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Patterns and Determinants of Community Participation in Community Clinics in Rural Bangladesh

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Abstract: This paper aims to assess the patterns, determinants and magnitude of local peoples' involvement in community clinics (CCs) in rural Bangladesh. We endeavor to show how these clinics function in rural settings, taking account of local socio-economic and political contexts, and additionally to explore how community members perceive their participation in the clinics' activities. To this end, an ethnographic approach has been used as a methodology. Drawing on ethnographic data from rural settings, we argue that rural healthcare provision may be usefully examined in light of a community-based approach. The findings indicate that CCs have played a crucial role in providing primary healthcare among rural women, poor and marginalized people; however, the utilization of the existing healthcare services is still low compared to the target set in the policy. The extent of local's engagement in clinics is determined by different contextual factors, including social stratification, power dynamics, and the possession of social and cultural capitals. Although there has been an observed rise in the extent of community engagement, it has not yet reached the expected level. Sociocultural dynamics, political and economic factors, and a lack of awareness among locals are the key barriers in this regard. More specifically, both structural arrangements and cultural factors within the local community determine the success of CC programs. The effectiveness and sustainability of CCs are believed by local people to be greatly enhanced by the implementation of a community-participatory strategy, provided that the goals behind this approach are really adhered to and put into action. Hence, conducting comprehensive research is necessary in order to develop future action plans that may improve the quality, magnitude and level of community engagement in CCs. Aside from its scholarly contribution to public healthcare management, the findings may be useful for policymakers who are involved in the decision-making processes of CCs.

Keywords: Community clinics, community participation, empowerment, rural Bangladesh, SDGs

Introduction

The involvement of people and communities is of utmost importance in the advancement of public health, as it acts as a means of mobilizing efforts and motivating both individuals and communities. Furthermore, it assists individuals in formulating policies and programs that are tailored to address their particular requirements (Chu, 2016). When it comes to interventions, it becomes an important tool for effective changes in individuals' attitudes and behaviors, with the ultimate goal of fostering a

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heightened feeling of responsibility. The Alma Ata Declaration of 1978 emphasized the need of involving local communities in primary healthcare, as highlighted by WHO and UNICEF. Since then, a total of 150 Member States of WHO and the United Nations (UN), including Bangladesh, have made a commitment to enhance the involvement of people in the management of healthcare facilities at the community level. The primary objective was to bring about a transformation in the advancement of healthcare systems with the aim of attaining 'Health For All' by the year 2000.

However, it was discovered in 1998 that Bangladesh was significantly far from the designated goal in terms of health for all (Khan, n.d.). The limited availability and accessibility of primary healthcare facilities to the vast rural population, comprising 75 percent of the national populace, and especially to marginalized, destitute, and vulnerable groups, were the ultimate sufferers in this situation. Within this particular context, the idea of the then government was effectively implemented through a strategic initiative aiming at establishing community clinics in various rural areas across the country, including those that are geographically challenging and isolated. The endeavor was to facilitate the accessibility of primary healthcare services to the rural populace, thereby ensuring their convenience and proximity to such essential provisions (Parvin et al., 2021). So, Community Clinic, the lowest-tier health care facility, started its journey in 1998 with a view to introducing a one-point service outlet for healthcare for the people of rural Bangladesh (Khan, n.d.).

Throughout the course of human history, different strategies have been used to foster collaboration among individuals with the aim of collectively pursuing a shared objective. For example, there is a growing emphasis on promoting development projects that engage people at the grassroot level in order to enhance their long-term viability (Kieya, 2016). Community involvement is characterized by a proactive approach in which the beneficiaries exert influence over the conception and administration of development efforts, rather than just receiving a portion of the project's benefits (Adesida & Okunlola, 2015). The achievement of sustainable development is facilitated by giving users the authority to choose the extent of services, make critical investment and management decisions, and allocate resources to support their chosen actions (Adesida & Okunlola, 2015; Sara & Katz, 1998). The participation in sustainabile initiatives may lead to self-initiated engagement, giving individuals a voice, the opportunity to make choices, and a sense of empowerment (Adesida & Okunlola, 2015; Mansuri & Rao, 2004).

