

**Bangladesh Development Research Working Paper Series
(BDRWPS)**

BDRWPS 7 (June 2009)

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A Study of Bangladesh's Rural Health
Complex**

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People's Participation in Health Services: A Study of Bangladesh's Rural Health Complex

Mohammad Shafiqul Islam and Mohammad Woli Ullah *

Abstract

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 health care facilities. The lack of participation in health service is a problem that has many dimensions and complexities. Education has a significant effect on participation in health services and administrative factors could play a significant role in increasing the people's participation in Bangladesh's health sector. But the present health policy is not people oriented. It mainly emphasizes the construction of Thana Health Complexes (THCs) and Union Health and Family Welfare Centers (UHFWCs) without giving much attention to their utilization and delivery services. The study reveals that financial and technical support is very helpful to ensure health service among village people. However, the Government allocates only 5 percent of the budget to the health sector, while it allocates 13 percent for defense. The paper shows that the Government's allocation and technical support (medical equipments) are not sufficient in the rural health complex and that the people's participation is far from being satisfactory. The paper concludes with a variety of recommendations.

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I. Introduction

Bangladesh is a mostly rural, developing country of South Asia, located on the northern shore of the Bay of Bengal, covering 147,570 square km. People of this country are known as hardworking, with proven capability to preserve mental strength in the event of unexpected extensive loss due to natural calamities, such as floods, cyclones, epidemics, etc. But, their basic needs have remained unfulfilled. Health is a basic requirement to improve the quality of life. National economic and social development depends on the status of a country's health facilities. A health care system reflects the socio-economic and technological development of a country and is also a measure of the responsibilities a community or government assumes for its people's health care. The effectiveness of a health system depends on the availability and accessibility of services in a form which the people are able to understand, accept and utilize.

The Government of Bangladesh is constitutionally committed to “the supply of basic medical requirements to all levels of the people in the society” and the “improvement of nutrition status of the people and public health status” (Bangladesh Constitution, Article-18). The health service functions were initially restricted to curative services. With the development of modern science and technology, health services emphasize promotive and preventive rather than curative health care. Yet, a large number of people of Bangladesh, particularly in rural areas, remain with no or little access to health care facilities. It would be critical for making progress in Bangladesh's health services to improve the people's participation in the health sector. The Government therefore seeks to create conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health. Bangladesh has a good infrastructure for delivering primary health care, but the full potential of this infrastructure has due to lack of adequate logistics never been utilized.

This study aims to explore the sequence of the development and status of people's participation in Bangladesh's public health services. It uses the methodological triangulation qualitative and quantitative approach as well as a case study design in analyzing data, whereby the exploratory-descriptive design is followed. The study explores people's participation in health services through personal interview as well as case studies for which Muradnagar Upazila had been chosen as it provides an ideal research setting.

This paper is structured as follows. The next section provides some background, including a review of the literature and the methodology of this study. The third section then presents Bangladesh's public health service delivery pattern and mechanisms, while the fourth section provides a summary of Bangladesh's health problems and health care needs. The fifth section presents an analysis based on the opinion and comments of government officials and different categories of people at the village level, which were collected through interviews, structured questionnaires and observation. The last section provides the conclusion and recommendations.

II. Background and Methodology

According to the Alma-Ata conference in 1978, people's participation was described not as an optional extra but as an essential component of primary health care (PHC). Despite being an essential component of Bangladesh's PHC approach,¹ the people's involvement in PHC is still very much at an experimental stage in Bangladesh. Excluding a few initiatives of non-governmental organizations (NGOs) that were adopted shortly after independence, there is little experience with people's participation in Bangladesh's health sector. The following literature summarizes some of the main experiences at the national and international levels.

A study undertaken for the United Nations (UN) Panel on People's Participation in 1982 (cited in Oakley, 1988, p. 6) reviewed the practice of participation in rural development and suggested four different, but not mutually exclusive, forms of participation:

- Participation as Collaboration: Whereby rural people are involved in rural health service programs and health policy and their collaboration is sought, but they have no direct control over the policy, decision making activities.
- Participation through Organization: Organization is a crucial part for participation. So health service should be decentralized for ensuring participation through organization. Whereby organizations and government health facilities are set up which ostensibly have the objective of facilitating participation.
- Participation in Community Development Activities: Whereby the direct and active involvement in health service of local people is sought to undertake and complete a whole range of physical improvements at the community level. Local people have a meaningful say in their planning and execution, but the dynamic of participation is limited to the task at hand and does not extend beyond the completion period of the physical improvements.
- Participation as a Process of Empowering: Whereby a group of people who previously had no basis from which to intervene in or influence rural health service activities, achieve this basis and use it for their continued involvement in these activities.

