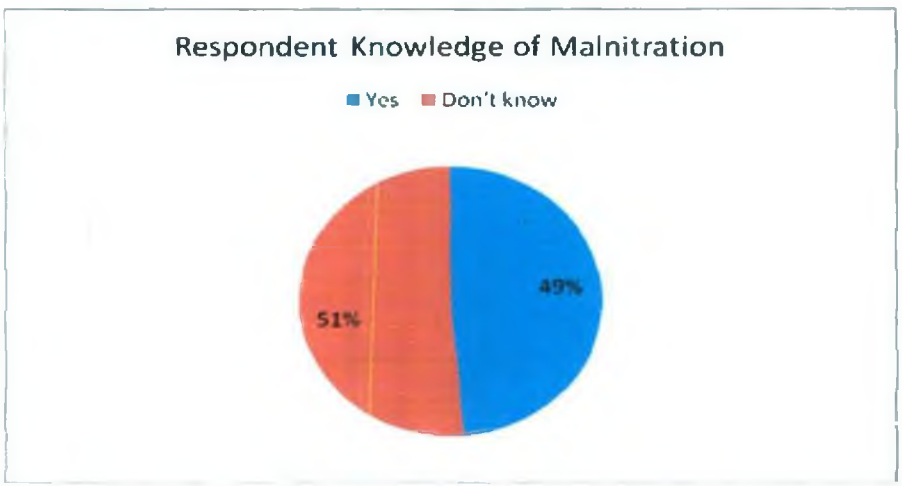
Here figure 5.19 shows that respondents were asked how they frequently watch TV, majorities of the respondents 62.0 percent had reported that they watch TV every day. However, a considerable number of respondents 22.5 percent also watch TV less than one term per week.

Figure 5.20 Distribution of Respondent's in terms of Exposure of Health Care Message from TV (N=280)



Here figure 5.20 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.

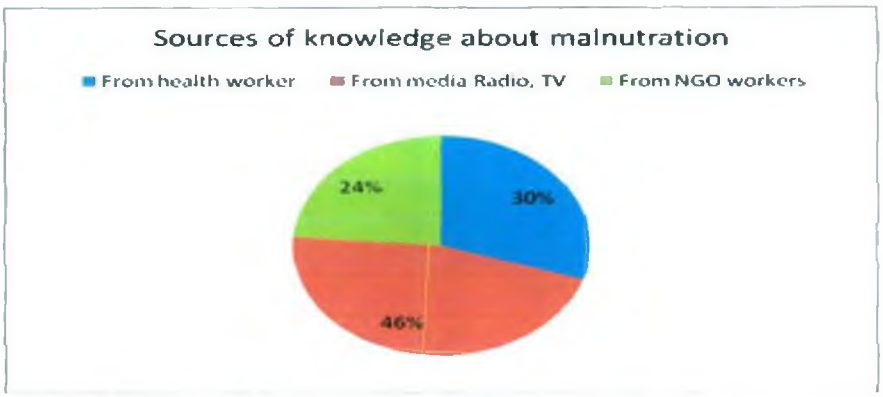
Figure 5.21 Distribution of Respondent's Knowledge about Malnutrition (N=280)



Respondents were asked to know about malnutrition here figure 5.26 shows that 48.6 percent respondents know about malnutrition from various sources like media, NGOs

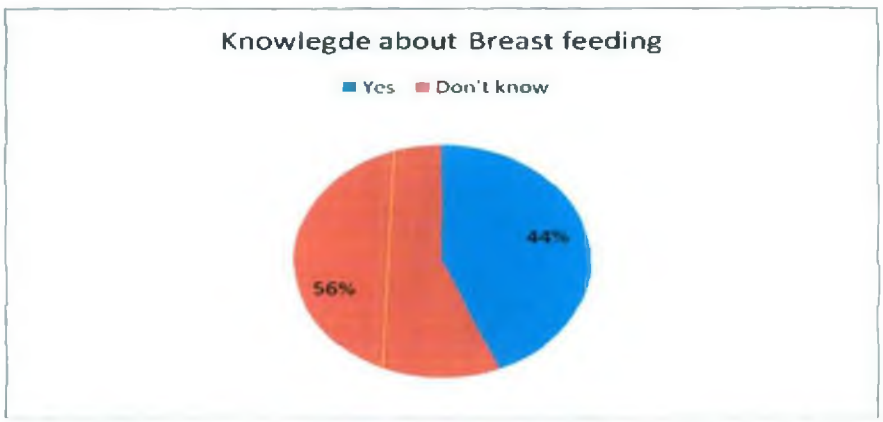
and health worker. However, another most of the respondents 51.4 percent do not know about malnutrition because they are not any idea about Nutrition, which is helpful for our health. It is government health sectors failure to give proper awareness about malnutrition.

Figure 5.22 Distribution of Respondent's Sources of Knowing about Malnutrition (N=280)



Respondents were asked to know about malnutrition here figure 5.22 shows that 46.3 percent respondents know about malnutrition from Radio, TV another 30 percent respondents know about malnutrition from health worker and lastly 23.7 percent know about malnutrition from NGO worker.

Figure 5.23 Distribution of 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 5.23 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.

CHAPTER.6

GENERAL DISCUSSION

The study shows medical facilitates enjoyed by the respondents .A significant number of respondents(52%) reports that they go to Upazila hospital for treatment when they get illness .?It is not anomaly to be significant in number because we know that it is source of health care for the rural people where the poor and rural people are supposed to receive free services, and it is the largest public health centre , even as a whole , in a Upazila unit regardless of public and private enterprise. Another significant number of respondents (45%) reports that that they went to Community clinic for their treatment. Interestingly a considerable number of respondents reports that they depend on alternative health care system like spiritual medicine (12 %), peer Hozor (36 %) and another traditional health care services, albeit the number of respondents go for modern medicine .There is a gap between the expectation and reality that is investigated in this study. The gap signifies that the rural people take the alternative medicine because they do not get the proper treatment from public hospitals, although there is a mounting evidence revealed that rural people of Bangladesh take traditional health care facilities because they believe in some socio cultural rituals, superstations, healing systems (Khan, 2008).In addition, they do not take the modern medicine because of lack of awareness.