Both Local Agenda 21 and Healthy Cities place significant emphasis on community engagement as a fundamental principle. The inclusion of sustainable development in the aims of the Earth Summit was a significant component of the United Nations' Agenda 21 action plan, aimed at fostering sustainable development throughout the 21st century. Since its establishment in 1992, the implementation of Local Agenda 21 has been accompanied by the promotion of a sharing and bottom-up approach to sustainable development (WHO, 2002). The implementation of Health for All and the Ottawa Charter for Health Promotion within respective communities is a responsibility assigned to local governments, as outlined by the "Healthy Cities" project (WHO, 2002). Engagement within the community is seen as an essential aspect shared across individuals (WHO, 2002).

During the 1950s, there was a prevailing perception that community development and community participation were synonymous. Currently, there is a debate about the correlation between the two entities. Consequently, the existing body of literature on this issue may be categorized into three separate schools of thought. According to de Kadt (1982), the first school of thought involves the substitution of community development with a more suitable form of community engagement. Within the realm of academic discourse, it has been observed that the concept of "community development" has undergone a transformation in the second school of thought, whereby it is now referred to as "community involvement". It is worth noting that despite the subtle variation in terminology, these two expressions bear striking resemblance to one another (Sheng,1990:57). Furthermore, community

development is widely recognized as a kind of engagement; nevertheless, its implementation is contingent upon varying and sometimes conflicting viewpoints (Ekong & Sekoya, 1982).

Active participation is a key expectation for those involved in community activities, since it entails taking a direct role in decision-making processes. According to Brown and Wocha (2017), community engagement encompasses the active participation of individuals, families, and groups in decision-making processes, which in turn enables them to cultivate the essential skills and capabilities for enhancing their own well-being as well as that of their fellow community members. According to Theron (2005), there exists a diversity of perspectives about the efficacy of citizen engagement. This is due to the belief that citizen engagement enables individuals to harness their creative potential, effectively allocate resources, exercise decision-making authority, and assume responsibility for matters that effect their lives. Based on all of these, Okafor (2011) came to the conclusion that popular participation is a clear depiction of how the people's involvement works together, pool their efforts, and use their resources to reach the goals they set for themselves.

Hence, according to post-development perspective, community participation approach is essential for promoting health as it empowers local people and reflects their priorities in policy-making and implementing of the project. In pursuit of this objective, the government has established over 13,500 CCs, each catering to a catchment area population of approximately 6,000 individuals (Shah, 2020). A community clinic is a small healthcare facility primarily developed in geographically isolated and underserved regions with the aim of facilitating health education and delivering essential primary healthcare services directly to individuals within the local communities. The participatory aspect of such clinics exemplifies a public-private partnership programme aimed at ensuring that health and healthcare quality align with Sustainable Development Goals 3. Additionally, these clinics seek to empower local people by including them in the processes of designing, implementing, managing, and monitoring community clinics.

Research Objectives and Methodology

The objective of this article is to analyse the patterns and factors that influence community engagement in community clinics located in rural areas of Bangladesh. Specifically,

(a) to explore the patterns of participation of community members in the need assessment, design and planning, implementation, monitoring, and evaluation of community clinic activities;
(b) to identify factors that affect the participation of locals in clinic activities, and
(c) to determine if community participation is effective in sustaining community clinics.

The research was undertaken by the first author of this article as a part of a wider ethnographic study (2020) in two rural community clinics situated in the Rajshahi region of Bangladesh. Chowdhury (1988) emphasized the significance of ethnographic enquiry in a rural context, highlighting its suitability for comprehending the societal and cultural dynamics of rural Bangladesh. This approach facilitates the establishment of a rapport between the ethnographer and the study population, fostering trust and minimizing potential misconceptions pertaining to the objectives of doing fieldwork. The selection of both clinics was purposive, taking into account the specific objectives of the research. This study has used the ethnographic methodology, applying several methods such as participant observation, key informant interviews, case studies, focus group discussions, and document analysis to gather the necessary primary data in order to achieve the research objectives. The combined sample size for the Key Informant Interviews (KII), Focus Group Discussions (FGD), and case studies included a total of 52 participants. Furthermore, a comprehensive compilation of secondary data has been acquired from pertinent books, scholarly papers, and reports. The participants were requested to provide their accounts of their participation in different aspects of community clinic operations, including planning, implementation, management and maintenance, monitoring and evaluation, quality

care, fundraising, and decision-making. In addition, the fieldwork included the consistent maintenance of four distinct kinds of notes, namely jottings, field notebooks, a diary and a logbook.

