CHAPTER VI

Participatory Problem Solving Approaches: Linking Philosophy and Methods to Problems and People.

Introduction

In this chapter I reflect on the study as a whole and make an attempt to link the concept of participation and the methods applied, to the specific setting that is, the *Garo* community in Bangladesh.

Reflecting on the essay, the research proposal, the rapid rural appraisal and participatory evaluations, I am looking for opportunities to use the knowledge gained in linking the different components and search for these aspects which need modification in terms of the local socio-cultural context.

This overview offers me also the opportunity to address briefly the limitations of the study as a whole and to examine how to overcome the difficulties.

Dealing with the Real World

1. The concept and the practice

As discussed in chapter II, scholars in participatory action research as Freire (1972), Rahman (1991), Fals-Borda (1991) and Freedman (1994) argue that we have to choose. One can not serve the oppressed and the oppressors at the same time. While others like Nichter (1984), Cohen and Purcal (1989) question this viewpoint and argue that choosing for the poor only is also choosing not to make use of the local resources and local political brokers. These viewpoints are based on differences in the perception of the development process.

The dilemma in designing a participatory approach in problem solving for this study is, to focus on the structure that is, a village, the health care system, the inter-sector co-ordination or on the *Garo* community as a specific group? Chapter II, III and IV deal with the specific aspects of this question. In addressing this question it is important to keep in mind the ultimate objective of participatory problem solving: improvement of the development process including the systems involved. The role of agents of change is not to take over the responsibility of a government in taking care for the common good. Therefore the ultimate goal should be to link people's initiatives with governmental plans, but this assumes a political commitment and a readiness of the bureaucracy to re-orient itself. This does not exclude that the entry point can be a specific group as the focus for action. As argued by Paul (1987): "A participatory approach is appropriate when the community, rather than the weak or overloaded public sector, is

better able to initiate and manage a program" (p. 29). A careful examination of the target community and the social environment offers answers in defining the choice of strategy. In case of the *Garo* community it is clear that they are marginalized, that there are strong cultural contrasts which makes it very difficult to undertake joint activities with other communities living in the same area, they have a higher degree of readiness to practice participatory problem solving, there is a strong leadership present and so forth. Further the political instability, the heavy centralized bureaucracy, the deep rooted corruption and the poor coverage of basic primary health care services indicate that the community is better able to initiate and manage activities which improve the quality of their life.

2. The community characteristics

Within the *Garo* area that is, Arankhola, Ausnara and Sholakuri unions of Madhupur *thana* in Tangail District, Bangladesh, there are almost no homogeneous *Garo* villages. As explained in chapter III each village contains two to three hamlet or settlements. In most of the cases you will have one *Garo* hamlet and two Bengali-Muslim hamlets or opposite. The study area, Dorgachola village, as proposed by the religious leaders, contains not less than seven hamlets. These seven settlements are a mixture of four different communities as there are: *Garo* people, *Mandai* people, Bengali-Muslim people and Bengali-Hindu people. Taking into account the strong contrasts each community has compared with the other, it is very unlikely that bringing these people together to address their common problems would be successful. This together with the

characteristics of the local *Garo* community in the Dorgachola village would indicate that focusing on the *Garo* people should be the entry point.

3. The religious leaders' viewpoint

From my communication with the religious leaders and the exploratory inquiry, I realize that the religious leaders see health development initiatives in terms of their target group: the *Garo* community. They distrust any proposal for a joint venture, based on the threat of loosing control. As mentioned before, they are strong leaders, have access to external contacts and resources and highly appreciated by the *Garo* people. Finding a partner in taking care for community health development among *Garo* people would enforce the position of the religious leaders as well. It is clear that if one wants to work with *Garo* people in Bangladesh, he will need the support of the religious leaders.

4. Participation and the culture

Talking about participation in problem solving is talking about people and their socio-cultural values. As discussed in chapter II, participation is not apolitical, it is strongly related to the principles of democracy. Looking at the proposed area for study, we should question whether the rural communities in Bangladesh are ready to adopt participatory approaches.

4.1 The Bengali-Muslim community

As Abecassis (1990) reported on the Bengali-Muslim community:

> Leadership is connected with patronage and with the concept of personal aura. There is a strong desire among Bengali-Muslims to follow someone, they will follow rather a person than an idea or ideology..." and: "Leadership by committee is a strange and new idea for rural Muslims..." (p. 109).

