Attachment 1. A-000009 17 January 1994

(FACE SHEET) ETHICAL REVIEW COMMITTEE, ICDDR,B. 18/1/94

Principal Investigator Abbas Bhuiya

Application No. 94-002

Title of Study Improvement of health through community development oriented program ~~in rural Bangladesh~~

Trainee Investigator (if any) None

Supporting Agency (if Non-ICDDR,B) The Swiss Red Cro

Project status:
(✓) New Study
( ) Continuation with change
( ) No change (do not fill out rest of form)

Circle the appropriate answer to each of the following (If Not Applicable write NA).

1. Source of Population:
   (a) Ill subjects Yes (No)
   (b) Non-ill subjects Yes (No)
   (c) Minors or persons under guardianship Yes (No)
2. Does the study involve:
   (a) Physical risks to the subjects Yes (No)
   (b) Social Risks Yes (No)
   (c) Psychological risks to subjects Yes (No)
   (d) Discomfort to subjects Yes (No)
   (e) Invasion of privacy Yes (No)
   (f) Disclosure of information damaging to subject or others Yes (No)
3. Does the study involve:
   (a) Use of records, (hospital, medical, death, birth or other) Yes (No)
   (b) Use of fetal tissue or abortus Yes (No)
   (c) Use of organs or body fluids Yes (No)
4. Are subjects clearly informed about: Not Applicable
   (a) Nature and purposes of study Yes No
   (b) Procedures to be followed including alternatives used Yes No
   (c) Physical risks Yes No
   (d) Sensitive questions Yes No
   (e) Benefits to be derived Yes No
   (f) Right to refuse to participate or to withdraw from study Yes No
   (g) Confidential handling of data Yes No
   (h) Compensation &/or treatment where there are risks or privacy is involved in any particular procedure Yes No
5. Will signed consent form be required: Not Applicable
   (a) From subjects Yes No
   (b) From parent or guardian (if subjects are minors) Yes No
6. Will precautions be taken to protect anonymity of subjects Yes No
7. Check documents being submitted herewith to Committee:
   - ✓ Umbrella proposal - Initially submit an overview (all other requirements will be submitted with individual studies).
   - ~~Protocol (Required)~~
   - ___ Abstract Summary (Required)
   - ___ Statement given or read to subjects on nature of study, risks, types of questions to be asked, and right to refuse to participate or withdraw (Required)
   - ___ Informed consent form for subjects
   - ___ Informed consent form for parent or guardian
   - ___ Procedure for maintaining confidentiality
   - ___ Questionnaire or interview schedule *

* If the final instrument is not completed prior to review, the following information should be included in the abstract summary:
1. A description of the areas to be covered in the questionnaire or interview which could be considered either sensitive or which would constitute an invasion of privacy.
2. Examples of the type of specific questions to be asked in the sensitive areas.
3. An indication as to when the questionnaire will be presented to the Cttee. for review.

I agree to obtain approval of the Ethical Review Committee for any changes involving the rights and welfare of subjects before making such change.

Principal Investigator

Trainee

94-002
18/1/94

1. **Project Director:** Abbas Bhuiya, PhD

2. **Other investigators:** None

3. **Title of project:** Improvement of health through community development oriented program in rural Bangladesh

4. **Starting date:** 1 January 1994

5. **Date of completion:** 31 December 1998

6. **Total budget:** US Dollar two million

7. **Funding source:** The Swiss Red Cross

8. **Head of division:** Dr. Michael Strong

This proposal has been approved by the Population Science and Extension Division.

Signature of the Associate Director, PSED: _____

Date: 17 Jan 94

IMPROVEMENT OF HEALTH THROUGH COMMUNITY DEVELOPMENT ORIENTED PROGRAM IN RURAL BANGLADESH: A PROJECT FOR OPERATIONS RESEARCH

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I. INTRODUCTION

Health Situation

Bangladesh is one of the developing countries in the world. Its underdevelopment is characterized by low per capita income, high fertility and mortality, and poor health of its population.