In order to ensure the reliability, validity and trustworthiness of the collected data, different sources have been used and a triangulation procedure has been employed to ascertain the accuracy of the data. In this instance, the data obtained from observations, participant observation, and focus group discussions (FGDs) were analyzed and compared in conjunction with case histories and key informant interviews to provide a comprehensive understanding. The essential data acquired through interviews and observation was supplemented with documents pertaining to particular agency. Following the collection of data, the raw data underwent a coding process that included categorizing them according to the emergent themes. In conducting the data analysis, a thematic and systematic approach was used, and the presentation of the results was done using manual means. The study also prioritized ethical considerations by actively seeking and ensuring the permission, confidentiality, and voluntary participation of the research participants.

Theoretical Framework

The Social-Ecology Model (SEM) serves the theoretical basis for this study. It was established under the umbrella of ecological theory in which SEM makes substantial contributions to describe the many aspects of community involvement in development-related endeavors (Bronfenbrenner, 1979, 1994; Stokols, 1996, as cited in Sulaiman et al., 2014). The foundation of SEM is predicated upon the premise that people must actively participate in their own communities in order to have a comprehensive understanding and perspective on factors that influence their behaviour. Under this theoretical framework, individuals are conceptualized as being nested within a system of networks that has consistently shown growth and expansion. The immediate environmental circumstances that constitute the SEM include human, social, institutional, and policy factors (Stokols, 1996 as cited in Sulaiman et al., 2014). The choice of an individual to accept or deny participation in community clinic management is likely to be impacted by their contacts with the specific context in which they find themselves. Consequently, gaining comprehensive understanding of all possible scenarios inside the system in which individuals are embedded provide substantial insights into the factors that impact engagement within that system (Stokols, 1996 as cited in Sulaiman et al., 2014). Hence, we assert that SEM is a suitable framework for examining individuals' participation in community clinics. When it comes to the actual application of community clinic management, an individual's choice to accept or deny participation is determined by their encounters with the distinct environment. Hence, gaining a thorough understanding of all potential situations inside the system in which people participate will provide significant knowledge about the aspects that affect their engagement (see Figure 1).

Fig. 1: Social Ecology Model (SEM) drawn from Sulaiman et al., (2014).

The development of a four-level model by the Centers for Disease Control and Prevention (CDCP) may be attributed to the influence of social ecology theory on understanding the elements that affect health. The first level of the model incorporates biological and other individual characteristics, such as age, education, earnings, and medical history. Individuals who are part of immediate social network, consisting of close friends and family members, constitute the second tier of connections. This degree of social interaction has a substantial influence on an individual's behaviour and overall life experiences. When analyzing the societal environments in which people reside, the third tier of community attempts to identify the characteristics of these contexts that influence people's well-being. The fourth tier of analysis delves into the broader social factors that have the potential to either promote or hinder the state of public health. The existence of socioeconomic disparities may be ascribed to both cultural and social norms, as well as to the policies that aim to either perpetuate or alleviate these disparities (CDCP, 2015).

Community Participation: Conceptualization

The term 'community participation' is used to refer to a wide range of activities in which people are active in making decisions and working toward common goals. Community engagement starts to emerge when a collective of individuals unite to address their particular challenges. According to WHO (1991:4), there are three proposed meanings of participation: contribution, organization and empowerment. Participation in predetermined activities and initiatives is facilitated by the community's contributions of work, financial resources, or other supplies. To facilitate and streamline participation, the establishment of institutions is vital to enhance accessibility and engagement for individuals. In order to enhance participation, it is essential to provide groups and communities, especially those facing poverty and disadvantage, the capacity to have genuine influence or authority over healthcare initiatives and provisions. Participants are more inclined to exhibit proactive behaviour and engage in action when they get encouragement from the facilitator (Kumar, 2002). Okafor (2011) reiterated similar perspectives and said that via community involvement, individuals actively participate in decision-making, take action, and engage in reflective practices as conscious agents. Furthermore, according to Kofi (2013), active participation of individuals in the management of societal advancements is especially effective for the principles and practices of social democracy.

Community Clinic in Bangladesh: Origin and Development

Since gaining independence in 1971, Bangladesh has implemented various measures to decentralize its healthcare system. These measures include the establishment of upazila (sub-district) health complexes, which aim to gradually extend healthcare services to the local level. Currently, Bangladesh is actively pursuing its own strategy to attain universal healthcare coverage, with the goal of ensuring access to healthcare for all individuals within the country. In accordance with the Alma-Ata Declaration's commitment to achieving universal health coverage by the year 2000 via the implementation of primary health care, the government of Bangladesh, in collaboration with the WHO, devised a strategy to build a community clinic for every 6,000 people in 1996.

