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Ensuring community participation in MCH/FP activities: Lessons learned from a pilot project

Abbas Bhuiya

Ubaidur Rob
Population Council

Maruf Rabban Quaderi

Ensuring Community Participation in MCH-FP Activities in Rural Bangladesh Lessons Learned from a Pilot Project

Abbas Bhuiya[1]
Ubaidur Rob[2]
Maruf Rabban Quaderi[1]

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1- International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR.B)
2- Population Council, Dhaka

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Abstract

Community members were involved in a process of participatory need-assessment, identification of problems and solutions, designing a plan of action, and monitoring the implementation of the plan to improve the effectiveness of MCH-FP program. The service providers of the government MCH-FP program were also involved in the process at an appropriate time. As a result of the intervention, the community members became more aware of the population problem, came to know about the existing service facilities, and the role of various stakeholders including themselves. As a result of the intervention, the demand for services was increased and most of the service providers were responding positively to the growing demand.

Executive Summary

Background

Family planning and maternal and child health in Bangladesh has achieved commendable success in the recent past. This has mostly been possible through a large-scale service delivery system of the Government with donors' support and cooperation from non-governmental organizations. Although encouraged by this success, as measured by increased acceptance of modern methods of family planning and MCH services, the relevant quarters are concerned about the programmatic, financial and social sustainability of the program, including the quality of services. It is now widely believed that most of the above concerns will be taken care of if effective community participation in the program can be ensured. Accordingly, the, International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) implemented a pilot project in Anowara, a low family planning performing area in rural Chittagong during 1997 with assistance from the Population Council. The main objective of the project was to develop a strategy to ensure community participation in the FP-MCH program and to document the process.

Methods

The project activities were carried out in collaboration with the indigenous village-based self-help organizations (SHO) in the area. A series of workshops with the male members of the SHOs and female community members were conducted to review the health and population situation in the area. A review of the existing governmental facilities, including service providers and their utilization, was also made. As soon as the community members realized their and service providers' role in alleviating the population and health problems, a combined participatory learning workshop of the community members and the service providers was arranged. In that workshop a detailed plan of action with a distribution of the responsibilities was outlined. A monitoring and review committee with representatives from SHOs, service providers and project staff was formed, and a monthly meeting to review the progress and to define new actions was proposed.

Findings

- The community members became more aware about the population problem and the existing facilities and service providers in their locality. They could see their role in making the program more useful to the community. The SHOs took interest in making the most out of the existing government service facilities. In the combined workshops of the community members and service providers, both could discuss the problems they faced. The community members raised issues of irregular visits by the field workers, lack of information about the satellite clinics and EPI sessions, irregularity of the satellite clinic sessions and in the functioning of the union health center, lack of drugs, and charging of fees by some service providers for supposedly free services. The community members also raised issues of lack of support for contraceptive side-effect management.

- The service providers raised the issue of lack of awareness and motivation about family planning among the illiterate population. In some instances, outside the group meetings, they also mentioned their low compensation package and tried to justify service charges.

- As a result of growing awareness in the community the service providers were compelled to keep the union health center open during the scheduled times, as opposed to the erratic schedule in the past. They also had to make field visits and conduct the EPI sessions and satellite clinics regularly.

- After some time, some of the service providers started to avoid meetings with the community members on the plea that they did not have any authorization from the higher authority to attend the meetings with the representatives of the community members.

Model for Community Participation in MCH-FP Activities

- Identify the self-help organizations (SHO) and key and resource persons in the community.
- Carry out participatory review of the status of the existing MCH-FP situation in the area, separately with representatives of the SHOs including women, and service providers.
- Organize combined workshop with SHO representatives, key and resource persons, and service providers to identify gaps between the current and expected situation, obstacles to achieve the expected situation, and possible ways to overcome the obstacles.
- Carry out combined participatory learning workshop with SHO representatives and service providers to develop an action plan with clear indication of responsibilities and timeframe, and objectively verifiable indicators to measure progress.
- Organize experience sharing and feedback meetings with SHO representatives and service providers once a month to review the progress and to define new actions or refine the earlier ones.
- Share the experience once a year with various stakeholders including high-level program personnel.

Introduction

The Maternal Child Health and Family Planning (MCH-FP) health program in Bangladesh has in the recent past achieved tremendous success. This has been possible due to a large-scale delivery system of the Government, together with donors' support and cooperation from NGOs. There are 35,000 family planning service outlets currently in the country, a large majority of which are organised at the district level and below; with 3,000 Family Welfare Centres (FWCs); 1,275 Rural Dispensaries and 23 Mother and Child Welfare Centres (MCWCs). At the village level, basic MCH-FP services have been provided by the staff members of the FWCs at the satellite clinics at the rate of 30,000 clinic days per month. Additional door-to-door services have also been provided by 23,500 Family Welfare Assistants (FWAs) of the government and by over 8,000 field workers of non-government organizations.[1] The urban areas are mostly excluded from any effective organized service delivery system from the Government and non-government organizations.

