**Increasing Voice and Influence in the Health Sector in rural Bangladesh: Is there a role for community participation?**

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## I. Introduction

Increasing people's voice and influence in the health sector is generally believed to be an effective way of improving the performance of health systems, i.e. increasing access to services of the most vulnerable and disadvantaged groups, improving health outcomes generally and reducing health inequities. Participation of communities in decision making in the health sector, through ownership and implementation of local health services and interventions, is now a widely accepted means of ensuring such influence (M Dasgupta et al 2001; MoHFW 1997). Not only that, by creating public pressure and generating debate, community participation, actually facilitates the democratic process, reduces the gap between state and citizens and complements state responsibility for ensuring citizen's right to health and other services. In that respect informed and more inclusive community participation is not only good for the health system but also good for promoting citizenship practice and in claiming the right to good health care.

There is evidence that participation in decision making leads to better health outcomes and reduces inequality in outcomes and access to services, both for individuals and for households and at the community level. For example, educated women and women earning incomes, who are more likely to participate in household resource allocation and other decisions, also enjoy better health outcomes and reduced gender based bias in health outcomes for themselves and their children[1] In resource poor countries famines are avoided and people's entitlements are guaranteed when government action is galvanized by affected populations pressing their demands in various ways[2] (Dreze and Sen 1989). Hence, the belief is strong that active community participation in health services and interventions at the local level could enhance people's influence on health systems to be more responsive to the needs of the poor and more vulnerable groups.

However, experiments with community involvement in health (or CIH in the language of the World Health Organization) in developing countries have not yielded very conclusive results. As one researcher put it "it is impossible to say either that the … experiment succeeded or failed" and that it "did not quite achieve what they set out to do" (Oakley 1999). While it has been relatively easy to make initial contact with community representatives, increase coverage and sometimes garner active local involvement in specific health activities, e.g. vaccination campaigns, actual mechanisms of community participation have been problematic.
The experience with community participation has not been very encouraging because of lack of conceptual clarity regarding what is the community and who represents the

[1] The experience of micro credit in Bangladesh.
[2] Maharastra experience.

community, the process of community participation, and the content of community engagement (a real transfer of authority and responsibility or merely sponsored collaboration); as well as weakness of effort for promoting the mechanisms of community involvement. One major lesson that emerges from experiments around the world is that community participation cannot be seen simply as a component of health sector reform, but must be seen more broadly as a complete approach to health development.

In this paper we will explore the Bangladesh experience with community involvement in health systems initiated under the health sector reform programme as part of the Health and Population Strategy Programme (MoHFW 1997) launched in 1998.

## II. Background

In the 1970s a more ‘people centered’ development model, one that promoted people’s participation more directly, was suggested as a reaction to the prevailing dominant ‘top-down’ development model, which while helping to improve the health conditions of some people failed to give the poor a role in the development process and to “develop the talents, skills and abilities of the mass of urban and rural poor” (Kahssay and Oakley 1999). The rationale of such a proposed model was that it was important to develop people’s ability to change the conditions of poverty and to give the excluded majority, primarily poor people bypassed by development programmes, a chance to benefit from development initiatives. This re-thinking filtered into the health sector and began to influence the concept of health development. In the Alma Ata declaration of 1978 a critical element for a more people centered health development was identified as the involvement of people not just in the support and functioning of local health systems but more importantly in the definition of health priorities and allocation of scarce resources.

Within the health development arena there are two distinct interpretations of the concept of participation, but these are neither clear-cut nor mutually exclusive (Kahssay and Oakley 1999). First, participation is seen as a means to ensure people’s collaboration in the health sector, often by contributing labour or other resources in return for some expected benefit. This interpretation implies externally designed interventions implemented in a participatory way by seeking the views of previously excluded and specifically targeted groups and taking those into account for the direction and execution of projects, for example through stakeholder analysis and participation. The danger in this case is that local people’s participation is limited because they are not directly involved in design, control or management. Requires methods and techniques that ease (reduce cost of) local people’s collaboration in development programmes.

In the second interpretation participation is seen as an end or goal in itself and equates participation with empowerment of people in terms of acquisition of skills, abilities and knowledge that enable people to have a say in and manage delivery systems better. Pre-existing tradition of community involvement in development and actual practices of involvement can play a crucial role for community participation for better health outcomes (Baum and Kahssay 1999). Community participation is also seen as a political

process that enables people to identify and undertake actions they believe are essential for their own health development. Participation can help to reverse exclusion of people from the benefits of development and provide a basis for direct involvement of people in development. However, the links with action not are clear. Requires requisite structural relationships and skills development to promote participation.

For the most part, however, community participation continues to be defined as an additional ingredient in health care delivery and valued primarily for its instrumental role in making health services more responsive and appropriate. Community participation is variously seen as the means for more cost-effective utilization of limited resources, intensifying the impact of health sector investment, increasing the chance of success of health sector reforms, change the health seeking behaviour of poor people, build partnership between government and local communities, and so on (Kahssay and Oakley 1999). While these are no doubt a very desirable and even essential objectives, the broader objective of participation as establishing the citizen right to have a voice and to influence health systems are only made in passing, if at all. In fact, the means for achieving community participation are still debated and it was only since the late 1980s that community participation emerged as an explicit strategy in health development.

## III. The structures and pre-conditions for participation

The issue of decentralization is critical for operationalising community involvement. A reorientation of the existing formal health system and devolution of authority together with strengthening of local health systems emerge as an important structural condition for community participation. Local government or decentralization is commonly seen as a way of empowering communities through local level planning, resource mobilization, administrative and judicial powers, etc. In Bangladesh formal local representative institutions like the Union Parishad that devolve control over state resources are premised upon universal notions of democracy, but in reality operate within the context of local power structures, prevailing political culture and firmly entrenched social practices (Bode 2002). There are questions about how to tackle local power hierarchies, which may be more powerful at the local level than bureaucrats and professionals from the center. Decentralization of participation (participation by local people) may also actually weaken ability and capacity to challenge national policy (Loewenson 1999). Hence, decentralization is not always the answer to public participation since there are weaknesses in the participation mechanism.