Within the given environment, the realization of the government's initiative to establish community clinics in rural regions throughout Bangladesh, including the most challenging and isolated areas, was achieved via a strategic approach aimed at providing primary healthcare services directly to the rural population (Khan, n.d.). The community clinic initiative is an innovative endeavour aimed at delivering essential healthcare services to the remote areas of Bangladesh. The CCs are healthcare facilities that serve as the main providers of primary healthcare services at rural areas. These institutions are established and managed by the government in partnership with local communities (Riaz et al., 2020). It is worth mentioning that Bangladesh encountered a range of challenges stemming from resource scarcity and the limited availability of basic healthcare services to its vast rural population (Ministry of Health and Family Welfare, n.d.). This initiative was developed as a substitute for pre-existing outreach programmes. The establishment of community clinic has played a significant

role in the attainment of Millennium Development Goal (MDG)-4, which aims to reduce child mortality, while also setting the stage for enhancing maternal health as outlined in MDG Goal 5 (Bhuiyan et al., 2018). The transition from MDGs to SDGs is expected to result in community clinics assuming a pivotal role in the attainment of the SDGs and the provision of essential healthcare services to the majority of Bangladesh's populace (Sterne et al., 2016). Moreover, the attainment of universal health care stands as a fundamental aim of SDG-3. The realization of this target necessitates the establishment of partnership between the private and public sectors.

The community clinic is a compact facility comprising of two rooms, equipped with drinking water and sanitary amenities. The structure is built on a parcel of land that is generously donated by the local community. According to Bhuiyan et al. (2018), the provision of staff and resources by the government is seen in each clinic, where there is a presence of one community healthcare provider (CHCP), one health assistant and one family welfare assistant. In spite of several challenges, the aforementioned effort was revived in 2009 under the *"Revitalization of Community Health Care Initiatives in Bangladesh (RCHCIB)."* This initiative aimed to create a total of 18,000 community clinics in rural Bangladesh (ibid). In order to facilitate effective administration, every community clinic has formed a Community Group (CG) led by a locally elected Union Council member. This group should have a minimum of 13 to 17 individuals, with a requirement that at least one-third of the members be either female or teenagers. The collective encompasses many constituents of the catchment population, with the individual serving as the member secretary being a Community Health Care Provider (CHCP). In order to facilitate the clinic's management and promote community health education, every CC is equipped with three Community Support Groups (CSGs). These CSGs consist of 13-17 members, ensuring that at least one-third of the group is comprised of female members. The concerned-UP chairman serves as the principal patron for all of the Union's CCs. Both group members have received orientation and volunteer their time. It is found that if group members are proactive and the UP chairman is engaged and supportive, certain CCs do better than others (Khan, n.d.).

Patterns of Community Participation in Community Clinic

The establishment of a community necessitates more than just physical proximity among individuals; it also requires a collective adherence to a common system of principles, beliefs, and actions (Suffian et al., 2012). The concept of participation in community development refers to the active participation and endorsement of individuals or groups in the established activities and objectives of a community (Cavaye, 2010 as cited in Sulaiman et al., 2014). The active participation and contribution of all community members are vital in the development and implementation of any activities or initiatives within their locality. According to Lyndon et al. (2012), this intervention is expected to have positive outcomes for individuals, leading to an enhancement in the quality of life (as cited in Sulaiman et al., 2014). Community engagement should include the provision of assistance to grassroots communities, the establishment and enhancement of professional work networks, and a willingness to expedite the program's implementation to guarantee its efficacy for the majority of populations. It often encompasses different stages, including planning, execution, assessment, and monitoring (see Figure 2).

