

Centre
for Health
Research

Rethinking Community Participation

**Prospects of
health initiatives
by indigenous
self-help organizations
in rural Bangladesh**

**Abbas Bhuiya
Claude A Ribaux**

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(See inside of the back cover...)

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Abstract

This paper illustrates the process of implementation of a project, aimed at discovering ways of achieving community participation in health matters, through indigenous village-based self-help organizations in Chakaria, a remote rural area of Bangladesh. The lessons learned during the first two years of project operation have also been presented in this paper.

The project strategies included establishment of a confident relationship with the community members, identification and study of self-help organizations, participatory needs assessment, bringing health on the agenda of the self-help organizations, participatory planning, action, monitoring and evaluation. The promotion of preventive health messages has been the major input from the project. Volunteers from the self-help organizations have also been trained by the project staff to disseminate health messages among the community members, including women and school children.

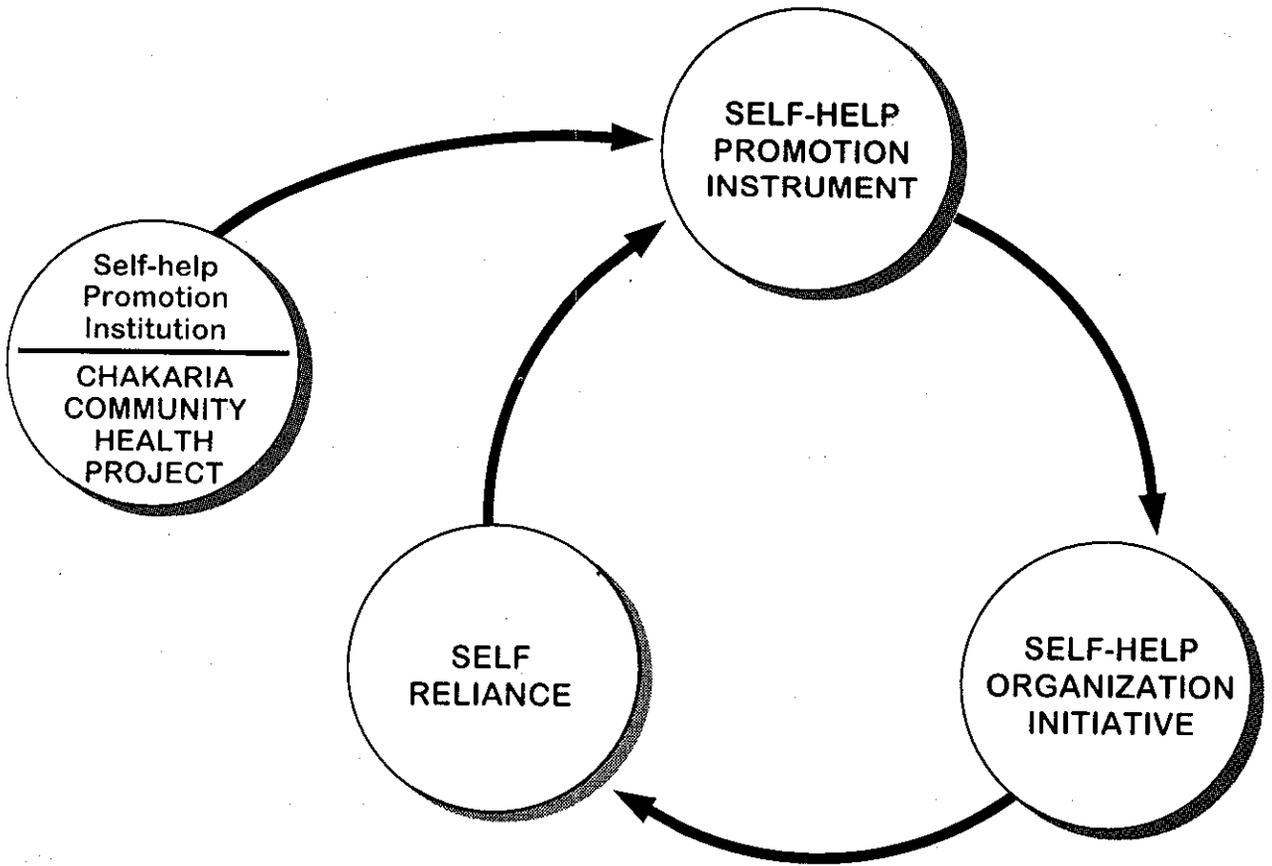
As a result of the project input, health could be brought on the agenda of the self-help organizations. Health messages could be disseminated among the villagers through volunteers, without any material support from the project. In some villages, the self-help organizations have established village health posts to carry out growth monitoring, nutrition counselling, and prescription services by trained village health care providers.

During implementation, the project faced various problems. These included issues related to motivation of the project staff, relief mentality of the villagers, access to women, and suspicion against outside agencies. Appropriate steps taken had helped overcome the problems effectively.

It was concluded that the existing village-based self-help organizations can be activated to take on health-related initiatives. However, the identification of a minimum level of external input, without which the organizations will not be optimally activated and the organizations will become dependent on external agencies, remains to be one of the future challenges.