This paper demonstrates that the absenteeism and unavailability of providers at the right time plague the rural health services. These findings are consistent with many other studies in different parts of the developing world, including Bangladesh (Justice, 1987; Chowdhury, 1990; Lewis, 1996; Chaudhury & Hammer, 2004). In the case of the Bangladesh health caresystem, the absenteeism and a lack of motivation was documented in a seminal research on rural health workers (Chowdhury, 1990). This research provides support in favour of Chowdhury's (1990) research, indicating doctors' unavailability and absenteeism. The results further indicate that there are fewer numbers of doctors to provide adequate services to the rural masses. The Upazila I conducted this research has a large population which is about four times higher than the average population in a

sub-district in Bangladesh. The shortage of doctors supports the argument that there is a manpower shortage in rural Bangladesh plaguing the obstetric reproductive health care services (Anwar, Kalim & Koblinsky, 2009). This must, however, be emphasised 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. Apart from the weak structure of the rural health institution, this study suggests that the processes of health services at the UHC tend to influence the quality of health services. This means that provider-centric consultation, poor provider behaviour, demand for bribe, harassment, lack of motivations among providers, inadequate consultation time, faulty referral procedures cause patient dissatisfaction and result in ineffectiveness of care. Zaman (2005, pp.123-134, 155-176) and Andaleeb (2000) suggested that doctors and support staff such as ward boys, cleaners and gatekeepers misbehave with patients in the context of the urban health systems. Chowdhury (1990) suggested a lack of commitment, cordiality and motivation among rural health workers in Bangladesh.

This study provides support in favor of these study findings in the UHC context. This research indicates that people avoid the lower tiers of the rural health system. This provides support in favor of Paul's (1999) findings. Paul (1999) had suggested that people tend to by-pass the national health care system due to perceived low quality. This research points to the by-passing within the rural health care system. People bypass the Union or village level health tier and seek health care at the Upazila level. Some relatively wealthy ones bypass the Upazila system and seek health care at the city or town levels. The richest seek health services in India.

Thus the bypassing of health services occurs at different levels within the Upazila. However, the research does not show that the majority of the rural people bypass the national boundary for better treatment, perhaps because of lower income. The bypassing appears to be connected with higher income and perceived low quality in the government health facilities. The results further indicate that income, geographic isolation, and poverty translate into health inequalities in terms of access to quality health services. It appears that low income groups and women find it difficult to access quality health services. Consistent with Zaman (2005, p.104), this study shows that the poorer village people seek health services in low-cost government health centres. The low income groups cannot afford to pay for privately provided health services, whether provided by the Government-appointed doctors or other private providers. Similarly, women face social barriers to access health services. The World Health Organization (WHO) suggests that health systems need to be designed in such a way that they cater to the needs of the periphery (cited in Newell, 1988).

This paper demonstrates some key structure, process and outcome-related quality shortcomings in the rural health system in Bangladesh. The structure-related shortcomings are associated with inadequate resource allocation on the one hand and misuse and even non-use of the same on the other. In other words, while there is manpower shortages and resource constraints; this paper suggests that the existing resources are not lower level remain unused as doctors frequently remain absent from their posts.

Therefore, the existing manpower and health service resources need to be utilized properly prior to employing more doctors and health professionals to address the structure-related quality shortcomings. To achieve this goal, it is essential to properly monitor and evaluate the Upazila health service delivery on a continuous basis. Citizens' voices and participation in ensuring accountability of the UHC may also help achieve this goal. An appropriate needs assessment of the rural health services need to be done taking due cognizance of the proportion of population and not merely on the basis of administrative unit such as Upazila. 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".

CHAPTER.7

CONCLUSION AND RECOMMENDATIONS

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 based on primary health services. Which have been expanding gradually in Bangladesh to improve the health 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 of Bangladesh has taken some initiatives according to the Alma-Ata Declaration of 1978 to increase the people's participation in health service. However, these initiatives have not been achieved in Bangladesh till now. Now days, the Government tries to create awareness among the village people as stipulated in the constitution. It also tries to encourage the disadvantaged group to become self-reliant and self-dependent and conscious. However, these in initiatives have been limited and their goal has not been achieved yet. 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.

Recommendations:

The following recommendations given below based on my research findings;

1. 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.

2. Accountability and transparency is an important factor for all sectors. However, the health sector is absence of accountability and transparency. So the accountability of the concerned staff should be ensuring in rural health complex.

3. Bureaucratic response is also very important in the health sector. Therefore, the bureaucratic response should be a positive view to the mass people for ensuring participation in health.

4. The Government should be give accessibility of community based health service providers in the rural health complex and other Non-Government organizations.

5. The Government needs to make sure that the donors view does not negatively influence its policymaking and implementation in the health sector.

6. Campaigns of government health programs, such as family planning, safe motherhood and expanded program of immunization (EPI) should be increase.

7. The qualities and the behavior of health employees working should be helpful to the people in order to improve the participation in rural health service.

8. Most of the doctors said that the public salary is not enough and that`s why they forced to go to the private sector. The Government should revise the current salary structure and improve the working conditions of rural doctors.

9. 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.

10. 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.

11. 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.

12. 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.

13. Regular monitoring and supervision should adopt in government health sector for ensuring participation of people in rural health complex.

14. 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.

REFERANCES:

Abedin, M. N. 1997: Health and Population Sector: An Overview and Vision. Paper prepared for the Logical Framework Workshop for the Fifth Health and Population Programme (HAPP-5), 23-25 February 1997. Dhaka: Ministry of Health and Family Welfare

Allison M. Kennedy, Cedric J. Brown, and Deborah A. *Gust* vaccine beliefs of parents who oppose compulsory vaccination. Public Health Report. *2005* May-Jun; 120(3): 252–258.

