

Achieving Universal Health Coverage: State of Community Empowerment in Bangladesh

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Initial attempts at Universal Health Coverage (UHC) meet with resistance from different quarters. Therefore, it is imperative to empower the community and generate demand for it. This paper argues that community empowerment can facilitate health equity either directly or indirectly through facilitating UHC. In order to empower the community, first it is important to know its status, which was the aim of this study. The mixed method research found that 90% of people had some source of information, but there was almost absolute lack of empowerment in terms of participation in decision making, demanding accountability, and local organizational capacity. The knowledge obtained by this research can help policy makers to make evidence-informed decisions towards achieving health equity.

BACKGROUND

Debates around Community Empowerment

‘Community Empowerment,’ as the name itself implies, means the process by which relatively powerless people in the community work together to attain control over the events influencing their life. However, the term ‘community empowerment’ has traditionally been mentioned loosely, especially by policy makers and NGO movers. In some literature, the terms community participation/involvement,¹ social capital, community capacity,² human capability,³ community competence, and community cohesiveness⁴ have been used either synonymously with, or with subtle distinction from, the term ‘community empowerment’. While ‘community empowerment’ is similar to these other terms, it has a different meaning. The concept became popular in the development field during the 1980s, with the emergence of the ‘new health promotion’ movement, the focus of which, in keeping with the emergent concept of community empowerment, was to achieve equity in health and to increase public participation in health program decision-making.⁵ However, the origin of the term as a theory is linked with the Brazilian humanitarian and educator Paulo Friere’s seminal works ‘Pedagogy of the Oppressed’ and ‘Education for Critical Consciousness.’⁶

The term has been defined from different perspectives by different academics and researchers. Laverack identified nine domains of community empowerment, which are as follows: participation, leadership, problem assessment, organizational structures, resources mobilization, links to others, asking ‘why,’ program management, and the role of the outside agents.^{7,4} While the connotation of ‘community empowerment’ varies across peoples, countries, and cultures, the concept shares some common underpinnings. For example, it universally applies to the individual as well as the community; addresses the issue of controlling direction of resource flow in the community and one’s own life; addresses the issues related to capacity and confidence

building; and considers active participation as a necessary, but not sufficient condition for community empowerment.⁸

Different disciplines (e.g. community psychology, nursing studies, management, health studies, political theory, social work, education, women studies, and sociology) have used this concept from their own perspectives.⁹ Psychological studies have sought to understand whether ‘empowerment’ is a process, an outcome, or both; and also to understand the nature of ‘empowerment’ at the individual level, with respect to the group, and at the community level.¹⁰ During the 1990s, an increasing number of nursing studies were conducted on ‘empowerment’ issues. According to a literature review by Kuokkanen and Leino-Kilpi, the concept has been utilized in the nursing field largely to understand the interplay of power dynamics among nurses; between nurses and patients; and between nurses and other health care professionals.¹¹ In the domain of public health, Laverack explored the role of community empowerment in improving health outcomes in an extensive review of literature published between 1992 and 2005.⁷ In the realm of health promotion, the debates on community empowerment have been dominated by the ethical dilemmas emerged from tensions between the top-down approaches of some health promoters and the bottom-up demands from communities for certain interventions (which were seen as ill-advised, or even harmful, by health promoters).^{12,5} Finally, the concept of Primary Health Care adopted ‘community participation’ as one of its principles since its inception in 1978. The term ‘community participation’ has been gradually replaced by ‘community empowerment’ since the 1990s.⁸ Given the increasing interest in Universal Health Coverage (UHC), we argue that empowerment issues need to be extensively explored in the context of UHC as well.