Although the information above conveys an impressive view of an extensive service structure, it is mostly maintained with donors' support. The success rate as measured by an increase in acceptance of modern methods of family planning and the MCH service is also improving every year. However, concern has been voiced by relevant quarters on the programmatic, financial and social sustainability of the program. Also, the external support currently being received may not be forthcoming in the future. It is believed that effective community participation in the program can solve most of the concerns. Thus, the importance of community participation in the MCH-FP program has been underscored as one of the strategic options in the near future.[2]

Though the theme of community participation in the Primary Health Care arena has been incorporated into the agenda of both Government and non-Governmental organizations alike, set in the context of Bangladesh, the success rate in achieving community participation has so far been limited.[3] The current project is an attempt to discover strategies to achieve community participation in government MCH-FP activities. The project drew a lot from the experiences gained from an ongoing community development oriented health project in Chakaria, Bangladesh. [4]

The project had two phases: the first included a literature review to identify and design appropriate intervention strategies. The second phase included an implementation of the strategy and documentation of the process and lessons learned.

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[1] Haider S. H., Streatfield K. and Karim M.A. 1995. Comprehensive Guidebook to the Bangladesh Family Planning-MCH Program. Research Evaluation Associates for Development (READ), The Population Council, Ministry of Health and Family Welfare, Dhaka.

[2] Pinkham F. et al. 1995. The Bangladesh Family Planning and Health Services Project: Strategic Option Report. USAID (RFA-USAID/Bangladesh-96-p-002).

[3] Bhuiya et al. 1997. Community Participation in Health, Family Planning and Development Programmes: International Experiences. Special Publication No. 59. ICDDR.B, Dhaka.

[4] Bhuiya A. and Ribaux C. 1997. Rethinking Community Participation: Prospects of Health Initiatives by indigenous self-help organizations in rural Bangladesh. Special Publication No. 65. ICDDR.B, Dhaka.

Project Site

The project activity was carried out in the Battali union of Anowara thana in Chittagong district from December 1996 to June 1998. The area was purposively selected in view of its low family planning performance. Chittagong is basically a low CPR (contraceptive prevalence rate) area as identified by the GoB Family Planning department.

Battali union had a population of 19,883 in 1991 (Union Council record); out of which 10,079 were males and 9,804 were females. There were 3,365 fertile couples in 1997 (Thana Family Planning Office). There is a Family Welfare Centre (FWC) and 5 cyclone shelters in the area. The union is comprised of six villages and has 9 primary schools, 2 high schools and 1 college.

Battali is a coastal area. The union is within 4 kilometers of the Bay of Bengal. The area experiences regular flooding, tidal surges, and cyclones. The North and part of the North-east is surrounded by the Deyang Hill. To the South there is the Sapmara Lake and in the East there is the Shah Mohsin Awlia Lake.

The nearest hospital is in Anowara thana, where there are 31 beds and provision for family planning services. Many non-governmental organisations are working in the area. The important ones included World Vision of Bangladesh, CARITAS, Bangladesh Red Crescent Society (BDRCS) and Gono Unnayan Prochesta (GUP). Apart from that, more than 60 local organisations are registered with the Government for carrying out development work in the thana.

Even though the people of Battali are predominantly farmers, in the past people of various other occupations have formed communities of weavers, anglers, barbers, washermen, butchers, and blacksmiths. The wind of change has blown over Battali too, and has brought about a change in occupations. For instance, businessmen, office-workers and foreign resident workers now make up a tangible number of the community. At the heart of the union is the Battali bazar, which encircles Hazrat Shah Mohsen Awolia's Mazar, a business centre for a long time where people of miscellaneous occupations congregate.

The literacy rate according to the 1991 census for Battali union stands at a low 39% for men and 20% for women (for the 7 and above age group). As for the use of sanitary latrines, the situation is deplorable. And, though, there are sufficient tubewells in Battali, after the 1991 cyclone various organisations reported an outbreak of diarrhoea due to the use of impure water from ponds and lakes by the inhabitants. Hence the prevalence of diarrhoea is still perceived to be the highest in the area.

Strategies

The overall strategy for this project was to work in partnership with the indigenous village-based self-help organizations (SHO) and the government Family Planning and Health service providers and to take the SHO members and the FP-MCH service providers through a

participatory process of identification of goals and problems, finding solutions, defining and planning actions, and implementing and monitoring the activities, including the outcome. The project was not designed to provide any material support and services but to mobilize community members and the service providers to work together to ensure optimum use of the existing facilities.