Andaleeb, S. S. (2000). "Public and private hospitals in Bangladesh: Service quality and predictors of hospital choice. Health policy and planning, 15(1), 95-102

Andaleeb,S. S., Siddoqui, *N.*, & Khandakar, *S. (2007)*, Patient Satisfaction with Health Services in Bangladesh. Health Policy and planning, 22(4), 263-273

Anwar, I., Kalim, N., & Koblinsky, M. (2009). Quality of obstetric care in public sector facilities and constraints to implementing emergency obstetric care services: Evidence from high and low performing districts of Bangladesh. *Journal of Health, Population and Nutrition*, 27(2), 139-155.

Bangladesh Health Watch. (2010). How healthy is health sector governance? Bangladesh Health Watch Report 2009. Retrieved August 15, 2010.

BBS 1997: Progothir Pathey: Achieving the Goals for Children in Bangladesh. Dhaka: Ministry of Planning, Bangladesh.

Bloom, D. E., Canning, D. and Jamson, D. T. (2004). Health, wealth and welfare. *Finance and Development*, March 2004. Available from: http://www.imf.org/external/pubs/ft/fandd/2004/03/pdf/bloom.pdf (accessed 3 August 2005).

Centre For Policy Dialogue (CPD), 2003. Developing a Policy Agenda for Bangladesh: Civil Society's Task Force Reports 2001. Bangladesh: CPD and The University Press Limited (UPL).

Champion, V.L. (1984). Instrument development for health belief model constructs, *Advances in Nursing Science, 6*. 73-85.

Chaudhury, N., Hammer, J.S. (2004). Ghost doctors: Absenteeism in rural Bangladeshi health facilities. The World Bank Economic Review, 18(3), 423-441.

Chowdhury, A. M. R. (1990). A tale of two wings: Health and family planning programmes in an Upazila in Northern Bangladesh. Dhaka: BRAC.

Cockcroft, A., Milne, D. and Anderson, N. (2004). The Third Service Delivery Survey 2003: Final Report. Dhaka: CIET Canada and ministry of Health and Family Welfare, Government of Bangladesh. Available from: http://www.ciet.org/www/image/ country/ bangladeswh.html#1(accessed 5 May 2005).

Gillstrom, P. (2001). Fair Care. Thesis (PhD). Stockhom University, Swedish Institute for Social Research dissertation series 50.

GOB (Government of Bangladesh). 1973. The First Five-Year Plan. Dhaka: Planning Commission, Government of Bangladesh

Harrison JA, Mullen PD, Green LW. A meta-analysis of studies of the Health Belief Model with adults. Health Educ Res. 1992; 7: 107-116.

Hasan, M. K. (2011) Power and quality of primary health care: Narratives from rural Bangladesh. Unpublished Master thesis, The University of Auckland, Auckland.

Hashem, Farhana (2006) Governmental and non-Governmental Organization Linkage in Health Services in Bangladesh /Dhaka: LD Publication).

Henderson RH. Global control of vaccine-preventable diseases: how progress can be evaluated. Reviews of Infectious Diseases. 1999; 11: S649-54.

Hıdıroğlu, S., Topuzolu, A., Ay, P., & Karavuş, M. (2006). Kadın ve çocuklara karşı fiziksel şiddeti etkileyen faktörlerin değerlendirilmesi: İstanbulda sağlık ocağı tabanlı bir çalışma. [Evaluation of the factors affecting violence against women and children: a primary health care center based study in Istanbul]. New/Yeni Semposium Journal, 44, 196–202. http://www.emekdunyasi.net/upload/data/File/siddet.pdf.

Institute of Medicine (2001). Crossing the quality chasm: Anew health system for the 21st century. Washington, DC: Institute of Medicine.

Islam, Kazi Maruful. 2007. Impact of Health Sector Reform on State and Society in Bangladesh. Published online PhD Thesis. *archiv.ub.uni-heidelberg.de/volltextserver/volltexte/2007/7862/pdf/Table_of_content_final_with_cover_page.pdf.*

Jahan, Rounak and Salehin, Masudus 2006. 'Health Care for Rural People of Bangladesh: Overview of Some Governance Issues' in Salahuddin M. Aminuzzaman eds 'Governance and Development: Bangladesh and Regional Experiences'. Shrabon Prokashoni, Dhaka.

Janz NK, Becker MH. The Health Belief Model: A Decade Later. Health Education Q.1984; 11:1-47

Justice, J. (1987). The bureaucratic context of international health: A social scientist's view. *Social Science and Medicine*, 25(12), 1301-1306.

Kabir, S. H. (2006). Reproductive health care services. Retrieved August 23, 2010. From http://www.banglapedia.org/httpdocs/HTR_0182.HTM.

Khan, M. R. 1993. Evaluation of Primary Health Care and Family Planning Facilities and Their Limitations Specially in the Rural Areas of Bangladesh. Dhaka: Bangladesh Institute of Development Studies. (p-111)

Khan, M. R. (1997). A review of the health problems plans and programmes. In M. R. Khan, Bangladesh Health Finance and Expenditure Pattern (16-17). Dhaka, Bangladesh: BIDS.

Khan, Tauhid Hossain (2008) Socio-Cultural Construction of Beliefs about Vaccination and Children's Health: A Study on Child Bearing Mothers at Jastila Village, Gazaria Munshigonj, and An unpublished research monograph submitted to Department of Sociology, University of Dhaka: Dhaka.

Lewis, M. (2006). Governance and corruption in public health care system. Retrieved August 11, 2010.from www.cgdev.org/files/5967_file_WP_78.pdf.

Lloyd, R. (2004). Quality health care: A guide to developing and using indicators. Massachusetts: Jones and Bartlett Publishers.

Mahdy, H.A. (2009). Reforming the Bangladesh healthcare system. *International Journal of Health Care Quality Assurance, 22(4), 411-416.*

National Health Policy 2000, undertaken in Bangladesh.

National Institute of Preventive and Social Medicine (NIPSOM) 1998.

Newell, K. W. (1988). Selective primary health care: The Counter Revolution. *Social Science and Medicine, 26(9),* 903-906.

Onta SR. The quality of immunization data from routine primary health care reports: A Case from Nepal. Health Policy and Planning. 1998; 13: 131-139.