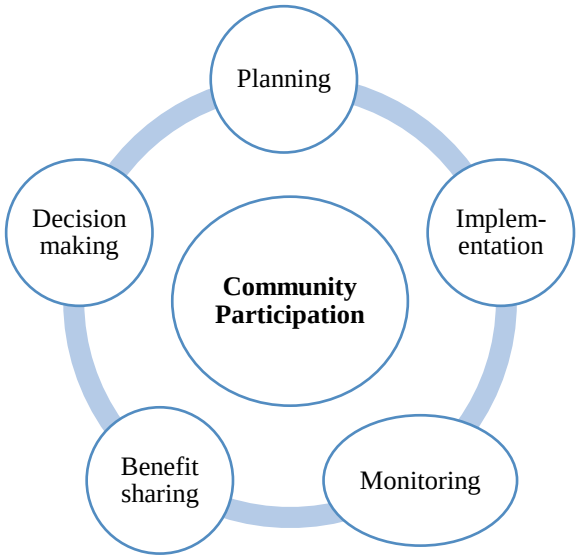

Fig. 2: Elements of Community Participation (Lyndon et al., 2012 as cited in Sulaiman et al., 2014: 2442)

Challenging Lyndon's argument, Wilson and Wilde (2003) established a framework consisting of four distinct aspects that pertain to community participation: influence, inclusiveness, communication, and capacity (as cited in Sulaiman et al., 2014). Cavaye (2010) drew an analogy to an onion ring characterized by layers that include the essence of the community, including those actively engaged, those passively involved, as well as those who possess awareness but lack active involvement. Individuals who possess knowledge of a certain project or activity but lack interest in it might be categorized within the bigger group referred to as the "aware circle" (as cited in Sulaiman et al., 2014). According to this analysis, seven characteristics of community engagement have been taken into account to better comprehend these three models in this study (Fig 3).

Community Participation	Planning
	Implementation
	Management/ Maintenance
	Monitoring and Evaluation
	Quality Care
	Fund Raising
	Decision Making

Fig. 3: Community participation elements for understanding the patterns.

Planning

The significance of strategic planning for the smooth operation of the community clinics is recognized by individuals residing in the study areas. It is often regarded as an inherent and essential element in the administration of the clinics. Nevertheless, during the early phase, there was a lack of community involvement in the planning process of the clinic projects. The planning was made by the higher authority in relation to CC, reflecting a top-down perspective. Both clinics were founded on land that was donated by the community. Following the formation of the clinics, there were instances when local individuals were engaged in consultations pertaining to the efficient operation of those clinics. However, the significant planning related decisions are often made by the relevant officials of the clinics. According to a local named Rafik commented,

> This clinic is very useful for us. Essential medications can be obtained from the clinic to be cured. However, the involvement of local residents throughout all phases of the planning might potentially enhance its use. Occasionally, meetings are organized with the purpose of soliciting enquiries and seeking guidance, although the outcomes of these interactions fail to manifest in actuality. The highest level of planning is derived from the governing body. The prioritization of opinions is not given to us.

The above statement suggests that there is a lack of substantive engagement from local people in the planning process of the clinics. Brown and Wocha (2017) assert that effective participation in community development requires active engagement in the processes of planning and decision-making. A fundamental aspect of community involvement within the context of the United Nations (UN) is the need of guaranteeing equal chances for everyone to actively engage in the development of their own communities, while simultaneously assuring the allocation of related advantages. The notion of community participation encompasses the dynamic engagement of community members in planning-making processes, so affording them a substantial role.

Decision Making

Armitage (1988) argued that community participation is a means where residents respond to public issues, express their views on significant choices affecting them, and assume responsibility for the development of the community (as cited in Papa, 2016). Nevertheless, the nature of this contact might manifest in several forms. Within clinic settings, the process of decision-making is usually conducted via community meetings. Representatives from several groups continue to be in attendance at the meeting. Evidently, the meeting adheres to a bottom-up approach in which the clinic committee president actively engages in listening to all participants before making a final decision. Nevertheless, the participants consistently expressed that their perspectives were not taken into consideration. The purpose of the meeting is merely ceremonial. In the realm of decision-making, individuals who possess significant influence, hold political leadership positions, or rich get priority in decision making process. The impact of social hierarchy and power dynamics on community involvement in rural Bangladesh is significant. The decision-making process mostly revolves on the local Union Council Member, who assumes the role of committee head. The Member in conjunction with other prominent committee members, cultivates a positive rapport with the community health care provider (CHCP) and makes decision that priorities the interests of the committee as a whole rather than the wider community. If the CHCP fails to cater to the needs and concerns of the aforementioned group, he/she may encounter difficulties or face adverse consequences. This scenario evolves into a mutually beneficial arrangement in which the welfare of the general people can be undermined. A member of the CG remarked:

> Healthcare practitioners usually make decisions. In the event of a clinic closure due to unforeseen situations, the decision is made by the CHCP in collaboration with the health official. In this particular scenario, the decision may remain unknown. Nevertheless, in the event that a significant matter arises pertaining to the clinic, we are sometimes approached for consultation in order to address the issue at hand.