Project Team

The Project Team comprised of a Community Organizer, a liberal arts graduate, and a Health Assistant with twelve years of schooling at the field level. They were guided by a social demographer.

Staff Training and Orientation

The field staffs were first given an orientation on project philosophy and strategies. Subsequently, they had two weeks' residency at the Chakaria Community Health Project of ICDDR.B to have the necessary exposure and hands-on training in participatory research methods.

Methods and Procedures

A number of participatory research methods were used in implementing the project activities. They included rapport building, transect, mapping, and participatory planning.[5]

The rapport-building phase included visits to villages and meeting the influential persons in the locality and to list the existing self-help organizations in the villages. A sketch of the village, with roads, location of schools, mosques, market, health centres, was also prepared with the help of the villagers during the rapport-building phase.

The project staff introduced themselves as employees of ICDDR,B who were there to learn more about the health and family planning situation in the area. It was also mentioned that eventually the exercise could help improve the situation in the area and in other parts of the country. At the initial phase the project staff members were not proactive to meet the government family planning service providers in the area. It was only after sometime that the project staff met the officials in the thana headquarters and the service providers in the field. No attempt was made to obtain an executive order from the capital directing health and family planning workers at the thana level and below to provide assistance to the project staff.

The rapport-building phase was followed by a quantitative survey of the SHOs in the union. The survey included various information about the SHOs. After the survey, when the relationship with the villagers-- especially with the members of the SHOs-- was considered to be strong a proposal for group discussions was made. Subsequently 16 PRA exercises were

[5] ShoGuRiP. 1991. PRA in Bangladesh. ShaGuRiP (Crop storage credit programme), Dhaka. Koning K. D. and Martin M. 1996. Participatory Research in Health: Issues and Experiences. Zed Books Ltd. London. Burkey S. 1996. People First: A guide to Self-Reliant, Participatory Rural Development. Zed Books, London.

carried out in 8 groups in the villages to review the situation of health and family planning in the area. Of the 16 groups, one was with only women.

The first phase exercises were on general health problems and the water and sanitation situation. The area being a very conservative, the discussion on family planning in the first meeting was not considered appropriate. During the second round of meetings the situation of family planning and the problems faced by the villagers in getting family planning services was discussed.

As an outcome of the second round meeting, the participants expressed a need for combined meetings of the representatives of the SHOs and the FP service providers in the area. Subsequently, one combined meeting was held with all the service providers excepting the Thana Family Planning Officer. The Thana Health Administrator attended the day-long meeting/workshop.

The combined meeting was conducted by three external resource persons, trained in participatory planning exercise, with the help of the project staff. The outcome of the meeting was an identification of barriers to family planning and health goals and appropriate agreed solutions. A work plan was also developed and various individuals took the responsibility of carrying out the tasks. A follow-up and monitoring mechanism was also developed in this workshop.

Findings

Characteristics of Self-help Organizations

There were 20 SHOs identified in the union. They varied in nature and in scope of work. Of them 9 were youth clubs meant for social development, four sports clubs, five cooperatives, one Red Crescent Society, and one religious welfare club. Of the clubs, five were registered with the social welfare department of the Bangladesh Government. All but one had an active executive committee to run their activities. The clubs are mandated to carry out development and welfare activities of community members, especially of the most disadvantaged segment of the community. The sports clubs normally arrange and participate in sports and games. The cooperatives on the other hand collect savings from their members and borrow money from central cooperatives to provide credit to their members. The Red Crescent groups mainly works for managing natural disasters. The oldest of the organizations was established in 1958 and the most recent one in 1996.

Situation of FP-MCH Services

The situation of MCH-FP services in terms of the availability of the services and barriers in adopting family planning methods was assessed through participatory group discussion with the villagers. The major points that came out of the discussion are presented below.

Lack of adequate knowledge about the service facilities and providers was found to exist. Many were aware of the Union Health and Family Welfare Centre (UH&FWC), which is in

their opinion inconveniently located, but were unaware about the details of the services available. The participants almost always complained about the service providers for their irregularity in visits, charging money, and lack of supplies in the UH&FWC. It was clear from the discussions that the SHOs/villagers saw the importance of their roles in FP-MCH and are willing to participate to make the program a success.

The narratives of some of the group discussions are presented below:

Exercise -1

This PRA exercise was carried out with teachers of East Battali Primary School. They reported that the immunization service through EPI program is available in the locality. Family planning workers also make doorstep visits. They are also available for antenatal check-up of pregnant women in exchange of service charge. FWVs render midwifery service on payment (one of the respondents stated, one of her family members had to pay TK. 500 to the FWV for delivery service, another paid TK. 200 to the FWV to deliver her youngest). The participants stated that family planning workers supply oral pills to the village women whilst paying door-to-door visits to couples.

