

# Citizen Participation in the Health Sector in Rural Bangladesh: Perceptions and Reality

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## 1 Introduction

Citizen participation in governance is widely accepted as an expression of citizen rights and a manifestation of citizen agency. Citizen engagement with institutions and policy processes gives shape and content to the meaning of citizenship by emphasising direct intervention of citizens in public activities; it places obligation on both citizens and state, helps to ground the abstract relationship of citizenship within the consciousness of people, and reduces the often vast distance between the state and its citizens (Commonwealth Foundation and CIVICUS 1999). Citizen participation also produces tangible benefits by meeting the concern not only for citizen “voice”, but also for citizen agency and influence (Cornwall and Gaventa 2001). Where it takes the shape of collective action, it may also be seen as a mechanism to claim rights based on equal and full citizenship of the modern state, replacing traditional claims based on ‘norms, charity, benevolence, or patronage’ (Kabeer 2002: 20).

One area where citizen participation in the development policy process has featured very prominently is health. This article explores people’s perceptions about participation for claiming the right to health in rural Bangladesh, and the reality of experiences of participation in newly opened spaces for participation within the state health care delivery system, known as “community groups” (CGs). This article presents preliminary findings from research into the CGs that sought to explore the enabling and disabling factors for citizen participation in these intermediary spaces for citizen participation in governance.<sup>1</sup>

## 2 Citizen participation in the health sector

The right to health is generally seen as the state’s obligation ‘to deliver affordable, accessible health services to all’ (Cornwall *et al.* 2002: 1). Increasing people’s voice and influence in the health sector is believed to be an effective way of improving the performance of health systems to meet the right to health, by increasing access to services of the most vulnerable and disadvantaged groups, improving health outcomes generally and reducing health inequities. Active community participation through ownership and implementation of local health services is now a widely accepted means of ensuring such influence (MoHFW 1997; Das Gupta *et al.* 2000).

In the context of the broader shift towards a more “people-centred” development model, the Alma Ata declaration of 1978 identified as a critical element 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. However, it was only in the late 1980s that community participation emerged as an explicit strategy in health development; the means for achieving community participation are still debated. A lack of conceptual clarity persists about who exactly “the community” and their representatives are, about what “community participation” actually involves and about whether community engagement amounts to a real transfer of authority and responsibility or merely sponsored collaboration.

For the most part, community participation continues to be defined as an additional ingredient

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in health care delivery and is valued primarily for its instrumental role in making health services more cost-effective by intensifying the impact of health sector investment, by increasing the chance of success of health sector reforms, by changing the health-seeking behaviour of poor people, by building partnerships between government and local communities, and so on (Kahssay and Oakley 1999). References to 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.

Experiments with community involvement in health in developing countries have not yielded very conclusive results (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, for example vaccination campaigns, actual mechanisms of community participation have been problematic. Several factors have been identified as contributing to this situation (Kahssay and Oakley 1999; Oakley 1999; Loewenson 1999). One is the nature of decentralisation and the difficulty of tackling local power hierarchies, which may be more powerful at the local level than bureaucrats and professionals from the centre. Another is the fact that formal attempts at promoting community participation seldom include the documentation of procedures for participation, especially legal and institutional, in planning, management and arbitration (Loewenson 1999). Further, the gap that often exists between community expectations and provider perceptions of what is needed and hence provided gives poor people little incentive to invest time and effort. Factors such as unofficial user fees, negative and disrespectful attitudes of health workers and lack of information for users increase the distance between communities and the health system and create barriers to participation.

### 3 Empowerment and citizen participation

A 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. A key determinant of the potential of community involvement for fostering participation is the

understanding and practice of citizenship. Higgins (1999) writes of the importance for participation of having a sense of full citizenship, being defined as having equal status by being accorded rights. Some authors have argued that community participation requires transforming the passive client into active citizen, first by empowering people with citizenship as a formally ascribed political status, and next by mobilising people to act collectively, realizing citizenship as a collectively asserted social practice (Shaw and Martin 2000). In the absence of a widespread sense of full citizenship, there is a tendency for activists to dominate the world of participatory politics and for ordinary citizens to be excluded. Participants are often not representative of the ordinary people that health systems wish to serve, while those who do not participate feel they have little control and feel unimportant, marginalised or excluded as citizens (Mahmud 2002).