Putting in place the mechanism for participation is the second structural condition for participation, often overlooked in very formal attempts at promoting community participation as part of more financially sustainable reforms. There is little documentation of procedures for participation, especially legal and institutional, in planning and management (Loewenson 1999). Rules for arbitration and reaching agreement are needed because underlying norms that govern arbitration of claims may be biased or are not neutral. The existing hierarchical power relations also mean that these rules have to be learned, and highlights the need for capacity building in participatory methods both at the community level and at the provider level.

Thirdly, there is often a gap between the expectations of the community and those of the providers that has to be reconciled if the community and especially poor people are to perceive an incentive to participate. The aim of investing time and effort by the community should be to meet the expectations of the poor and to make health services more responsive to the needs of the poor rather than for meeting the external pressure of ensuring participation by the poor. The rationale for participation is weak if there is a gap between community expectations and provider perceptions of what is needed and hence provided. Factors such as user fees, poor transport, negative and disrespectful attitude of health workers, and poor explanation or information on health problems increases the distance between community and the health system and creates barriers to participation even at the local level. Often claims of decentralization may be questioned, eg mutually incompatible claims such as reducing expenditure and at the same time improving quality of and access to service; or claims about provider accountability at local level when they are not even accountable to the center.

There are also several pre-conditions for initiating the process of participation. There is now wide agreement that the process of participation is not an inclusive one and only the empowered actually participate. This is because personal empowerment encompasses a sense of connectedness to the community and empowered people perceive they are in control and can contribute through participation. On the other hand, those who do not participate feel they have no control, are not important and feel marginalized or excluded as citizens (Mahmud 2003; Higgins 1999). 'Activists' dominate the world of participatory politics and ordinary citizens are excluded. Participants are not representative of the common people that health systems wish to serve. Moreover, the experience of participation reinforces personal empowerment, so that empowerment both precedes and is a consequence of participation (Higgins 1999). Hence, the implicit link is from empowerment to participation, which is then assumed to lead to voice and influence, so that to participate one has to first become empowered.

There is also the 'myth of the community'. Since community participation, almost by definition, is a collective action there must be some sense of community identity, of shared concerns and interests that will eventually lead to collective action for claiming rights. A community that feels powerless to effect change in local health systems is unlikely to be willing to participate to claim rights or become involved in decision making and management of health systems. Thus, there has to be community empowerment and a growing perception that collectively they can influence and control events. In other words, community empowerment becomes a prerequisite for community participation.

Although the literature on community participation in health makes the link between empowerment and participation, the further link with citizenship is not evident. The question that remains is 'where do rights come in'. The decision to participate must be viewed in terms of citizenship rights and responsibilities rather than solely in terms of personal empowerment. This is because participation arises from a sense of agency and in turn fosters that sense of agency and citizenship (Lister 1997). It is a process of acting as

a citizen, for which the first step is 'being a citizen'[3]. From this perspective the notion of 'being a citizen' implies being a member of society (inclusion) and being accorded the same legal and political rights as all other members; while acting as a citizen implies the fulfillment of certain further rights, or social rights (education) that provide capabilities for realizing and enjoying the status of full citizenship.

Those who do not participate do not feel full or equal citizens; they often feel forsaken by society, disrespected and unimportant. Non-participants inability to participate derives from their fragmented sense of citizenship, and to the extent that citizenship or acting as a citizen requires participation, citizenship itself was exclusionary. Indeed, it has been stated that "participation in community life requires at a minimum threshold a sense of full citizenship, of being accorded rights that define one's equal status" (Higgins 1999). Equality can be secured only after social and economic rights have been acquired. When these rights are withheld or violated people are marginalized and feel unable to participate. In fact equality of status confers personal empowerment as the outcome of full citizenship- accessing one's entitlements or rights, sharing an identity and sense of belonging, and fulfilling one's obligations by participating toward the common good.

Since participation is contingent upon empowerment, this implies that participation is an acquired capability since not everyone feels empowered enough to participate. Moreover, even among those who are 'empowered' or feel that they are indeed 'full' citizens not everyone wishes to be an 'active citizen'. This is because people are not willing to participate if they do not believe that they are able to make a difference, if they do not perceive any gains from participation, or if the mechanism and procedures for participation are unfamiliar or too costly, or if they feel they are not in control. Hence, in order to ensure community participation it is important that the conditions be created that enable all citizens to participate or to act as citizens if they so wish, thereby developing their capacities as citizens in a virtuous cycle of citizenship participation (Lister 1997). Or in other words community mobilization is needed for effective community participation. A first step in mobilizing marginalized or excluded people for participation is to treat all as equal or full citizens and to transform 'the passive client into active citizen, (Shaw and Martin 2000). Thus, community participation requires first that people be empowered by being accorded a full and equal citizen status, i.e. 'citizenship as a formally ascribed political status', and next that people need to be mobilized or activated to act collectively, i.e. 'citizenship as a collectively asserted social practice' (Shaw and Martin 2000).

## IV. Assessing community participation in health systems in Bangladesh

In recent years there has been quite visible effort at incorporating participatory processes into development policy making. Primarily in response to external donor conditionality there has been a plethora of forms of public participation in policy and strategy formulation, ranging from stakeholder analysis and consultations to public dialogues with

[3] To be a citizen means to enjoy the rights of citizenship necessary for agency and social and political participation. To act as a citizen involves fulfilling the full potential of that status. Everyone will not necessarily choose to act as a citizen because it is a time consuming process (Lister 1997).

'civil society' and community workshops for exchange of ideas and opinions between local residents and service providers. Among these the most elaborate has been the formulation of the Health and Population Sector Programme (Mahmud and Mahmud 2000) in the mid 1990s and more recently the preparation of the Poverty Reduction Strategy.

The health sector in Bangladesh is a combination of both private and public health care delivery, but the public policy approach to service delivery and attitude to users dominates both sectors. In other words, apart from a number of targeted vertical services like the expanded programme of immunization, health care delivery is of poor quality, access to services is inequitable, and providers are non-accountable. In 1998, partly to address these weaknesses and to set up a more pro-poor health care delivery system government, at the insistence of donors, decided to set up community clinics in every village/ward with the aim of providing accessible essential health services to the most deprived population groups (women, children and the very poor). The strategy for achieving this objective was to mobilize community participation to establish community owned and managed local level health facility. Community ownership would be ensured by building the clinic on land donated by the village and by having the community share costs of construction and operation of the clinic with government.