The above remark unequivocally suggests that the community members possess limited access to the decision-making procedures of the clinics. Ratanavaraha and Jomnonkwao (2013) argued that authentic community involvement entails a deliberate method that permits citizens to actively participate in the design and execution of development endeavors. This strategy promotes the cultivation of collaborative thinking and decision-making processes, so empowering communities to effectively tackle their own challenges. The facilitation of the effective resolution of community issues may be achieved via the involvement of appropriate experts, along with rigors organizational monitoring and staff management to support the progress of living circumstances. Besides, interactive participation is an additional kind of community engagement characterized by citizens engaging in collaborative efforts with external specialists to assess their circumstances, develop strategic goals, and make collective decisions about community initiatives (Abbott, 1995 as cited in Sulaiman et al., 2014).

Implementation, Management and Maintenance

The participation of public engagement is facilitated by the communication of future decision to be enacted. In order to ensure efficient management and maintenance, it is necessary for each community clinic to establish a Community Group (CG) led by a locally elected UP member. This group is comprised of a minimum of 13 to 17 members, with a requirement that at least one-third of the members be either female. A CC is led by a Community Health Care Provider (CHCP), a Health Assistant (HA), and a Family Welfare Assistant (FWA), who together rotate their work schedules, each of HA and FWA working three days each week. Every CG is supported by three Community Support Groups (CSGs), each consisting of 13 to 17 people, with a minimum requirement of at least one-third of the members being female. The selection process involves individuals from different layers of the society. The objective of this group formation is to ensure the representation of different groups and provide them with a feeling of ownership as their involvement in planning, implementation, monitoring, benefit sharing, and decision-making was anticipated. The chairman of the local Union Parishad assumes the role of the primary patron for all clinics within the area. A regular monthly meeting of the CG is often convened. Both CG and CSG are formulated to facilitate and enhance the activities in the clinics. However, the formation of CG and CSG has not been in a neutral manner, since these entities have been subject to politicization. The members of the clinic possess significant local and political power, and actively seek to capitalize on this influence for personal gain. Consequently, the development of a complete feeling of ownership was not seen among the members. The CSGs may be characterized as mostly dysfunctional. As a teacher from a nearby educational institution said,

> Despite the volunteer nature of this group, its creation exhibits political bias. The majority of the committee members are affiliated with political parties that support the current ruling government. Rather of striving to improve the clinic, they use their position for personal gain. Consequently, there is no significant increase in the general public's feeling of ownership.

The aforementioned narrative illustrates the presence of discontent among the populace regarding the execution, administration, and maintenance of many initiatives. The notion of participatory development, as defined by the Learning Group on Participatory Development of the World Bank (1995), necessitates an interactive and ongoing procedure in which multiple stakeholders exert influence and collaboratively exercise control over the initiatives. Participating in intervention programs or projects enabled by governmental, non-profit, or corporate groups may be seen as a tangible expression of community participation.

Monitoring

The task of monitoring is often carried out by healthcare professionals employed by community clinics. Typically, routine visits to community clinics are conducted by both the Assistant Health Inspector and the Health Inspector. The monthly reports are made and discussed during the CG meeting. Regular reports are sent to superior authorities through virtual channels. In actuality, the prevailing approach is one of conventional monitoring, which prioritizes the augmentation of care recipients over participatory monitoring, since decision-making mostly rests with health authorities. Furthermore, a state of conflict exists between the CHCP and the committee members. The members said that the CHCP exhibits hesitancy towards them and solicits their cooperation alone when it is required. Contrarily, according to CHCP, the members exhibit sporadic attendance and lack motivation when it comes to participating in meetings. Specifically, the head of the CSG and members of the CHP engage in mutual accusations. According to a CHCP,

> The perception among locals is that this is a public clinic. We have nothing to do. Service providers has the capability to effectively address and resolve any issue that may emerge. From a certain perspective, this is good for us. The presence of members belonging to Community Groups and Community Support Groups may have a disruptive impact on the smooth execution of clinic activities. They usually fail to fulfil their responsibilities. Instead, they engage in the abuse of their positions as members of the CG for personal benefit, for example, they just want medicine from me.