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Introduction

There has been a growing realization that the myriad of problems the future population of Bangladesh is going to face, especially in relation to health and environment, may be so large and peculiar that no government and non-governmental machinery will be able to address these adequately, without an effective participation from the community members. As one of the pillars of Primary Health Care philosophy, community participation has been on the agenda of health programmes of government and non-governmental agencies since the Alma Ata Conference in 1978.¹ Although it was expected that effective community participation would involve community members in planning, organizing, and managing primary health care activities, the limited achievement in the world by mid-1980s, was largely characterized by participation of community members in activities planned by government or non-governmental agencies with little or no say.² By the first quarter of the 1990s, community participation in health activities has been reported to have been achieved in some places in the developing world.^{3 4 5}

The Bangladesh scenario, in the context of community participation, has been limited in obtaining community support in immunization, housing satellite clinics, and forming village health committees in some occasions in response to persuasion either from the Government or non-governmental organizations. A close look will reveal that the direction has been unclear, and a systematic attempt to achieve effective community participation in health matters has largely been ignored.^{6,7} While all concerned with health matters see the benefit

¹ World Health Organization. Primary health care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Geneva: World Health Organization, 1978

² Morley D, Rohde J, Williams G. Conclusions: practicing health for all. Oxford: Oxford University Press, 1983: 319-27

³ Rohde J, Chatterjee M, Morley D. Reaching health for all. Delhi: Oxford University Press, 1993: 501-17

⁴ Arole M, Rajanikant A. A comprehensive rural health project. London: Macmillan Press, 1994

⁵ Bhuiya A, et al. Community participation in health, family planning and development programmes: international experiences. Dhaka: International Centre for Diarrhoeal Disease Research, Bangladesh, 1996 (Special publication, 59)

⁶ Chowdhury AMR. Empowerment through health education: the approach of an NGO in Bangladesh. *In*: Streafand P, Chabot J, editors. Experiences since Alma-Ata: implementing primary health care. Amsterdam: Royal Tropical Institute, 1990: 113-20

⁷ Lovell C, Abed FH. Scaling-up in health: two decades of learning in Bangladesh. *In*: Rohde J, Chatterjee M, Morley D, editors. Reaching health for all. Delhi: Oxford University Press, 1993: 212-32

of effective community participation, progress so far has been limited perhaps due to a lack of clear-cut understanding about how this can be achieved.

Rural Bangladeshi society has been traditionally rich in community initiatives, in building educational institutions, roads, playgrounds, orphanage, mosques, temples, and cultural organizations. Currently, there are 893 colleges, 9,822 secondary schools, 45,783 primary schools, 5,766 *madrashas* (religious schools), 131,641 mosques and 58,126 *maktabs* (non-formal religious schools) attached to mosques. Of these, 76% of the colleges, 97% of the secondary schools, 18% of the primary schools, and almost all *madrashas* and *maktabs* are managed by the community, with little or no support from the Government.⁸ Almost all primary and secondary schools came into existence through community initiatives. This entails over 6,000 registered village-based voluntary social welfare organizations, formed and managed by the community.⁹ So far, community initiatives for health have been rare, but not totally absent. Despite this tradition, it is not understood why community initiative for health has not developed as it had in many other aspects of community life such as education.

To examine the possibility and feasibility of activating community initiatives for the improvement of health through existing indigenous self-help organizations (SHO), ICDDR,B, in 1994, started a community development-oriented health project in Chakaria, a rural area of Bangladesh. This paper presents an overview of the achievements of the project during the first two years of operation; which includes process of implementation, problems faced, solutions suggested, and lessons learned.

⁸ Bangladesh Bureau of Statistics. Statistical Yearbook of Bangladesh 1991. Dhaka: Government of Bangladesh; 1991: 537-95

⁹ Government of Bangladesh. Directory of voluntary social welfare organizations in Bangladesh. Dhaka: Bangladesh National Social Welfare Council, 1985.

The Study Area

Chakaria is located in between 21°34" and 21°55" north latitude and 91°54" and 92°13" east longitude in the south-east coast of the Bay of Bengal. Administratively, it is a *thana* in the Cox's Bazar district, which has a population of 400,000 in 19 unions, covering an area of 643 square kilometres, including 100 square kilometres of rivers and canals (BBS, 1994).¹⁰ The highway from Chittagong to Cox's Bazar passes through Chakaria. The east side of Chakaria is hilly while the west side is low along the Bay of Bengal.

The climate of Chakaria from May to September is characterized by tropical monsoons and heavy rainfall, and is mostly dry during the remainder of the year, January being the coolest month with the lowest temperature falling to around 10°C.

In addition to regular monsoon flooding, the location of Chakaria has made it very vulnerable to cyclone and tidal bore. The most recent severe cyclone and tidal bore was in 1991, when a large number of inhabitants and cattle were killed. Innumerable houses and other properties were damaged as well.¹¹ The Chakarian people have battled with cyclones and floods perhaps all through their life (Cox's Bazar Foundation, 1995).¹²

Despite its vulnerability to natural calamities, externally financed development efforts in the area have been scarce. However, after the 1991 catastrophe, Chakaria began to receive some attention from development agencies. Efforts have been made to improve roads, build cyclone shelters and undertake social afforestation programmes. Traditionally, the main economic activities in the area have been agriculture, forestry and sea-fishing. More recently, production of shrimp mainly for international markets has become a significant economic activity as well.

The population comprises mainly Muslims with a small fraction of Hindus and Buddhists. Traditionally, the area is strongly influenced by Islam, and the population is not very open to modern ideas and outsiders. The nationwide anti-NGO backlash in 1994 originated from this area. This reaction to modern development efforts in Chakaria and elsewhere resulted, at times, in physical

¹⁰ Bangladesh Bureau of Statistics. Statistical Pocket Book 1994. Dhaka: Government of Bangladesh, 1994.

¹¹ Hossain H, Dodge CP, Abed FH. From crisis to development: coping with disasters in Bangladesh. Dhaka: University Press Limited, 1992

¹² Cox's Bazar Foundation. A history of Cox's Bazar. Cox's Bazar: Cox's Bazar Foundation, 1991

assaults on NGO workers, especially female workers.¹³ The social life in Chakaria is also quite precarious with incidences of dacoity being observed during the study period, and clashes over land dispute quite often result in violence and murders.

The area is also one of the poorest-performing areas in the country, in terms of health and family planning indicators. Despite a commendable success of the national family planning and EPI programmes during the last decade, the present study area lagged far behind the other parts of the country in relation to contraceptive prevalence and immunization coverage.¹⁴

¹³ Female NGO workers were assaulted in several occasions during 1994-1995. Our project staff also faced strong resistance at the beginning.