The mortality situation in the recent past has shown some improvement. Crude death rate fell from 40 per 1,000 at the end of the 1940s decade to 30 per 1,000 during 1950s, and just below 20 per 1,000 in the 1960s. Current level of crude death rate is around 12 per 1,000. However, the mortality trend has interrupted by occasional crises of varied nature starting from famine of 1943 and 1974, political disruptions during 1947 and 1971, and natural calamities like cyclones during 1970 and 1992, and flooding in 1987 and 1988.

Mortality in some special groups such as of infants, children, and mothers is still very high. The current level of infant mortality is around 100 per 1,000 live births, and child mortality is around 15 per 1,000 children. Maternal mortality is one of the highest in the world, 6 per 1,000 live births. Female children experience higher mortality than males even if they are biologically superior than males to survive. The vulnerability of the socially disadvantaged group increases many-fold during crises like food shortage and natural catastrophes.

During the last several decades death from some major diseases has been reduced. After 1950s malaria, typhoid, diarrhoeal diseases, and respiratory diseases were the major causes of death being responsible for two thirds of all deaths. Malaria had been largely checked by 1970 by virtue of the malaria eradication program of the government. By the mid 1970s a number of important infectious diseases such as typhoid were playing less important role on the overall mortality. Other infectious diseases, such as diarrhoeas and respiratory diseases persists and show little sign of coming under control. This is despite the fact that ORT is developed in Bangladesh and all out efforts are being made to prevent diarrhoea case fatality by using ORT. The emphasis regarding diarrhoea has been on case management which to some extent diverted attention from their underlying causes such as unclean drinking water, poor hygiene, and poor sanitary conditions. Emphasis on health education to empower the community members to prevent diarrhoeal diseases has been far from satisfactory.

Neonatal tetanus has persisted as a major cause of infant deaths. Underlying reasons for the high tetanus deaths are common to the high maternal mortality causes, namely the unsanitary conditions surrounding the process of childbirth. Recent studies revealed that at least two thirds of births in Bangladesh are not attended by a trained medical attendant. Compliance with prescribed procedures even among the trained birth attendants have been unsatisfactory.

In the context of maternal mortality by far the most important causes are eclampsia at the time of delivery, and the combination of hemorrhage and obstructed labor. Improvement of these requires more than appropriate cord cutting practice such as comprehensive system of antenatal care where potential high risk cases are detected and treated, and referred to health facilities for appropriate management.

The other major causes of mortality such as diarrhoeas, respiratory diseases, and unclassified fevers are common to all ages. Recent successful expansion of immunization program among children and pregnant women is expected to have a significant impact on measles and tetanus. A sizable short-term improvement in the safety of childbirth is most likely to result from the effects of widespread acceptance of family planning resulting in fewer pregnancies in the higher risk younger and older women.

The health status of those who survive is also deplorable. A large proportion of children suffer from undernutrition. Women at large are malnourished, anemic, and suffer from various reproductive tract infections. Everybody including adults suffer from incapacitating illnesses quite frequently and in most cases remain out of modern treatment facilities.

All the above are not only due to lack of appropriate health programs, but also the outcome of prevailing social, economic, and cultural factors. People even attribute diseases to supernatural causes. This not only results in inappropriate preventive and curative measures but also delay initiation of modern methods. Poorest segment of the population in particular, and women in general are the worst victims of the prevailing socio-cultural situation. The attitude towards women and the matters in relation to reproduction and health is a subject of taboo. Thus women, especially from the rural areas, never get appropriate attention for their health.

Natural catastrophes such as cyclone and tidal bore have also been important in the context of increased vulnerability of the population especially in the coastal areas. Ineffectiveness of the warning system resulted in heavy loss of human life in the past. The warning system was very complicated for the target population to understand and community participation was lacking in designing and implementing the system. Aggressive post catastrophe relief operation managed to reduce the after-effect considerably in the recent past, however, the situation of the community members in terms of their capacity to cope with any crises remained somewhat unaltered.