They are aware of the health workers activities/responsibilities to visit house to house and advise and distribute contraceptive methods, and to distribute pills, injections and condoms.

Two of the respondents said that they did not know whether there was any clinic or service centre to render family planning services to the clients of Battali union. They did not know that there was a Family Welfare Centre in East Baraiya, within the union.

Comparatively well-off and literate people usually call for a trained midwife on payment in times of delivery.

The educated and rich people of the area hire trained midwives, while the illiterate and poor people of the area get the help of the village midwife. The village midwife does not accept any fees, because she believes that if she can deliver her services to 40 women in labor, then this will secure her a place in heaven.

Respondents did not know about the responsibilities of the health and family welfare workers, nor could they say whether other people knew about the facilities in the area.

Exercise – 2

A total of 41 SHO members of the West Baraiya Palli Unnayan Samity and villagers of Paschimpara and West Baraiya were the participants. The following is an account of the discussion.

Many of the villagers are unaware of the services provided in the FWC. If anybody goes there for services, neither prescription nor medicine is obtained without payment. There is an MBBS doctor who refuses to even speak without money. No family planning services are offered to the local people. Sometimes, when the local women visit there, they do not find the

hospital open, and even when it is open, no method of FP is provided without money. The people of the area are keen on adopting a form of FP method, but are too poor to afford it. Simultaneously, other participants noted that many of them still believe that it is disgraceful to use contraceptives from a religious point of view-- that is, just as food is guaranteed by divinity, so is procreation. However, the same people saw a large family as a problem, as the strain would fall on the one earning member.

Many of the local people accept family planning and many of them do not. Those who adopt a method obtain it from either the market or from shops.

Family planning workers do not come to the village for home visitations. They come once a month or even bi-monthly, but they do not use their time constructively, spending much time gossiping with well-off housewives and, after chewing of beetle leaf, they leave the village. They do not visit all the families in the village.

Many of the village women are interested in adopting a form of contraceptive, but they cannot mention this to their husband out of shyness, neither can they manage to adopt anything themselves.

The participants had no idea about the multiple family planning services created by the Government in the FWCs for interested people. They asked for detailed information about them from the facilitator.

The facilitator then told them to find out about the services by themselves. They in turn insisted that if they were not told, how were they expected to know about the services? They (the participants) went on to say that family planning services are matter of interest to all of us but if information is not within your grasp and if they are not providing proper services, how would you ensure better services from them? This is how the participants probed, and became more and more interested in finding out about service provision from the project staff.

Exercise – 3

This session was held at the Puja Mandir in Tulatuli village, and the participants were members of the Naba Udayan Club. The group was of the opinion that, other than EPI, no other notable service facilities are available in the village. They usually go to Battali Bazar for medical services but, in case of complications, they need to go to the Chittagong Medical College Hospital. There is no midwifery service for mothers in the village, as they call the available TBAs for delivery purposes; the well off people call GoB trained birth attendants.

There is one GoB family planning worker in the village, who offers motivational services to the couples by moving from door to door but they need to purchase the contraceptives from the market. They do not go to the FWC, located in East-Baraiya, much. Battali bazar is a more convenient stop, which is also nearby. The people in the area are interested in family planning.

Exercise – 4

This exercise was held in Mahajerpara, Battali village. The venue was Rahim Sawdagar's tea stall. Ten male community members took part.

The group reported that there is one immunization center in the area and mothers and children are offered immunization at this service point. There are no TBAs available in the area though local birth attendants, whose services are free, are available on call. The birth attendants do not need to be paid for services. They are satisfied with gifts or TK. 10/20 in cash for bidi and betel nut because they believe that if one can assist in 40 deliveries this will earn them a place in paradise/heaven. However, no trained birth attendant from Battali bazar provides services free. People are generally interested in family planning but the number of acceptors is low, largely because many people are not aware of the programs. The family planning workers come to the area sometimes but they just gossip with some of their acquaintances and then leave the area. They do not visit every household, for motivational purposes or supply anything other than oral pills. Moreover, the area people are too poor to afford contraceptives from the market. Women are interested in adopting contraceptive methods, so if the family planning workers perform motivational services and provide medicine from a particular household in the locality, family planning will receive a boost. Currently, there are some women who do not know when the workers are available, so cannot benefit from services provided for them even though they are interested in the services.

Exercise -- 5

This session took place in a village tea-stall in the village of West-Baraiya with 10 villagers.