The 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. 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. Thus, participation and empowerment are interdependent. As Sen puts it:

What people can positively achieve is influenced by economic opportunities, political liberties, social powers, and the enabling conditions of good health, basic education, and the encouragement and cultivation of initiatives ... the institutional arrangements for these opportunities are also influenced by the exercise of people's freedoms, through the liberty to participate in social choice and in the making of public decisions that impel the progress of these opportunities. (1999: 5)

People are not willing to participate if they do not feel that they are able to make a difference, if the mechanism and procedures for participation are unfamiliar or too costly, or if they feel they are not in control. Hence, it is important that the conditions be created that enable citizens to participate or to

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act as citizens if they so wish, thereby developing their capacities as citizens in a virtuous cycle of citizenship participation (Lister 1997).

In societies such as Bangladesh, the acceptance of inequality and tolerance of invisibility of the poor and the marginalised represent major barriers to the establishment of this virtuous cycle. It is argued that participation can reverse this by creating a willingness among these groups to contest their devalued status, marking the beginning of a transformation in their citizen status (Kabeer 2002). This involves a journey from being an occasional citizen with only formal voting rights to claiming, realising and eventually enjoying other social and economic rights needed to achieve “full” citizen status. The steps in this journey are:

1. Acquiring social and human resources necessary for participation and engagement, like self-esteem, self-confidence, visibility and recognition.
2. Acquiring physical and institutional resources like space for participation and deliberation and requisite information, appropriate rules for deliberation and conflict resolution on a more equal basis, capabilities and skills for deliberation and participation.
3. Establishing mechanisms for building trust, assessing change and learning deliberation and engagement to be effective in reducing inequality and increasing access.

This article examines the extent to which community participation institutions in the health sector in rural Bangladesh function as spaces within which this journey can commence and progress, enabling citizen “voice” to be heard, citizen influence to be felt and provider accountability to be established. The purpose of this article is not to trace the entire journey (which is covered more fully in Mahmud 2003), but to focus on exploring prevailing notions about citizen participation as perceived by ordinary people and to determine people’s perceptions about the boundaries of their participation space which create barriers to citizen agency.

### 4 The Bangladesh context

The spaces for participation, which are the focus of this study, form part of 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 (HPSP) launched in 1998. This experience is located in a context which has a number of distinguishing features.

First, the prevalent perception is that of the state as guarantor of citizen status and custodian of all rights, legal, political, economic and social. However, the actual experience of rights is implicitly shaped by the culture of the paternalistic state and dependent citizen, causing a gap between formal recognised rights and real experienced rights. This gap is differentiated by the extent of dependency and powerlessness (or lack of economic and institutional resources) and by the degree of non-recognition and invisibility (or lack of social and human resources) (see Kabeer 2002).

In a society like Bangladesh, a sense of control and feeling of being useful and able to contribute, essential for citizen agency, is strongly linked to access to material resources like land and education and to non-material resources like position and authority within the community. The poor and marginalised are understandably very risk averse and unlikely to behave in ways that violate traditional norms and common practices of allegiance and submission. The greater the degree of dependency and invisibility, the wider the gap is between the formal and the real. This creates “lesser” citizens and “unequal” rights. This, in turn, leads to perceptions of differentiated citizen roles with respect to responsibility for engagement and deliberation for informing and influencing policy.

Linked to this reality and perception is the construction of a citizen identity shaped by tolerance and silent acceptance of inequality in status and rights. Thus, the belief is common that not everyone has equal rights or are “full” citizens. Inequality of rights and even denial of rights is rationalised and accepted as the natural order of things in a class and power differentiated society. As Kabeer (2002: 21) points out, this ‘absence of question’ by the marginalised and powerless is the result of mutually reinforcing experiences of denial of recognition and persistent devaluation by others (bureaucrats, service providers, professionals, elected representatives, well-to-do people, etc.) and their own low self-esteem and low self-confidence.

Institutions and systems responsible for providing and ensuring social and economic rights in Bangladesh, starting from the parliament down

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to local elected bodies, markets, courts and public service delivery systems, operate at very low levels of effectiveness and accountability. This contributes to socio-economic polarisation and extreme inequality of access. Formal local elected bodies like the Union Parishad (UP) 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). In addition, institutions and systems that implement policy view the people they are supposed to serve more as passive recipients and unquestioning beneficiaries, and at best clients and users, instead of as citizens with rights to claim and dissent. Thus, the dominant policy view regarding citizen participation and civic engagement for voicing needs and influencing policy is that participation is unnecessary and even viewed with suspicion and hostility. Indeed, policy may even be described as “managerial paternalism” and as “disciplining” to create “good” citizens who are compliant users of public provision (Cornwall *et al.* 2002).