Quality of Care

In the event that community clinics remain closed, individuals experiencing financial hardship may experience heightened dissatisfaction due to their reliance on seeking medical care from local private practitioners. The clinics continue to provide services from 10 a.m. to 12 p.m. as a result of limited resources, despite originally being scheduled to operate until 3 p.m. The degree to which care recipients are satisfied is largely determined by the amount of medication provided. The practice of delivering health education is implemented in limited instances. Regardless of the intricacy of health conditions, medications are administered to all individuals. Nevertheless, in regards to obtaining high-quality medical care, a local care seeker made the following comment:

> Treatments are often accessible to those who possess a level of knowledge and personal connections with care providers, rather than being readily available to individuals of average standing such as myself. The provider exhibits a lack of sincerity towards those who are unknown to them; yet, if a personal connection is established, one may expect to get quality treatment.

According to Kotalova (1996), social hierarchy is deeply embedded into Bangladeshi culture, with individuals possessing a keen awareness and ability to discern their relative positions of superiority or inferiority. The status of rank is seen in both informal discussions and formal places, when individuals are identified based on factors such as skin colour, income, educational attainment, and birth order within their family. The aforementioned hierarchical structure is also evident in the manner in which patients are attended to inside the clinics. Various medical tools are available for health diagnosis, including blood pressure (BP) monitors, weighing scales, and thermometers. Nevertheless, it is often observed that these tools are mostly used for those individuals who are affiliated with more priviliged social status (Shah, 2020).

Fundraising

The clinics, operating as a public-private partnership project, are intended to generate financial resources from other sources. Fundraising via the use of Donation Boxes serves as the primary means of accumulating financial resources. It has been observed that the primary source of funding often comes from governmental entities. Simultaneously, community members also contribute to the

development of the clinics by donating to the fullest extent feasible. Furthermore, these donations foster a sense of ownership throughout the local community. In this regard, a CHCP mentioned:

> Funding is sourced from local individuals as the support from the government is not enough. Besides, the act of individuals contributing monetary funds or resources fosters a heightened feeling of ownership among them. Hence, a donation box has been established in front of the clinic.

Determinants of Community Participation in Community Clinic

Being guided by the work of Sulaiman et.al (2014) on community policing in the context of Malaysia framed by the socio-ecological model, this study has identified the key determinants that may influence individual to participate in community clinic such as individual factors, community factors, organizational factors, and policy factors.

Individual Factors

The individual component that has the most significance in fostering active engagement in community clinic management is the perspective of the community. In terms of the perception of management, the relation seems to be reciprocal. The study reveals that several factors, such as age, gender, perspective, knowledge, healthcare effectiveness, awareness, and feeling of ownership, significantly influence community engagement in clinics. Suffian et al. (2012) emphasize that the acquisition of information may have a dual effect on participation, as it can both enhance individuals' engagement and contribute to the overall efficacy of a community program. The association between engagement in community activities and heightened consciousness and dedication, sometimes referred to as commitment, has been linked to increased willingness (Suffian et al., 2012; Bahaman et al., 2009, as cited in Sulaiman et al., 2014). According to Olorunfemi (2020), individuals residing in close proximity to a project site tend to exhibit passive contributions.

Sociocultural Factors

Participation among locals is influenced by a range of sociocultural factors, such as social hierarchy, power dynamics, social and cultural capital, collective interests, community cohesion, the cultural norms about health, community leadership, and the availability of healthcare services. In relation to other factors, community leadership has a unique place along the continuum. The most influential factors in facilitating successful community participation in clinics include social hierarchy, power dynamics, and social and cultural capital. When an individual from the upper class intercedes in a process of decision-making, the prevailing response from the mass of the populace tends to be one of apathy and discouragement. They often refrain from expressing their views. Moreover, cohesion is influenced by many significant characteristics, including collective interest and community integrity, which are closely interconnected. It is found that an attachment has a beneficial influence on both individuals and the communities in which they reside. Given these circumstances, it is imperative to acknowledge the significance of community health culture and the available healthcare service provision. If the community lacks the belief in the need of healthcare or exhibits unwillingness to engage in the aforementioned process, their participation in the process will be absent.

Organizational Factors

Community engagement is influenced by several elements of the clinics as organization, including perceptions, trust in services, quality of care, contentment, provider attitudes and sincerity, clinic culture, and laws and regulations. Specifically, if organizations have a negative attitude towards public involvement and lack confidence in the quality of their services and care, community engagement may become ineffective or inconspicuous. In addition, the attitudes and genuineness of service providers have a significant influence on community engagement. When considering the extent of influence, it may be argued that the rules and regulations implemented by the clinics have similar significance in this context.