These participants said that the family planning situation was not fair in the area because the workers do not come to the village regularly and proper motivation and services are not available in the village. In the adjacent East-Baraiya there is a FWC but no health services are available there. The participants did not know about the services provided at the center, though they understood that there was one doctor and two family planning workers there. But, according to them, the staffs at the FWC are supposed to offer family planning services to the community but they do not do it without payment. Comments made were: "They used to take money by inserting Copper T, and if not paid, they do not even push family planning injections. Do they have the right to sell government medicines for money?" They made these complaints with much discontent. As for the supply of contraceptives, they buy them from dispensaries and shops, as they are not available at the government service points. Many of the villagers are interested in family planning but majority, who are not solvent enough, can not afford to pay for services or supplies. Local untrained TBAs are called for delivery services. They have no trained birth attendants in the village, however there is one at Minnat Ali Haat, who does not offer her services unless TK. 500 is offered for each case. Though there is publicity from the government by radio and television to go to service points marked by a green umbrella, the doctors and workers on duty there say that the government is not providing them either medicines or contraceptives.

Exercise -- 6

This PRA exercise was carried out in the Mosque premises, in the village of West-Baraiya. The participants were 18 *musullees* (muslim devotees) of the mosque after Friday prayers. It was somewhat difficult to focus on family planning with this group. They kept trying to divert the discussion from family planning to health and water and sanitation. The highlights of the discussion relevant to family planning are presented below.

They were aware about the availability of EPI services, and the existence of an FWC in East-Baraiya, which offers no services to them. When asked about the services available at the FWC, they mentioned motivational service by family planning workers and availability of oral contraceptives. There is one doctor, and they said that he claims to be an MBBS.

Exercise – 7

This was held at the Champatali mosque premises in the village of Champatali. The participants were 22 male members of the village.

There is no trained TBA in the area. However, there is one available in Boalkhali, who charges TK. 500 to TK. 1,000 for each delivery. There is another untrained birth attendant in that area. They did not know whether there is any health service provider in the area or not, but said that some workers come from Anowara government hospital to vaccinate the children of the village. There is one service center in East Baraiya, where a few women go for family planning services (that is, those who can afford it). Two female family planning workers come to the village once a month (one worker is supposed to visit each family in each assigned area).

The workers supply oral pill to the acceptors, and another person said that they also give medicine and vitamin tablets to pregnant women.

Exercise – 8

Twelve male members of the Halayderpara Youth Welfare committee took part in this session and were joined by the women of the surrounding houses.

The participants reported that there is a vaccination center that provides vaccination for the children but that there are no facilities for the mothers. There are no trained birth attendants in the area to help women in labour. Those who are well off enlist the help of a trained birth attendant from Minnat Ali Hat at a fee ranging between TK. 200– 1,000. One participant said that when his wife was in labor, he took her to Chittagong Medical College Hospital, and it cost TK. 10,000. For health facilities this couple usually visits Rustam Hat (Battali Bazar) but if that is not possible they go to Chittagong Medical College Hospital. When the participants were asked to draw the travel route they take to visit health facilities, they started drawing all the locations they visit, and also the location of the FWC. They were next asked about the services they receive from the FWC. One person said he went there for ointment. Another person said, "We don't go there much." Another person said that the FP services provided there are for women, and sometimes some women from the FWC visit the area, talk to the women and then leave.

The women do not discuss these matters with us, due to shyness. The FP workers do not discuss these matters with us either, but they did disclose that they sold FP pills to the women, 3 Taka per page.

In our area, people are not too enthusiastic about adopting FP methods. Amongst the enthusiasts, some buy their products from Rustam Hat (Battali Bazar), some buy from the FP workers whilst visiting the area, but for the operation and the injection some travel to Anowara Hospital. They do not visit the FWC, as it is not accessible.

All the above sessions concluded that, despite the availability of government services, the villagers are not getting the most out of them. Thus, the matter should get importance and the SHOs can play a role to improve the situation. The project staff offered to keep in touch with the representatives of the SHOs and be available for any help in this regard.

Perspectives of the Service Providers

The government health and family planning service providers in the union and the Thana Health and Family Planning Officer (TH&FPO) were informally interviewed on repeated occasions. The TH&FPO was found to be very committed to the alleviation of health and population problems. He tended to believe that the commitment of the field staff is very important and quite often it was not up to the expected level. The other staff members, especially the family planning workers believed that the people in the area are illiterate and do not see the importance of family planning. In terms of poor hygiene practices and use of safe toilets, the health workers also largely held the illiteracy among the people as the factor most responsible and poor economic conditions to some extent. The combined meetings of the representatives of the SHOs, family planning and health workers were somewhat difficult to convene, especially because of the reluctance of family planning workers to sit with the health workers. The other major problem was the Family Planning Inspector (FPI), who had two full-time jobs and one part-time job. He was very reluctant to face the representatives of the SHOs, and to take steps to improve the performance of his staff. As a local, he tried his best to make ICDDR.,B controversial in the area.