From my own experience in Bangladesh and my exploratory inquiry, I do agree with Abecassis. Therefore an important factor in initiating change in the rural society is to support a new local leadership within a community, who are following the concept of participation instead of the patronage system. This is a critical point because from my discussions with managers of some non-governmental organizations it is clear that progress in this regard in rural Bangladesh is slow and difficult.

4.2 The *Garo* community

The *Garo* community has a history of participation. Their religious leaders have a strong position and the concept of participation is practiced, but also controlled, by them in the different development initiatives undertaken. As one of the respondents pointed out (verbatim): "*Garo* people do have great respect for religious leaders and teachers", therefore the proposed participatory action research should use these entry points. Initiating participatory approaches in problem solving in health among *Garo* people would be less problematic as long their specific community is the focus. A joint venture with Bengali-Muslim communities would face

difficulties and lack of support, based on the deep rooted distrust towards Muslims, and the discriminations experienced.

5. The support mechanisms

5.1 The public sector

Another aspect of the Bengali society is the public sector. The recent political turmoil in Bangladesh indicates that this society is facing difficulties in practicing democracy. As discussed in chapter III, the public sector is a predominantly centralized bureaucracy facing serious constraints in organizing and delivering services. As stated by Abecassis (1990):

> The corruption in Bangladeshi society is so endemic and so deep that corruption is actually accepted as the social norm. There is no justice for the poor in the courts or among the activities of the police because many police, court officials and lawyers are bribable. Business is completely riddled with corruption. There is no sign that the constitutional authorities in Bangladesh want to initiate a restructuring of the society, nor that they would be able to implement such a change (p. 107, 108, 113).

My personal experience in Bangladesh learned me that the situation in the health care sector is quite similar to what Abecassis reported. On top of all this there is the rigid professionalism, the assumed monopoly of knowledge of health professionals, and the reluctance to do things in a different or non conventional way. In a situation like this we do not have to expect that: political commitment, decentralization of the bureaucracy, or minimum basic health service coverage can be achieved in short term. This situation in the public sector is a serious handicap to initiate participatory problem solving approaches, it will be difficult, but it should not be used as an excuse to the people that they have to accept the burden of poverty,

diseases, inability and so forth (see chapter 1). None-the-less it will be essential to consider proposed plans and actions during the participatory action research carefully to avoid frustrating experiences and even hindrance in dealing with the public sectors including the health care services.

5.2 External resources

I included in this study a presentation on participatory evaluations because it is introducing the concept of participation in a wider context than community self-help initiatives. Participatory evaluations are as well applicable in the more institutionalized services and programs. From my own experience I do realize that this is a controversial idea for donor agencies and project authorities. Notwithstanding these obstacles it is my position that participatory approaches in problem solving offer valuable opportunities to meet the real goals of programs and to sustainable development. There is a long way to go in realizing this critical change. If the participants of participatory action research do not include this participatory evaluation idea in their negotiations with external resources the philosophy would be overruled by the power of those who have access to resources.

6. Limitations

6.1 Literature review

Access to the literature was not optimal and therefore I made have missed some of the publications important for this study. One of my

conclusions in the exploratory inquiry in chapter IV is that there is a need for further literature search for reports on participatory experiments in Bangladesh of relevant non-governmental organizations. It would also be useful to explore the literature on sociological studies on the *Garo* culture. Further it would be meaningful to compare the basic minimum needs approach with other approaches in different settings.

6.2 The proposed participatory action research

The research proposal is based on the concern of *Garo* leaders, their religious leaders and myself. The difficult communication with the local leaders, at the moment of designing the proposal, caused that the religious leaders developed a different interpretations than the author on certain aspects of the proposal. The communication was limited to correspondence and I had to experience that this can cause a lot of misinterpretation and confusion. The exploratory study was very useful in creating clarity for some of the issues.

6.3 The rapid rural appraisal

The limitations of the conducted rapid rural appraisal are discussed in detail in chapter IV. Reflecting on this inquiry I think that although the limitations of the approach and the delimitation inherent on the method, the outcome contributes significantly in giving direction in the preparation of the proposed participatory action research.

Besides the value of this rapid rural appraisal in the design of the proposed research, it was an excellent learning experience. Hard labor, but

the experience learned me how to bring knowledge into practice and improved my insight and understanding in the inquiry process as well as the pitfalls inherent to human activities in using methods and techniques to understand the real world.