Salahuddin, Ali, Alam and Ali (1988) stated that Bangladesh, being a poor country with scarce resources, cannot afford to provide sophisticated medical care to the entire population. Emphasis is therefore given to primary health care covering the unmet and underserved population with the minimum cost in the shortest time.

Mahmud (2004) explored people's perceptions and reality about participation in newly opened spaces within the Bangladesh public health care delivery system. The empirical

¹ Bangladesh's National Health Policy (2000) envisages a participatory approach to caring for people's health, at least at the local level. It calls for the decentralization of services and the participation of the local population and local government institutions in the policy development, financing, and monitoring of health services. In reality, however, such participation is far from adequate. Consequently, decisions at the national level have been made in a non-participatory manner. Of course, the ordinary people have no scope of participating in the national decision-making processes regarding how health services should be delivered to them. Regardless of the quality of service they receive, the absence of participation itself constitutes a violation of the people's right to health.

findings suggest that the effectiveness and ability of community groups to function as spaces for participation and provide the means for developing capabilities to participate is limited, being constrained by poverty, social inequality and dependency relationships, invisibility, low self-esteem and absence of political clout.

Uzochukwu, Akpala and Onwujekwe (2004) assessed the perceptions and practices of health workers and households in relation to community participation in the Bamako Initiative (BI) program. The study was conducted in the Oji River local government area of South-East Nigeria, where the BI program has been operational since 1993. Coelho (2004) examined the experience of municipal and district health councils in the city of São Paulo in the light of the literature on citizen participation in Brazil. This literature has attributed the success or failure of participatory mechanisms either to the degree of civil society involvement or to the level of commitment to such mechanisms on the part of the political authorities.

Hoque and Hoque (1994) evaluated the NGOs' water and sanitation programs in Bangladesh's rural areas. The rural villagers were provided hand pumps, latrines, and hygienic education. Interviews were conducted with the women users, women pump projects. The study shows that there were problems of people's participation, hygienic practices as well as effective use and maintenance of hand pumps and latrines. The study points out that there should be effective measures for the sustainability of water and sanitation projects.

Chowdhury (2005) reviewed Bangladesh's health sector reform and concluded that these reforms are influenced by many factors and that the main problems are related to political agenda, professional unionism, and that they are done in haste without much preparation and without a long-term vision.

II.1. Significance of the Study

Despite being a vital issue for the welfare state, there is no research work regarding the development of health service through people's participation in Bangladesh. The present study makes a preliminary effort at understanding the people's participation of health service in Bangladesh. It explores people's participation in health services by focusing especially on the rural health complex and asks the following five questions:

- 1) How does education influence the people's participation in the public health service of Bangladesh?
- 2) How do policy factors work in the people's participation of health services? What are the factors involved here and how do they impact health services?
- 3) Does organizational capacity and policy issues of government impact on people's participation in public health service of Bangladesh?
- 4) How the financial support and bureaucrats impacts in people's participation as well as policy formulation and implementation in public health service of Bangladesh?
- 5) What are the barriers to participate in health services of Bangladesh? How to overcome these barriers to ensure the people's participation in the health services?

II.2. Research Problem

Health service is one of the fundamental rights of the people. It is the constitutional liability of the state to ensure adequate health service delivery to the people (Bangladesh Constitution, Article-18). However, in the case of Bangladesh, the state is not able to deliver door to door health service as yet. There are various reasons responsible for this condition. One of the main reasons is that Bangladesh is an overpopulated country. It is a difficult task for the government to ensure health services for its population of about 160 million people. In 1978, the World Health Organization (WHO) declared “*Health for All by the year 2000*” in the Alma Ata Declaration. However, this grand vision of primary health care for all has not yet been achieved in Bangladesh. To the contrary, despite some progress, Bangladesh remains a country where poverty prevails at its gravest rate, income inequality is enormous, and the effective literacy rate is low. Basic primary health care services are not accessed equally and the marginalized people of rural Bangladesh are treated in a highly discriminatory nature to access health facilities.

There are already a number of awareness programs focusing on health issues that are being implemented by the development agencies in rural Bangladesh. In spite of some very rare exceptions, all the health awareness programs have aimed at improving the knowledge level on health and hygiene issues. They have not been aimed at promoting the right for all to have access to primary health care facilities. Very often, the common people think that they are lucky of getting some access to health services (no matter how small an amount they receive). They do not demand equitable access to health facilities. In this situation, too many corrupt doctors do not serve the common people well, take bribes, and do not maintain office time at the public health centers. Instead, they prefer to run private clinics for their own profit during their office time. Of course, not all doctors are corrupt, but this is a general picture in most rural areas. Common people most often do not complain about this simply because they lack awareness about their rights.