Participatory Learning and Action Workshop

All the above PRA exercises were concluded with a feeling that the Government health and family planning services have been under-utilized for various reasons. It was also felt that a joint effort of the community members and the service providers could be very effective to improve the situation. Thus, proposals were made to find ways how the SHO representatives and the government workers can complement each other's efforts. The project staff members informed the SHO representatives that they are in constant touch with the Government service providers and will let the SHO representatives know of any development in due course. It is against this background that the combined workshop of the SHO representatives and government service providers was arranged.

A total of 43 participants took part in the workshop. They included 11 government health and family planning workers; 20 SHO members (10 male and 10 female); 3 Union Population and Development Committee members; 9 Union Parishad members and the Chairman. A team of

four members, including three from the Chakaria Community Health Project of ICDDR,B, facilitated the workshop.

The objective of the Participatory Learning and Action Workshop was to identify the barriers to improving the health and population situation and to develop an action plan for implementation. The workshop was held on the 18th of October 1997. Various methods were used in conducting the workshop. The following is a summary of the major outcomes of the workshop:

Part-A. Assessment of the situation of health and population
Methods used: - Group and plenary discussion
Materials used: – Poster and pen

In this session the participants were divided into 3 groups, and they prepared 3 posters on the present health situation of Battali union. The problems identified were:

- High morbidity rate
- Poor nutritional status (specially among the women and children)
- Improper management of diseases, and shortage of MBBS doctors
- Rapid population growth
- Scarcity of safe water and safe latrine
- Traditional treatment seeking behavior - during illness people seek treatment from local healers
- Irregularity of EPI and SC sessions
- EPI/SC center and UH&FWC are not located in convenient places, and are difficult for community people to attend
- Community people are not aware about health
- Inadequately trained TBAs
- Improper management of Government health and family planning services

The above exercise was followed by a plenary discussion to assess the implications of the present situation.

The results of the group discussion as recorded in the posters were presented in a plenary session. The implications of the situation revealed through group discussions for the individual and the community were discussed. This was done through questions and answers. The most important implications identified were:

- Physical and economic loss
- High mortality
- Rapid population growth
- Unhygienic environment
- Improper management of Government facilities hinders national development

The participants realized that:

As a consequence of the situation, people were losing money; suffering poor physical and mental health, which can lead to high morbidity and rapid population growth. This can affect development activities both at the individual and the community level.

A lot of the money spent by the Government for better health of the community is wasted and this is creating an impediment to overall national development.

Part B: Identification of the existing resources
Methods: Question and answer
Materials used: Pen and poster

The objective of this session was to determine the available resources at the union level to alleviate the problems.

The participants realized that one of the ways to improve the current situation in Battali union is to make proper utilization of the existing health and FP facilities. Thus, an identification of the resources is important. The participants identified the following facilities.

Health facilities

- EPI Centers - 24
- Health Education Program
- ORS and Vitamin A capsule distribution
- Primary treatment
- ORS depot

Family Planning Facilities

- Health and Family Welfare Center – 1
- Satellite Clinic – 8
- Family Planning services

Health Workers

- Assistant Health Inspector (AHI) – 1
- Health Assistant (HA) – 3

Family Planning Workers

- Family Planning Inspector (FPI) – 1
- Family Welfare Visitor (FWV) – 1
- Sub Assistant Community Medical Officer (SACMO) – 1
- Family Welfare Assistant (FWA) - 4

Part C: Major Users of the Facilities
Methods: Matrix Ranking
Materials: Pen and Paper

This was to examine who mostly use the available facilities.

Findings related to health

According to the workshop participants, the poorer segment of the population is using both the health and family planning services of the Government. Female members of the society were also the main users of both the services. The tabulated results are presented below:

Table – 1
Users of the Health and Family Planning services

Users of health services	%	Users of family planning services	%
Male	20	Rich	20
Female	80	Poor	80
Total	**100**	**Total**	**100**
Rich	40	Male	5
Poor	60	Female	95
Total	**100**	**Total**	**100**
Child	80	Educated	60
Adult	20	Uneducated	40
Total	**100**	**Total**	**100**

Part D: Problems with the health and family planning facilities
Methods: Plenary and Question-answer
Materials used: Pen and poster

This session was to determine the major problems in using Government health and family planning facilities.

Findings related to health

- TT/Vaccines are not available in the field in due time
- EPI Center (venue) is not acceptable to all
- Lack of awareness on health among community people
- People did not know about the EPI/SC schedule
- People did not know about the Government health facilities
- EPI centers and H&FWC are not easily accessible for all

- GoB workers demand money from the mothers for TT vaccines

Findings related to Family Planning

- Government FP workers always favor their kin (close relatives)
- People are not aware about the use of FP methods and GoB FP facilities
- People are not getting advice about the side-effects of family planning methods
- Government workers usually distribute contraceptives without giving proper advice
- Females are not getting Vitamin/Iron tablets free of charge
- The number of FP workers is small compared to eligible couples
- There tends to be a long time-gap in visiting clients

The group after a long discussion on the above, identified the following as major problems in utilising the existing government health and family planning services in Battali union.