¹⁴ Bhuiya A. Health knowledge and behaviour in five Unions of Chakaria. Dhaka: International Centre for Diarrhoeal Disease Research, Bangladesh, 1995 (Special publication, 52)

Achievements during the First Twenty-four Months

During the reporting period, the project activities have been limited to three unions with a population of 70,000. During the first six months of the project, members of the staff were able to establish a confident relationship with the villagers. In the beginning, the female community organizers faced resistance from the villagers even to meet village women. With the situation improving significantly after three to four months, work could proceed. Participatory research methods could be utilized and group discussion on health issues could be held. A quantitative baseline survey was also carried out, in the three intervention and two comparison unions during the first six months of field operation, by locally recruited female field workers. The villagers provided full cooperation, with a few isolated exceptions.

Information on all of the 54 self-help organizations in one of the three unions was collected. Regular contact with key personalities in the union was established. Representatives of the self-help organizations participated in health orientation sessions organized by the project. Over 50 People's Participatory Planning¹⁵ (PPP) sessions were organized, jointly by project staff and the self-help organizations. These were held mostly at night. Action plans were developed for implementing health education programmes by village health volunteers, female health volunteers, and school health volunteers. During the first two years, over 1000 volunteers (males, females, and students) have been nominated by the SHOs and neighbourhood clusters of women (in case of female volunteers). Most of them have participated in training programmes organized by the project, without receiving any material or cash incentives from the project.¹⁶

There was evidence that the volunteers have started to disseminate health messages to the community. The school health volunteers communicate health messages to fellow students, once a week for half an hour. The students also take the messages to their homes and share information with their family members and immediate neighbours. The male village health volunteers disseminate health messages in mosques during Friday prayers, and in informal

¹⁵ A workshop with members of the SHOs to discuss health issues and possible solutions leading to an action plan.

¹⁶ They are volunteers of the SHOs. Only lunch and light refreshment with tea have been provided by the project.

gatherings at tea stalls and at other casual meeting places. The female volunteers disseminate to women in nearby households.

The self-help organizations have also started to engage themselves in health matters beyond dissemination of health messages. In three villages, the self-help organizations have implemented, in collaboration with the government health authorities, a programme to control malaria by using impregnated mosquito bednets. The project facilitated this government-community collaboration. At the end of the first year of interaction with the project, five organizations have taken initiatives to establish village health posts. The local people provided space, houses, and furniture. SHOs have selected one village doctor (allopathic practitioner) for each village health post to provide services with assistance from the volunteers. The project helped them in obtaining growth monitoring charts from the Institute of Public Health Nutrition of the Government free of charge, and also provided them with locally-made weighing scales (the project is yet to decide whether it will take money from the self-help organizations—the organizations are ready to pay). The organizations have also started to raise money from the villagers to run the health posts. Members of the project staff have trained the volunteers to weigh children, record weights in the chart, interpret the results and provide nutrition counselling to the mothers. The project also helped the SHOs negotiate with the thana health authority to train the SHO-nominated health care providers. The training was being provided by the local health authority. The authority appreciated the proposal and agreed to accept a discounted fee from the self-help organizations.

The Project Strategy

Given the socio-political circumstances of the locality, and the current trend in development activities with outside resources, the accomplishments so far, in terms of promotion of self-help, has reached far beyond expectations.¹⁷ Thus, it is important to document how these results have been achieved. In addition to this, the problems faced, solutions offered and challenges ahead need to be examined. The following is a narrative in relation to the above.

Methods of Implementation

Project Staff

The project started with a team of six community organizers (3 female and 3 male), two self-help trainers, two applied social researchers, and a field team leader. They were under the supervision of a social scientist, with technical assistance from an expatriate anthropologist throughout—a trainer at the beginning and a resident anthropologist at a later stage. The project started with personnel of non-medical backgrounds.¹⁸ After a year of operation, two paramedics and a public health physician were included in the team. Six community health workers with a minimum of twelfth grade of schooling, recruited from the locality, joined the project later. The public health physician has been responsible mainly for ensuring quality of the health messages transmitted and for defining the contents of preventive and curative health initiatives. The paramedics have been currently engaged in health education-related activities and are expected to provide technical assistance in running the village health posts at a later period. The trainers are engaged in developing training curricula, as well as in training the project staff and volunteers. The trainers are also responsible for conducting PPP. The community organizers are responsible for establishing their links with SHOs and the community members eventually for mobilizing the community members through the SHOs. The community health workers have been maintaining contact with the SHOs, and are gradually carrying out the work used to be done by the community organizers. The applied social researchers have been engaged in monitoring,

¹⁷ Benini A, Khan M, Krueger H. Chakaria community health project: 1997 review. Dhaka: International Centre for Diarrhoeal Disease Research, Bangladesh, 1997

¹⁸ This was done intentionally, so that the field staff could in no way start offering curative health services to the community since this would have undermined the promotion of preventive health activities and raised undesired expectations.

evaluating, and providing feedback to the programme. The field team leader is responsible for overall supervision in the field, and for maintaining links with the government and NGO activities in the locality.

Training of the Project Staff

All project staff went through an orientation programme before starting to work in the field. The orientation itself consisted of a participatory exercise to review the past experience of the staff with respect to sustainable development in Bangladesh. The orientation also included discussions about issues relating to establishing linkage with the community, social and power structure, casual meeting places in rural areas, key (with power and influence) and resource persons (may not have power but have influence), and the role of indigenous self-help organizations in the society. The training programme combined various methodologies which included role playing, field visit, and review of the self performance.

After reviewing the current situation in relation to the existing initiatives in the villages, all members of the staff arrived at the conclusion that initiatives taken by the villagers are the ones sustained in the long run. Thus, if health can somehow be brought on the agenda of these initiatives, it will not only activate health initiatives by them, but will also be very effective in terms of adopting health and hygiene-related behaviour, leading to sustained improved health status. The issue of creating new organizations and sustaining them—a major concern in any development initiative—will not arise automatically because the organizations have already been in place for years and are being managed by the community.