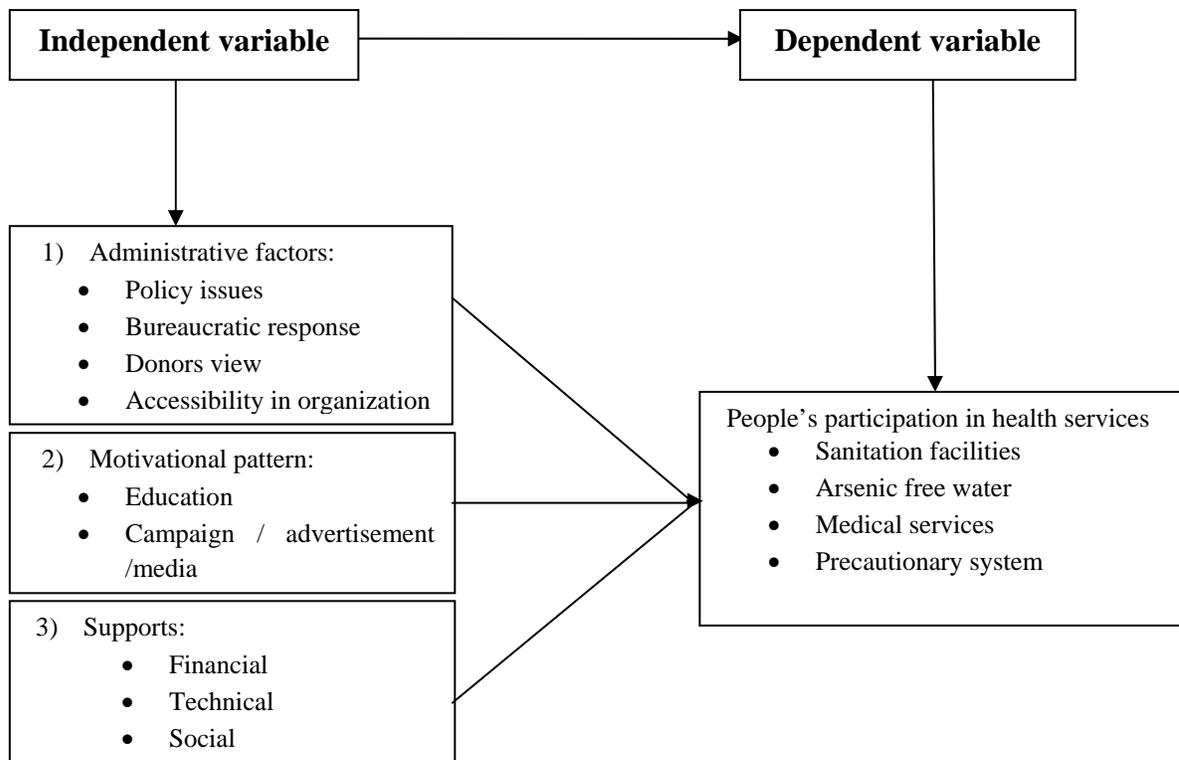
According to the National Health Policy (2000), the Government has accepted the financier role of the Essential Service Package (ESP)² on the ground of market failures and poverty/equity considerations. Insurance against risks of injuries, disabilities and death is very important for Bangladesh because of its impact on the poor. However, government intervention in insurance matter is not possible due to resource scarcity. Considering the importance of the ESP in the context of Bangladesh, the Government has also assumed the provider role. “Government health services are provided by a four-tier system of government owned and staffed facilities. The municipalities are responsible for the publicly financed health service provision in urban areas (see World Bank, 2001, pp. 21-22). However, the ESP has until now not been implemented.

² The Essential Service Package is an expanded program on immunization and micro-nutrient supplementation that includes (a) school health programs to treat worm infections and micronutrient deficiencies, (b) programs to increase public knowledge about family planning and nutrition, self-cure, and vector control/disease surveillance activities, and (c) an AIDS prevention program with strong components for sexually transmitted diseases (STD).

Local government is the latest decentralized administrative unit of Bangladesh. The main purpose of local government is to provide on service provision in general. When it comes to the health sector, it is apparent that health facilities are brought down to the local level but actual devolution is lacking as decisions on policy, finance and administration are in the hands of the central government. Complete devolution of power to the local level may not have worked to the benefit of common people in Bangladesh because of the risk of elite capture and weak capability of the local-level workers in policy formulation, design and delivery of health services.

It is a known fact that there is mismanagement, lack of proper coordination and accountability in the health administration. Ex-ray machine and ambulances are out of the order most of the time. Uncontrolled trade union is one of the main reasons for this. Thus it becomes a difficult for the administration to take action against their corrupt practices and irregularity in the services. Taking more money for ticket from out-door patient, absence of senior doctors in the out-door department, corruption in admission of in-door patient, lack of sympathy for patients among the doctors and nurses make the health service inaccessible to the beneficiaries. From various observations it has become clear that the Government is not able to provide service as well as people’s participation in the public health service of Bangladesh even at the basic level.