Finally, the overriding feature of the Bangladeshi context is one of poverty, setting a context against which all systems with the responsibility of rights provisioning, such as health, education, social safety nets, and financial services, and institutions like markets, courts and media have to operate and need to be set. Poverty mediates all action and non-action, participation and non-participation, being and well-being, determining the rationalisation and action not only of the powerless poor but also of the powerful non-poor.

### 5 Participation in rural Bangladesh

Significant efforts have been aimed at initiating and introducing participatory processes into the development policy arena. Mostly, 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 and community workshops for exchange of ideas and opinions between local residents and service providers, particularly during the preparation of the Poverty Reduction Strategy. Participatory consultations also featured prominently in the preparation of the HPSP (Mahmud and Mahmud 2000).

The health sector in Bangladesh is a combination of private and public delivery systems, and is largely of poor quality, inequitable access, and non-accountable provision (with the exception of a number of targeted vertical programmes like immunisation). In 1998, partly to address these weaknesses, the government decided, as part of the HPSP, 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). 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. The CG was, thus, a new space for community participation and deliberation in the provision of accessible and affordable health services. It was believed that the community's need to have a reliable and responsive health service that was accessible by the most vulnerable groups and was answerable to them would be sufficient incentive for the community to participate in the operation of the state delivery system at the local level, something that was quite unique given the existing social and policy environment.

An initial study of the CGs by the author (Mahmud 2002) concluded that their operation and functional performance had been constrained by several factors. These included: the selection of members was usually biased towards the well-off and professional classes; the lack of official recognition from the Ministry of Health, which contributed to the absence of authority, and the credibility of the CGs and the frequent absence of effective leadership and proper delineation of authority and responsibility within the CG. Surveys of residents showed that levels of use were relatively high at 60 per cent, with women accounting for 84 per cent of the total: indeed men in one village stated that the clinic was for women only, given the overwhelming emphasis on oral contraception among the services it offered. Most respondents were unaware of the existence of a channel for

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registering their complaints about the clinics. Only 35 per cent of respondents actually knew about the CG, and only 18 per cent of those who knew about it (6 per cent of all respondents) reported that CG members actually spoke to them and enquired about their health problems and needs.

The survey of CG members confirmed the initial finding (Mahmud 2002) that they were generally drawn from the village élite, with significantly higher levels of both education and income than the majority of the clinic users and frequently with strong connections to local power structures. Nearly half of CG members owned or cultivated three acres or more of land, which puts them in the large land-owning category, and all of them had tin or brick homes. All but one of the CGs included elected members of the UP, the lowest level of local government, and the UP chairman was most frequently cited as the source of the original invitation to join the CG. In most cases there had been very little interaction or communication with the larger community about the selection of CG members.

There was also a widespread lack of clarity about the function of CG members, both among clinic users and among CG members themselves. Some of those interviewed were actually unaware of their CG membership (which was often conferred as an honorary status in recognition of land donations). Others were unable to name any specific functions of CG membership. Meetings of the CG were infrequently held and poorly attended, even by the chairpersons, the most frequently cited reason given being 'lack of time'. In one CG the chairperson was not aware of which days of the week the clinic was open and which days the health providers were making home visits for immunisation.

In discussions with CG members, participation was not identified as an expression of citizen rights or responsibility. The primary responsibility for creating a "good society", one that would provide education, health care, jobs, security and make and implement laws to get rid of all bad sides of society, was invariably vested in the *sarkar* (government). The perception of the omnipresent state and its supreme legitimacy was evident in the ease with which land donors were identified and construction work completed, and the almost casual and unilateral way in which such a new and untested delivery mechanism was put in place purely on the basis that it was the action of government. Everyone

who was invited to be a member of the CG readily agreed without having a clear notion of responsibilities. No doubts were expressed about the chances of success of the system and if there were any differences of opinion or hesitations these were not articulated.