In each locality a community group (CG), composed of local government representatives, local service providers and local residents committed to social work and representing various professions and social classes including the landless and women, would be responsible for the operation of the clinic and delivery of health service to the residents of the community through a one stop service for reproductive and primary health care[4]. The CG was, thus, a new space for community participation and deliberation in the provision of accessible and affordable health care. It was believed that the community's need for accessible, reliable and responsive health care and a service that was answerable to them, would be sufficient incentive for ensuring community participation in the operation of the state delivery system at the local level, something that was quite unique given the existing top down policy making environment.

In addition to these efforts of government there have been initiatives by non-governmental organizations (NGO) to establish community clinics managed by local communities as a response to the low quality of public service at the local level. Although the number of these initiatives is extremely limited they can serve as a comparison group when assessing the experience of community participation in health systems.

[4] The operation and functional performance of the CGs has been constrained by several factors (Mahmud 2002). Although the CGs were supposed to be formed through broad-based local consultation in reality the selection of members of the CG was quite selective and usually biased towards better-off and professional classes, sometimes limiting acceptability within the community. CGs are frequently referred to as the 'personal family hospital' of some influential local elite. Lack of official recognition from the Ministry of Health has also contributed to the absence of authority and credibility of the CGs. There is also usually absence of effective leadership and proper delineation of authority and responsibility within the CG, generally rendering the CG non-functional.

The main research question posed in this analysis is “Does this model of community participation in the health sector work well or function effectively to ensure peoples’ voice and influence on the local level health system? The more specific questions are as follows:

1. At what level of decision making and accountability is community participation directed, with whose involvement and in what process?
2. Do the CGs meet the pre-requisites for community participation?
3. Are the structural changes necessary for community participation in place?
4. Finally, what has been the outcome and impact, if any, of this experiment in community participation?

These questions will be answered using the following framework: The context within which community participation in the local health system takes place has certain structural features that influence the process of participation. These structures need to be transformed for effective community participation. There are also several pre-conditions for participation that have to be met for effective community participation. The results of process of community participation will be outcomes that indicate the extent to which the community has participated in the local health system to make services more responsive to their needs and the extent to which the community claims ownership of the health system.

Certain structural changes are critical for community participation to be operationalised. Among them **decentralization** of decision making and devolution of authority is particularly important because it is also a mechanism for community empowerment. The degree of decentralization will be difficult to assess but some indication is provided by examining the role of local elected representatives and local employees of the relevant government department, in this case the Thana Health and Family Planning Officer (THFPO), in promoting community participation. The **mechanism of participation**, i.e. the rules and procedures for participation, is crucial for effective participation and has to be established and learned. The existence of acknowledged procedures for participation, including rules for decision making and planning and dissemination of decisions, is indicated by the extent to which objectives and responsibilities are articulated and understood and by examining how these responsibilities are carried out. The need for rules of participation becomes even more crucial in situations of unequal local power structures. Finally, community participation is undermined or strengthened depending upon how closely **community expectations** match provider expectations. A large gap between expectations is a barrier to community participation. The degree of mismatch in expectations can be assessed by identifying what the community expects from participation and what the health care providers feel the community needs.

The review of literature suggests several pre-requisites for effective community participation in development activity including in the health sector. First, participation requires some degree of **individual empowerment** reflected in a sense of control over one’s life and individual agency, the feeling that one can contribute by participating. In Bangladesh poor people and illiterate people feel they are ignorant and that no one pays them any attention. The sense of control and feeling of being useful and able to contribute

is thus strongly linked to access to material resources like land and education and to non-material resources like position and authority within the community. Second, participation also requires a **sense of community empowerment** or the belief that the collective voice will be more likely to be heard and have greater influence than individual voices. A shared or common interest is needed for undertaking a collective action and for a collective voice to be generated. Evidence of a common and shared concern and the belief in the power of collective action can be assessed from the reasons people give for joining the group and the benefits they expect from participation as well as what effects they hope to see as a result of their participation. Third, participation requires a **sense of citizen responsibility and agency**, as part of being a full citizen with all rights but also carrying the responsibility to act as a citizen. The sense of citizen agency is indicated by whether joining the group was something that they wanted to do or felt they had to do, and whether the reason for joining the group was for collective good or individual benefit. Fourthly, participation requires **identifying the community** that shares interests and has common concerns. It also requires identifying persons who represent that community and can speak for them. Often this requires community mobilization since conditions have to be created that enable people in the community to participate to represent the community. The extent to which the community has been identified is relatively more difficult to assess. Some indication of the level of community identification and mobilization is provided by the extent to which residents are aware of the CG and its activities, the process of selection of community representatives to form the group and the degree to which the CG recognizes common concern addressed by the group.

Outcomes of community participation will be assessed by addressing the following questions:
Is the CC functioning as planned (opens regularly; provides responsive services; addresses the needs of the most vulnerable groups, women, children and the poor)?
Is there community ownership of the CC?
Does the CG function effectively in managing the CC (in terms of resolving the operational problems of the CC)?
Has the CG emerged as a space for community participation?
To what extent is variation in the operation of the CG explained by whether it was established by the government or established by an NGO?

## V. Empirical findings from case studies

To answer the research questions posed this paper uses recent data from 11 case studies of community groups managing community clinics (CCs) in rural areas using the analytical framework described above. Seven of the CGs were set up under the sector-wide health programme of government initiated in 1998; the remaining 4 were set up by NGOs. Two government CGs were selected from each thana (locality) where there was an NGO established CG. This was to ensure some degree of comparability of the socio-economic context in which CGs operated. Each case study is based on interviews using semi structured and open ended questions with members of the CG, users and nonusers resident in the locality, and in some places union and thana level health personnel. In all

40 CGs were visited, out of which 11 were selected for indepth study and the criteria for selection was that the CG had been functional for at least one year or was currently so. Fieldwork and interviews were conducted during July to September 2002.

Table 1 shows the profile of user and non-user respondents representing residents in the locality of the community clinics. Among the 241 respondents residing in the vicinity of the community clinics 59% were women and 60% had used the clinic at some time. Respondents were adults (over age 15) and the majority (52%) had never been to school. Only one third actually knew that there was a committee to run the clinic and the level of knowledge varied considerably between different locations. The perception about the CG among residents was not very positive as only one fourth of those who knew about the CG and merely 9% of all respondents reported that CG members actually spoke to them and enquired about their health problems and needs.