Figure 1: Illustration of the Study’s Dependent and Independent Variables



In this study, participation has been taken as an end as well as a means. It is understood as a process of empowerment. Using Uphoff's classification of participation,³ the focus of this study has been on the following stages of participation: 1) decision-making, 2) implementation of the health policy and programs, and 3) participation in health service benefit sharing. Hence, the dependent variable of this study is the people's participation in health services which is determined by sanitation facilities, arsenic free water, medical services and precautionary system. The independent variables of the research are administrative factors, motivational factors as well as supports. These independent variables impact on people's participation in health service in different ways and is illustrated in Figure 1 above.

III. Public Health Service Delivery Pattern and Mechanisms in Bangladesh

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 was 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.

In 1974, the National Institute of Preventive and Social Medicine (NIPSOM) was 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 (see Rashid and Hyder, 1995). Bangladesh signed the

³ Norman Uphoff (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 etc. 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.

III.1. Central or National Level

The supervisory structure of Bangladesh's 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.⁴ 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.

III.2. Regional/ Division Level

Within Bangladesh's six divisions (bibhags), there are fourteen 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. 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.

⁴ The DGHS website (http://www.dghs.gov.bd/App_Pages/Client/DGHS_Show.aspx?val=2) also provides some information on the health care delivery systems of Bangladesh.

III.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 Narayanganj has 200 bed capacities. All hospitals deal with referred cases of the thanas 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.

III.4. Thana/Upazila Level

Bangladesh has currently 482 upazilas and 599 administrative thanas. The upazilas are the lowest level of administrative government in Bangladesh. As mentioned above, Thana health authority is 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 Centres (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 THC is 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 UHFPO is also assisted by the health inspector, sanitary inspector and other staffs. Of course many posts remain vacant. At this level domiciliary health and family planning service is provided which comprises of counseling on family planning services, preventive, promotive health care and treatment of minor ailments. Health volunteer and trained traditional birth attendants assist domiciliary workers (see Hashem (2006), p. 81).

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.

III.5. Union Level

At this level health care services are delivery through both USC and UHFWC. This is the smallest and most peripheral healthcare service unit having sub-center which provides out-patient 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.

III.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. 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.

IV. 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, filariasis and worm infestations. Malnutrition and infections are very common among children, pregnant and lactating mothers also 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 (see Khan, 1997, p. 7).

IV.1. Public Consciousness about Government Health Facilities

From above the study, it is observed that the health facility is not sufficient, even though there are more free beds available than paying beds. Moreover, admission for in-patient care is not easy. The supply of medical and surgical equipment is inadequate. Further, misuse, mismanagement and corruption, along with limited health amenities, weakened the overall health system. Health personnel are over burdened. The staff-people ratio is not in proportion and many doctors generally violate government rules.

On the other hand, many people, especially who are living in the rural areas, are not aware about health facilities in the public health institutions. As for example, people are sometime unaware about the schedule time of the satellite clinics. That is why, dropout cases of EPI are usually happening. The main reason for such problem is improper campaign and irregularity in the organization of these clinics. Family Welfare Assistant (FWA) and Health Assistant (HA) mainly work to motivate people. They could provide more publicity to make people aware about the location and timing of these clinics. Lack of supervision in all aspects identified is a major fault in the government health service system. This causes mismanagement in the health administration.

IV.2. Financial Allocation in Health Care

Public health services programs and the operation maintenance of health facilities, etc. are 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. But this increase is not sufficient. Till 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).⁵ 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 or 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 allocation 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).

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).

IV.3. Government Strategies Regarding General Health Services

The main 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:

⁵ One crore equals 100 lakh or 10 million.

- providing health and family planning services to the entire population,
- reducing morbidity, mortality and population growth rate and improving nutritional status,
- strengthening the health care delivery system at all levels to make the service effective to the entire population,
- expansion of health education program to increase people's awareness, and
- expansion of safe drinking water and sanitation program.

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.

IV.4. Government Strategy Regarding Arsenic Mitigation

To mitigate Bangladesh's serious arsenic water problem, the Government has initiated various actions through the Department of Public Health Engineering (DPHE), local administration, union and ward committees of local government. The Government emphasizes public participation on this issue. It has conducted different surveys with the collaboration of different international organizations. An action research project has been undertaken through joint collaboration of the Government and the United Nations Children's Fund (UNICEF) in five upazilas, where 744 arsenicosis patients have been identified. Under this survey project, 13,733 safe drinking water sources have been set up. Following the success of the project it has been extended to another 15 arsenic affected upazila. This project has been implemented by eight NGOs (Hashem, 2006, pp. 98-99).