Findings related to health

- Lack of knowledge about the existing Government facilities
- Irregularity of EPI sessions, vaccination supplies and absence of health workers
- Lack of awareness about health among the people

Findings related to family planning

- Lack of effective communication between the clients and FP workers
- Lack of adequate awareness among the community members about family planning
- Inadequate counseling and treatment about the side effects of family planning methods.

Part E: Search for solutions
Methods: Plenary and ranking
Materials: Pen and poster

In this session the participants discussed how the above stated problems could be minimized. Here the participants identified the role of different community members and then prioritized their roles. According to their perception, SHOs can play the main role with active co-operation from GoB personnel and other community members. In the following table the role of different sections of the community, as seen by the participants, are presented.

Table 2
Role of different parties in improving the health and population situation

Community members	Roles/activities	Ranks*
Male	• Making women aware of health and family planning facilities • Actively participating in health and family planning programs	4
Female	• Will come to know about the facilities from the health workers and disseminate the messages to neighboring households	5
Educated members	• Will support the activities and support the people	3
SHO members	• Will discuss in their regular meetings • Will discuss in the mosque on Friday after Zumma Prayer • Co-ordinate with the Government health and FP workers and the community • Arrange training for the SHO members on primary health issues, GoB FP & health facilities, and TBA	1
UP members	• Regular contact with the Government health workers • Co-ordinate with the Government workers, SHOs and the community • Discuss in the monthly co-ordination meeting of the Union Parishad about the health and FP activities of the union	6
Government health & family planning personnel	• Will make the people aware about the facilities • Ensure regular supply of vaccine in EPI Center • Ensure the regularity of EPI/SC sessions • Will attend in the meetings organized by the SHOs • Facilitate in training arranged by the SHOs • Ensure regular operation of H&FWC	2
ICDDR,B staff	• Motivate the community • Arrange workshops time to time with SHOs, GoB worker, UP members, and rural elites • Co-ordinate the whole process	7

* In order of importance starting from 1.

Part F: Development of Action Plan
Methods: Plenary: Question-Answer
Materials: Pen and poster

Based on the above information the participants reached a consensus, and formulated an action plan to alleviate the major problems facing the community.

Action Plan: November 1997 - October 1998

What	Who	How
Ensure the regular supply of vaccines, medicines and presence of workers in H&FWC, EPI/Satellite Clinics	GoB Health Workers	• Timely presence in the field • Timely contact with the office for duly supply of vaccines, medicine • Contact with the community/SHO and dissemination time schedules • Proper supervision of workers
	Self-help Organization	• Contact with GoB workers, Contact and motivate the community
Ensure effective communication between clients and FP workers	GoB FP workers	• Regular presence in satellite clinic session and H&FWC • Provide proper counseling and primary treatment in H&FWC • Proper supervision of workers
	UP members	• Time to time contact with GoB officials
	Self-help Organizations	• Find out problems and will take steps to minimize the gaps in regular meetings • Co-operate with the GoB workers
Ensure proper counseling/treatment of side effects of FP methods	GoB FP workers	• Provide proper counseling about side effects of FP methods during the time of acceptance • Refer the complicated cases to the Thana Hospital
	Educated persons	• Aware the villagers about the side effects and inform them where the villagers will get the facilities

Part G: Assessment of Possible Impact
Methods: Plenary, discussion
Materials: Pen and poster

The participants objectified their views as to, possible changes that might take place after a year of implementation of the above plan.

The findings are:

- Prevalence of diseases will decrease
- Use of EPI/FWC Center will increase
- Use of FP methods will increase
- Mortality and fertility will decrease

Part H: Formation of a Progress Review Committee
Plenary: Discussion
Materials: Pen and poster

After an elaborate discussion the participants formed a general committee consisting of 21 member who decided to review the progress every quarter. The members of the committee decided upon are:

- UP Chairman - 1
- UP member - 3 males from each ward and 1 female member
- GoB Health and Family Planning personnel - 6 (AHI, HA, SACMO, FWV, FWA, FPI)
- Representatives from SHOs - 3 (1 from each SHO)
- Representative of ICDDR,B - 1
- High School Teacher - 1
- Imam - 3 (1 from each ward)
- Ansar VDP - 1
- Dedicated Social Worker - 1

*The adviser of the committee is TH&FPO

*Representatives of UP members for the above committee will be decided by the parishad

*The TH&FPO will elect representatives for the GoB health and family planning workers for the above committee.

*Representatives of SHOs for the above committee will be decided by concerned SHOs.