On questions about health awareness (not shown) about half the respondents knew of oral saline as the treatment for diarrhoea; slightly more could mention names of vaccinations but not the timing of vaccinations; but only one third were aware about risky pregnancy and safe delivery. Thus, the overall level of health awareness was quite poor, particularly with respect to reproductive health.

The socio-economic profile of members is described in Table 2. The majority of members of both government and non government clinic CGs, including women members, have secondary or higher level of schooling, which shows that they are much better educated then the adult population of the local communities among whom less than 40 percent had ever been to school (Table 1). Overall 37% of CG members owned 3 acres or more of land and almost all of them had tin or brick homes, which puts them in the high income category. Especially CG members of government clinics were more likely (41%) to be a large landowner and to be a local elected representative. Eight of the members including one woman were elected union parishad (UP) members, i.e. the lowest level of local government. Elected representatives sat on all but one of the government CG. Professional occupations, such as school teachers and businessmen, and farmers in the government CGs, were the most common occupations of members. Women members who were not health care providers were housewives with considerable schooling (in some cases more than the men) but without any income earning activity.

Table 3 shows how CG members were inducted into the participation process, namely their source of information about the CG, how they were chosen for participation and their own willingness to participate. In the case of government clinics members learnt about the CG from a variety of sources, but most frequently from the local UP member or chairman. Health care providers (HCP) at the community clinic were informed by the medical officer posted at the thana or subdivision, who was their overall supervisor. For the non government clinics both the local health worker and interested persons informed members.

All CG members in government clinics were nominated and selected at a meeting of local elite and village leaders held at the union parishad office under the chairmanship of the

UP chairman, and in all of them, except one (DR), the local UP member was nominated the chairman of the CG[5]. The land donor and the health assistant (HA) were selected as members ex-officio, while two women members in each CG were selected as stipulated by the guidelines of the Ministry of Health. In two cases where the clinic was not functional some members did not know they were on the CG and only discovered it at the time of our interview. More than a third wanted to be a member while half of them were encouraged by others to become a member. More than two thirds felt they had been selected because they were trusted and respected, while those who wanted to join felt confident about themselves. A few thought there would be some future personal gain from membership, like a job. However, in one case women members complained that they had not been informed about their inclusion in the CG and that membership was thrust upon them.

In the non government clinics also members were nominated and selected at a meeting, except in one case where they were elected from among members of local self help groups. More than half wanted to become a member and most were encouraged by others. Again, almost all members felt they were trusted and respected, and one third had self confidence that they could do the work well.

Hence, a large proportion of CG members actually had an interest in participation, which may have emerged from a sense of citizen responsibility and agency. Many of those who wanted to join themselves said they thought it was a good cause and might bring some benefit to the community and poor people in terms of essential and accessible health care. People who encouraged others also used the same argument for membership. There was little opposition at the meetings to the names proposed and nominated to the CG membership.

Table 4 reports on members' knowledge about the objectives of the CG. Members' knowledge about the objectives of the CG coincided well with the stated objectives, namely to operate and maintain the CC to ensure that poor people got health service; motivate people to use the clinic and raise health awareness. In the government CG monitoring service provision and getting and distributing medicine were seen as important roles of the CG. These were not important objectives in the non government CG, where fund mobilization was an important role. Women members were less likely to know the objectives of the CG. Thus, the general view of CG members about the role of the CG agreed with the view of the health care providers and the Ministry who initiated this process.

Table 5 describes the actual activities of CG members to attain the above objectives. In the government CG the most common activity was to visit the clinic 'to look after the clinic', but the frequency of these visits was not clear. Motivation to use the clinic (only in those areas where the clinic was actually functional) was the next important activity followed by attending meeting and talking to users. Members felt that they were performing their duty simply by attending meetings and participating in the discussion about clinic maintenance and getting drugs. There was very little fund raising although

[5] In DR the land donor was the chairman, but he himself did not know it.

clinic maintenance (cleaning, repair, tubewell) required funds that were to be contributed by the community. In one clinic (BB) where the family planning worker charged Taka 2 for pills or vaccination people complained that she was charging them fees unduly and for herself whereas actually the money was used for paying the wages of a cleaning woman. This shows that the notion of community ownership of the clinic was not well established.

In the non government CG attending meeting and motivation were very important activities, while fund raising also featured prominently unlike the government CG. Fund raising was done through private donations but mainly through membership of the clinic using the family health card. Visiting the clinic was comparatively less important.

Table 6 shows the perceptions of CG members about the effects of their activities and internal relationships between CG members. Most members believed that their activity was bringing benefit to the community. Personal and family benefit were also seen as an effect because their families were getting health service and also from the sense of satisfaction from their role in the CG. Personal and family benefits were seen as more common among CG members in the non government clinics. Some members stated feeling pressure on their time from membership, and in the government clinic CG members faced the problem of peoples' accusations at not keeping the clinic open.

Almost all members reported that they had very good relations with other members, saying that they all lived in the same community and shared common concerns and problems and helped one another when needed. But there was very little reciprocal exchanges or interaction between CG members, suggesting that relationships were in fact quite hierarchical.

Table 7 gives information on routine meetings of the CG, the main mechanism for participation. In the government CG meetings, supposed to be held every month, are extremely irregular, and convened by word of mouth. Irregularity could be linked to the fact that at least two clinics were closed. Minutes are not written and attendance is poor. The chairman and health care provider are most vocal at meetings, while women are largely silent. The non government CG meetings are held regularly and attendance is good. Minutes are written and meetings are usually convened by written notice. In other words, meetings are seen as relatively more important, and conducted in a more systematic manner.

## VI. Discussion

In the case of the government community clinics, community participation (CP) is directed at a level where almost no policy decisions are taken. The community clinic is the lowest tier of public service delivery with only very rudimentary health care provision. Decisions taken by the CG consisted primarily of routine clinic operation and maintenance, how to ensure drug supply and only occasionally fund raising. The more fundamental decision to establish the clinic was a government decision taken from

outside and community participation was not sought to determine whether a clinic was the felt need or demand from the community. There was no CP in the decision about composition of the CG and actual selection of the members who were all, except the health workers who were government designated, nominated at a meeting convened at the UP office.