IV.5. Social Mobilization for Sanitation

In Bangladesh, people are habitual of open defecation. This encourages flies, mosquitoes which spread various diseases. Open defecation and improper sanitation system pollutes water of rivers and ponds, etc. Every day 310 children die due to diarrhea. People are also not aware about other health precautions. The Government has identified behavioral, economic and natural causes for the low rate of use of scientific sanitation method. With this perception the Government of Bangladesh encourages its various agencies and NGOs to contribute to the program. NGOs, especially the small NGOs, are complementing government in this sector in large numbers. The main objectives of the social mobilization program implemented by the DPHE are as follows:

- Extend the coverage of sanitary latrines up to grass root level.
- Build alliance with different partners and allies like local administration, elected representatives, schools, religious leaders, local elites, NGOs, etc. to initiate social mobilization activities and campaigns to promote hygiene, sanitation and safe water use.

- Motivate people with the help of allies and partners to use safe water for all purposes.
- Adopt safe personal hygiene practices.
- Construct, use and maintain sanitary latrines avoid open defecation and discontinue use of hanging latrines.

In 1988, the “Integrated Water and Sanitation Programme through NGOs” was conducted by an NGO forum. The project was funded by Germany’s MISEREOR. All of the forum’s NGO partners participated in the water management program and 52 percent participated in the sanitation program. In Bangladesh, the healthy method of disposal of human excreta has increased from 21 percent in 1990 to 43 percent in 2000.⁶ In the meantime, the NGO forum installed latrines in 97 percent of the households in 20 thanas. The Urban Environmental Sanitation and Water Supply Project involved small urban NGOs associated in the coalition of the urban poor. The project covered 75 percent of Dhaka city slums, which house more than 9000 families.⁷ In September 1995, Cooperative Assistance and Relief Everywhere (CARE) had introduced a Sanitation and Family Education Resource project.

IV.6. Family Planning Program

The majority population of Bangladesh resides in rural areas, but the share of the population in urban areas is gradually increasing. Presently, 23.4 percent of the total population live in urban areas, which is about 4 percent more than in 1991. The Government has taken serious precautions to reduce population growth by promoting family planning services. After independence, the Government adopted certain strategies to reduce the rate of population growth. It followed a motivational strategy through personal contact with beneficiaries either at their home or at satellite clinics to convince people to use contraceptives for birth spacing and for birth control. The service providers also supply non-clinical family planning materials to the beneficiaries. The Government has declared awards for those who adopt permanent method of family planning (see Hashem, 2006).

However, the performance of the family planning schemes was not satisfactory in the beginning. Ignorance, fanaticism, lack of skilled health provider, lack of trained staff, lack of motivational efforts, lack of access to information and services at grass root levels etc. posed hurdles to government efforts to achieve full success. The total fertility rate decreased from 4.3 in 191 to 3.3 in 1998, which was due mostly to an increase of contraceptive use. The Government has declared free education for girls up to twelve classes and provides them books and a monthly stipend because it was observed that family size depends on having a male child in a family.⁸ The Government also designed the National Integrated Population and Health Programme (NIPHP) in 1997, with the financial assistance of the United States of America, where NGOs were partners in the policy making process along with other national and international experts.

⁶ See the Ministry of Women and Children Affairs’ (2000) National Report, pp. 16-23.

⁷ See Mia (1998), p. 5.

⁸ See the Ministry of Women and Children Affairs’ (2000) National Report, pp. 16-23.

V. People's Participation in Health Services: Results of Field Data

This section presents an analysis based on the opinion and comments collected through interviews, structured questionnaires and observation. Apart from consulting Government officials at the local level (of the Muradnagar case study area) and the Dhaka-based head offices, we have also collected and analyzed the views, opinions and comments of local beneficiaries, local elites (i.e., union parishad (council) chairman/members), teachers, students, businesses, farmers, housewives and social workers.

Health service is a basic requirement for every human being and it is liability of government to ensure adequate medical facilities to the people. People involvement is central to all aspects of human development of which health is one. During the last two decades it becomes obvious that people's participation is not only beneficial but essential in the pursuit of better health objectives. According to the Alma-Ata conference in 1978, community participation was described as an essential component of primary health care.

The following paragraphs analyze the degree of participation in the rural health complex of Bangladesh, for which various rural health services were selected for in-depth study. The analysis is based on both qualitative and quantitative data, and used primary as well as secondary sources. The data was collected through questionnaire surveys, observations, interviews and informal discussion with different types of village people. Further details on the questions and replies are provided in the Appendix.

Our observations reveal that the Government was not able to provide health services even at the basic level. Various factors are responsible for that. Continuous political intervention in health programs and implementation process and a lack of continuity appear as major impediments. The present study shows that the existing government infrastructure is not used properly due to the irresponsible mentality of the government staff, lack of accountability, mismanagement, malpractice of doctors and the lack of coordination of the health service providers.