Achieving Health Equity through Community Empowerment

Inequities are subset of inequalities that are considered unfair and are potentially avoidable.¹³ There is a malignant discrepancy in health outcomes as well as health care utilization between rich and poor countries and within countries across socio-economic strata.¹⁴ Unequal social and political conditions are pushing 25 million households each year towards abject poverty as a consequence of health care payment. Worldwide, 1.3 billion people do not receive necessary drugs or surgery because they cannot afford them.¹⁵ In order to alleviate this problem multifaceted interventions, designed to be reinforcing rather than mutually exclusive, have to be put into action. This paper considers ‘community empowerment’ to be one of the interventions that can contribute, both directly and indirectly, to achieving health equity, particularly in the context of Bangladesh.

The link between community empowerment and health equity has been explored in a number of seminal publications, including ‘The World Development Report 2000/2001,’ and Nobel Laureate Amartya Sen’s book ‘Development as Freedom.’ The World Development Report 2000/2001, based on its qualitative and quantitative evaluation of poverty and inequity all over the globe, made three specific policy recommendations, including ‘facilitating empowerment’ (others were ‘promoting opportunity’ and ‘enhancing security’).¹⁶ In his book, Sen argues that capability deprivation leads to compromised freedom. He cites data to establish a crucial link between equity and empowerment.¹⁷ In her 2003 paper, “A framework linking

community empowerment and health equity,” Susan Rifkin notes that this linkage has also been explored and discussed extensively by other scholars.⁸

Community empowerment promotes health equity, in that it is imperative to achieving UHC, and UHC is integral to health equity. Evidence from different countries suggests that initial attempts at establishing UHC meet with resistance from different quarters, such as professional associations of physicians or from national financial experts.¹⁸ Some resist UHC due to vested interests, while others resist because of a lack of understanding of the idea, or as a result of a habitual antagonism towards anything new. In the context of Bangladesh, which is a majority Muslim country, health insurance may be regarded as associated with commercial insurance, which many consider as haram (prohibited from an Islamic point of view).and Adoption of prepayment-based health financing may be resisted for this reason. Therefore, it is the people who should be informed and convinced first to demand their health entitlements based on informed decisions.¹⁰ Experiences from successful programs suggest that popular demand can be effectively generated through the concerted effort of the people themselves, guided by civil society.¹⁸ Hence, ‘community empowerment’ emerges as an important prerequisite for establishing UHC.

There is a convincing body of evidence available to attest to the necessity of a prepayment-based health financing system, which is the heart of UHC, for ensuring health equity. The World Health Assembly in 2005 unanimously adopted a resolution urging participating governments to achieve the following two goals, which were eventually termed UHC: 1) provide all people with access to required health services sufficiently and effectively, and 2) ensure that the services do not push the users into financial hardship. In line with this proposition, Cambodia, Kyrgyzstan, and several other countries introduced health equity funds. This increased the utilization of health facilities and decreased borrowing money for healthcare by the poorest population groups.¹⁹ In Mexico, introduction of the public health insurance program ‘Seguro Popular’ (People’s Insurance) resulted in improved health service utilization and financial protection.²⁰ Therefore, it can be rightly argued that introduction of UHC can effectively interrupt the vicious cycle of illness, impoverishment, further illness, and, consequently, aid in achieving health equity.²¹

Our view in regards to the relationship between community empowerment and UHC boils down to the conceptual model shown in Figure 1.

Community Empowerment in the Context of our Study

The research on empowerment was originally nested in a broader research project which aimed at developing a model for comprehensive primary health care (CPHC) in Bangladesh. Our proposed model of CPHC raised the demand the inclusion of ‘community empowerment’ as one of its components. This necessitated the evaluation of the current status of ‘community empowerment’ in Bangladesh. The researchers had to accommodate the ‘community empowerment’ component in the greater scope of the CPHC research project in a practical and operational fashion. As described in the opening section of this paper, ‘community empowerment’ has been defined by different disciplines differently; adding more complexity to the already complex concept. Therefore, like many others conducting research on community empowerment, it was crucial to provide adequate clarity to the concept and to make it practically

operationalizable.⁴ Drawing upon this understanding, our rigorous literature review led us to adopt an operational definition based on the following four parameters:²²

