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Spaces for Participation in Health Systems in Rural Bangladesh: The Experience of Stakeholder Community Groups

Simeen Mahmud

In 1998, as part of health sector reforms, the Bangladesh government initiated efforts to enhance community participation in the public health system. This chapter examines two experimental initiatives that sought to bring about more 'people-centred' public health provisioning. It seeks to identify barriers in establishing people's participation, as well as factors and processes that contribute to making participation effective, even if in a very limited fashion. Analysis of this experience finds that the absence of prior mobilization is liable to make these spaces ineffective in realizing the right to health and promoting citizen participation. Additionally, although citizen participation is adopted as a strategy by the state, forms of participation that fail to engage public providers and local state officials may offer little prospect of holding the state to account at the local level. Simply creating spaces will not lead to participation if people are not also sufficiently motivated to engage in them, but participation without engagement with providers may not be adequate to bring about the anticipated change in provider attitudes and behaviour vis-à-vis citizens.

Origins and Experiences of People's Participation in Health in Bangladesh

In the Alma-Ata Declaration of 1978, a 'people-centred' approach to health was put forward as not just involving contributions to support the functioning of local health systems, but also involving people

actively in defining health priorities and allocating scarce resources. Community participation, through ownership and implementation of local health services, is now a widely accepted means of ensuring that people have a say in local health systems (Dasgupta et al. 2001; MoHFW 1997). Behind this lies a widely held expectation that participation in decision-making will lead to better health outcomes and reduce inequality in outcomes and access to services. When the link between policymakers and providers is weak and supervisory mechanisms are inadequate, users are often best placed to monitor provider performance (World Bank 2004: 64). Giving people 'voice' in the health system is thought to allow them to translate their knowledge of poor service quality into political power and influence at the local level.

By creating public pressure and generating debate, people's participation also facilitates the democratic process. Informed and more inclusive participation is held to be good not only for the health system but also for promoting citizenship practice and rights claiming. If the government is unable or unwilling to ensure provider accountability, people may have no option but to develop mechanisms for engagement and inclusion in local-level service institutions. This type of citizen action by poor people, whether on their own or in alliance with others, may even make politicians and policymakers respond in ways that compensate for systemic weaknesses. However, while a more engaged, and indeed political, understanding of public involvement informs efforts to bring about accountability through participation, it is more common in practice for people's participation to be seen simply as an additional ingredient in healthcare delivery, valued primarily for its instrumental role in making health services more cost effective (Kahssay and Oakley 1999). The long-term broader objective of enabling poor people to become more active citizens through participation in the management of delivery systems is not usually recognized as an expected outcome.

The health sector in Bangladesh is a combination of both private and public healthcare delivery, but the public policy approach to service delivery and attitude to users dominates both sectors. Apart from a number of targeted vertical services, like the expanded programme of immunization, public healthcare provision is plagued by negligence of duty and unprofessional behaviour by healthcare providers, poor maintenance of physical facilities, illegal user fees and long waiting times. In addition, there is extreme wastage of

scarce resources by leakages of medical supplies and provisions. The national government has for some time realized that state provisioning of health services does not meet minimal standards of care quality and service accountability, and that access to services is inequitable. Although internal mechanisms to ensure quality of care and accountability of service providers have traditionally been in place within the health system, these have been non-functional.

Since the mid-1990s, the Ministry of Health and Family Welfare (MoHFW) undertook massive reforms of the health system through the Health and Population Sector Programme (HPSP), designed to reduce wastage and ensure long-term financial sustainability (Mahmud and Mahmud 2000). Influenced by prevailing thinking within international development agencies, notably the World Bank, these reforms were intended to make health services 'responsive to clients' needs, especially those of children and women and the poor, and achieve quality of care with adequate delivery capacity and financial sustainability' (MoHFW 1997). The HPSP comprised six separate but interwoven components[1] that were to be implemented through a strategy involving direct participation by all stakeholders (health service users at the grassroots level, healthcare professionals and care providers, government, private and volunteer organizations engaged in healthcare planning and provision, and donor agencies providing financial assistance). In addition, there was to be a shift in the approach to service delivery, from separate health and family planning services to a reproductive health approach with integrated services. This coincided well with the donor condition of a shift from project aid to sector-wide programme aid. A number of challenges confronted the implementation of this ambitious strategy in the context of Bangladesh.

Community Participation: Challenges and Prospects

In Bangladesh, most people rely totally on the state to provide and ensure all rights, almost precluding any role for citizen engagement in overseeing state provisioning. The primary responsibility for creating a 'good society' is invariably vested upon the *sarkar* (government), which is expected to provide education, healthcare, jobs and personal security (Mahmud 2004a: 6). Poor people see themselves as having very limited responsibility and even less ability with respect to