During the orientation, the participants also developed a definition of self-help organizations and an instrument for collecting information about the organizations. Organizations which were initiated by the villagers without any external input were considered to be self-help organizations. Thus, NGO groups were excluded by this definition.

During the training, a consensus was arrived at, as to phrases to be used on introduction by the project staff to the villagers, for describing the objectives of the project. The introduction which was agreed upon was: “recently, a branch of the Cholera Hospital (widely known name of ICDDR,B) of Dhaka, has opened an office in Chakaria—I am from that office.” If the villagers expressed their ignorance about the Cholera Hospital, it was said that, “you must have heard about ORS—it was discovered at the Cholera Hospital. We are here to learn about the health problems you face and what you do about them. We are also

here to assist you, if you want to do anything to solve your own health problems. We are here for demonstrative purposes only, that is, we will try to provide technical information to you if you would like to take initiatives.” The members of the staff were very clearly instructed not to say anything beyond this and to be particularly careful not to give false hopes or raise expectations, since the project was not designed to provide resources or curative services.

Knowing the Community and Building Confident Relationships

After initial training, members of the project staff began visiting villages in Baraitali. They walked through the villages and tried to explain the purpose of the project, if asked. They started talking about health problems, location and number of schools, mosques, clubs, and other community organizations, key and resource persons in the locality. They also started making maps of the villages with assistance from the villagers. At a later stage, they were trained in participatory research methods. Subsequently, they applied various participatory research methodologies to draw village maps, mobility maps in relation to health care, to rank diseases, and to carry out group discussions about health problems. These activities consequently helped understand the major health problems, health beliefs, sickness care, and feeding practices. In addition, right from the start, villagers were involved in these activities, enhancing and building of a relationship of mutual trust.

During this process, the project staff also participated in a school-based maternal and child health (MCH) fortnight, sponsored by the Government. There, they talked about MCH issues with the high school students in the project area. These school children spoke highly of the project staff and the programme to their parents, thereby, facilitating access of field staff to their families. This experience helped the project staff realize the potential of school-based programmes, and this has been incorporated into the project activities.

Identification of Indigenous Organizations

Data Collection

After a duration lasting four weeks of relationship building activities, the project staff directed their attention to compile a list of indigenous village organizations and key and resource persons.¹⁹ Subsequently, contact with the resource and key persons was made. Detailed information about the

¹⁹ An individual was considered key person who has power and influence on the community. An individual was considered resource person if he/she was found knowledgeable and had interest on community development, and not necessarily had power and influence on the community.

organizations was collected by using a questionnaire developed during the orientation.

An organization was defined as any ongoing coordinated effort by the villagers, initiated by one or more individuals of the village for the benefit of the villagers, irrespective of registration from the Government. Quite often they have/had executive committees, material resources, and initiatives. Educational institutions which began as initiatives by the villagers have also been listed as indigenous village organizations, even if they currently receive support from the Government or NGOs. Groups or cooperatives formed solely by NGOs or government agencies were not considered indigenous village organizations since they were formed through external initiatives.

Seven members of the project staff with university level of education carried out a survey of the existing indigenous organizations. Field visits were made to identify the existing SHOs/initiatives. This was done through discussions with local people casually encountered on the road, at the market, in restaurants, shops, and educational institutions.

A list of the organizations and initiatives mentioned by the villagers was created and then physically visited. During some visits, no one could confirm the validity about certain organizations and initiatives. In other visits, contradictory information was obtained on these organizations. Such organizations were excluded.²⁰

Data were collected, through visits to individuals who were certified by the villagers to be associated with or well-informed about the organizations. Cross-checks with at least three different sources were made before final recording of information. In cases of discrepancies in information supplied by various respondents, attempts were made to cross-check the information with the respondents, through repeated visits, before a final recording of information was made by the project staff.

Selection of Organizations: Analyzing the Information

Fifty-four organizations were listed in one union. However, information from only 45 of them were collected because the existence of the remaining organizations was doubtful or because unsubstantiated information was received.

²⁰ In some localities there was a tendency to hang new signboards of dormant or newly-created organizations. There appeared to be an expectation that financial/material help might be forthcoming from the project.

The age of the organizations varied from 3 to 50 years, and 60% of the organizations came into existence during the last 10 years. Most (more than 90%) of the organizations were formed through initiatives taken by individuals from the same village. The rest were initiated from a neighbouring village. The initiators largely came from the middle or higher socioeconomic group.

Most of the organizations were not multipurpose. Different organizations have been carrying out different activities. Most organizations were engaged in activities relating to economic improvement of their members. Twenty-one per cent of the organizations have been engaged in providing secular primary education, while 11% provided religious education, mostly to children. The other activities of the organizations included agriculture, helping the poor, and maintaining social order.

The organizations were formed in a participatory manner. However, the extent of participation varied from a small number of persons to the whole community. Forty-seven per cent of the organizations were formed through discussion among the founding members only, and 49% through discussions between the key initiators and the villagers.

As to the management of the organizations, a majority (78%) of them had written by-laws. There were executive committees for more than 95% of the organizations. Ninety-six per cent of the committees were formed through direct election of their members, 33% through selection and 16% through both selection and election. Forty-two per cent of the committees limited the membership for one year, 16% for two years, 22% for three and the rest for five years. The by-laws of the organizations had provision for changing the committee members before the expiry of their normal tenure, if need arose. For 18% of the organizations, it was reported that such changes, in fact, took place in the past. A large majority of the organizations holds executive committee meetings once a month; 36% convene meetings whenever necessary. Seventy-one per cent said that they document minutes of the meetings regularly, and 4% said they do it occasionally.

Most of the organizations (60%) reported that they depended on contribution from members. Sixteen per cent reported that they received small grants from the Government, 13% raised contributions from the villagers for carrying out their activities. Some organizations raised contributions from individuals other than the members.

Nearly 70% of the organizations mentioned that the executive committees prepare annual financial reports. Eleven per cent mentioned that they maintain

account. However, no report was prepared. The remaining 20% did not maintain any accounts.