Osman, Ferdous Arfina, 2004. Policy Making in Bangladesh: A Study of the Health Policy Process. Bangladesh: A H Development Publishing House.

Patwardhan, B., 2005. Traditional Medicine: A Novel Approach for Available, Accessible and Affordable Health Care, A paper submitted for Regional consultation on Development of Traditional Medicine in the South-East Asia Region, Korea, World Health Organization, 2005.

Paul, B. K. (1999). National health care bypassing in Bangladesh: A comparative study. *Journal of Social Science and Medicine, 49(5), 679-689.*

Perry, B. (2000). Health for all in Bangladesh: Lessons in primary health care for the twenty first century. Dhaka: University Press Limited.

Perry, Henry B. 1999. Quest For a Healthy Bangladesh: A Vision for the Twenty-First Century. Bangladesh: The University Press Limited (UPL).

Peruga,A. & Celentano, D. D. (1993). Correlates of AIDS knowledge in samples of the general population. *Journal of Social Science and Medicine* 36, 509.

Public Expenditure Review (2003:67).

Rahman M. Redwanur (1999) Political Economy of Health in Bangladesh (New Delhi, India: Jawaharlal Nehru University, unpublished M. Phil dissertation).

Rashid K. M. and S. Hyder (1995) ''Public Health Administration'', in: K. M. Rashid, M. Khabiruddin and S. Hyder (eds.) *Textbook of Community Medicine and Public Health* (Dhaka, Bangladesh: RKH Publishers).

Rosenstock IM. The Health Belief Model: Explaining health behavior through expectancies. In:Glanz K, Lewis FM, Rimer BK, eds. Health Behavior and Health Education: Theory, Research and Practice. San Francisco: Jossey-Bass Publishers; 1990: 39-62.

Rosenstock IM. Why people use health services. Milbank Memorial Fund Q.1966; 44

Sen, A. K. (1999). Health in Development. Bulletin of the World Health Organization, 77: 619-23.

Sen, B & Acharya, S (1997). Health and poverty in Bangladesh. World Health,5.28-29

Sohail, M. (2005). Accessibility and quality of government health care: Achievement and constraints. The Bangladesh Institute of Development Studies BIBS, 31(3-4), 63-98.

Tuan, T., Dung, V. T. M., Neu, I., & Dibley, M. J. (2005). Comparative quality of private and public health services in rural Vietnam. *Health Policy and Planning, 20(5), 319-327.*

Unnikrishnan, P. M., "Intellectuality in Ayurvedic Practice," *Heritage Amruth,* Vol. 4, Issue 6, 2009, pp. 10—16.

Unconfirmed Census report-2011. Bangladesh

Van der Geest, S., "Is there a Role for Traditional Medicine in Basic Health Services in Africa? A Plea for a Community Perspective," *Tropical Medicine and International Health*, Vol. 2, Issue 9, 1997, pp. 903—911.

WHO World Health Organization. Traditional Medicine Strategy 2002—2005, World Health Organization, 2002.

World Health Organization (WHO), 2007. WHO Country Cooperation Strategy 2008-2013: Bangladesh. Country Office in Bangladesh WHO.

Zaman, S. (2005). Broken limbs, broken lives: Ethnography of a hospital ward in Bangladesh. Amsterdam: Het Spinhuis, (pp.123-134,155-176)

ANNEXURE-1

Interview Schedule
On
"Primary Health Care in Rural Bangladesh: A Sociological Analysis of Two Villages of Bangladesh"
(For partial fulfillment of the M.Phil degree 2011,
Department of Sociology, University of Dhaka)

Informed Consent

Dear participants,

Assalamulaikum / Adab

We are currently conducting an interview survey on the Primary Health Care in Rural Bangladesh: "A Sociological Analysis of two villages of Bangladesh" (For partial fulfillment of the M-Phil 2011 degree in the Department of Sociology, University of Dhaka) For the present survey, we need to collect data related to people's opinion, attitude and perception, practice regarding the topic. Data collected from you would entirely be used only for the above mentioned academic purpose. Personal identity of the respondents would be kept strictly confidential. No individuals except those are involved with this work would have access to the data collected. If you do not like to participate in this survey, you can do it. However, we request you to participate in this survey for the considering our academic purpose. It will take 30-35 minutes to answer the questions herein interview schedule. You have full right to stop answering at any

stage of this interview session; even you may leave any particular question if you wish.

My I start the interview? (If the Respondent Agrees, Please Start Interview)

Section A: Socio –demographic & Economic characteristics		
	Questions	**Categories**
1	Age (in complete year)	20-30 30-40 40-55
2	Sex	Male……1 Female……..2
3	Marital status	Married ……..1 Unmarried……..2 Divorced……3 Separated……4 Widowed……5 Deserted……..6
4	Level of education : completed highest level of education	No education ……..1 Primary ……2 Secondary ……..3 Higher secondary ……..4 Graduation ……..5 Post graduation ……..6
5	Occupation	Student ……..1 House wife ……..2 Business ……3 Government service……4 Non government/NGO Service….5 Farmer……6
6	Total monthly family income	> 10,000-20,000……1 20,000-30,000……...2 30,000+……..……...3
7	The nature of hospitals for medical facilities in your area	Upazila Hospital……1 Union Parishad Hospital ……..2 Community clinic ……3 NGO provided health services ……4 Dispensary ……..……...5 Local doctor……...6 Peer /Hozor……..…7 Homeopathic doctor……..8

