

Community participation in health care

Editor – I agree, but only in part, with the views expressed in the editorial “Community participation in health impact assessment: intuitively appealing but practically difficult” (1). The authors have considered many important issues relating to community participation, such as democratic processes, community empowerment, and top-down professionally-led exercises. Since the Alma-Ata declaration, the Government of Bangladesh has made community participation a priority but in reality, the community plays a negligible role in selecting priorities and in planning, monitoring and evaluating services because community participation is usually initiated under the guidance of a government authority.

The political situation in Bangladesh is feudal and authoritarian and we have found that community participation is difficult for a number of reasons. Although community participation is important, motivating community members to participate in health care is not an easy task. Generally, community members will participate if the health problem is important to them. Professional decision-makers control the health-care system, and they do not respect the wisdom and knowledge that the community can provide. Therefore, equity is not maintained, so-called community participation is controlled by the wealthy, and priorities identified are based on the needs of the wealthy and powerful.

At the local level, community participation in Bangladesh involves donation of land, building materials and cost-sharing; participation in the delivery of services, such as the National Immunization Day programme; and construction of clinics by volunteers who provide free labour. As a rule, the people of the area are forced to pay indirectly via the loss of a day's income.

Many people feel that health care is not a priority, but will participate in the health impact assessment (HIA) process if they can be involved from the planning stage through to the later stages of implementation, monitoring and finally, evaluation of services.

Sustaining productive voluntary work at the village level is a large problem. Community leadership is dominated by members of the ruling political party, and changes in national-level politics affect volunteers, whose ranks are being filled by the political cadres of the new ruling party. When the ruling party changes, those who have been community leaders may be persecuted and have to flee their village.

Most economic activity in Bangladesh is city-centred, and young men and women leave rural communities, lured by the prospect of better earnings, rarely returning permanently to their own communities. Few educated young men and women are willing to assume the traditional professions practised by their parents and, consequently, villages do not profit from their knowledge and skills. This pattern results in a continuous loss of young volunteers from the villages. Consequently, the work experience cycle is broken and the motivation level of villagers declines.

Since The World Bank, Asian Development Bank (ADB), USAID and other international agencies became involved in health-care services, hundreds

of smaller nongovernmental organizations (NGOs) have ceased operations in Bangladesh. Tenders advertised by donors specify that financial and working capacity are key to their operations, and it is normally only the larger NGOs that fulfil these criteria. The projects sponsored by international donors have destroyed people's initiative and sense of community participation by allowing the needs of the community to be decided by the donors. Decisions are made without adequately considering the community's expectations and financial capacity; and the utilization of funds, whether they are grants or loans, is guided by international agencies. This market-based approach has overshadowed the multi-dimensional actions required to improve health and not merely health-care services. Such a vertical approach neglects other health improvement issues. Moreover, traditional health practices are not taken into consideration and the health programmes become western based and donordriven. So, is community participation a myth rather than a reality? ■

Conflicts of interest: none declared.

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1. Parry J, Wright J. Community participation in health impact assessments: intuitively appealing but practically difficult. *Bulletin of the World Health Organization* 2003;82:388.

Erratum

“Regulatory pathways for vaccines for developing countries” 128–33, of vol. 82, issue number 2, 2003 by Milstien & Belgharbi.

The authors wish to acknowledge that Ms Natalia Shunmugan contributed to this article in that she worked with the main author for several months helping to summarize information on practices of national regulatory authorities on authorization and evaluation of clinical trials and prepared a preliminary inventory of immunization advisory committees.

Corrigendum

On page 809, of vol. 82, issue number 10, 2004: Ebrahim Samba, Regional Director for Africa, was incorrectly described as hailing from Angola. He is in fact from the Gambia.

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