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Achieving universal health coverage through community empowerment: A proposition for Bangladesh

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Introduction

Bangladesh is one of the countries with highest out of pocket (OOP) payment, where 96.52% of the private health expenditure is OOP. [1] Three to 7% of all households in Bangladesh spend more than 40% of household expenditure on OOP healthcare payment. Each year 3.8% additional people go below the poverty line only because of making health care payments OOP. [2] In order to deal with the malignant discrepancy of health outcomes as well as health care utilization across different socio-economic strata both across and within countries, public health experts coined the concept of Universal Health Coverage (UHC). By UHC we mean a health financing system which ensures that all people have access to required health services without suffering financial hardship paying for it. [3]

Universal Health Coverage: Challenges and Prospects

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Evidence from different countries suggests that initial attempts at establishing UHC are often faced with challenges. An anecdote from Malaysia identifies some of those challenges as 'loser versus gainer differences' (opposition by the formal sector service holders to pay anything on top of existing income tax); 'private interest' (strong lobbying by private health insurance providers in fear of dilution of their existing profit); 'institutional conflict of interest' (fear of the existing service providers to lose their authority); and 'technical barriers' (difficulty in collection of premium from a massive informal sector). [4] Another potential challenge is the high cost associated with establishing such a mechanism, which necessitates policy makers to ask for public opinion in favor of such expenditures. [5]

We believe that despite the challenges towards establishing UHC, policy makers should not give up their commitment to UHC as this is the most effective way to free the people from catastrophic health expenditure. [3] Experiences from successful countries suggest that UHC can effectively be achieved through the concerted effort of the people guided by civil society activists. The optimistic case of Thailand stands out as an example of political stewardship, which was

reinforced by the popular support. [5] Social movements, motivated by the need for social justice in health care, can push political leaders to opt for UHC. [6] 'Community empowerment' as a key aspect of social movements, therefore, emerges as one of the most important pre-requisites for establishing UHC.

This paper aims to argue, based on some examples from Bangladesh that a community empowerment approach is useful and should be used in establishing UHC in Bangladesh. Findings from current research on Comprehensive Primary Health Care (CPHC) in the context of Bangladesh, which aims to introduce a culturally sensitive and demand driven Primary Health Care (PHC) model for Bangladesh, suggested a model that emphasizes empowering communities. Therefore, adoption of CPHC (based on the research) will not only equip the Bangladesh health system with an improved PHC delivery mechanism but also will pave the way for policy makers to achieve UHC through generation of demand from the public.

Community Empowerment: A Way to Overcome the Challenges

By Community Empowerment (CE) we mean the process by which relatively powerless people in the community work together to attain control over the events influencing their life. [7] The term 'community empowerment' has a tendency to be mentioned loosely, especially by the policy makers as well as the NGO movers. In several literature community participation/involvement, social capital, community capacity, human capability, community competence, community cohesiveness, [8] etc. have been used either synonymously, or with subtle distinctions. However, several parameters of community empowerment have been proposed, the research work mentioned earlier in this paper (the CPHC research) was founded on the following four parameters:

1. Access to information
2. Participation in decision-making forums
3. Ability to demand accountability from decision makers
4. Capacity to work in partnership with public service. [9]

In the context of Bangladesh, where more than 40% of the people are still devoid of the gift of education, [10] the rhetoric of community empowerment has been highly debated. However, successes have also been documented. Bangladesh has established its eminence as the home for the micro-credit success stories of Muhammad Yunus and various encouraging activities by other NGOs. One of the largest NGOs of the world, Bangladesh Rural Advancement Committed (BRAC) has been carrying out empowering activities since its initiation after the liberation war of Bangladesh in 1971. In addition to its nationwide education program, women empowerment approaches, legal aid services, and micro-credit programs, BRAC has been running massive health programs throughout the country. [11] Bangladesh has a very successful immunization program with 96% DPT and measles vaccine, and 94% tetanus toxoid immunization coverage, [10] which are one of the highest in South Asia. The Expanded Program on Immunization (EPI) program in Bangladesh successfully incorporated the contributions from the NGOs, local commercial enterprises, and even community volunteers. This inclusive nature of the EPI program is indicative of people's involvement from different spheres and eventually empowering them. [12] The Directly Observed Treatment Short-course (DOTS) program to treat tuberculosis (TB) is another such example of partnership of the people with the government. During the inception of the program in 1993, treatment was provided through government health clinics, which was faced with challenges such as limited capacity and quality, shortage of infrastructure and human resources, and social stigma associated with the disease. With the inclusion

of six NGOs, the program turned out to be a successful one, with a regional (South Asia) highest treatment success rate of 92%. [10] The largest NGO collaborator BRAC (which implements in 23% of the total coverage area) implements the program through the locally recruited community health volunteers known as Shasthya Sebikas (SS). [13] These SSs are again recruited from the microcredit beneficiary women's groups, known as the Village Organizations (VO). The VO members usually meet every month and discuss on issues like violence against women, human rights, essential health care, family planning, water and sanitation, immunization, nutrition, basic curative services, etc. The VO meeting process and the engagement of SSs from these groups itself is an example of empowering approach, the success of which have been documented in many literature. [14],[15] Another initiative, the Community Clinic approach of Government of Bangladesh, although too early to comment on its success, has already created enthusiasm and optimism among the communities. [7] Examples abound where communities were empowered and successes ensued.

Suggested Approach: A Comprehensive Primary Health Care Model

Community empowerment has been shown by Laverack to improve health outcomes in various settings and through different pathways. For example, in Nepal participatory learning exercises in women's groups helped reduction of maternal mortality; in Samoa neighborhood-based self-help system helped improvement of sanitary and health facilities; in Central Asia (Kazakhstan, Kyrgyzstan, and Uzbekistan) sensitizing and involving the local village leaders helped improved water supply; in Florida among the African-American women formation of mothers' circles helped reduction of infant mortality; and many more. [16] Now the question is how to utilize this time-tested approach of community empowerment in achieving UHC.

A group researcher from James P Grant School of Public Health, BRAC University conducted a research (during 2009-2010) with an aim of designing an appropriate CPHC model for Bangladesh, which includes 'community empowerment' as an integral component. [7] They, besides other issues pertinent of CPHC, embarked on assessing the status of community empowerment and also deriving suggestions from them how to achieve it. In short, some of the findings were that, although the status of community empowerment (according to the parameters mentioned earlier) was not satisfactory, the intention of the government was positive; and most importantly the willingness of the people towards becoming empowered was explicitly pronounced. They even went steps forward in suggesting innovative approaches for achieving this goal. Some of their many creative suggestions were to engage the local government in organizing regular health meetings; developing health promoting display materials around the issues of entitlements and not just health practices; utilizing the existing vast network of government health educators (known as the Health Assistants) in informing people about their health rights besides the healthy practices they currently promote, etc. The full version of the paper with detailed findings is available elsewhere. [7]

This proactive attitude of the community people clearly transmits the signal to our policy makers that time has arrived to go ahead with the blessed message of UHC, and create the virtuous cycle of mutual persuasion for a greater good.

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