1. **Access to information:** Informed people in the community can take advantage of opportunities, access services, claim their rights, negotiate effectively, and hold the actors responsible for their actions. Access to media (e.g. radio, television, and newspaper) was considered critical for accessing information.
2. **Inclusion and participation:** It is important to know whether the community members are included in decision making forums and whether they can effectively participate in the discussion and decision making.
3. **Accountability:** The ability of community members to hold public officials, or service providers, responsible for their decisions and actions. Access to information feeds into the capacity of the community to hold the responsible persons accountable.
4. **Local organizational capacity:** The ability of community members to work together, organize themselves, and mobilize resources to solve problems of mutual interest.

In the second section of this paper we describe how community empowerment is crucial to achieving health equity. In order to empower the community, first it is imperative to know the present state of community empowerment in Bangladesh, to be able to provide informed policy feedback on areas requiring enhanced emphasis. Therefore, the aim of this study was to understand the current status of community empowerment in Bangladesh, and to explore suggestions from community members themselves.

METHODOLOGY

Study Design and Sampling

The study adopted a mixed-method design. The first stage of the study was comprised of Key Informant Interviews (KII) to gain conceptual insight into the matter. Key informants were selected purposively, and included one government high official from the Directorate General of Health Services under the Ministry of Health and Family Welfare. They also included three veteran public health professionals, who were involved in early stage policy formulation and implementation of Primary Health Care (PHC). We also interviewed a Public Administration specialist from the University of Dhaka, who conducted doctoral research on the health policy process of Bangladesh and helped us to understand the critical underpinnings of community empowerment in the realm of health systems.

The second stage of the study involved focused ethnographic study (FES) in two Upazila Health Complexes (PHC centers at the sub-district level), a household survey in a randomly selected village within the catchment area of each Upazila Health Complex, and Participatory Rapid Appraisal (PRA) in the same two villages. The Upazila Health Complexes were selected as part of the greater CPHC research project, in which WHO Health Systems Performance Assessment Guidelines²³ were used to rank 20 Upazila Health Complexes based on their performance. The second stage of the study was conducted in the 'highest performing' as well as the 'lowest performing' health center. In

order to perform the household survey and the PRA, a list of all the villages in the respective Upazila (sub-division) was compiled and one village from each Upazila was selected randomly.

The FES involved observation for two weeks of patients utilizing the Upazila Health Complexes. In-depth interviews were conducted with two local government leaders (one in each site), 15 health service providers (total number), and 20 service seekers (total number). Respondents for in-depth interviews were selected purposively. For the household survey in the village, a systematic random sample of 5% of the total population was interviewed. The PRA session was arranged with the help of the local leader, and 30 people (both male and female) from different socio-economic strata participated in each of the villages.

Study Site

One of the two health complexes where the second stage of the study was carried out was Dhamrai Upazila Health Complex, located 20 kilometers west of the capital city of Dhaka. This health center was identified as the 'highest performing'. A household survey and PRA was conducted in the nearby village of Kashipur. The health complex is located adjacent to the Dhaka-Aricha highway, one of the busiest highways in the country. Dhamrai Upazila had a very good communication facility, which was approachable both by road and river.

On the contrary, Mehendigonj Upazila Health Complex in Barisal district was identified as the 'lowest performing' health center. The village of Charlata was selected for the household survey and the PRA. Mehendigonj is an Upazila of Barisal, one of the southern districts of Bangladesh, crisscrossed by many rivers, making communication very difficult. While Barisal city is approachable by road and river as well, our study site Mehendigonj Upazila was approachable only by river.