		Spiritual Doctor(Zin Pori)……..…9
8	If yes, what type of hospital?	Government Hospital……1 Private clinic……2 NGO Hospital…… …….3 Others…… …….88
9	What types of health care facilities provided by Hospital?	Primary health care ……1 Emergency health care ……2 Maternity health ……3 Child care service……4 Fertility Health care……..5 Tuberculosis /TV……6 Malaria services……..7 Road accident services……..8 Diarrhea/Cholera services ……..9 Others …… …88
10	The respondents history of illness Did you ill last one year?	Yes……..…..1 No…… 2
11	Where did you go for treatment?	Dispensary……..1 Community clinic……..2 Upazila hospital ……3 Medical College Hospitals ……..4 District headquarters' Hospital ……5 Homeopathic doctor ……...6 Private clinic……..7 Traditional doctor……..8 Peer /Hozor……..…9 Homeopathic doctor……..10 Folk medicine Spiritual Doctor(zin pori) 12
12	Do you think that traditional medicines are helpful to cure?	Yes……...1 No……..…..2
13	Did you go for traditional medicine Treatment?	Yes……..…..1 No……2
14	Nature of traditional medicine / Types of traditional medicine	*Pani para* (Holy water) ……1 *Jar fokh*……2 *Gacer pata* and *mul* (leaves and root of trees)……3 *Tabij pora*……4 *Chal pora (*Rice*)*……5 Folk medicine Spiritual (zin pori)……..6 Cover of tree……7 Folkways beliefs ……..…8

		Others.....88
15	How much satisfaction you get about traditional medicine?	Highly satisfied .....1 Satisfied.....2 Average Satisfied.....3 Not satisfied 4
16	Are doctors available in the Hospital?	Yes.....1 No..... 2
17	If No, why doctors are not available in Government Hospital?	Private Practice.....1 Lower standard of living.....2 Own private clinic.....3 Lack of facilities.....4 Poor salary.....5 Posting at remote area.....6 Shortage of Doctors.....7 Lack of suitable accommodations .....8 Fare from residence.....9 Others.....88
18	What types of health care provided to the people in your village?	Government hospital.....1 NGO,S.....2 Traditional health care.....3 Private clinic.....4 Dispensary.....5 Others.....88
19	What type of Services provided by Gov Hospitals?	Primary treatment.....1 Emergency treatment.....2 Family planning .....3 Health awareness .....4 Maternal health services .....5 Reproductive health services .....6 Child care services.....7 EPI Services.....8 Others 88
20	How much satisfaction do you get from their services?	Highly Satisfied.....1 Satisfied.....2 Average Satisfied.....3 Not Satisfied 4
21	Do you think that the service what you receive are sufficient?	Yes.....1 No.....2
22	Causes of insufficient services If no why?	Lack of hospital bed.....1 Shortage of doctors / nurse.....2 Private practice.....3 Lack of proper monitoring.....4 Influence of private clinic to doctors...5 Corruption of hospital staffs.....6

		Service for poor people……..…..7 Remote area from divisional city……..8 Mental dissatisfaction of doctors……..9 Others ……88
23	What type of services do you expect form Government hospital?	Free medicine / drugs……..1 Free diagnostic service ……..2 Surgical service with low cost ……3 Emergency health care service ……4 Special child care ……..5 Reproductive health service ……...6 Special maternal health service ……7 Special service for burnt patient ……8 Post disaster infectious and water born disease ……..9 Brest cancer related service ……10 Others……88
24	Did you receive any NGO health care services?	Yes……..1 No……..2
25	If yes. what type of services provide by NGOs?	Family planning related services ……1 Free medicine services ……..2 Health Awareness ……..3 Reproductive & Maternity health ……..4 Child care services……5 Emergency health care……..6 TV Tuberculosis……..8 Malaria care services……9. EPI Services……..10 Others ……..88
26	How much satisfaction about NGOs health care services.	Highly Satisfied……1 Satisfied……..2 Average Satisfied……..3 Not Satisfied ……..4
27	Do you think that health awareness is important?	Yes ……..1 No……..2
28	If yes, where did you know about this?	From health worker……1 From NGO worker……..2 From Radio TV……..3
29	Health awareness exposed to media from radio /Television	Yes……..1 No……..2 Don't know……..3
30	Respondents in terms of the level of Listening Radio	Regularly/ Every day……1 At least 4 days in a week……..2 Less than 4days in a week……3
31	Respondent in terms of	Yes……..1

	exposure of health care message from Radio	No.....2 Don't know.....3
32	Respondent in terms of exposure of health care message from TV	Yes.....1 No.....2 Don't know.....3
33	Respondents by frequency of watching TV	Everyday.....1 At least one term per week.....2 Less than one term per week.....3
34	Do you know about malnutrition?	Yes.....1 No.....2
	If yes, where did you know about this?	From health worker.....1 From NGO worker.....2 From media Radio TV.....3
35	Do you know about breast-feeding?	Yes.....1 No.....2
36	Is it necessary for your baby? (female respondent only)	Yes.....1 No.....2 Does not know.....3

ANNEXURE-2

CHEEK LIST OF CASE STUDIES

Applicable for Both Male & Female

1. Socio-economic and demographic characteristics, Age, Marital Status, Family Income, Occupation, Level of education.
2. Access to health care facilities.
3. What Types of facilities provide by hospital?
4. The respondents history of illness
5. Where did you go for treatment?
6. Do you think that traditional medicines are helpful to cure?
7. Nature of traditional medicine / Types of traditional medicine
8. How much satisfaction you get about traditional medicine?
9. Are doctors available in the Hospital?

10. What types of health care provided to the people in your village?
11. why doctors are not available in Government Hospital?
12. What type of Services provided by Gov Hospitals?
13. How much satisfaction do you get from their services?
14. What type of services do you expect form Government hospital?
15. What type of services provide by NGOs?
16. How much satisfaction about NGOs health care services.
17. Do you know about malnutrition?
18. Where did you know about this?
19. Do you know about breast-feeding?
20. Do have experience about nutrition?