The process of selection of the CG was not entirely participatory, except to the extent that the local elected representative chaired the meeting for nomination of members. Nor was the process very transparent regarding selection criteria for membership. This is confirmed by the fact that only about one third of the respondents from the locality had actually heard about the CG or its purpose. Since CG members were all well off farmers or professionals and had good connections with local power structure they did not represent the marginalized and vulnerable groups in the community, reflected also in the fact that few local residents knew any of the CG members. Hence, the process of CP was neither very representative nor very transparent.

In the case of the non government (NG) clinics CP was directed at the local level also, but since clinics were providing relatively full service (including referral) there was scope for greater participation in policy decisions. The CG made routine decisions regarding clinic maintenance and operation, but also major policy decisions for fund raising for a pathological laboratory in one case and a new clinic building in another. There was some genuine CP in the selection of CG since one fourth (8 members) of the CG members were elected to local community based organizations.

However, the remaining members were all nominated in a meeting of local elite social workers and professionals. CG members were all highly educated and well off local elite, so again unlikely to represent marginal and vulnerable groups in the community, except for the clinic where members were elected members of CBOs. In the case of NG clinics too CG members were not widely known in the community. The scope for CP in both policy decision and in the selection of the CG was better with the non government clinics.

Do CGs meet pre-requisite for CP, such as personal empowerment, citizen agencyand shared community identity?

The description of CG members by occupation, land ownership and type of home suggests that CG members in both government and non government clinics had quite secure livelihoods and incomes. Most CG members were in powerful and stable enough positions within the community to feel able to contribute by participating in the CG. Almost all CG members either wanted to become members themselves or were encouraged by others, suggesting some degree of personal empowerment behind the choice to become a CG member. Specially, in the NG clinics a common response to the question “what is your own benefit from participation?” was a sense of satisfaction and work that earns respect. It is not clear, however, whether women members also felt empowered given that CG membership meant participation in the male dominated public sphere. Silent members at CG meetings were generally women.

Willingness to participate in the CG was quite common (37-55%) although not universal, and stronger in the NG clinics. Those willing to participate in the CG wanted to do so because they were confident that they could work to achieve the objectives of the CG. Others who were encouraged to participate thought they were chosen because they were respected and trusted, and considered eligible for the work. Only very few wanted to participate because they thought it would be to their own advantage. In the NG clinics attending meetings was seen as an important element of participation, which was not seen for the government clinics. Thus, although community representation may be questioned since CG members were generally unknown to local residents, most CG members enjoyed a sense of citizen responsibility and agency and believed they could contribute significantly by participation. The sense of agency appeared stronger among the CG members of the NG clinics.

The interviews do not provide enough information to determine the extent of community identity shared by residents and CG members. The sense of community empowerment, a pre-requisite for CP, is not clearly indicated from existing data. More context specific indicators and adequate information is needed to assess both community identity and empowerment.

Are structural changes necessary for CP in place?

Decentralisation has been a festering development problem in Bangladesh since long; government administrative bureaucracy is decentralized down to the thana level with elected representatives up to the lower union parishad, but there has been no genuine devolution of financial or policy making authority. This is very clear from the way the decision on establishing government community clinics was handed down by the Ministry of Health (MoH) from the center. Neither local health providers serving at the thana level nor the community had any say in that decision. In many instances local residents were not even consulted about the clinic site, and often the clinic was established on land donated by the UP member, who was instructed to mobilize the CG and choose the land donor. It comes as no surprise that the majority of CG members first learnt about the clinic from the local UP member. The absence of authority of the CG, especially financial authority, is quite apparent from the types of decisions taken at meetings and their lack of activity, apart from visiting the clinic, especially inability to raise funds for clinic maintenance activities.

In the case of the NG clinics, there is considerable devolution of policy making and financial authority from the NGO head office to the local CG. This is partly the result of greater flexibility in the NGO decision making process, which is usually less bureaucratic than government systems. CG members are much more active in mobilizing residents to become clinic card holders, motivating people to use the clinic and in fund raising for the clinic. This is reflected also in the discussion of the meetings and in the regularity and attendance at meetings.
The classic gap between community expectations and health providers' perception of what the community needs is quite obvious in the case of the government clinics. The apparent lack of community demand for a clinic of this type is clear from the fact that for

almost all illnesses people sought more qualified health care elsewhere, the only services provided by the clinic being contraceptive delivery and immunisation and some treatment for diarhhoea and fever. Many local residents reported that they had expected the clinic would provide qualified health personnel who could make prescriptions; now it is just for women (family planning, ante natal care) and children (vaccination).

In contrast, the NG clinics emerged from the demand of the community and the CG members for a local health facility[6]. The NG clinics all provided a wide range of services including prescription for medication and referral, and in some cases low cost drugs. In that respect they met the community's expectation more closely than the government clinics. There was an appropriate response from the providers to meet the need/demand of the community so gap between actual expectation of the community and providers' perception of those expectations was small.

To what extent have mechanisms and rules for participation been laid down? The starting point for establishing a mechanism of participation is to clearly spell out the objectives of the CG and ensure that members are fully aware of them and of their roles in achieving theses objectives. Members are quite aware about the stated objectives of the CG (motivation, raising awareness, operating the clinic and monitoring service provision). In the government clinics members' knowledge reflects the objectives of the MoH who passed on its decision to establish community clinics to the local UP member for implementation. So members are largely aware of their roles as members of the CG, both in the government and in the NG clinics. However, a few members of government clinics particularly women reported no knowledge of the CG objectives.

In the government clinics the actual role of members is restricted to visiting the clinic and motivating people to use the clinic when open. Clinic visits could be used for monitoring service provision but this is not stated explicitly. Attending CG meetings or fund raising were not seen as roles or activities of members. The formal participation mechanism of the CG meeting was not well established; meetings were irregular and not well attended, minutes were written in two CG meetings out of seven. Within the meetings some members were more vocal (health worker, UP member) while women remained silent. In the NG clinics attending meetings and motivation, including talking to people and asking about their problems, were seen as the most important roles of members. Raising funds was also a fairly important role. Meetings were a well established means for participation. Meetings were held regularly and were well attended and minutes were written. Meeting notices were generally sent by letter. But some members (those 'who know more') were usually more vocal in meetings than others.

