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Public Health Promotion in Bangladesh Through the Community Health Clinics: A Foucauldian Analysis

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ABSTRACT

The system of community health clinics in Bangladesh is contributing largely to improving the public health status of rural communities in Bangladesh. The significant success of this health promotion program leads medicine to its summit of power to influence the prevalent power structure in rural Bangladesh. A critical analysis of this paradigm shift is demanded in the context of public health. A Foucauldian analysis of the public health scenario of Bangladesh is most relevant in this context. In the paper, I propose a critical analysis of the public health apparatus of Bangladesh as manifested in the community health clinics, from the Foucauldian perspective of Discipline, Body, Power, and Space. Definitely, Foucault's historical analysis of health in eighteenth century Europe in his *Power/Knowledge* is instrumental in the analysis of the medicalization of family in the public-private partnership model of Community Health Clinics. However, his other writings such as *Discipline and Punish* and *Madness and Civilization* are also relevant to the analysis of a) how self-subjection becomes an element in the empowerment process of the public health initiative in Bangladesh; b) how the concept of hygiene and new diseases serve as a means of social control in the politics of medicine; c) how medicine accumulates morals like trust, solidarity, and common good in its normative role to the exercise of bio-power; and, finally d) how rural space becomes an important phenomenon of medicine in contemporary Bangladesh. It is taken for granted that the community health clinics are contributing positively to improving the public health condition. However, many stories are untold in this picture of health promotion. In this paper, I analyze the public health promotion program of Bangladesh in light of the above questions to understand the power structure and the paradigm shift of the body politic in terms of health.

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Introduction:

Twenty years back, a pregnant woman in rural Bangladesh would have gestated without any sort of maternal care; a newborn baby would have been raised without any type of immunization. Now, in Bangladesh, it is impossible that a pregnant woman or a newborn child would go unnoticed by community health workers, even in the rural areas. Consequently, the infant mortality rate has declined from 9.7% live births in 1990 to 3.7% live births in 2011.

82.6% children of age ≥ 12 months are now receiving all essential vaccinations (Ministry of Health Bulletin, 2015). This is a remarkable change for the public health sector of Bangladesh. The establishment of community health clinics in the rural areas of Bangladesh has played a significant role in making this huge change in public health. People in the rural area of Bangladesh actively participate in public health management through the community clinics (CC). The marginalized population has become more empowered than ever in Bangladesh in terms of regulating the CCs. The decentralization of health services from the hospitals of urban area to the CCs of rural areas has made a significant change in the power structure and social control mechanisms of medicine. This paradigm-shift of power relations in public health demands a critical analysis. A Foucauldian analysis of the public health scenario of Bangladesh is most relevant in this context. In this paper, I propose a critical analysis of the public health apparatuses of Bangladesh as manifested in community health clinics, from the Foucauldian perspective of Discipline, Body, Power, and Space. Definitely, Foucault's historical analysis of health in eighteenth century Europe in his *Power/Knowledge* is instrumental in the analysis of the medicalization of family in the public-private partnership model of CCs. However, his other writings such as *Discipline and Punish* and *Madness and Civilization* are also relevant to the analysis of a) how self-subjection becomes an element in the empowerment process of the public health initiative in Bangladesh; b) how the concept of hygiene and new diseases serve as a means of social control in the politics of medicine; c) how medicine accumulates morals like trust, solidarity, and common good in its normative role in the exercise of bio-power; and, finally d) how rural space becomes an important phenomenon of medicine in contemporary Bangladesh. It is taken for granted that the community health clinics are contributing positively to improve the public health condition. However, many stories are untold in this picture of health promotion. In this paper, I analyze the public health promotion program of Bangladesh in light of the above questions to understand the power structure and the paradigm shift of the body politic in terms of health.