Data Collection and Analysis

A range of tools and techniques (e.g. checklists, semi-structured questionnaires, PRA guidelines) were pretested and employed to collect data for this study. Qualitative data were collected using checklists and PRA tools; and quantitative data were collected using a semi-structured questionnaire. Quality control visits were made during data collection. Qualitative data were collected by researchers trained in medical anthropology. A field research assistant was recruited and trained to conduct the household survey. The interviews were all tape-recorded and transcribed. Qualitative data were coded according to grounded and a-priori themes using ATLAS.ti5.5 software. Quantitative data were analyzed using SPSS version 13.0.

Ethical Considerations

Respondents agreed to take part in the research by giving their written informed consent. They were informed about how they were selected, about their rights not to answer the questions, to leave the project any time, to be protected from revealing their identity, and to know their roles in the process of collecting data before joining the project. Each respondent was compensated for his or her time by a gift item offered by

the research team. The researchers also responded to the queries at the end of each conversation. The research project passed through the Ethical Review Committee of James P Grant School of Public Health, BRAC University, and received due approval.

RESULTS

Background Characteristics

Respondents, although drawn from two distant areas of Bangladesh, were similar in many respects. Gender distribution, mean age, marital status, age of marriage, and family size were considerably similar in the two villages. However, we observed some differences in terms of educational qualification, household income, and occupational profile. In the village of Kashipur, situated near the capital city of Dhaka, respondents had better education, occupations, and income. Almost half of the respondents in Kashipur were illiterate, whereas the literacy rate was as high as three-quarters in the distant island of Charlata. In Kashipur, 37% of respondents belonged to the highest income quintile, whereas in Charlata only about 5% belonged to that group. There were also differences in the livelihood pattern (Table 1).

Access to Information

Household Survey Findings

Every individual had access to some source of information through mass media- 43% of people had at least one household member with a mobile phone – but the type of mass media providing the most health information varied between the two villages. Kashipur, being close to Dhaka, had better network access to television, whereas radio was the main source of information in Charlata (Table 2).

Television was used by the people from the highest two income quintiles, whereas radio was used by the lowest two. Newspaper was found to be a largely unused media (Figure 2).

Qualitative Findings

The Bangladeshi government has made it mandatory to mount the Citizen Charter in all government facilities in order to inform the people of their entitlements. In Dhamrai, the Citizen Charter was not only visibly placed but also a large billboard was erected at the main entrance of the health complex to inform the patients about available facilities. In addition, available services were enumerated on a black board in a familiar language inside the health complex building. The Chief of the health complex held regular monthly coordination meetings with field staff where he urged them to inform the rural patients about available services. Many services (e.g. Caesarian Section delivery) were made popular through this approach among the poor rural population. Local music groups were also used to inform people of available health services. Relevant services were also advertised in mosques by the Imams during Friday prayers, and during Hindu religious sessions.

The initiatives to inform people about health services in the island health center of Mehendigonj were quite the opposite. We found a Citizen Charter in the center, but it was placed in a shabby corner, on a damp wall where hardly any patients would view it. The Chief strongly acknowledged the importance of the Citizen Charter, but expressed his skepticism of its utility given the low literacy level among the people. But he expressed his optimism about the government's newly launched Community Clinic program, which he believed would bring health care closer to the people. Acknowledging the importance of community empowerment through information, he opined that Community Clinics can serve the purpose of informing people of their health entitlements as well.

Inclusion and Participation

Household Survey Findings

63% of respondents in Kashipur said there were no decision-making forums on health, while 35% said that they did not know whether there were any. In Charlata, all the respondents said that there were no such forums. None of the respondents had ever participated in any type of decision-making forum on health issues. The only two persons who reported that they participated in a decision-making forum said that their opinions had not been taken into consideration.

Qualitative Findings

Almost none of our patient respondents were found to be involved in a forum where issues related to health are discussed and decisions are made. Only one person, who was a Village Organization (VO) member of BRAC (a renowned development organization based in Bangladesh), said that she regularly attends weekly health meetings organized by BRAC where they discuss different health issues and how they can get involved in improving community health. All of the respondents unanimously and strongly expressed their opinion that such a forum is necessary.