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[6] In Ruppur the community's immediate need was the treatment of arsenic patients and prevention of arsenic contamination. In Madaripur the community felt the need for a local hospital providing low cost health care because of the long distance to the nearest public health center. In Chokoria people were mobilized by ICDDR,B through local self help groups for health awareness and decided to set up their own hospital with all facilities with the technical assistance of the ICDDR,B. In Pabna a free Friday clinic was operating but the demand was felt for a full service low cost health facility.

Thus, the CG meeting is the only explicit mechanism for community participation but the rules for deliberation in the new participatory space are not well established. Relatively speaking, the meetings are far more effective and functional in the NG clinics compared to the government clinics.

Finally, what outcomes or effects can be attributed to the CG? CG members of government clinics perceive the community as the major beneficiary because of availability of health care close to home, provided the clinic is open and functional. Only a few members perceive any benefit for their families or themselves personally. In other words, CG members do not see themselves as users of the clinic, suggesting that CG members do not identify strongly with the vulnerable and marginal groups for whom the clinic was established. Thus, the sense of community identity between CG members and local clinic users is weak. Within the CG members have generally amiable but non reciprocal relationships in the sense that CG members have no other relationship among themselves (such as labour sharing, exchange of gifts, etc) except CG membership.

In contrast, CG members of NG clinics perceive benefits equally at the community and at the personal and family levels. Thus, they and their family members are users of the clinics together with other vulnerable and marginal groups. Many state a sense of satisfaction and earning respect from the community as a personal benefit. Hence, their identification with the community is strong. CG members enjoy good relationships among themselves, and relationships are more likely to be reciprocal compared to relationships among the government CG members.

## VII. Conclusions

1. CP experience in Bangladesh not the most effective in influencing health systems, particularly in the newly opened public spaces at the community/village level.

2. CP experience in influencing health systems is more encouraging in the non government or informal or private sector.

3. Better performance of NG efforts may be linked to a relatively stronger sense of community empowerment and shared community identity among CG members with local community. The greater acceptability of the non government CGs was related to the fact that they offered other social and economic development programmes to the community.

4. Selection of community representatives was not transparent or participatory. CP is elite and professional based and male dominated, and required personal empowerment; but there is little effort to empower community or more marginalized CG members like women. Individual empowerment of members has been the direct outcome of members' existing social and economic status in the community. CP is also generally driven by a sense of citizen responsibility and agency of the elite.

5. The only formal recognized mechanism of participation was the group meeting. CG meetings were relatively more institutionalized in the NG health system, but extremely informal bordering on casual in the public health system. However, rules for deliberation to ensure democracy and participation were not well established.

# Tables

Table 1: Profile of respondents (users and non-users)

| Name of clinic | No. of respondents | | | No. of users | | | Education level (years of school) | | | Ownership | | | Perception about CG (% respondents) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | B | M | F | B | 0 | 1-10 | SSC+ | land | Home stead | Tin roof home | Knows CG members | CG members ask welfare |
| Ghorakanda | 7 | 11 | 18 | 1 | 9 | 10 | 9 | 6 | 3 | 16 | 16 | 17 | 3 | 1 |
| Betbaria | 11 | 13 | 24 | 0 | 10 | 10 | 18 | 5 | 1 | 8 | 24 | 16 | 12 | 1 |
| Goalbathan | 6 | 19 | 25 | 0 | 16 | 16 | 20 | 3 | 2 | 11 | 21 | 21 | 13 | 4 |
| Shibpur | 17 | 8 | 25 | 6 | 6 | 12 | 11 | 8 | 6 | 23 | 24 | 18 | 14 | 3 |
| Fashiakhali | 5 | 20 | 25 | 1 | 17 | 18 | 14 | 11 | 0 | 9 | 25 | 14 | 2 | 0 |
| Darirchar | 9 | 7 | 16 | 6 | 6 | 12 | 12 | 3 | 1 | 5 | 15 | 11 | 6 | 1 |
| Ghotmajhi | 4 | 16 | 20 | 1 | 13 | 14 | 9 | 8 | 3 | 5 | 19 | 8 | 4 | 0 |
| Subtotal for Govt CC | 59 | 94 | 153 | 15 | 77 | 92 | 61% | 29% | 10% | 50% | 94% | 69% | 35% | 7% |
| ICDDR,B | 12 | 12 | 24 | 7 | 7 | 14 | 19 | 3 | 2 | 2 | 24 | 12 | 7 | 0 |
| CH-Pabna | 12 | 13 | 25 | 5 | 11 | 16 | 2 | 15 | 8 | 4 | 14 | 13 | 7 | 6 |
| CH-Ruppur | 11 | 12 | 23 | 7 | 5 | 12 | 7 | 3 | 13 | 9 | 9 | 12 | 9 | 5 |
| CARSA | 4 | 12 | 16 | 2 | 8 | 10 | 5 | 6 | 5 | 7 | 15 | 8 | 5 | 0 |
| Subtotal for non govt CC | 39 | 49 | 88 | 21 | 31 | 52 | 38% | 31% | 32% | 25% | 70% | 51% | 32% | 13% |