The community health clinic project in Bangladesh at a glance

Bangladesh is one of the developing countries of South-east Asia with a large population. It has made substantial developments in the public health sector, especially in the areas of sanitation, hygiene, maternal and child health, infectious disease control, vaccination, and family planning. In order to enable the vulnerable population of rural areas to have access to basic health services, the government of Bangladesh with the assistance of international organizations, initiated a public health project nation-wide, establishing one community health clinic for every 6,000 people within each region. Currently the program has provided access to basic services for almost all the people of rural Bangladesh, with the establishment of 13,094 community clinics providing primary health care services. The major services include supplying essential drugs for common illness like malaria, cough, fever, cold, and diarrhea; providing family planning services such as supplying contraceptives and counseling prospective parents; immunizing children from some common diseases such as measles and polio; supplying children with vitamin A capsules and micronutrient food supplements; providing maternal and child health care; and providing health counseling and health education to fight communicable diseases and to create awareness about hygiene and sanitation. The community health clinics also function as the gatekeeper to accessing health care services at the secondary or tertiary levels. The functional process of the CCs is divided into a service provision wing and a community engagement wing. The service provision wing includes recruiting and training of the community health workers, supplying

drugs and logistics, and developing and monitoring the Management Information System (MIS). The community health wing includes developing the operational guidelines, training of the community group members, and collaborating with the local government. It is to be noted that community engagement is one of the significant apparatuses of CCs. The donation of land and the management of CCs are totally dependent on the local community. The achievements and success of Bangladesh in the public health sector has been highly praised by various global and local organizations. International organizations such as WHO, UNICEF, USAID and the local and international NGOs are recommending the community health clinic model for other developing countries.

The establishment of community health clinics has contributed to the empowerment of the rural community. Those who are part of the vulnerable population in the rural areas of Bangladesh now make their own health choices. However, this empowerment of the vulnerable population through community engagement can be critically analyzed from a Foucauldian perspective.

Self-subjection through empowerment and community engagement

Michel Foucault in his *The Birth of the Clinic* analyses (in discussing the history of medicine in nineteenth century Europe) how the body was regarded as a subject of domination through different types of categorization. Institutions such as hospitals and asylums categorized individuals with the aid of the knowledge of medicine. For example, different diseases were defined in order to confine people within a designated area. Psychiatry played a huge role in constructing the concept of mental illness to validate the confinement of “mad people.”

In the historical context of Europe, in the process of categorization or confinement of the subject, the body is passive. The subject does not participate in the “subjectification” process actively, but rather the subject is somewhat coerced to be categorized in certain groups. However, Foucault has also identified another mode of subjectification which is active in nature and more powerful, where the individuals themselves are responsible for their own subjection. This can be called the “self-subjection.” In the concept of self-subjection, individuals actively participate in the process of categorization. It is not the case that the subject is perpetuating the system of subjection unknowingly. Rather the subject is aware of the process of the subjection and devotes himself or herself to the structure. There is no “false consciousness” among the individuals in this process. Foucault, in his Howison Lectures, mentions the complicated genealogy of self-formation and analyzes how the self-formation occurs through a variety of “operations on [people’s] own bodies, on their own souls, on their own thoughts, on their own conduct” (Rabinow, 1984, p. 11). This can be exemplified through the concept of self-surveillance and self-policing. As a patient, we often tend to compromise our autonomy and accommodate ourselves within the physician’s paternalistic approach, irrespective of our desire. The physician does not have to always ask us to conform to the suggested medical regimen; rather we make ourselves abide by the suggested approach because of the mechanism of power. We submit so that we do not break the rules, and we condemn ourselves if we depart from the norms.

The self-formation (which is also a self-subjection) process takes place through the public health promotion programs of the CCs of Bangladesh in terms of the function of body, thoughts, and conduct. With the emergence of public health promotion programs, people of the rural area of Bangladesh have started to change the concept of their own body. Now, people recognize their

own body in relation to the concept of health. The concept of health, through the mass awareness campaigns, in rural areas has become a powerful tool to redefine the body. This is a new recognition of the body in terms of the health phenomenon. For example, now people of rural areas of Bangladesh think that their body can contribute to the overall public health of that area or can be a threat to the public health as well. In other words, each individual body has transformed into a particular health unit in the collective concept of public health. According to this new self-formation of their own body in terms of public health, individual conduct and behaviors are also being transformed. Individuals maintain certain health regimes to promote better health, e.g. maintaining sanitation and hygiene etiquettes; at the same time, they compromise their autonomy for the betterment of the overall public health goal, e.g. quarantining themselves in health emergencies or completing a full course of TB medication.