This study comprises the result of a field survey on the participation status of the people in Bangladesh's health service. The study shows that most of the people (52.3 percent) are not participating in rural health services and that only 34.1 percent are participating in health services. The study also reveals that female participation in rural health complex is higher than male participation.

The study also reveals that people's participation is essential for all sectors and that the health sector is more important than others sectors. Yet, most of the people are not participating in health services because the participation process is not decentralized. People have no involvement in decision making process and that is why health policy is not people-oriented. Most of the doctors are regularly absent from their peripheral posting places, because most of them are interested in staying in big cities. The negative mentality of such doctors makes the health service inaccessible to the needy patients. The study suggests immediate supervision of such corrupt doctors who are drawing salary but are not interested to serve the people and that the Government should recruit only those doctors who are mentally prepared to go to remote places in the country to serve the

people. Until now, the Government budget allocation for the health sector did not get proper attention.

The study reveals that lack of proper economic management is hampering the participation of people in health services. In the fiscal year 2003 budget, the allocation for the health sector was only 5 percent, whereas the allocation for defense was 13 percent. The study reveals that 28.4 percent said that financial problems are a great hamper to participate in health service. Side by side, the lack of an adequate number of doctors, staff, equipment and availability of medicine also create great problems in Bangladesh's health sector. The study reveals that most of the respondents expressed that the availability of medicine is absent in the rural health complex and that this non-availability of medicine is a great hamper for the participation of the people.

The study reveals that government and institutional supports is not enough for ensuring participation in health sector. Besides, financial, technical, and institutional support, the sharing of information and the proper planning and implementation of a program could be effective in forging a cordial collaboration. The study shows that community-based health providers have a significant role in health services of Bangladesh (unlike public health service providers). NGOs also provide community-based health services. They always follow the participatory approach to deliver their health services and are able to reach the remote areas for providing health service to poor people.

The study reveals that the participation status of the people is very significant for the health characteristics, viz., facing physical problem, proper sanitation, frequency of doctor visits, and distance to hospital. The respondents that had good health live nearby hospitals and are thus able to take treatment from the hospital.

Finally, the study reveals that the age of respondents, types of the family, occupation status, place of residence, access to safe drinking water, having physical problems, having access to proper sanitation, administrative factors, bureaucratic norms and motivational patterns are also important determinants for the people's participation in the rural health complex.

VI. Conclusion and Recommendations

Health service is most important factor for human well being. So people's participation in health service is very significant in ensuring health policy of Bangladesh. Health services based on primary health services have been expanding gradually in Bangladesh to improve the health status of the people, especially in rural areas where more than 85 percent of the people are living and are underserved and underprivileged groups. The study focused on the degree of people's participation in public health services of Bangladesh. 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-a-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 initiatives have been limited and their goal has not been achieved yet. The Government also tries to motivate 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.

On the basis of our findings we present the following recommendations:

1. Though the National Health Policy is essentially people-oriented, our analysis shows that the problem lies in the implementation of these 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. But the health sector is absence of accountability and transparency. So the accountability of the concerned staff should be ensured in rural health complex.
3. Bureaucratic response is also very important in the health sector. So the bureaucratic response should be a positive view to the mass people for ensuring participation in health.
4. The Government should be given accessibility of community based health service providers in the rural health complex and other organizations.
5. The Government needs to make sure that the donors' view does not negatively influence its policy making and implementation in the health sector.
6. Campaigns of government health programs, such as-family planning, safe motherhood, expanded program of immunization, should be increased.
7. The qualities and the behavior of health personnel 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 they are therefore forced to go to the private sector. The Government should revise the current pay 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 be strictly followed on the development programs.
10. Financial and technical support is also important for ensuring a high quality of health care but the government's allocation does not match the demand. The Government should provide the necessary financial and technical support to the rural health complex.

11. Given that the Government receives foreign funds, they are accountable to the foreign donors. But the Government should also keep in mind national interests. Donor's performance may go against national interests. So 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. These doctors should be identified and punished in order to improve the efficiency of health services.
13. Regular monitoring and supervision should be adopted in government health sector for ensuring participation of people in rural health complex.
14. Seminars and focus group discussions can be arranged to attract the people's information about health services. Television programs, radio programs, and newspaper advertisements can be helpful in this regard.

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Appendix: Details on Replies by Question

Table 1 shows the education level of the sample's respondents. It shows that 18.2 percent of the total respondents are illiterate, 42 percent have primary education, 28.4 percent have secondary education, 4.5 percent have higher secondary education, and 6.8 percent have higher education. The present study reveals that more literate respondents participate more in health services than illiterate respondents.