ANNEXURE-3

Case Studies (1-5)

Case 1: Mahabub Illness experience;

A 54 years old man Mahabub suffered from rheumatism (painful disorder of the joints) during five years but learned to live with it. It had not bothered him so much during the previous year (the year before the interview), but he suffered from Temporary loss of strength and energy resulting from hard physical or mental work. He tended to spend the day reclined, and when he got up, his head spun and he had a burning sensation in his body. He felt as if someone was pushing him from behind. He attributed this to his arthritis. After suffering for about four months, he went to a *kabiraj* (herbalist) recommended by his neighbors. His brother took him to several *kabiraj*, who treated him with holy oil and water and one of them told him that he was suffering from the force of evil spirits (*porir asor)*. The *kabiraj* asked for a payment

of Tk. 5001 for a cure, but he did not have money, so he paid Tk. 50 for the first day's consultation fees. For all the *kabiraj* visits, he spent around Tk. 500 in total but still remained ill. Finally, when he became too weak to even walk, his brother took him to the Narsingdi General Hospital. His brother and his sister-in-law stayed with him, and he had to stay there two days and two nights. The doctor examined him by doing an ultra-sonogram and giving him a blood transfusion. One of his brothers donated a bag of blood and bought another bag for him. In two days, they spent Tk. 4000 for the hospital bill, rickshaw fare, and blood. He did not work for a year due to the illness, and he spent all his savings on subsistence and *kabiraj* treatments. He had to sell of his goat Tk. 4000. He said he felt better during his time in the hospital, and the doctors and nurses were good, but he started to feel ill again after returning home. He could not walk easily, felt depressed and anxious, and he only wondered why he did not get well.

Case 2: Kalim Uddin Health care seeking experience of a stroke;

A 43 years old male, Kalim Uddin had been suffering from diabetes for some years. One day during Ramadan, while fasting he felt dizzy, his head was spinning and he lost his balance. He could not understand what is happening. Early morning he prayed as usual, and went to sleep; however, he woke up feeling that he could not move the left side of his body. In his words, "*I could not move my left side, it was senseless, and my left side was totally paralyzed*". The next morning, Kalim Uddin's brother took him to a doctor who gave him medicine and asked him to take blood and urine tests as well as takes an X-ray. After examining the results, the doctor informed him: "*You have had a stroke, from cold weather, blood pressure and diabetes...*" The doctor gave him medication for two months during which time he was totally bed-ridden. As

his situation did not get better, he went to see another doctor and was given more medication. In order to manage his treatment expenses, he sold most of his belongings and capital assets, including his cows. The hospital treatment cost him around Taka 5,000. After five months, his condition remained unchanged. His brother-in-law suggested seeking treatment from a *kabiraj* who gave him some medicine and ointment to massage. It cost him Taka 1000 but he felt a little bit better. He visited another *kabiraj* who gave a holy bracelet, which cost another Taka 201, and following his advice, he bought some tonic, which did not work. He is still following any advice he gets from his neighbors and often tries new forms of treatment. So far, he has spent about Taka 18,000 and feels very depressed that he cannot get well.

Case 3: Fatema Begum Health Care Seeking Experience of Heart Diseases;

Fatema Begum 31 year's old female, she had been suffering Heart Disease problem during couple of month. One day she felt dizzy, stomachs pain, heart pain his head was spinning and he was physically weak. She could not understand what is happening. Next morning he went to Traditional Medicine (Homeopathic doctor) and gives some drugs for next three days. She feels a little bit better. But after some days again feel illness such as water of the body and test less of food and other symptom of illness. As a result, she went to Narsingdi General Hospital and stay there three days but physical condition was not improved. After three days, Doctors and Nurse came to see her only two times. Her husband request Doctors for better treatment after that Doctor suggest for some test such as ECG, ECHO Test and refer a private clinic of Narsingdi name Narsingdi Squire Hospital. After one day, Doctor saw report of ECHO and said that you have heart disease and you must be operation and suggest to National Heart Foundation Hospital at Mirpur. However, she could not feel better, her

parents and husband family arrange to Operation from National Heart Foundation Hospital at Mirpur. However, when she comes to get admission for operation Doctor said to her husband 1.5000 taka is necessary for operation and she is not physically fit for operation stay here three weeks for improve physical condition. However, it is a matter of huge cost, which cost bearing her family, is not possible because of expensive.

Case 4: Khairul Islam Health Care Seeking Experience of Hepatitis B

Khairul Islam 43 year's old male, he had been suffering from health problem for during five month. His physical illness symptom was urine yellow eye condition was white that means lacking of blood. He went to dispensary and takes some drugs for illuminate physical illness. But could not improve as a result, He went to hospital and Doctor said to him you are suffering Hepatitis B it is long time treatment for cure. But he came to home and thinking what to? His another neighbor suggest him to go Homeopathic doctor for Treatment at fast sight village traditional doctor give him some suggestion to it juice of some tree leafs for seven days and give him date to come next Tuesday. When He come Tuesday traditional doctor give him a ***Mala*** that was made from stick of grass. It was very small traditional doctor said to him it (***Mala***) Keep your head and stay outside of the shadow of room when time is passing and ***Mala*** gradually increase that means spread of size automatically it is unbelievable matter what is happening?. After some days, his illness is illuminating gradually and finally after three month he was fully free from disease.

Case 5: Mature Rahman Health Care Seeking Experience of Snake Biting;

Mature Rahman age of 46 one-day night he was walking at the village street. But walking some time he feel that something touch his lag, after a few minutes he feel

pain and saw his lag which are bleeding. He understands that poisons Snake biting him, quickly he go through home and binding lag with rope. Some local people came and people suggest doing to start local treatment system such as eating pupil *Kacha Morich* and touch *Bronze Kasa chamoch* affected place. Another treatment was that cut of hen and touch affected place. When they gradually doing that Hens was died quickly and cut another Hens it is also died and Mature Rahman gradually increase after two hours up to 25 hens died and fully Mature Rahman is cure. It is another Traditional Treatment system of local area, which is very helpful for local people. As a result, it is very popular treatment systems of emergency health care treatment of local area. Because remote area modern healths care system are not available for poor people. Local people use such kind of health care treatment for their local demand. Most of cases Traditional Treatment system is very helpful rather than modern treatment. It is also true that huge raw materials of drugs are available in Bangladesh. Only qualified Doctors are not available in Bangladesh, it is failure to our Government Ministry of Health and Health Sectors.

ANNEXURE-4

Demographic and Socio-economic Profile of the Respondents (Based on Census)

The obtainable 'Narsingdi' district is a part of the historical place Narayongonj district of the ancient Bengal. Narsingdi was merely a village in that time whose ancient name was Norashinopur. There is a hearsay that an individual named Narashino lived in Saterpara village in the Mughal regime .He was appointed as a Zamidar by Mughal rulers .Thus Saterpara became Narsingdi according to the name of the very virtuous and philanthropist Narashino . Narsingdi was developed as Thana and subdivision (Mahkuma) for the sake of British India administrative

merits in 1845. Finally, Narsingdi mahkuma was turned into Narsingdi district in 1985.