7. Alternatives in participation

7.1 Methodology

Considering alternatives in participation is moving on the scale between participation as a means and participation as an end. The two viewpoints are fundamental different in their perception of the development process. So the many ways of looking at participation depends much on how one is viewing development. It is clear that community participation in health development is a multidimensional process which varies from place to place depending on the local context.

Moving on this scale of participatory approaches we need to consider participation in terms of the objectives of the planned initiatives. Looking at the wide range of services provided by the health care system and the different viewpoints among scholars, we can view participation as a process to meet one or more of the following objectives as mentioned in the literature (White, 1982; Paul, 1987; Oakley, 1989): (1) empowerment of people, (2) capacity building of people, (3) improved project effectiveness, (4) share the cost of the project, and (5) improve the efficiency of the project. The first two objectives deal with participation as an end, while the objectives from 3 to 5 deal with participation as a means.

Another aspect is the intensity of the participation aimed at. Again this is a controversial point were scholars disagree and viewpoints vary. The taxonomy used by Paul (1987, p. 4) offers us a range of intensity varying from: (1) information sharing, (2) consultation, (3) decision making, to (4) initiating action.

The people addressed to organize and sustain participation depends also on the relevance it has to the type of program and its context (Isely, 1986; Paul, 1987). How relevant is it for a program and in a specific context to aim at participation of staff, community committees, user groups, and other sectors, and what is the community profile? To which extend is a community ready to enable participatory approaches in problem solving?

Finally as argued by Paul (1987):

> The objectives, intensity and people involved in community participation are interrelated. There are certain combinations which are more likely to be consistent. In general we could say that the more complex the objectives related to participation, the greater the need for a higher level of intensity, and the more levels of people involved will be needed... (p. 6).

In other words if you aim at empowering people, you should aim at decision making and initiating action at the level of community members.

The first two aspects, objectives and intensity, in terms of aiming at health for all, are policy choices at the level of a government or donor agencies. The factor of who and how to involve at the community level is rather a matter of assessing the socio-cultural context. To which extend is there a relative degree of readiness in a community to initiate participatory problem solving. What is the best entry point and so forth.

In conclusion I would say that an alternative could be to go for pre-defined programs (a sector or professional approach) aiming at participation of the community to be effective, efficient and at a minimum cost, but this assumes a proper functioning of the public sectors. Unfortunately this is not the case in Bangladesh. This alternative method for participation would be in conflict with the underlaying assumption in this study, that capacity building and enpowerment of the community in the development process is a pre-condition to sustainable initiatives.

7.2 Approach

The basic minimum needs approach of Thailand in aiming at health for all, is used as resource material for the exploratory inquiry as well as the proposed participatory action research. The reason for doing so is the research done and experience gained with the basic minimum needs approach in Thailand. We can not compare Bangladesh with Thailand, the differences are to obvious in terms of socio-cultural political and economic setting as well as in terms of the performance of governmental services. This does not mean that the basic minimum needs concept can not function as a source of inspiration for the facilitator in the proposed participatory action research or even as a framework, although several adaptations need to be made to fit the local context.

An alternative approach could be to start from the *Garo* people's own specific situation, unbiased by external approaches of problem solving. For the proposed village Dorgachola it was clear that the highest priority among the *Garo* people was given to the organization of minimum basic health care

services. So the proposed participatory action research could focus on the provision of health care facilities instead of a full package of the basic minimum needs approach.

There are two distinct ways to initiate participation: the framework approach and the open-ended approach. The latter does not mean a blank mind.

Conclusion

This study offered me the opportunity to explore the concept of participation and its applications. A controversial issue in many aspects, calling for a critical change in the organization of (health) development. Indeed participatory approaches, if initiated, will rock the boat within the world of politics, the governmental bureaucracy, professionalism in the health sector, in the field of science, and last but not least within communities. A difficult process requiring hard labor and patience, but fundamental if development wants to attack on poverty, abuse and poor community health.

In conclusion I would say that the profile of the *Garo* community in Bangladesh does indicate that participatory approaches in problem solving are viable. The information obtained tells us that initiating participatory problem solving would be best started up within the local structures. Working with the *Garo* people could be an entry point in aiming at improvement of health systems development by linking the people's actions to governmental plans and the local public service infrastructures.

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