Policy Factors

In addition to the aforementioned three elements, community participation in community clinics is also influenced by policy, strategy, and practice. The involvement of community members is often viewed unfavorably by those in positions of power, since it raises concerns about potential disruptions to the established processes. The presence of government policies in this domain has the potential to enhance individuals' motivation to engage more efficiently, hence increasing the likelihood of their acceptance by the organization. However, it is essential to establish a cordial and efficient means of communication in this context. This is because any instances of inappropriate behavior may lead to a decrease in motivation for all parties involved in the clinics.

Discussion

The establishment of community clinics was in accordance with the Alma-Ata Declaration's commitment to provide universal access to primary healthcare, as stated in the promise to offer HFL (Bhuiyan et al., 2018). The decision to construct community clinics (CC) in rural regions throughout Bangladesh, including the most challenging and isolated areas, was put up in this regard (Khan, n.d.). To ensure efficient administration, every community clinic is equipped with a Community Group (CG) and three CSGs (Ibid.). The purpose of creating these groups is to guarantee the representation of individuals and empower them with a feeling of ownership (Cavaye, 2010). The impact of social hierarchy and power dynamics on community engagement is significant in rural Bangladesh. While individuals have a large role in the planning and execution stages, they have little impact in the decision-making process. The interactions between care givers and recipients are influenced by power dynamics, familial connections, social status, and gendered relationships. In general, those who are more affluent tend to get superior service in social, political, and financial contexts. Furthermore, the availability of medication is restricted, leading to significant difficulties for the service providers. Monitoring is a viable solution in this situation, but community clinics lack the presence of a monitoring authority. The meetings, intended to occur on a monthly basis, were shown to be very inconsistent. In the two clinics we examined, one clinic's meeting occurred two months later, whereas in the other country, it occurred three months later. The CG head, CHCP members, and others accuse each other over the respective roles. The CHCPs are hesitant to involve its members and only seeks their support when necessary. Conversely, CHCPs claim that the community members exhibit significant irregularity and lack motivation when it comes to attending meetings. Consequently, both the provision of high-quality healthcare and the process of generating funds have also been impeded. This situation demands to create awareness among both parties. In addition, the government should consider establishing a regulatory body to ensure efficient administration of the clinics.

Community clinics have played a pivotal role in delivering essential healthcare services. However, the usage of these services remains below the objective specified in the policy. The level of involvement of local residents in CCs is influenced by several factors specific to the local environment, such as social stratification, dynamics of power, and social and cultural resources (Shah, 2020). Essentially, this research demonstrates that community clinics in Bangladesh mostly fail to ensure the involvement of locals in decision-making, management, monitoring, and the provision of high-quality healthcare. As a result of the hierarchical structure of classes, large numbers of locals are disregarded in the process of making decisions. When it comes to management, the input of locals is hardly taken into consideration. Despite voicing their grievances, they continue to go unnoticed. Regarding monitoring, individuals continue to be disengaged in all aspects, including quality care. Mass involvement is only guaranteed in the implementation phase, and to a certain degree in the planning phase.

Conclusion

The establishment of community clinics was undertaken in accordance with the Alma-Ata Declaration's commitment to ensuring universal access to healthcare via the provision of primary healthcare services (Bhuiyan et al., 2018). In rural Bangladesh, community clinics have been vital in

delivering primary healthcare services. Nevertheless, the usage of healthcare services remains below the desired level outlined in the policy. This study highlights the limited extent to which community clinics in Bangladesh priorities the inclusion of locals in decision-making processes, management practices, monitoring activities, and the provision of quality care. The exclusion of large segments of the locals from decision-making processes is a consequence of social stratification. In the context of management, the voices of locals are seldom acknowledged or taken into consideration. When it comes to monitoring, locals continue to lack active involvement. The current practices indicate that the degree of community involvement has not yet reached the necessary threshold. The primary obstacles in this context are sociocultural dynamics and structural constraints. The efficacy and long-term viability of community clinics are believed by local residents to be enhanced by the implementation of a community participatory approach, provided that meaningful involvement is guaranteed. The aforementioned discussion illustrates the concept of "contributive participation", whereby community involvement is mostly predetermined. The social and economic structures in place have the potential to transform healthcare clinics into agents that perpetuate disparities in access and quality of care.

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