The enormous credibility enjoyed by government and the strong belief in its benevolence precludes any role for citizen participation in the provision of rights or in oversight of state provisioning. This also inhibits willingness of people to challenge public action of any kind. People's limited knowledge about state delivery mechanisms limits their capability to assess how the system operates and undermines their self-confidence in questioning government action.

Citizens are seen as having very limited responsibility, mainly focused on changing the behaviour of their fellow citizens rather than on oversight of the actions of the state. CG members mentioned their responsibility to create awareness about good health and hygiene practices and the importance of sending children to school, to motivate others to refrain from "bad deeds" and to remove people's "superstitions". In addition, wealthy citizens are seen as having the responsibility for helping the poor in times of need, a perception supported by the Muslim norm of giving *zakat* (distributing a certain fixed percentage of one's income among the more needy).

This combination of limited legitimacy, élite political affiliation, unclear responsibilities and deeply-rooted reluctance to challenge the state has contributed to limiting the effectiveness of the CGs in mobilising collective action. For example, when the supply of medicines from the *thana* (subdivision) health complex to community clinics was stopped for political reasons in late 2000, CGs did not openly challenge the decision. While CGs in many villages agreed that they should raise their own funds from the community in order to meet costs of maintenance and to ensure at the least a limited supply of medicines, they have so far been unable to mobilise community support for or participation in this endeavour.

The following section deepens the analysis of the reasons behind this limited effectiveness by exploring people's own understandings of the boundaries of their participation space and the structural constraints in developing the capabilities needed for citizen participation. The last section

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discusses these findings and suggests some tentative conclusions about two sources outside the CGs of potential support for addressing the perceived resource needs of people for developing capabilities for participation.

### 6 Boundaries of participation space

Several constraints were identified by CG members and by local residents (clinic users and non-users), which delineated the boundaries of their participation spaces. Many of these echo the challenges to inclusive citizenship discussed by Kabeer (2002).

#### 6.1 Poverty

Poverty poses a very real challenge to citizen agency and restricts the boundaries of participation in rural Bangladesh. Poor people have to work long and hard to make a living. Anything not directly impinging upon their livelihoods or not of immediate urgency is low on their priority of time allocation. Participation is not costless; indeed, the costs of participation can be quite prohibitive, especially for poor people and women. We found that women members of the CGs were very irregular in attending meetings, and the most common reason given was the burden of housework and the need to take care of sick family members. For most people there is little incentive to participate in activities that do not have immediate and relevant outcomes or which have little chance of being effective. One male CG member commented on the ability of the poor: 'Ordinary village people do not have the ability to do anything because they are poor. They live from hand to mouth, what are they able to do?' About his own ability a poor farmer said, 'I am poor. I can hardly bear the burden of family expenses, thinking about health care is a long way off'.

#### 6.2 Power inequalities

Forms of inequality that reflect social relations in the "private" sphere (family, kin, community) are reproduced in the "public" sphere and constrain what people are capable of doing to influence public action. These unequal social relationships between rich and poor, young and old, women and men, not only inhibit citizen agency in general, but are even superimposed upon the interpersonal relationships within the CG. As a result, women and the poor are less likely to participate on an equal footing or to the same extent as men or the

non-poor. Women CG members were also generally silent members, and attributed their silence to lack of education and knowledge. One educated woman CG member, who was the vice chairman, speaking about her own inability to participate more fully in the CG, said, 'I have no ability on my own, and besides I am a woman'. A landless woman CG member said, 'I am poor and ignorant, what will I say? Those who are more knowledgeable speak more [at meetings]'.

#### 6.3 Anticipated reaction

Fear of anticipated reaction or threat of withdrawal of support from the powerful can be a very real barrier to citizen participation. Because they have to live in the village and have to rely on more powerful persons, people fear being singled out and do not want to get into any sort of confrontation. One poor woman who does not use the clinic said 'if we all go together to complain [about the clinic] ... we will become identified'. A male respondent who was not a clinic user identified the role of this fear in undermining accountability: 'They are all thieves, they steal the medicine, but we can't complain ... we have to live here, don't we?'

#### 6.4 Low self-esteem

The fact that the poor and women are not accorded value by the powerful and elite reinforces low self-esteem and the belief that they are not important. The low value placed on women and the poor by society impinges upon the ability to believe one has rights and that one can "act as a citizen". To claim one's rights there has to be prior belief in one's right to have rights and the ability to act upon them, that is to have belief in one's agency. Poor people interviewed rationalised the fact of not being informed about the CG by stating that they are not important enough. One woman commented 'it is no use speaking with the chairman or a member ... nothing happens because they don't give us any importance'.