Although the entire community has been involved in some form or the other with most of the organizations, the degrees of involvement varied. In terms of the number of active members, 24% of the organizations have less than 5 active members, 38% have 5 to 9 active members, and 10% of the organizations have more than 20 active members.

A one-day workshop was organized with the project staff to analyze the data and to select the possible organizations and the key and resource persons for cooperation. After a critical re-examination of all the organizations, four were short-listed for cooperation. The selection criteria included: existence of a committee, ongoing activities, and financial resources. From the list of key and resource persons a list of supportive and neutral (not hostile to modern ideas) key/resource persons were prepared. It was decided to maintain contact with other organizations and key/resource persons. The organizations that were selected had a maximum community representation, in terms of membership and community support, regularity in convening meetings, ongoing activities, and resources at their disposal. These four organizations included a mosque committee, two temple committees, and one cultural organization run mostly by youths. Subsequently, project staff continued to maintain a close relationship with the selected organizations and key and resource persons. In addition to this, links with other organizations and key/resource persons were also maintained.

Bringing Health on the Agenda

None of the organizations had health on their agenda previously. Thus, encouraging them to include health issues on their agenda was a major challenge. The discussion started with the context of well-being, which was a priority for all the organizations: some gave emphasis on economic well-being, others to afterworld, social order, and human values through education. In relation to economic issues, the villagers were requested to identify the most disadvantaged individuals and households in the village. Quite often, it revealed that the most disadvantaged households had poor health or the only wage-earner had had an early death. There, the villagers mentioned instances in which households had to liquidate whatever assets they had for meeting the medical costs of their family members. The families fell into the trap of the vicious cycle of poverty from which they could never come out.

A conclusion that, in many cases poor health is a factor responsible for economic disadvantage, could easily be drawn through discussion. Even the religious groups saw the importance of good health for regular offering of prayer. The educational institutions too could very easily see a relationship between poor performance at school and poor health of the students. Thus, all the indigenous organizations, through a systematic discussion, realized the importance of good health (in its narrow sense—free from disease and disability) for human development, be it materialistic or spiritual. However, they had no idea as to what could bring about good health. So far, tackling health problems through preventive measures, such as immunization and epidemic control, was viewed solely as a government responsibility. The curative services, on the other hand, can be obtained for a fee (nearly free) from the government facilities or can be obtained for a fee from private sources on an individual basis. The community members could not identify a role for them in health matters.

At this stage, the project staff brought to the villagers the possibility of prevention by avoiding harmful behaviours. The issue of diarrhoea was raised, and an attempt was made to explain its mechanism of transmission, and the role of breaking the transmission route, and thereby saving oneself from an attack of diarrhoea. It seemed that the villagers were not aware of the scientific causes and routes of transmission of diarrhoea. The need and advantage of preventive behaviour was further emphasized, through a participatory discussion about the consequences of illness on health and economic well-being. As one villager said “this (prevention) is most important for us, especially those of us who are not economically well-off. Illness makes one unable to work and dependent on care-givers for treatment, which costs money. Thus we need it (prevention) most.”

Points were also raised about the adequacy of the preventive measures adopted by the selected individuals. The whole community needs to take such measures. The project staff indicated that, if the SHOs want, the project will try to assist them by making such knowledge available to them, but the SHOs will have to make their own plans and attempt such dissemination. The project staff will be happy to participate in any meetings arranged by the SHOs in the future. Subsequently, members of the project staff were invited to participate in meetings arranged by the organizations. While participating in these kinds of meetings, it was realized that an orientation of the community members to common health problems, their causes, transmission and appropriate management would increase the effectiveness of the meetings significantly.

Afterwards, the project, in collaboration with SHOs, arranged three orientation sessions in three unions with 15-20 participants from each SHO.

Each session was one day long. The orientation sessions were facilitated by project staff and attended by a medical officer from the Thana Health Complex. The orientation was conducted in a participatory manner. The representatives of the SHOs were requested to share with the rest of the participants what they consider the major health problems in the locality, what they think these problems are caused and transmitted by, and what they think are the best ways to manage them. Diarrhoeal diseases, respiratory illness, malaria, complications relating to delivery, and lack of curative services were the most commonly cited health problems. Regarding causes and transmission, traditional beliefs were dominant. ORT was mentioned as valuable for the management of diarrhoea, especially watery diarrhoea.

After listening to the discussion, the facilitator said: "that's what we already knew, but things have changed now, let us hear what our medical officer has to say in this regard." Then the medical officer shared the scientific concepts about the above mentioned diseases, and emphasized that, an individual can avoid a large number of the health problems by modifying one's behaviour. The participants reacted by saying that nobody ever had told them about this, and that if they had known ahead they could have avoided many of their sufferings. They also indicated that this knowledge should be disseminated (*janajani howa darkar*) among the villagers. The sessions concluded with an invitation from the project members to the participants to go back and discuss their experiences with other members of the SHOs. If they consider that the knowledge should be disseminated, they should find a way to do this. The project is willing to provide technical support in this regard if they so desire. The project staff also indicated that they are willing to participate in meetings that SHOs may organize in the near future.

People's Participatory Planning (PPP) and Actions

The project staff attended some of the meetings of the SHOs. These discussions were like the earlier ones, and centred around the importance of good health, major health problems, possibilities of preventing diseases through behaviour modification and the role of individuals and community in improving health. The project staff mentioned that if the SHO members decide to take any initiatives, the project could provide technical assistance. If they meet again to discuss the matter among themselves, the project staff would be happy to be present, if invited.

Afterwards, repeated contacts with the SHOs were made by the project staff, regarding arrangement of meetings with the SHO members to develop a plan of action. Eventually, PPP sessions were held with assistance from the

project staff. During the first PPP sessions, the SHOs selected volunteers for dissemination of health messages among the community members. They also requested the project staff to talk to some of the female members of the community about a strategy for disseminating health messages to women. Eventually, commitment from a number of male and female volunteers was obtained. The project started training these volunteers at the village level. The only material support provided by the project covered the cost of tea and lunch on the days of training.