Narsingdi is a district in central Bangladesh. It is located 55 km east side of Dhaka capital city of Bangladesh. It is a district of the Dhaka Division, and it is the only district in Bangladesh that does not depend solely on agriculture. The district is famous for its textile craft industry. Narsingdi is bordered by Kishoreganj in the north & north-east, by Brahmanbaria in the east & south-east, Narayanganj at south & south-west and by Gazipur in the west.

Demographic Profile of the Narsingdi District: At a Glance

Total Area of Narsingdi District	: 1141 Sq.km
Total No. of Upazila	: 7
Total No. of Village	: 1370
Total No of House Hold	: 477,700 (2011)
Total Population	: 2202580
Male	: 1191485
Female	: 1091387
Sex Ratio	: 98.3
Population density	: 1930
Household Size	: 4.6
Rate of Education	: 74.8%
Total No. of Hospital	: 38
Total No. of Nurse	: 824
Total No. of beds	: 2208
Total No. of doctor	: 261
Total No. of Primary Health care	: 18
Total No. of private Clinic	: 195
Total No. of Primary School (Gov. +NonGo)	: 679
Total No. of Secondary School	: 157
Total No. of College (G. +Non G.)	: 34
Total No. of Madrasha (Dhakil+Alim+Fazil)	:123
Total No. of Mosque	: 3750
Total No. of Temple	: 184

Total No. of post office	: 125
Total No. of church	: 5
Total No. of Cinema Hall	: 36

Sources: Census 2001-11 Narsingdi Parichiti, District Administration Office, Narsingdi.

Area and Location

The Upazila occupies an area of 173.92 sq km. Shibpur has 9 Unions, 125 Mauzas/Mahallas, and 196 villages. Name of Union of Shibpur. 1. Aiubpur 2. Chakradha 3. Putia 4. Sadarchar 5. Joynagor 6. Jossor Bazar 7. Bagabo 8. Dulalpur 9. Masimpur .It is bounded on the north by Monohordi Upazila , on the east by Ripura upazila, on the south by Narsingdi Sadur upazila, and the west by Polash upazila all are narsingdi district.

Notable residents: 1. Abdul Mannan Bhuiyan 2. Shaheed Asad

Demographic Profile of the Shibpur Upazila: At a Glance

Total no. of Union	: 9
Total No. of Village	: 196
Total No. of mauza	: 125
Total No. of Upazila Hospital	: 1
Total No. of Upazila Hospital beds	: 31
Total No. of Upazila Hospital doctor	: 17
Total No. of Primary Health care	: 8
Total No. of private Clinic	: 25
Total No of House Hold	: 54561
Total Population	: 307570
Male	: 155260
Female	: 152310
Sex Ratio	: 98.2
Household Size	: 4.8
Rate of Education	: 69%
Total No. of Primary School (G. +Non G.)	: 110
Total No. of Secondary School	: 66

Total No. of College (G. +NonGo.)	: 8
Total No. of Madrasha (Dhakil+Alim+Fazil)	: 49
Total No. of Mosque	: 555
Total No. of Temple	: 25
Total No. of church	: 0
Total No. of Cinema Hall	: 9

Sources: Census 2011 Narsingdj Parichiti, District Administration Office, Narsingdi

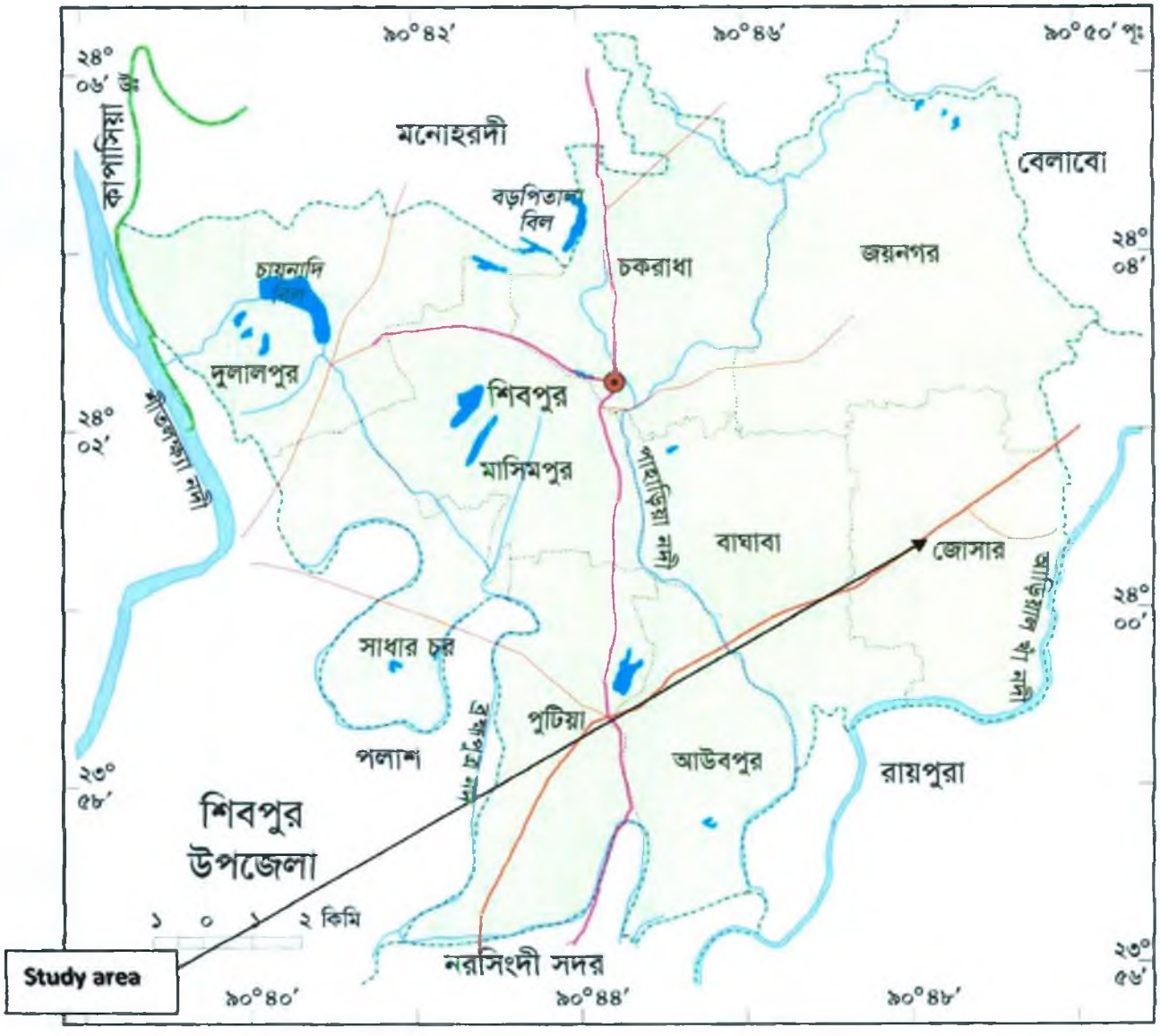
Demographic Profile of the Jossor Union: At a Glance