#### 6.5 Invisibility

Invisibility from the public sphere restricts people's participation space. For the vast majority of people participation is limited to the sphere of their daily productive, reproductive and social activities, located within the family and extended family, the immediate community of neighbours and kin, and the *goshti* or patron group. Invisibility is

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compounded by the fact that people do not have a clear notion of the interrelationship between state and citizen or about their own rights and obligations. The feeling of invisibility among the poor and women is created because they are not called on to participate in any “important” public space. Poor people are hardly ever invited to sit on the *shalish* (village court) or to mediate disputes around land.

### 6.6 Party politics

The politically connected and powerful donate the land and are selected into the CG membership, even if they lack qualities stated as necessary to participate (as in the case of one woman selected to be a CG member purely on the basis that she was the wife of the politically influential contractor who had built the clinic). Conversely, those out of political favour are unable to participate or are prevented from participating. For example, one CG chairman was ousted, with false legal cases, as soon as the political party he belonged to lost the election.

### 7 Discussion and some concluding remarks

So far, the effectiveness of the CGs in operating community clinics for service delivery to the most disadvantaged groups of the population has been limited, and their ability to function as a space for citizen participation and a means for developing capabilities to participate has been negligible. The CGs have not been able to address the constraints of poverty, dependence on powerful groups, social inequality and invisibility, low self-esteem and lack of interpersonal skills and absence of political clout, all of which prevent citizens from engaging with state institutions in decision-making processes affecting their lives. If anything, these structural constraints have been reproduced and reinforced within the CG, undermining participation within. Hence, citizen capabilities to participate in governance and accountability of state institutions have not been developed. Neither have the CGs been able to foster a sense of community since perceptions of rich–poor differences in capabilities and citizen responsibility remain very strong.

When interviewees in the case study villages were asked what resources they believed helped in acquiring the capabilities for citizen participation, the two most strongly identified were formal schooling and mobilisation of the poor. People feel that knowledge gained formally through schooling,

rather than through less visible non-formal means, allows one to contribute to improving society and influencing public action. Being “educated in school” is believed to impart status (respect) and social value (especially for girls by their in-laws) and increase visibility. Education is believed to enhance interpersonal skills and reduce exposure to exploitation. Unity and solidarity is highly valued, especially by poor people, since it is believed to generate strength and power to confront both the lack of accountability of state institutions as well as deal with the dependence of the poor on the patronage and support of more powerful groups. Being part of a group also reduces the possibility of being identified or singled out and minimises individual costs of participation. It is felt, even by the non-poor, that if poor people are united they can articulate their demands more forcefully.

Evidence suggests that schooling to a certain threshold level can be an important resource to develop capabilities for participation and that group membership can provide a fall back against different kinds of class- and gender-based oppression, creating a social and political space for organising collective action and enhancing individual agency in taking positive actions that improve well-being. In rural Bangladesh, the key educational factor is access to secondary schooling, which for the poor is severely constrained as a result of direct and indirect costs and the associated pressures to drop out for marriage or to enter the labour market. Access to institutions that promote organisation and mobilisation is relatively greater, and for the poor and women group membership appears to be a promising resource for developing participation capabilities.

What this analysis has shown is that even if structural factors are addressed, fundamental questions of power, hierarchy and exclusion will continue to condition the potential for the emergence of a process of empowerment as both driver and consequence of citizen participation. Investing in education and group solidarity as sources of empowerment are neither easy nor short-term solutions. But implementing initiatives for community involvement in health such as the CGs, without adequate attention to these questions, carries the risk of simply reinforcing existing power hierarchies and generating further frustrated expectations among the poor and marginalised.

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### Notes

1. Each case study was based on interviews using semi-structured and open-ended questions with members of the CG, clinic users and non-users and, in some places, health personnel. In all 40, CGs were covered, out of which nine were covered in depth. Field work

and interviews were conducted by Mita Zaman, Khaled Sinha and Rezaul Karim, who were trained and supervised by the author during July to September 2002. For a fuller summary of preliminary findings, see Mahmud (2003).

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