The above exercise has also been carried out in secular primary and high schools. Progress so far has been limited in religious educational institutions for their lack of interest in the activity. In the high schools, roughly one volunteer per 10 students has been chosen by the students in each class, and one teacher was put in charge. In primary schools, the volunteers came from class IV and V only. Formal approval from the Thana Education Officer was obtained to provide these school-based health education activities.

Problems Faced and Solutions Suggested

During the first two years of operation, the project was confronted with many types of problems. The broad range of problems included steering of the project personnel centering on the project philosophy, maintaining the project philosophy in the face of the current trend of development with external material support and responding to the needs of the community without creating a dependency relation between the community and the project. A description of various problems faced and subsequent strategies adopted is presented below:

Morale of the Project Staff: Philosophical Clarity

Despite the orientation on the promotion of self-help philosophy of the project, some members of the project staff, at times, were apprehensive that nothing much will happen without material support from the project. Under these circumstances, it was necessary to reassure the staff that the process will be slow at the beginning. It was also reiterated that with material support the project will be like any other development activity in the country, and will suffer from limitations thus creating dependency of the community on the project and will have a low prospect of sustainability. It was further assured that even if the project fails, the documentation of the procedures adopted and reasons for failure will be a valuable contribution of the project. Thus, slow and/or minimum achievement or even failure will not result in early closure of the project, and no one will be held responsible for this.

Distrust among the Villagers: Slow Speed and Transparency

Since the project is located in a very conservative, Muslim-dominated area with a history of creating problems and opposing development NGOs (especially around the time when this project was launched), it was particularly difficult to earn the trust of the community members. The project personnel were challenged in many occasions about their intentions, and health was seen by some community members as a means for the project to enter into the community and eventually to engage in anti-religious activities, as did the East India Company, before the British colonized the country. Obviously, this was quite serious and led to discouragement, for quite sometime, among expatriate colleagues who wanted to visit the project area.

The project adhered to its philosophy of not initiating anything of its own, and the villagers never saw the project staff to be very proactive. The control of all initiatives always resided with the SHOs. Project personnel only participated if requested. Thus, the villagers did not see any project initiatives *per se*. Rather, it was their own organization's activities, and there was little scope for suspicion of outside control or ulterior motives.

The training of volunteers was provided by the project staff only after the decision was made by the SHOs, and upon receiving request from them. Contact was always maintained with key/resource persons who were often involved with the SHOs. The participation of the project staff in school programmes brought student support for the project, and helped promote acceptance of the project in the community.

The project's attention, as given to the problems identified by the villagers, also contributed to the development of trust and respect. Bringing the government malaria control programme in some villages also demonstrated the project's adherence to its philosophy of linking the self-help organizations with a third party to mitigate health problems. In addition, participation in various other government initiatives also demonstrated the acceptance of the project by the government authorities and the respect it has earned from the government officials.

More recently, the project's commitment to provide technical support in managing the village health posts established by the self-help organizations has also helped in earning community trust and removing misconceptions.

Relief Mentality: Emphasizing Respect for Self-help

Expectation of the villagers to receive material support from outside has been a problem to cope with in promoting self-help for health. Because the area has experienced many cyclones and tidal surges in the past, it has often received relief from outside agencies. It was somewhat hard for the villagers to believe that no material support would be forthcoming from the project. Thus, they continued to request free tubewells, latrines, curative services, hospitals, allowances for participating in health education training, and so forth. All the time, the project staff politely clarified the project position in this regard and maintained this position constantly. In one village, the demand for free medicine was strong, especially from a person who had been identified earlier by the project as a resource person. The situation became difficult since at that time a local NGO was distributing free medicine to the villagers. At a meeting with the mosque committee of this village and some expatriate visitors, the

spokesman of the committee demanded two sanitary latrines for the mosque from the project. The project spokesperson responded by making a suggestion that to establish latrines what one needs is labour for digging holes and for constructing wooden or bamboo platforms and fences. Volunteers could complete such a project in a day or two.²¹ At times, this kind of confrontation had to be made to shake off the relief mentality. Nevertheless, the project staff maintained relationships with the committee and the person behind the demand, but did not give in to the demand.

In addition to maintaining the project philosophy of not providing financial and material support to the community, the project also maintained a very low profile in terms of project staff using vehicular transportation. The male members of the staff used motorcycles, and female workers used local public transports and manual tri-cycles. This further helped limit the expectation of the community members from the project.

Village Feud: Keeping Distance

At the beginning, village disputes did not seem to be a hindrance, especially in initiating health education programmes. At a later stage, when an initiative was taken to establish a village health post in one locality, a conflict between two groups of villagers stood against unity, and the initiative did not take off. An investigation to unveil the causes revealed that there exists an intra-village dispute and the villagers could not work together.

Some individuals in the village suggested the project to call a meeting in the village with both parties present and to help the villagers remove the barriers which had developed. The project strategy, however, has been one toward non-participation in such meetings. The project viewed the conflict as a lack of readiness amongst villagers and decided to wait until the conflict has been resolved.

Reaching Women and the Poor: Underscoring Their Role

Although the strategy of promoting health initiatives seemed to be promising, it lacks effective participation by the poorest segment of the community and by women. There is virtually no direct representation of the poor and women in the SHOs. The school health education programme also does not cover children

²¹ Lanzenderfer M, Boulter A, Yahia M. Report: review of the improvement of health through community development-oriented programme in rural Bangladesh (Chakaria Community Health Project). Dhaka: International Centre for Diarrhoeal Disease Research, Bangladesh, 1995

from the very poor households. The mosque-based programme, to some extent, includes male members from the poor households. To reach individuals from the poor households and women, it was decided to start health education among women in neighbourhood household clusters by female volunteers. In addition, woman groups formed by development NGOs for the poorest of the poor also have been brought under the health education programme. It is not yet clear how effective the village health posts will be in meeting the needs of women and individuals from the very poor households.