When asked why they were not involved with such initiatives, the answer was plain and simple: "There is none". One respondent from Dhamrai said: "There are big people like doctors; among them how do I expect to make a scope to talk?"

Another patient from Mehendigonj also had the same expression: "Even if I want to get involved, they will include only the local elites. They will never include common folks like me."

Accountability

Household Survey Findings

Since there was no formal way of demanding accountability from decision makers, we used a 'client feedback mechanism' as a proxy. 93% of respondents from Kashipur said that they did not know whether there was any client feedback mechanism. In Charlata, 99% of respondents said that there was no formal client feedback mechanism. 83% of people in Kashipur and 100% of people in Charlata suggested that a person must be

appointed at the health center to listen to their complaints and suggest a solution. 15% of people in Kashipur suggested that a complaint box be installed for that purpose. A list of suggested methods of client feedback is shown in Table 3.

Qualitative Findings

One patient from Mehendigonj acerbically remarked, “Here we get some medication however trivial it might be; that’s all we can expect. How can we hold these important persons responsible?”

There was no formal way to challenge the accountability of the health complex personnel. As a result, a set of informal ways had developed, ranging from shouting and quarreling to even inflicting physical abuse on health care providers.

According to the government directive, previously every health center had a Health Management Committee headed by the Upazila Chairman (local government leader). According to a decision by the government, the local government leaders were removed from this responsibility and replaced by the local Member of the Parliament. Tensions raised by this decision eventually led to inactivation of the whole committee in many health complexes. Local government leaders felt that, on account of their greater involvement with the common people, they deserved more authority to monitor the health complexes, and ensure greater accountability of the health complex personnel.

We heard many stories from the patients about negligence and misbehavior of the health care providers, about which they could do nothing. According to patients, accountability was there, but it could only be sought by the influential people, not by common patients like them.

Local Organizational Capacity

Household Survey Findings

One of the proxies used for understanding the local organizational capacity was to explore whether communities could contribute, by any means, to the different government initiatives. Half of the respondents from Kashipur expressed their ignorance over the issue. In Charlata, all the respondents said that there were no such means. None of the respondents in any of the villages were found to have any experience of working in partnership with the government health services.

Qualitative Findings

Bangladesh is a disaster-prone country. During natural calamities people from all walks of life voluntarily collaborate with government bodies, including the Upazila Health Complexes. However, unfortunately, this enterprising practice is not nurtured during other times, especially in regards to health activities.

One of the most successful government programs was the Expanded Program on Immunization (EPI), which was also a great example of partnership of the people with the government. Community volunteers were recruited and trained by the health department, and the program became very successful. Reflecting on this success story, one Medical Officer (physician) at Dhamrai health complex told us, “You know about

the monumental success of National Immunization Day (NID) and EPI. Because of this program Bangladesh became free from polio and it still is. This reputation could never have been achieved without the participation of the people”.

The recent Community Clinic approach of the government also depended greatly on voluntary contributions from the people. Government was only responsible for building the structure, supplying the equipment and medicines, and employing staff. The community was responsible for management, maintenance, and security, and the land was donated by the local people.

Suggestions from Respondents

The PRA method helped us obtain suggestions directly from the community members about ways to empower them. They maintained that participatory research itself can be regarded as an empowering tool. Some other suggestions emerging from the PRA sessions include: 1) training the community members on health issues so that they in turn may educate other people in the community; 2) galvanizing already existing health education program; 3) organizing health education sessions regularly on the health complex premises; 4) involving mass media (radio and television) more closely to inform people of their health entitlements; 5) involving the local government to carry out health education programs; and 6) revitalizing the school health education program. In addition to the PRA, key informants, service providers, and service seekers at the health complexes made additional suggestions as follows.