The participants also realize the necessity to form a Monitoring Committee, consisting of 13 members; who will monitor the activities and meet on the first Saturday of every month, and report to the general committee and draw an action plan for the next month. The committee members will be as follows:

- Representatives from THC - 2
- Medical Assistant - 1
- Family Planning Inspector - 1
- Assistant Health Inspector - 1
- ICDDR,B - 2
- Union Parishad - 3 (2 males and 1 female)
- SHO - 3

*The participants decided that representatives of ICDDR,B will coordinate the process.

*The first meeting of the monitoring committee will be held on the first Saturday of November, and will start at 10:00 am and close at 12:00 p.m. The venue for the meeting will be the H&FWC.

Learning from the Workshop

During the process of the participatory learning and action workshop the facilitators observed that:

- At the beginning of the session, female participants covered their faces with *Burkhas* (veil) and did not want to say anything at all, but gradually they voiced themselves through other male participants in the discussion. So women can participate effectively in public affairs through this type of workshop.

- Through involving different communities like SHO members, members of local government, GoB workers, ICDDR,B and KP/RPs, it is possible to find out effective ways to alleviate problems.

- This type of workshop can be used as a tool to raise consciousness of GoB workers about their duties and the community members about their rights and responsibilities.

- If the community members become aware of their health and GoB workers are sincere in their duties (proper supervision), it will be possible to alleviate the existing health and family planning problems in a satisfactory manner.

- Male members of the community are not aware of women's health problems though the women want to express their problems but have no platform to express their views. The workshop helped them to raise their problems in the presence of male members of the community.

- Representatives of the local government realized that they should play an active role in utilizing the GoB Health and FP facilities.

Continuity of the Activities

During the project period the progress review committee could meet only twice. Almost every member attended the first meeting. The meeting was presided over by the TH&FPO. In that meeting the activities carried out during the month preceding the meeting were reported by various individuals. The SHO members reported about the visits or lack of visits of the service providers in their locality. The staff members from the HF&WC reported the regular operation of the center and its hours of operation during the week. They also reported about the satellite clinics held. There were some minor instances of dissatisfaction expressed by the SHO members about the supply of medicine in the health centers. The service providers tried to explain the gap between the limited supply and large demand. The tendency of accusing the service providers for charging fees and selling government medicines was also felt. Some of the service providers informally expressed that they need to charge for their services for the salary they receive was not enough for their livelihood. The chairman of the meeting (TH&FPO) was very enthusiastic and took the advantage of the public demand to advise the Government service providers to put more sincerity in their work. Many of the family planning workers did not like the advice from the chairman. They also did not like the emerging accountability to the SHO/community members. The meeting was concluded with a call for further collaboration between the service providers and the members of the self-help organizations.

Afterwards a tragic event happened. The project Community Organizer (Maruf Rabban Quaderi) met a road accident on his way to Dhaka and died. Consequently, the third meeting of the monitoring committee could not be held before closure of the project. However, a meeting of the project staff with the representatives of the SHOs and a number of the service providers was held before closure of the field office.

Conclusion

The project staff could mobilize the community members through the existing self-help organizations to take initiatives for the improvement of health and family planning situation in the area in three months time. It was also possible to establish a platform where the community members and the service providers could sit and discuss the problems and define solutions for solving the problems. During the process, the community members became more aware about the population problem and the existing facilities and service providers in their locality. They could see their role in making the program more useful to the community members. Also, the service providers could see the enthusiasm among the community members and were encouraged to be more responsive to the community needs. The process of sharing meetings helped to remove the misunderstandings between the service providers and the community members about the level of services available through the government system. As a result of growing awareness in the community, the service providers had to keep the

union health center open during the scheduled time, as opposed to the irregularity of the past. They also had to make field visits and the EPI sessions and satellite clinics regularly.

During the later stage of the project, some of the service providers started to avoid meetings with the community members on the plea that they did not have any authorization from the higher authority to attend meetings with the representatives of the community members.

Based on the experiences of the project the following can be recommended for testing on a larger scale to ensure community participation in FP-MCH programs:

- Identify the self-help organizations (SHO) and key and resource persons in the community.

- Carry out participatory reviews of the status of the existing MCH-FP situation in each area, separately with representatives of the SHOs including women, and service providers.

- Organize combined workshops with SHO representatives, key and resource persons, and service providers to identify gaps between the current and expected situation, obstacles to achieve the expected goals, and possible ways to overcome these obstacles.

- Carry out combined participatory learning workshop with SHO representatives and service providers to develop an action plan with clear indication of responsibilities and timeframe, and objectively verifiable indicators to measure progress.

- Organize experience sharing and feedback meetings with SHO representatives and service providers once a month to review the progress and to define new actions or refine the earlier ones.

- Share the experience once a year with various stakeholders including high-level program personnel.