Table 2: Summary profile of CG members

| Name Of CC | No. of members interviewed | | Mean Age | | Mean Years of school | | Land over 300 dec | Broad occupation group | | | | | Tin/ Brk Home | Elected Representative | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | M | F | M | F | | HCP[1] | School Teacher /service | Busi Ness | Far-Mer | HW | | M | F |
| **Government community clinics** | | | | | | | | | | | | | | | |
| GK | 4 | 3 | 50 | 32 | 7 | 9 | 4 | 2 | 1 | | | 2 | 7 | 1 | - |
| BB | 2 | 3 | 47 | 39 | 9 | 2 | 2 | - | 1 | - | 2 | 2 | 4 | 1 | - |
| GB | 4 | 3 | 45 | 29 | 8 | 7 | 3 | 1 | 1 | | 3 | 2 | 6 | 1 | - |
| SB | 7 | 2 | 51 | 34 | 12 | 9 | 4 | 3 | 3 | 1 | 1 | 1 | 9 | 2 | - |
| FS | 6 | 2 | 47 | 37 | 6 | 9 | 2 | 1 | - | 6 | - | 1 | 7 | 2 | 1 |
| DR | 7 | 0 | | - | | - | 4 | 1[2] | 2 | 1 | 3 | - | 6 | - | |
| GM | 4 | 2 | 47 | 34 | 9 | 13 | 1 | 2 | 2 | 1 | 1 | - | 6 | 1 | - |
| All GCC | 34 | 15 | | | | | 41% | 10 | 10 | 9 | 12 | 8 | 45 | 8 | 1 |
| **Non-government community clinics** | | | | | | | | | | | | | | | |
| CH-RP | 6 | 2[2] | 30 | - | 13 | - | 2 | 3[3] | - | 2 | | 1[4] | 6 | - | - |
| SH | 4 | 2 | 62 | 35 | 12 | 9 | 2 | - | 4 | - | - | 2 | 6 | - | 2 |
| MD | 8 | 2 | 51 | 49 | 12 | 11 | 2 | 1[5] | 3 | 4 | - | 2 | 10 | - | - |
| CH-PB | 9 | - | 45 | - | 12 | - | 5 | - | 8 | 1 | - | - | 9 | - | - |
| All NGCC | 27 | 6 | 46 | 42 | 12 | 10 | 33% | 4 | 15 | 7 | - | 5 | 31 | - | 2 |

Note: 1=health care provider; 2=no interview available; 3=rural doctor; 4=student

Table 3: Selection procedure of CG members (number of members)

| Selection process | Government community clinics | | | | | | | | Non government community clinics | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | GK | BB | GB | SB | FS | DR | GM | Total GCC | ICDDR SH | CH-PB | CH-RP | CARSA MD | Total NGCC |
| **Number of members** | 7 | 7 | 7 | 9 | 8 | 7 | 6 | 49 | 9 | 6 | 10 | 9 | |
| **How did you learn about CG** | | | | | | | | | | | | | |
| Local health Worker | 2 | - | 1 | 4 | - | 3 | 1 | 11 | 5 | - | - | 9 | 14 |
| Land donor/ Interested person | 3 | - | 1 | 2 | - | 2 | 1 | 9 | 1 | 5 | 9 | - | 15 |
| UP member/ Chairman | 2 | 5 | 4 | 1 | 7 | - | - | 19 | - | 1 | - | - | 1 |
| THFPO | - | - | 1 | 2 | 1 | 1 | 4 | 9 | - | - | - | - | 0 |
| **How were you selected** | | | | | | | | | | | | | |
| Nominated in meeting | 5 | 5 | 7 | 6 | 4 | 5 | 4 | 36 | 2[4] | 6 | 9 | 9 | 26 |
| As health worker | 2 | 2 | 1 | 3 | | 1[2] | 2 | 9 | - | - | - | - | 0 |
| Elected[1] | - | - | | | | | | 0 | 6 | - | - | - | 6 |
| Does not know | - | - | - | - | 2 | 2 | - | 4 | - | - | 1 | - | 1 |
| **Willingness to participate** | | | | | | | | | | | | | |
| Wanted to be member | 2 | 2 | 4 | 3 | 2 | 2 | 3 | 18 | 5 | 4 | 5 | 5 | 19 |
| Encouraged by others | 3 | 3 | 5 | 4 | 3 | 3 | 4 | 25 | 4 | 6 | 7 | 6 | 23 |
| Opposed by others | 0 | 0 | 2[1] | 0 | 0 | | 0 | 2 | 0 | 0 | 0 | 0 | 0 |
| **Reason for selection in CG** | | | | | | | | | | | | | |
| Self confidence | 1 | 3 | 3 | 2 | 3 | 2 | 2 | 16 | 4 | - | 4 | 5 | 13 |
| Able/right Person | 3 | 5 | 4 | 7 | 4 | 5 | 5 | 33 | 6 | 6 | 9 | 9 | 30 |
| Member of Other CBO[3] | - | - | - | - | - | - | - | 0 | 3 | 1 | 4 | - | 8 |
| Own gain | - | 3 | 2 | - | - | - | 2 | 7 | - | 1 | - | - | 1 |

Note: 1=by members of self help group; 2=imterview with HA not available; 3= opposed by the chairman of the CG who is the UP member; 4=two women members who were not members of the self help groups

Table 4: Members' knowledge about objectives of CG (number of members)

| | Government community clinics | | | | | | | | Non government community clinics | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Objectives | GK | BB | GB | SB | FS | DR | GM | Total GCC | ICDDR SH | CH-PB | CH-RP | CARSA MD | Total NGCC |
| Motivate people to use CC | 3 | 3 | - | 4 | 2 | - | 5 | 17 | 4 | 4 | 5 | 6 | 19 |
| Operate/ Maintain CC | 7 | 5 | 7 | 5 | 2 | 3 | 1 | 30 | 6 | 6 | 9 | 9 | 30 |
| Fund Mobili-Zation | 1 | - | - | 2 | - | -- | - | 3 | 1 | 3 | 2 | 6 | 12 |
| Get and Distribute Medicines | 5 | 5 | 3 | 2 | 4 | - | 1 | 20 | - | - | - | - | 0 |
| Monitor Service provision | 7 | - | 5 | 4 | 4 | 1 | 3 | 24 | - | 2 | 4 | 3 | 9 |
| Do not know | 0 | 0 | 0 | 2 wo | 1 | 2 | 0 | 5 | 4 | 4 | 5 | - | |

Table 5: Actual activities of CG members (other than health workers)

| | Government community clinics | | | | | | | | Non government community clinics | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | GK | BB | GB | SB | FS | DR | GM | Total GCC | ICDDR SH | CH-PB | CH-RP | CARSA MD | Total NGCC |
| Visit CC | 5 | 4 | 6 | 2 | 3 | 1 | 5 | 26 | 1 | 4 | 2 | 1 | 8 |
| Raise funds | 1 | 1 | - | - | - | - | - | 2 | 3 | 1 | 2 | 7 | 13 |
| Attend Meetings | 2 | 5 | - | - | - | - | - | 7 | 3 | 7 | 5 | 8 | 23 |
| Motivate People to Use CC | 2 | 3 | 3 | 4 | - | - | 2 | 14 | 5 | 6 | 3 | 9 | 23 |
| Talk to Users | 3 | - | - | 2 | 1 | - | 2 | 8 | 1 | - | 2 | - | 3 |
| Talk to HCP | - | - | - | - | 1 | - | - | 1 | - | - | 1 | - | 1 |
| No activity | - | - | - | - | 4 | 6 | - | 10 | - | - | - | - | 0 |