Respondents shared innovative suggestions for how to empower them to attain their health entitlements. Information is imperative in empowering the community. Mass media, as noted by the respondents, can play a pivotal role in informing people of their health entitlements. In addition to that, materials outlining health entitlements and the available facilities in the nearby health centers could be developed to supplement existing Behavior Change Communication (BCC) materials, which concentrate on health practices only. There is already a wide network of government health workers who are primarily responsible for disseminating health education messages. These existing workers can play a fundamental role by informing people about the available services and the entitlement of the people, in addition to their usual health education messages. A more active role for the local government was also recommended as a factor in community empowerment. Local governments can organize regular community meetings where health issues can be discussed. These local government meetings can also pave the way for the community members to express their complaints and experiences regarding their encounters with health facilities.

Involving the males in the community was suggested by one key informant, who said, “I experienced that if males are motivated they can be supportive towards their female counterparts. Most of the health and development programs are targeted towards females in Bangladesh. However women empowerment is essential, it should be achieved through the understanding, responsiveness and involvement of males as well. If males were not supportive, micro-credit programs of Grameen Bank or BRAC could not be successful.”

It was suggested that people of the community must be involved in such a way that they develop a sense of ownership of the health center. Local people and local governments must have a mechanism of monitoring and ensuring transparency and

accountability of the health center staff. Local health authorities, including people from different arenas (e.g. local government, civil society, and other government cadres) can be commissioned to form an authority mandated to monitor and provide feedback. But above all, the level of education of the population must be improved and updated health issues should be addressed in the school curriculum.

DISCUSSION AND CONCLUSION

Owing to the good mobile network and affordable cost of mobile connection, many people use mobile phones even in rural areas of Bangladesh. Labrique et al. found 45.1% household ownership of mobile phone in rural Bangladesh,²⁴ which is similar to our findings in this study. Television and radio are also widely available; however, their use varies across regions and income groups. When deciding on the best mediums for health message delivery, this finding regarding the variability of communities' main sources of information should be kept in mind. Information targeted towards lower income groups can be more effectively distributed using radio instead of television or newspaper.

The importance of informing people of their health entitlements has been acknowledged by the government. However, there are two major caveats to achieving the objective. First, the implementation of the government order of informing people of their health rights is not uniformly implemented throughout the country. This is again related to other macro-level factors such as monitoring, resource availability, and commitment of personnel. Second, low literacy rates can inhibit achievement of the desired outcomes of the government directive. Education is a prerequisite for realization of the right to information, and Bangladesh is grappling with an adult literacy rate of only 56%.²⁵

Inclusion and participation, accountability, and local organizational capacity are the domains which cut a sorry figure according to our study. There were hardly any reported instances of health-related community engagement. Even where there was, it was perceived by the respondents to be ineffective. The issue of social hierarchy, and the distance between service seekers and service providers appears to be an important obstacle to inclusion and participation of community members, as well as to their ability to challenge decision makers about their deeds. Zaman described how extreme inequalities in power, influence, and opportunity create hierarchical behavior in countries like Bangladesh. He demonstrated in the context of a hospital ward in Bangladesh how patients are scolded and humiliated by all levels of health care providers, even the lowest level staff- the ward boys, and the cleaners.²⁶ This issue transfers to settings like the health complexes where we conducted our study and which are similar to small hospitals located in Upazilas.

Despite the dismal picture in the latter three domains of community empowerment, our study shows that there is persistent demand from the community for achieving goals in those domains, as reflected by community members' suggestions. The people of Bangladesh have a long history of social movements and successful collaboration with government initiatives. Unfortunately, many of those instances are limited to sectors other than health. In the health sector, the few examples are the Expanded Program on Immunization (EPI), Directly Observed Treatment-Short Course (DOTS) for tuberculosis, and family planning programs. These models deserve to be replicated in many other health programs in Bangladesh. The EPI program is a good

example of community involvement in a government-run program²⁷ – one that achieved a 95% child DTP3 immunization rate, one of the highest in South Asia.²⁸ The vibrant NGO movement in Bangladesh is also a testament to the social consciousness of the Bangladeshi rural community. Our research also found the evidence of NGO activity facilitating health decision-making.