Demand for Curative Service: Explaining What It Entails

During initial discussions with members of the SHOs, they almost always focused on curative services and asked about the technical background of the project staff. The issue of curative services was their only consideration in mapping the project role as a promoter of community health. During relation-building exercises the project staff always talked about major diseases and wanted to know the villagers' beliefs about their causes and transmission. Also, during health-orientation sessions, attempts to find out major health problems and their perceived causes and transmission were repeated. After listening to the participants, the opinion of a medical doctor was sought, and he shared the scientific concepts about the major diseases with the participants. It was clear to the participants that, by modifying behaviour, diarrhoeal diseases can be avoided, and appropriate management can save lives. In this context, the role of ORT and EPI was also reassuring to the participants. It was emphasized that once someone gets sick, she/he loses working days and becomes dependent on healers. This costs the patient in terms of money and physical strength. Thus, prevention is better than cure for the rich and even more so for the poor who do not have resources. Although the benefit of preventive measures was clear to the villagers, the interest in curative services continues. However, the message from the project staff was that if the SHOs take any initiatives for curative services, the project will try to provide technical assistance within its capacity.

During the first year of the project activities, the staff did not show any signs of responding to the demand for curative services, despite the conviction that there has been a dearth of curative services in most of the villages, and women are the worst sufferers. The availability of health facilities and government health personnel was always mentioned in the health education sessions. There has been a growing realization among the villagers that despite all preventive measures, illness will take place and that the project will not come forward with any services. Afterwards, the SHOs, in collaboration with the villagers, have started to come forward with the proposal that they are very

serious about establishing health facilities in their locality with their own resources, but they will need technical assistance from the project. In the meantime, the project also had two paramedics and one public health physician in the project team. The project staff started to respond by saying to SHO representatives what it means to establish a health post, what is feasible, and what resources will be needed. Having a detailed picture, if the organization still wanted to go for a health post, the project indicated its technical support in terms of procuring weighing scales, growth monitoring charts, training for volunteers who will use them, and negotiating with local health authorities so that nominees of self-help organizations can obtain training in curative services and in management of the health posts.

This led to the establishment of a number of health posts in the villages. The villagers themselves have provided accommodations, furniture, and a modest sum of cash for meeting initial expenses. All the health posts are named after the name of the village, and no mention of ICDDR,B contribution was requested by the project. A detailed description of the process of establishing the health posts has been reported elsewhere.²²

²² Eppler P, Bhuiya A, Hossain M. A process-oriented approach to the establishment of community-based village health posts. Dhaka: International Centre for Diarrhoeal Disease Research, Bangladesh. 1996 (Special publication, 54)

Challenges Ahead

The community initiatives taken by the SHOs hold great promise. Nevertheless, there are many challenges which ought to be met before they become effective. These challenges need to be envisaged so that appropriate strategies can be defined to deal with them.

Keeping the Wheel Moving: Showing Benefits

One of the challenges will be to sustain the enthusiasm of the villagers to keep the initiatives going. This will not be possible if the villagers do not obtain any benefit from the initiatives. To have significant health benefits, the programme, including the health posts, should be effective and well-managed. In this regard, technical support from outside will be needed.

Maintaining the Tradition: Linking the Public Sectors

Traditionally, community initiatives in Bangladesh eventually receive partial public sector support. The schools and roads which were first established through community initiatives, were later subsidized with public sector resources. Thus, the villagers will expect that the health posts which they have established, someday will receive assistance from the Government. One of the ways to achieve this would be to link the village health posts with existing government facilities. An example of beginning such a link is the hosting of EPI sessions and satellite clinics at these village health posts. Other options may evolve as time passes. This linkage will not only make these initiatives sustainable, but will also make the government programme more effective.

Extending the Process: Citing the Example

Replicability of this model beyond the project area is another challenge yet to be faced. Once these local community initiatives are well-grounded, the example can be cited elsewhere and interested parties can make physical visits and get guidance and encouragement to initiate similar activities elsewhere. Thus, extension of the process will not be a difficult task.

Another possibility for extension is through the relevant government departments under which the SHOs fall. In most cases, the relevant government departments have their branch offices at the thana level. Thus, the extension

activities beyond the project area could be carried out under the supervision of the government departments as well.

Lessons Learned: What Has Made the Difference

Given the current trend in development activities to be largely implemented by outsiders, the achievements in initiating health activities by the SHOs have been impressive. It is of interest now to review what have made it possible. The major factors considered to be important in this regard are discussed below:

Not Invitation, Rather Participation

One of the most important strategies adopted in this project was to augment the agenda of the existing self-help organizations rather than inviting the villagers to participate in activities designed, implemented and managed by outside agencies. The processes of relation building, needs assessment, health orientation, planning and implementation were carried out in a participatory manner, resulting in community involvement right from the beginning. Leadership from the self-help organizations was a pre-condition for the project to provide technical assistance. Thus, the leadership of the initiatives has always been with the self-help organizations.

The above strategy is a clear contrast to what has normally been practiced in ensuring community participation in community-based health and development activities in this country. Usually, development agencies invite community representatives to participate in the development activities by a way of being a member of a committee or attending meetings. The outside agency, however, designs, implements, and manages the project. In such a model, community members take no time to understand that they do not have an effective role in programme management or in control over resources, and decision has always been made by the agency. What is achieved in relation to community participation in such a circumstance, is in fact, a kind of politeness from the villagers' side to respond to the request for participation from educated urbanites.

Under the approach practiced in this project, the project does not invite villagers to participate in the project activities. Rather, the project participates in the initiatives taken by the already proven sustainable self-help organizations created and nurtured through effective community participation. Thus, sustainability of the organizations and community participation will no longer be issues to look for in the future; rather, they formed the basis of these new health initiatives.

Restrained Generosity

The other important strategy the project adopted while working with the SHOs has been to observe restraint in providing material and financial support even in the face of strong demands from the community. Giving in to such pressure could very easily dampen the self-help spirit of the community and produce a dependency relationship. In this age of resource-driven development assistance, this strategy has been difficult to implement, but has started to show signs of success.

