

# In Bangladesh Citizens Leave a Legacy in Health

The clinic was surrounded by trees and high weeds. One room was locked; researchers later discovered that a group of students was lodging there while away from home. Judging by the hay and droppings, the other room was being used to house one or several animals of the grazing variety. None of the current occupants of either room were present, and there was certainly no sign that health workers had ever provided care to local residents at the building.

In 1998, the Bangladeshi government resolved to enhance community participation in the public health system. The clinic described above, visited in 2002, was one of the thousands of community-owned and managed health clinics created by one programme designed to achieve this. The other programme relied on non-governmental organisations to set up Health Watch Committees. Neither of the programmes is considered an example of best practice, but while most of the community-owned health clinics were quickly abandoned, some of the committees survived.

At one such Health Watch Committee in the same region as the abandoned clinic, researchers found members still meeting each month. Each member would take a turn at the beginning of the meeting to stand up and fastidiously report his or her recent activities: how people had been made aware of their health rights or how a protest against unofficial user fees had taken place. Even in the face of threats and intimidation from officials, these ordinary citizens were devoting considerable time to carrying on this work.

## What explains why one initiative was abandoned while the other survived?

New participatory institutions set up by the state can provide opportunities for more inclusive forms of representation, bolster community acceptance and create real pressure for progressive policy change. Research on these particular health institutions in Bangladesh, however, found that unless citizens are politically aware and mobilised prior to participation

in these government initiatives, these new spaces for citizen participation can quickly lose their attraction for citizens. The research also found that governments have an interest in ensuring that citizens arrive informed and mobilised. Without these conditions, participatory spaces will fail to provide the legitimacy and efficiency that officials hope to obtain. Furthermore, if these initiatives for public participation are to deliver on their promise of strengthening accountability, they must allow for direct engagement between citizens, public providers and local and state officials.

## A common assumption

Behind the 'people-centred' Alma-Ata Declaration in 1978 lies an assumption that community participation in decisions about local health services will lead to better health outcomes. In 1998, as part of health sector reforms, the Bangladesh government attempted to enhance community participation in the public health system. Two experimental initiatives sought to bring about more 'people-centred' public health provisioning.

In one initiative the Ministry of Health and Family Welfare set up community-owned and managed health clinics in every village or ward. The community-run clinics were mobilised by the Union Parishad, an elected local administrative body. Nine councillors would comprise a committee composed of local representatives, local service providers, influential residents and landless people's representatives. This group would be responsible for the operation of the clinic.

In another initiative, the government set up Health Watch Committees, established to allow community members to monitor the performance of health service providers at the local level. The government enlisted non-state agencies such as NGOs working in the community to help set them up. Nijera Kori, a rights-based organisation working in rural areas, was one such NGO asked to help set up these committees. Nijera Kori proposed two Health Watch Committees

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be set up in the same area and that half the members be women. Representatives included people from the NGO landless groups, professionals (lawyer, journalist, non-government doctor), teachers, and a grassroots service holder. However the new health policy launched in 2004 disbanded these health committees, and only those mobilised by Nijera Kori have endured.

### One origin, two paths

Research found that the processes of recruitment to the two different initiatives differed significantly. Selection for the management of the clinics was neither transparent nor participatory. Membership was biased towards better-off and professional classes. The wives of wealthy men were usually selected to fill the spots reserved for women. This bias towards the elite limited its legitimacy among the rest of the community. Selection to Health Watch Committees, in contrast, was fairly transparent and more participatory, conducted through popular voting at an open workshop attended by a range of social classes and affiliates of Nijera Kori.

The selection process had far-reaching consequences for how these organisations have functioned. Social inequalities were still present among the members of the Health Watch Committees, but efforts have been made to overcome them. As one woman said, "I think that we always try to participate equally in the meetings, but there are differences in educational level and status, so there is a difference in people's ability to think and talk. However, if a member is remarkably silent, then we encourage them to speak up."

Another striking difference between the two institutions is in their impact on the participants and on service delivery. The community health clinics, most of which soon disappeared, had little positive impact or outcomes, while the Health Watch Committees produced a series of interesting outcomes. At the community level, people have become more aware of what services are available, as evidence by rising numbers of people in those areas seeking maternal healthcare, immunisation and family planning. Awareness of nutrition, hygiene and sanitation also improved. As one woman member of a Health Watch Committee said, "People are now...conscious about healthcare in general. When people refer to us in the hospital they get better attention. Now they get medicines more often.

And when they don't get proper healthcare and complain to me, then I go to the hospital and speak to the doctors."

### What can be improved in the design of institutional spaces for participation?

- The language and rhetoric of rights and people's participation among government agents and service providers were used to the advantage of the community to demand accountability, though the lack of a legal framework to regulate the performance of public healthcare professionals allowed government doctors to ignore the community's demands.
- The decision to establish community clinics did not involve any devolution of decision-making to villagers. Health Watch Committees did not have enough authority to monitor provider performance and with no legal backing, this authority declined even further.
- Resources are needed for people's effective participation in the form of official recognition and financial resources. The lack of strong and visible official support for community groups undermined the authority and effectiveness of these new spaces. With little financial support, community-run clinics and Health Watch Committees both closed down in great numbers.
- Participation for voice is only the first step in establishing accountability. Even strong voice can be meaningless and fail to influence the performance of service providers if policy makers are not interested or do not have the capacity to listen.
- Alliances of community representatives with administrators and managers are likely to be more successful in establishing accountability because this can ensure the support of higher administrative or powerful members of society.
- Community representatives tended to be from elite groups, and the poorer sections of the community were uninformed and unrepresented.