The aim of this paper was not to establish a cause and effect relationship or even an association between health equity and community empowerment in Bangladesh. Rather, our aim was to explore a reinforcing factor in the pursuit of establishing UHC, and eventually achieving health equity. This study, which was originally a part of a larger study on CPHC, explored the status of community empowerment in Bangladesh. In reporting our findings, we aim to sensitize academia and policy makers to the need to conduct further research to understand the critical factors pertaining to community empowerment in Bangladesh; designing community empowering programs; evaluating the outcome/impact of the intervention; and, finally, formulating evidence-informed policies in this regard. This paper unearthed the unsatisfactory picture of community empowerment in certain domains (inclusion and participation, accountability, and local organizational capacity), and a satisfactory picture in some others (access to information). This piece of information can be useful for policy makers to decide, if convinced, which domains to emphasize in attaining community empowerment. Through qualitative enquiry, this paper conveys community voices in the form of suggestions and demands for their own empowerment. By no means is this an exhaustive list of community empowerment needs, nor do these recommendations function exclusively to further community empowerment, and consequently health equity. However, these can be considered as a basis for taking initial steps towards the epic journey of achieving health equity.

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²⁸ The World Bank. World Development Indicators 2012. Washington DC: The World Bank, 2012.

Figure 1: Pathway of Achieving Health Equity through Community Empowerment

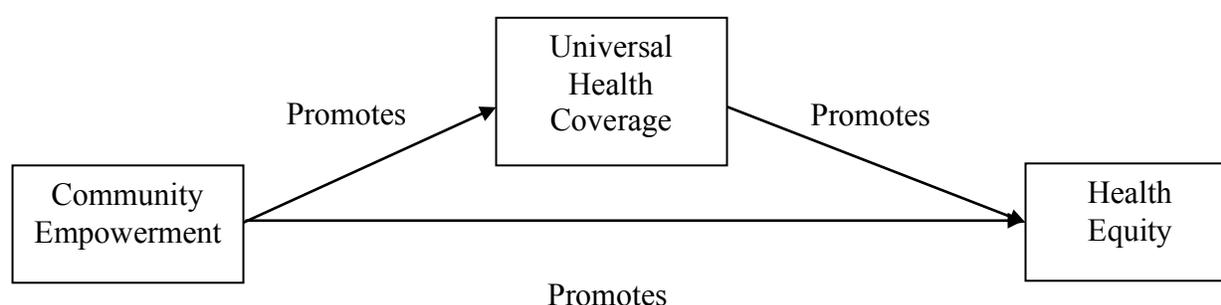


Table 1: Socioeconomic and Demographic Characteristic of Respondents

Characteristic	Aggregated	Kashipur	Charlata
Total Respondents	225	100	125
Number of Males	125	44	81
Number of Females	100	56	44
Mean Age (Years)	41.8	41.1	42.3
Age Group			
Younger (less than 35 years)	70 (31.1%)	33 (33%)	37 (30%)
Middle Age (35-50 years)	118 (52.4)	51 (51%)	67 (54%)
Older (more than 50 years)	37 (16.4)	16 (16%)	21 (17%)
Marital Status			
Unmarried	3 (1.3%)	2 (2%)	1 (0.8%)
Married	226 (96%)	95 (95%)	121 (96.8%)
Separated	6 (2.7%)	3 (3%)	3 (2.4%)
Age of Marriage (Years)	18	17.3	18.6
Family Size (Number)	5.5	5.3	5.7
Educational Qualification			
Illiterate	143 (63.6%)	48 (48%)	95 (76%)
Primary (Class 1-5)	72 (32%)	43 (43%)	29 (23.2%)
	7 (3.1%)	6 (6%)	1 (0.8%)