Not to Overtake, but to Follow the Community

The other important factor which played a role was to allow time for the community to establish its own momentum, and then for the project to support this momentum from behind. Overtaking the community by the project could be overpowering the community, which may result in a permanent impairment to promoting self-help.

Conclusion

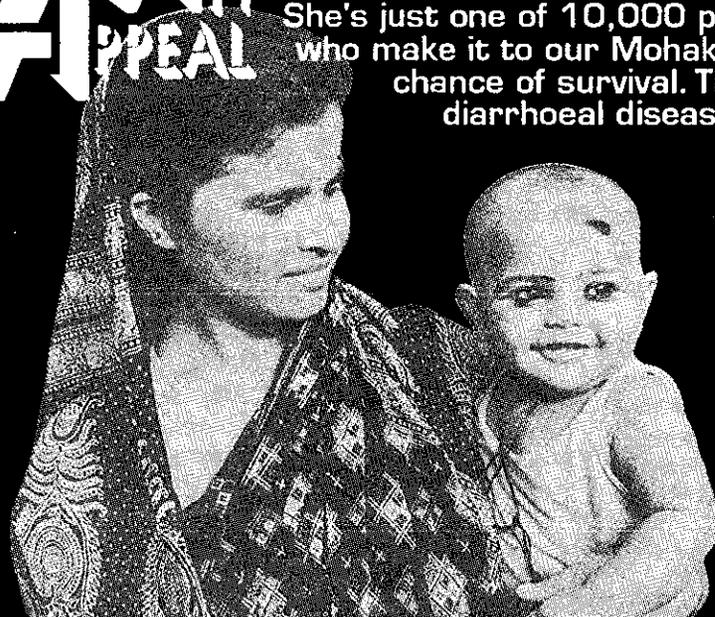
Community-led and self-help initiatives are in existence throughout rural Bangladesh. At times, the initiatives were taken by the community members, united under formal and non-formal organizations. These organizations can also be activated through participatory processes to embark on health initiatives. The outcome of such processes may lead to a situation in which the community will no longer be viewed as a passive recipient of the government and NGO services; rather, the Government and NGOs will participate in community-generated initiatives. Activities carried out in this way will have a better chance of sustainability and effectiveness. However, a full benefit of such an approach will require an understanding of the following issues:

- Type of activities which can be done best through community initiatives;
- How can self-help organizations be strengthened;
- The minimum level of outside input needed without which the organizations will not be well functioning and above which the organizations will become dependent;
- How can these organizations be best linked with the government programmes;
- How effective will be the activities.

An understanding of all these is crucial. Careful monitoring and evaluation of initiatives and continued experimentation with new approaches will be helpful to provide insights into the above issues, and eventually to develop a model of community participation in health matters.

AAN APPEAL

Designed and Produced by Asem Aneem & Ishfaq A. Zaman



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(continued from inside of the front cover)

This system provides the capacity to analyze large data sets, and is complemented by over 300 personal computers and a few Local Area Network (LANs) throughout the Centre. New e-mail facilities have been established in the Centre. A new information technology (IT) strategy is in the process of implementation to replace the old mainframe.

Dissemination and Information Services Centre: The Dissemination and Information Services Centre (DISC) provides access to the scientific literature on diarrhoeal diseases, nutrition, population studies, health, environmental, and behavioural studies in general by means of Current Contents (Life Sciences and Clinical Medicine), MEDLINE, AIDS and POPLINE databases, books, bound journals, reprints of articles, documents, some four hundred current periodicals, etc. DISC publishes the quarterly Journal of Diarrhoeal Diseases Research (and bibliography on diarrhoeal diseases within the Journal), two quarterly newsletters Glimpse (in English) and Shasthya Sanglap (in Bangla), a bimonthly bilingual staff news bulletin--the ICDDR,B News, working papers, scientific reports, special publications, monographs, etc.

Staff: The Centre currently has over 200 researchers and medical staff from more than ten countries doing research and providing expertise in many disciplines related to the Centre's areas of research. One thousand two hundred personnel are working in the Centre.

What is the Centre's Plan for the Future?

In the 37 years of its existence, ICDDR,B has evolved into a busy cosmopolitan research centre whose scientists have wide-ranging expertise. Future research will be directed toward finding cost-effective solutions to the health and population problems of the most disadvantaged people in the world. The Centre's Strategic Plan: "To The Year 2000" outlines work in the following key areas:

Child Survival: Diarrhoeal diseases are responsible for deaths of 3 million children every year. Acute and persistent diarrhoea and dysentery will remain priority areas for research on strategies for prevention, including modifications in personal and domestic hygiene behaviours, provision of appropriate water supply to and sanitation for the households, and the development of effective vaccines. The Centre's scientists will contribute to the improvement of the case management of diarrhoea based on better understanding of basic mechanisms, and national and international responses to epidemics. Risk factors for low birth rate and potential interventions, acute respiratory infections, nutritional deficiency states (including micronutrients), and immunization-preventable infectious diseases will also be examined, particularly as they interact with diarrhoea.

Population and Reproductive Health: The Centre has a long history of conducting pioneering research in the areas of population and family planning. The Centre played a key role in raising the contraceptive use rate among women of reproductive age in Bangladesh to almost 45% through technical assistance and operations research. So much so that the 1994 Cairo Conference hailed Bangladesh as a family planning success story. Matlab is now the model for MCH-FP programmes throughout the world, and the Centre is poised to make important contributions to maternal health and safe motherhood. In addition to continuing work in these areas, the Centre has initiated community-based research on reproductive health and STD/RTI/HIV infections.

Application and Policy: The Centre will continue to play a major part in improving both supply of and demand for existing health technologies, and in replicating the successful interventions piloted in its projects through health systems research. The Centre will increase its communication, dissemination and training efforts to influence international and national health policies in the areas of its expertise. ICDDR,B recognizes, and has given a high priority to, the need to transform research findings into actions.