Total area square Km	: 25.18 Km
Total No. of Village	: 33
Total No. of Mauza	: 16
Total No. of Primary Health care	: 4
Total No. of private Clinic	: 5
Total No of House Hold	: 5750
Total Population	: 34542
Household Size	: 5.8
Rate of Education	: 63%
Total No. of Primary School (G. +Non-G.)	: 10
Total No. of Secondary School	: 5
Total No. of College (G. +Non-G.)	: 2
Total No. of Madrasha (dhakil+Alim+fazil)	: 8
Total No. of Mosque	: 79
Total No. of Temple	: 5
Total No. of church	: 1
Total No. of Cinema Hall	: 1

Sources: Union Porishad Administration Office, Jossor Shibpur Narsingdi

ANNEXURE .5

MAP OF THE STUDY AREA



Figure–6 Map of the Study area

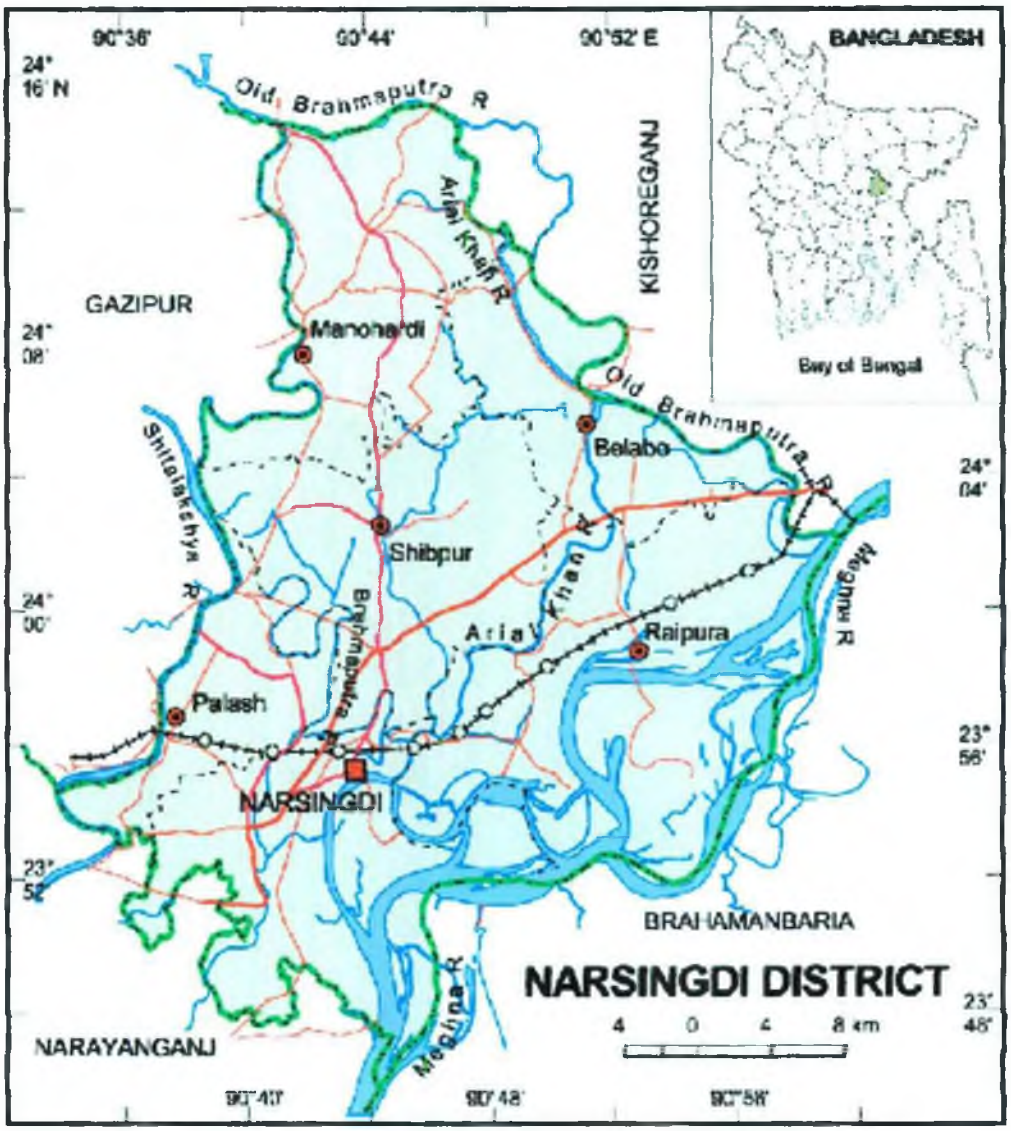


Figure-7 Map of Narsingdi District