I shall now present two predominating concepts of the public health promotion project of Bangladesh, namely empowerment and community engagement, that represent “self-formation” in a Foucauldian sense. The government has emphasized the empowerment of the vulnerable citizens who are residing in the rural areas of Bangladesh. The population is divided into different categories in terms of vulnerability, for example, recognizing the vulnerability of the poor, women, and the elderly. It is not the case that the government is dominating and subjugating the marginalized population of the rural area; rather the government has established a mechanism by which the vulnerable population can be empowered. For example, one of the priorities of CCs is maternal health care. The government wants to empower the women of rural areas by assuring easy access to maternal health care facilities. A strong network has been built among the Community Health Care Provider (HCCP), Community Support Group (CSG), Community Group (SG), pregnant women, and other stakeholders such as the local government and NGOs. Strict documentation is maintained in order that the government can have a birds-eye view of the overall maternal health status of different localities. Now in rural Bangladesh, no pregnant women can go unnoticed due to this strong network. Family planning, pregnancy and childbirth have become the major concern of public health. This initiative has also reduced the maternal mortality and morbidity rate dramatically. This is a strong indication of the empowerment of rural women in Bangladesh. However, this empowerment of women in the rural areas of Bangladesh has not been achieved without a cost. The women must follow certain rules and regulations of the government, e.g. regular health check-ups in the case of pregnant women or participation in screening programs such as for fistula or cervical cancer. The community health workers visit door-to-door to reach the public health goals of the government. Due to the health education campaigns, everybody is aware of the health risks that women face, and it is highly unlikely that health workers consider obtaining consent on the part of women to whom the health care is being offered. In fact, women are not autonomous to decline. However, in this context, the vulnerability of women and the importance placed on the empowerment of women justifies paternalism in the delivery of public health policies of the government almost without question. Nobody asks whether the women’s choice in family planning can override the family planning rules of the government. Women are empowered, but at the same time the government has achieved an unquestionable power to regulate the public health sector of Bangladesh.

Self-formation in this Foucauldian sense is also generated through community engagement in public health. The government has built a sense of ownership among the rural people of Bangladesh. They own the CCs. People contribute their own land to build the CCs;

they raise funds of their own to maintain the CCs; they are actively involved in the functionality and regulation of CCs. Through this engagement with the CCs, they are themselves contributing to the overall public health goals of the government. For example, they contribute to the 100% child immunization program or screening program. People are aware of the fact that they are participating in a greater goal and this is how their self-formation occurs for the sake of the greater good – an example of how the politics of medicine can “re-make” the self, from a Foucauldian perspective.

The politics of medicine: the concept of hygiene and new diseases as a means of social control

Michel Foucault analyzes, in the context of eighteenth century Europe, how the concept of hygiene helped medicine to occupy the urban space and served as a means of social control.

The old notion of the regime, understood at once as a rule of life and a form of preventive medicine, tends to become enlarged into that of the collective "regime" of a population in general, with the disappearance of the great epidemic tempests, the reduction of the death rate and the extension of the average lifespan and life expectation for every age group as its triple objective. This program of hygiene as a regime of health for populations entails a certain number of authoritarian medical interventions and controls (Foucault, 1984).

Foucault describes how physicians became influential during that period and hospitals gained their utmost administrative power. Environmental pollution, population density, and other non-human causes of mortality and morbidity demanded an authoritative intervention. Medicine played that authoritative role during that period in Europe. While Foucault conceptualized this politics of medicine in the urban context of eighteenth century Europe, similar politics of medicine are noticeable in the rural context of twentieth century Bangladesh.

Sanitation and of the understanding of hygiene emerged in the rural areas of Bangladesh during the past few decades. Massive public health awareness programs took place countrywide in that time. Scientific studies on the correlation between sanitation and diseases like cholera, diarrhea, and dysentery established the ground work for the government to implement new policies and regulations on public health. The public health authority of Bangladesh made remarkable achievements with reducing mortality and morbidity rates by implementing programs for “safe drinking water” by establishing tube wells in the rural areas, and “sanitation for all” by subsidizing sanitary latrines. These public health programs made a huge impact on the health behaviors of rural people. Along with the advent of new epidemic diseases, immunization became one of the significant tasks of public health authorities. For example, in case of epidemic chicken pox, the Hindu rural community would go to the temple of *Sitala*, the deity of fever and diseases, and offer certain rituals to worship her. After the advent of the vaccine for chicken pox, people rarely visit the temple of *Sitala*, at least not for the purpose of getting rid of chicken pox. The new knowledge of medicine almost replaced the traditional religious rituals of healing. People started to depend more on medicine than on deities, more on vaccinations than on

worshiping. However, there were always resistance against the dominion of medicine throughout the history of Bengal.