Table 6: Perception about benefits and effects of CG activity

| | Government community clinics | | | | | | | | Non government community clinics | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | GK | BB | GB | SB | FS | DR | GM | Total GCC | ICDDR SH | CH-PB | CH-RP | CARSA MD | Total NGCC |
| **Benefits of CG membership** | | | | | | | | | | | | | |
| Own benefit | 3 | 5 | 2 | 3[2] | 3 | - | 2 | 18 | 6 | 8 | 5 | 9 | |
| Family benefit | - | 3 | 2 | - | 7 | - | 4 | 16 | 6 | 6 | 6 | 9 | |
| Community Benefit[1] | 6 | 5 | 7 | 7 | 8 | 6 | 6 | 44 | 6 | 8 | 6 | 9 | |
| **Problems faced as member** | | | | | | | | | | | | | |
| Inability to Keep CC open | - | 1 | | 1 | - | - | - | 2 | - | - | - | - | |
| Time | 2 | 3 | - | - | - | - | - | 2 | 2 | 1 | - | - | |
| Face People's accusations | - | 2 | 3 | 1 | - | - | - | 6 | - | - | - | - | |
| **Relation between CG members** | | | | | | | | | | | | | |
| Good | 6 | 5 | 3 | 9 | 8 | 5 | 5 | 37 | 6 | 9 | 5 | 9 | 29 |
| Reciprocity[3] | 0 | 3 | 3 | 5 | 0 | 2 | 2 | 12 | 4 | 4 | 6 | 2 | 16 |

Note: 1=if CC is open and drugs are available; 2=training; 3=when there is some reciprocal relationship between members other than the CG membership

Table 7: Routine meetings of CG

| | Government community clinics | | | | | | | | Non government community clinics | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | GK | BB | GB | SB | FS | DR | GM | Total GCC | ICDDR SH | CH-PB | CH-RP | CARSA MD | Total NGO |
| Current status[1] | open | open | open | Open | Closed | Closed | open | | open | open | open | Open | |
| Number of Meetings held | 12 | 4/5 | 7 | 12 | 0 | 0 | 4 | | 10 | 11 | 2 | 12 | |
| Regularity | yes | no | no | yes | - | - | no | | yes | yes | no | yes | |
| Minutes written | ni | no | no | yes | - | - | Yes | | yes | yes | yes | yes | |
| Attendance | poor | poor | poor | good | - | - | good | | good | good | good | good | |
| Not informed # | | | 4 | | - | - | | | - | | | | |
| Who is vocal[2] | Chair-person | Chair-person | HA UPM | LD ST | - | - | UPM HW | | Those know more | Secre-tary | NGO, Chair-man | | |
| Who is silent | Wom | - | Wom | Wom | - | - | - | | ? | some | - | - | |
| How meetings Called | word | word | word | letter | - | - | letter | | word | letter | letter | letter | |
| Discuss drug Supply | yes | yes | yes | yes | - | - | Yes | | - | yes | | | |
| Discuss maintanance | yes | yes | yes | yes[3] | - | - | Yes | | yes | yes | yes | yes | |
| Discuss how to keep CC open | | Yes | yes | no | - | - | No | | - | - | yes | - | |
| Fund raising | no | no | no | yes | - | - | No | | yes | yes | yes | yes | |

Note: 1=government CCs are open for two days in the week only, rest of the time devoted to home visits
2: HA=health assistant, UPM=Union Parishad member, LD=land donor, ST=school teacher, HW=health worker; 3=roof leaks, tubewell broken

**References**

Ruth Lister 1997. Citizenship: Feminist Perspectives. Basingstoke: Macmillan.

S Mahmud 2002. “Making Rights Real in Bangladesh through Collective Citizen Action”, IDS Bulletin, Vol 33, No. 2: 31-39.

A Cornwall *et al* 2002. “Sectoral Dimensions of Participation in Policy: A Comparative View of Education, Health and Environment”, IDS Workshop Draft.

S Mahmud and W Mahmud 2000. “Policies, programs and financing since the International Conference on Population and Development: Bangladesh country study”, in S Forman and R Ghosh (eds) Promoting Reproductive Health: Investing in Health for Development, Lynne Reinner Publishers, Boulder and London.

S Mahmud 2003. “Citizen participation in rural Bangladesh: Reality and perception”, (forthcoming) IDS Bulletin.

H M Kahssay and P Oakley 1999. “Community involvement in health development: a review of the concept and practice”, World Health Organisation, Geneva.

F Baum and H M Kahssay 1999. “Health Development Structures: an untapped resource”, in H M Kahssay and P Oakley (eds.) Community involvement in health development: a review of the concept and practice, World Health Organisation, Geneva.

P Oakley 1999. “Caranavi district, Bolivia” in H M Kahssay and P Oakley (eds.) Community involvement in health development: a review of the concept and practice, World Health Organisation, Geneva.

R Loewenson 1999. “Public Participation in Health: Making People Matter”, IDS Working Paper 84, Institute of Development Studies, Sussex University, Brighton UK.

B Bode 2002. “In pursuit of power: local elites and union level governance in rural northwestern Bangladesh”, (Draft), CARE, Bangladesh.

J Higgins 1999. “Citizenship and empowerment: a remedy for citizen participationin health reform”, Community Development Journal, Vol.34, No.4, pp. 287-307.

M Shaw and I Martin 2000. “Community work, citizenship and democracy: re-making the connections”, Community Development Journal Vol.35, No. 4, pp. 401-413

MoHFW 1997. “Health and Population Sector Strategy”, Ministry of Health and family Welfare, Government of Bangladesh, Dhaka.

M Dasgupta, H Grandvoinnet and M Romani 2001 (?). "State-Community Synergies in Development: laying the basis for collective action", World Bank Policy Research working Paper No. 2439, World Bank, Washington D C.

J Dreze and A Sen 1989. Hunger and Public Action, Oxford India Paperback, Delhi.