Table 1: Participation according to education level of respondents

| Education level | No. of Respondent | Percent | Valid Percent | Cumulative Percent |
|------------------|-------------------|---------|---------------|--------------------|
| Illiterate | 16 | 18.2 | 18.2 | 18.2 |
| Primary | 37 | 42.0 | 42.0 | 60.2 |
| Secondary | 25 | 28.4 | 28.4 | 88.6 |
| Higher secondary | 4 | 4.5 | 4.5 | 93.2 |
| Graduate | 6 | 6.8 | 6.8 | 100.0 |
| Total | 88 | 100.0 | 100.0 | |

Table 2 shows that among 88 respondents, 60.2 percent of the total respondents go frequently to the doctor in rural health complexes for the purpose of taking some sort of treatment, while 35.3 percent stated that they are not going frequently to the doctor. The remaining 4.5 percent did not answer the question.

Table 2: Information about going frequently to doctor

| Go to doctor | No. of Respondent | Percent | Valid Percent | Cumulative Percent |
|--------------|-------------------|---------|---------------|--------------------|
| Yes | 53 | 60.2 | 60.2 | 60.2 |
| No | 31 | 35.2 | 35.2 | 95.5 |
| No comment | 4 | 4.5 | 4.5 | 100.0 |
| Total | 88 | 100.0 | 100.0 | |

Table 3 shows that 28.4 percent said that financial problems are a great hamper to participate in health service. Second large of the respondents are said that unconsciousness is also the barriers in participation in health service. 19.3 percent of the respondents think that illiterate is the main barriers and the rest of the respondents are said that improper health service, lack of experience doctor, religion, social custom and others are barriers to participate in health service.

Table 3: Information about barriers to participate in health service

| Barriers | No. of Respondent | Percent | Valid Percent | Cumulative Percent |
|---------------------------|-------------------|---------|---------------|--------------------|
| Unconscious | 21 | 23.9 | 23.9 | 23.9 |
| Illiterate | 17 | 19.3 | 19.3 | 43.2 |
| Religion | 3 | 3.4 | 3.4 | 46.6 |
| Social custom | 3 | 3.4 | 3.4 | 50.0 |
| Financial problem | 25 | 28.4 | 28.4 | 78.4 |
| Improper health service | 7 | 8.0 | 8.0 | 86.4 |
| Lack of experience doctor | 5 | 5.7 | 5.7 | 92.0 |
| Others | 7 | 8.0 | 8.0 | 100.0 |
| Total | 88 | 100.0 | 100.0 | |

Table 4 shows how barriers for ensuring people's participation in rural health service can be overcome. 37.5 percent of the total respondents expressed that they can be overcome by increasing education, another 37.5 percent stated these barriers can be overcome through the provision of proper health facilities. Other important reasons given (each reflecting 11.4 percent) were advertisement and the availability of doctors.

Table 4: How to overcome these barriers to participate in health service

| Overcome barriers | No. of Respondent | Percent | Valid Percent | Cumulative Percent |
|--------------------------|-------------------|---------|---------------|--------------------|
| Increase education | 33 | 37.5 | 37.5 | 37.5 |
| Proper health facilities | 33 | 37.5 | 37.5 | 75.0 |
| Advertisement | 10 | 11.4 | 11.4 | 86.4 |
| Available of doctor | 10 | 11.4 | 11.4 | 97.7 |
| Others | 2 | 2.3 | 2.3 | 100.0 |
| Total | 88 | 100.0 | 100.0 | |

Table 5 shows that, 84.1 percent of the total respondents expressed the view that the financial support impacts rural health service participation, which is a very large majority and calls for increased government allocation, while 10.2 percent said that financial support does not impact participation in health services. The rest (5.7 percent) of the respondent had no comment on this question.

Table 5: Perception about financial support impacts on participation health service

| Financial support | No. of Respondent | Percent | Valid Percent | Cumulative Percent |
|-------------------|-------------------|---------|---------------|--------------------|
| Yes | 74 | 84.1 | 84.1 | 84.1 |
| No | 9 | 10.2 | 10.2 | 94.3 |
| No comment | 5 | 5.7 | 5.7 | 100.0 |
| Total | 88 | 100.0 | 100.0 | |

Table 6 shows that 97.7 percent of the respondents said that government should come forward for people to ensure participation in rural health complex. Only 1.1 percent of the respondents suggested that government should not come forward to ensure the people's participation in health services. The rest (1.1 percent) had no comment.