Vaccination was differently regarded by different groups of people in various parts of Bengal during this period. Among Hindus, some government vaccinators usurped the roles of the old inoculators, becoming priests of *Sitala*. However, there were die-hard communities and localities that refused to have anything to do with what appeared to be interference in the domain of *Sitala*. Resistance to vaccination among uneducated Muslims was frequently quite strong. Thus, it was difficult to obtain a uniform pattern of vaccination in an epidemic locality. (Nicholas, 1981, p. 36)

Another interesting change in the phenomenon of public health in Bangladesh is the medicalization of maternity. Previously, maternity was perceived as a non-medical and regular occurrence of social and familial life. Giving birth to a child was more of a family matter than an individual reproductive choice. A separate room within the household used to be prepared for childbirth. The midwife was the only person to counsel during the whole gestational period and to administer the childbirth process, complying with social customs and rituals. However, maternal health and childbirth became one of the essential properties of public health promotion programs during the past decades. With the emergence of public health in Bangladesh, now community health clinics have become the sole authority to regulate maternal health and childbirth. People are more dependent now than before on medical intervention in the process of childbirth. The community health workers carefully document the maternal health status of women including nutrition, weight, and necessary vaccinations such as tetanus. This dependency on medicine also serves as a tool in the process of social control. The government, in partnership with local and global organizations and NGOs, trains the community health workers to be the ambassadors of the government's public health goals.

The new understandings of diseases and hygiene also served as a means of social control. New concepts of diseases were available to the rural people due to the emergence of mass media. Previously, an individual with epilepsy would be perceived as a possessed person. The family would leave him or her to their fate. Now, people understand that treatment is available for epilepsy. They praise medicine for its power. Moreover, significant statistical improvement in reducing child and maternal mortality and morbidity rates played as an incentive for the social control. Rural people were also motivated to change, based on their observations of the tremendous contribution of medicine in individual cases. Government policies for public health became easier to implement because of these achievements. For example, government policy on family planning was highly successful due to the accomplishment of the previous public health programs on hygiene and sanitation.

This politics of medicine and its role in social control became so powerful that it even sometimes overrode the control of religion, another powerful phenomenon which acts as a means of social control in Bangladesh. The majority of the population of Bangladesh are Muslims. The religious belief among the rural people of Bangladesh is so powerful that the government has a very insignificant control over individual behavior. However, with the emergence of public health, even the powerful religious beliefs of people have been compromised in some cases. For example, the rural people usually opposed vaccinations and medical check-ups for women, based

on the belief that women would then be more exposed to outsiders and have their values and behaviors inappropriately altered. The situation has been changed dramatically now. It is a very common phenomenon that even the announcements of the date and venue of vaccination are often made from the same loudspeakers of the mosques which are used for *azan*, a call for prayer. The *imams* (who lead the prayer) play a significant role in shaping public awareness about public health issues. This politics of medicine can be understood through the experience of a community health worker, Ms. Rita Rani Boidda.

“Initially, when we went house to house offering counseling on child and maternal health issues, the women treated us with suspicion...[and] the men were not supportive of our work,” explains Ms. Boidda. “There were many religious, conservative families that didn’t allow women to venture outside their homes during pregnancy. They weren’t allowed to go for regular medical check-ups in hospitals – the men thought women were too ‘exposed’ during the examination. They were also strongly against various temporary and permanent family planning methods,” she says.

MNCS workers have, however, broken barriers to institutionalized care. According to Ms. Boidda, it is the workers’ familiarity with their communities that has given them an advantage. “This change didn’t take place overnight. We had to work very hard for this. It was only when fathers and the elderly saw that our advice was saving lives, when their children with diseases like pneumonia returned from hospitals fully recovered, did they begin to trust us,” she says (Pruthi, UNICEF, 2012).

In fact, medicine is the most powerful tool that influences the public health choices of modern Bangladesh. Medicine achieved its summit through the success of different public health promotion programs in rural Bangladesh. Now, even an authoritative initiative of the government would be easily acceptable to the people.