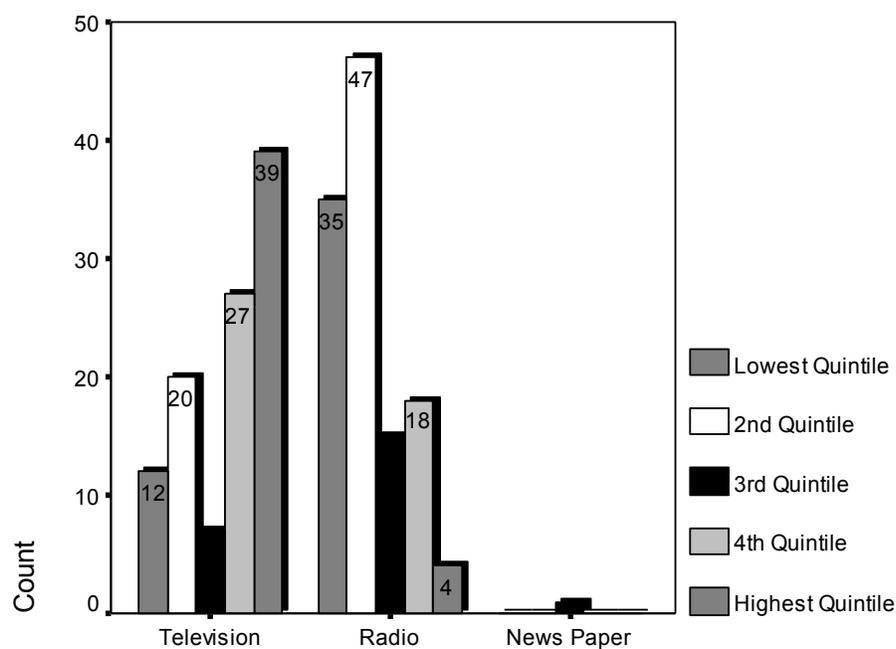
Secondary (Class 6-10) Higher Secondary (Class 11-12)	3 (1.3%)	3 (3%)	0 (0%)
Household Income (Taka)	8771.6	14015.0	4576.8
Income Quintile			
Lowest	47 (20.9%)	12 (12%)	35 (28%)
Second	67 (29.8%)	19 (19%)	48 (38.4%)
Third	23 (10.2%)	7 (7%)	16 (12.8%)
Fourth	45 (20%)	25 (25%)	20 (16%)
Highest	43 (19.1%)	37 (37%)	6 (4.8%)
Occupational Profile (Multiple Response Allowed)			
Farming in Own Land	85 (37.8%)	46 (46%)	39 (31.2%)
Agricultural Laborer	18 (8%)	7 (7%)	11 (8.8%)
Day Laborer	47 (20.9%)	16 (16%)	31 (24.8%)
Poultry Farming	4 (1.8%)	4 (4%)	0 (0%)
Dairy Farming	3 (1.3%)	3 (3%)	0 (0%)
Service Holder	40 (17.8%)	21 (21%)	19 (15.2%)
Trade and Business	98 (43.6%)	23 (23%)	75 (60%)
Expatriate Earning Member	42 (18.7%)	32 (32%)	10 (8%)
Other	4 (1.8%)	1 (1%)	3 (2.4%)

Table 2: Use of Mass Media Disaggregated by village

	Kashipur	Charlata
Television	100 (100%)	5 (4.0%)
Radio	0 (0%)	119 (95.2%)
News Paper	0 (0%)	1 (0.8%)

 (Pearson Chi-square P -value < 0.05)

Figure 2: Mass Media Usage by Income Quintile



Mass media giving most information

Table 3: Suggested Mechanisms for Client Feedback

Suggestion	Percentage
Government staff visit households to receive complaints	0.4
Installation of a complaint box	6.7
Local government members become involved	0.4
Appoint someone to receive complaints	92.4