Table 6: Government comes forward to ensure participation in health service

| Government help | No. of Respondent | Percent | Valid Percent | Cumulative Percent |
|-----------------|-------------------|---------|---------------|--------------------|
| Yes | 86 | 97.7 | 97.7 | 97.7 |
| No | 1 | 1.1 | 1.1 | 98.9 |
| No comment | 1 | 1.1 | 1.1 | 100.0 |
| Total | 88 | 100.0 | 100.0 | |

Table 7 shows that the majority of the respondents (52.3 percent) replied that bureaucrats play an important role in the rural health sector. 36.4 percent of the respondents think that bureaucrat's role is not important in rural health sector, while the remaining 11.4 percent of the respondents had no comment.

Table 7: Perception about bureaucrats' involvement in health service

| Bureaucrats involve in health service | No. of Respondent | Percent | Valid Percent | Cumulative Percent |
|---------------------------------------|-------------------|---------|---------------|--------------------|
| Yes | 46 | 52.3 | 52.3 | 52.3 |
| No | 32 | 36.4 | 36.4 | 88.6 |
| No comment | 10 | 11.4 | 11.4 | 100.0 |
| Total | 88 | 100.0 | 100.0 | |

Table 8 shows that most of the respondents (54.5 percent) said that bureaucrats are involved in rural health complex through their role in policy making and policy implementation. Another 30.7 percent commented that bureaucrats are increasingly involved in the rural health sector to increase awareness among the people. The remaining 14.8 percent suggested that bureaucrats are participated in the health sector for precautionary reasons. In fact, in the field survey we found that most of the rural people think that bureaucrats play an important role in the rural sector through the formulation and implementation of policy.

Table 8: How bureaucrats involve in health service

| Way of involving | No. of Respondent | Percent | Valid Percent | Cumulative Percent |
|--------------------------------|-------------------|---------|---------------|--------------------|
| Policy making & implementation | 48 | 54.5 | 54.5 | 54.5 |
| To make conscious | 27 | 30.7 | 30.7 | 85.2 |
| Precautionary system | 13 | 14.8 | 14.8 | 100.0 |
| Total | 88 | 100.0 | 100.0 | |

Table 9 shows that the majority of the respondents (70.5 percent) replied that the people's opinion is important for their participation in the rural health complex, while 29.5 percent replied that people's opinion is not important for ensuring participation in health services.

Table 9: People opinion is important in participating health service

| Opinion of people is importance for participation | No. of Respondent | Percent | Valid Percent | Cumulative Percent |
|---|-------------------|---------|---------------|--------------------|
| Yes | 62 | 70.5 | 70.5 | 70.5 |
| No | 26 | 29.5 | 29.5 | 100.0 |
| Total | 88 | 100.0 | 100.0 | |

Table 10 shows that 38.6 percent of the respondents replied that people's participation is ensured in rural health services through proper health policies. The majority of the respondents (43.2 percent) replied that the Government should take initiatives for ensuring people's participation in health service through financial allocation and 18.2 percent of the respondents replied that others initiatives should be taken for ensuring participation in the rural health complex.

Table 10: What initiatives should be taken for people's participation in health services?

| Initiatives for participation | No. of Respondent | Percent | Valid Percent | Cumulative Percent |
|-------------------------------|-------------------|---------|---------------|--------------------|
| Proper health policy | 34 | 38.6 | 38.6 | 38.6 |
| Financial allocation | 38 | 43.2 | 43.2 | 81.8 |
| Others | 16 | 18.2 | 18.2 | 100.0 |
| Total | 88 | 100.0 | 100.0 | |

Table 11 shows that the highest number (52.3 percent) of the respondents said that most of the people do not participate in rural health service because the health service system is very poor. On the other hand, 34.1 percent replied that they participated in rural health service, and the rest (13.6 percent) had no comments.

Table 11: Do you participate in health service?

| Participation in health service | No. of Respondent | Percent | Valid Percent | Cumulative Percent |
|---------------------------------|-------------------|---------|---------------|--------------------|
| Yes | 30 | 34.1 | 34.1 | 34.1 |
| No | 46 | 52.3 | 52.3 | 86.4 |
| No comment | 12 | 13.6 | 13.6 | 100.0 |
| Total | 88 | 100.0 | 100.0 | |

Finally, Table 12 shows that the majority (56.4 percent) of the respondents replied that in the rural health complex, the people's participation is ensured by the development of infrastructure, while 28.4 percent replied that people are participating in the rural health complex by strengthening organizational capacity. The rest (14.8 percent) provided other replies.

Table 12: What organizational systems ensure people's participation in health service?

| What organizational systems ensure participation in health service? | No. of Respondent | Percent | Valid Percent | Cumulative Percent |
|---|-------------------|---------|---------------|--------------------|
| Develop infrastructure | 50 | 56.8 | 56.8 | 56.8 |
| Strengthen organizational capacity | 25 | 28.4 | 28.4 | 85.2 |
| Others | 13 | 14.8 | 14.8 | 100.0 |
| Total | 88 | 100.0 | 100.0 | |