Bio-power and the normative role of medicine through the accumulation of values

Bio-power is the concept in Foucault’s writings that expresses the mechanism of subjecting the population through discipline or other latent instruments. Foucault analyzes bio-power by sketching out the centeredness of the body in power relations. It is not the case that power is on the top of the mechanism, as Marxism views it, and that it always oppresses the marginalized body; but rather, the body is the center of power relations. We cannot think of power without the role of the body, and vice-versa. In other words, we cannot separate the body from power, according to Foucault. He analyzes the history of medicine to demonstrate how the knowledge of medicine contributes to bio-power. For example, medicine defines the bodies as capable or incapable, healthy or sick, normal or abnormal which manifests as bio-power in a society. Bio-power was exercised by a range of authorities such as hospitals, physicians, psychiatrists, and various government authorities in eighteenth century Europe, which is revealed in the writings of Foucault. Public health programs, even sometimes public health promotion programs such as health education, can serve as a tool in the exercise of bio-power as well. As Robin Bunton puts it:

With the establishment of a net of human rights and citizenship practices, the art of government has had to develop more refined strategies in order to maintain control over the population while avoiding coercive actions. Seen from this perspective, health education can make a contribution to the exercise of bio-power because it deals with norms of healthy behaviours and promotes discipline for the achievement of good health. It is educational in nature because it promotes behaviours that should be adopted by the entire population and interferes with individual choice, providing information to foster 'healthy' lifestyles (Bunton, 1997).

The emergence of public health promotion programs in Bangladesh, especially the establishment of the community health clinics, contributed to the understanding of the social body which in turns helps us to understand the bio-power manifested in the rural area of Bangladesh. Medicine, with its success in the public health area of the rural area of Bangladesh, not only redefined the social body in terms of health but also played a normative role in health behavior and behavior modification. Medicine started to accumulate some values -- such as trust, solidarity, and common good -- in its public health programs in Bangladesh and then promoted those values. Being privileged, medicine had easy access to modify the health behavior of the rural population of Bangladesh. In the community health clinic project, the government promoted *trust* as one of the supreme moral values. Health workers were recruited from within the community so that people could build a trustworthy relationship with the health workers. Another such value was solidarity. The health education programs explained how solidarity can contribute to reduce mortality and morbidity. Public health workers illustrated how a community effort can save the life of a mother and newborn. The public health programs also promoted the common good as one of the primary values. Now in rural Bangladesh everybody upholds trust, solidarity, and common good in their health behavior. This becomes possible through the normative role of medicine. However, medicine in terms of public health is very much active in its normative role.

Occupying rural space

Foucault, in *Madness and Civilization*, analyzes how the knowledge of medicine helped the authorities to confine the poor and so called "mad" people. The establishment of asylums, prisons and clinics in the urban area exemplified how the urban space was occupied by medicine. Consequently, this occupation of urban space generated the enormous power of medicine. Foucault gives the example of the power of the General Hospital of Paris or the fathers of the churches in order to demonstrate how medicine is endowed with an authoritarian power.

This responsibility was entrusted to directors appointed for life, who exercised their powers, not only in the buildings of the Hospital but throughout the city of Paris, over all those who came under their jurisdiction: "They have all power of authority, of direction, of administration, of commerce, of police, of jurisdiction, of correction and punishment over all the poor of Paris, both within and without the Hospital General" (Foucault, trans. Rabinow, 1984).

However, the role of medicine is somewhat different in the case of public health promotion in Bangladesh. Instead of occupying the urban space, medicine occupied the rural

space. Instead of confining people in specific institutions in urban areas, medicine decentralized itself into the rural space, bringing the reach of the health establishment to the door step of the rural people. In the case of the eighteenth century Paris, the role of medicine to exercise bio-power was coercive in nature, whereas in modern Bangladesh the exercise of bio-power was achieved through the public health promotion programs. People themselves in Bangladesh serve as the soldiers to occupy the rural space.

Conclusion:

Public health promotion in Bangladesh through the community health clinics deserves the attention of a critical analysis due to its profound influence in modern Bangladesh as well as its global acceptance as a pro-people public health program model. However, a Foucauldian analysis can reveal how the politics of medicine exist in this model. Even a health promotion program such as health education can be used to exercise this kind of bio-power. In a Foucauldian analysis of discipline, power, and the body we get a clear picture of the history of medicine in Europe. We understand how the local institutions gathered power with the aid of the knowledge of medicine and dominated the docile bodies. However, in the case of public health promotion programs in Bangladesh these power relations are extended to the global level. International institutions have a huge influence over the government policies and regulations of public health. A Foucauldian analysis can reveal the web of power related to the public health promotion programs in Bangladesh.

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