Cyclone and tidal bores are extreme examples of crises at the community level and in most cases attract national and international attention in the event of heavy loss of human life. Death and poor health of adult earning member in a family can also have disastrous effect in extreme cases. It was observed that health related factors, such as child death, loss of working capacity, treatment of illness, lack of nutrition and health knowledge, and high fertility directly or

indirectly are responsible for extreme economic hardship among rural families. The above events become recurrent and in fact put the families in a cycle of crises ultimately leading to a situation similar to disaster which is quiet in nature and prevalent throughout the year.

In summary, rural families in Bangladesh have to contend with two separate core problems: the problem of downward mobility pressures arising from regular vulnerability to crises of diverse nature and problem of insufficiency of income. Any attempt to improve the overall condition of the rural poor including health must find ways to address the above problems in a very effective way.

II. REVIEW OF CURRENT ACTIVITIES

There have been some efforts made so far to alleviate rural poverty and improve health situation, especially during the last decade. Development approaches mainly led by NGOs have been targeted to the poorest of the poor often characterized by guided participation of the people. Health programs on the other hand has been dominated by massive development of infrastructure through government initiatives following the Western model for providing services. It is only very recently that the concept of primary health care has started to get priority in government activities, and in fact some pilot projects are undertaken now.

Health is not of primary focus of majority NGOs in the country. Those with health components mostly try to follow the primary health care philosophy in a limited scope. The most lacking seemed to be is the effective community participation in the health activities. Some NGOs are ahead of the others in terms of attempting community participation in their health programs, nevertheless, the achievement is meager.

Poor performance in achieving community's involvement to a sufficient degree, for making a transfer of program management responsibilities to the people possible, can be considered as a serious limitation of the current programs. Under the current strategy, a state of dependency of the community members on development agencies has been resulting and going to be maintained for time to come. This in the opinion of many may have undesirable consequences.

Government so far has built infrastructures for health services including establishment of health centers from the capital to village levels with adequate number of trained manpower. So far their level of efficiency is far from satisfactory. At the village level the quality of services and their utilization are far from satisfactory. The problems are characterized by inefficient management and supervision, shortage of supplies, and under utilization by the community members. As a result there has been a little impact on the health status of the population at large despite a large number of government health workers engaged at the grassroots level.

Another example of poor effectiveness could be cyclone warning system. The system had little participation of the target population in designing and implementation and has been very complex for the target population to understand.

III. THE CONCERN

It is understandable that no government or NGO can take the full responsibility of community welfare especially, of health. It is more true for a country like Bangladesh where resources are very limited. Sustainable improvement can only be achieved through real participation of the local people. It may be time consuming under the existing system for the government to fully achieve community participation and initiate the community mobilization be it awareness building, health education, utilization of existing facilities, material contribution, and management of local facilities by community. NGOs can contribute in achieving these for they enjoy the flexibility of reaching the community far more easily and quickly than government machineries.

NGOs have been working in this country for the last twenty years. Some of them are guided by the principle that through community participation one day some of the management tasks of the programs can be left with the people. Under this scenario people should be able to set their own priorities, organize, manage and supervise action programs, and mobilize resources from the community to manage such programs. A careful examination of the situation will reveal that by now there is no sign of this achievement.

Once in this society village schools and roads were built and managed by the community. Mosques are even now built and managed by the community cotribution and participation. These are also attended by a paid *moulvi* (priest). School teachers and mosque attendants had been provided with free lodging and food by the villagers. Various examples of community managed self-help activities in this country can still be cited.

The above tendency of community participation and ownership is presently declining and its causes are not well understood. If villagers could once manage the above mentioned activities why can they not manage a primary health care worker for their own health now? It is also a big puzzle why they still prefer traditional birth attendants to a trained female government or NGO worker for attending delivery of babies. It is quite unclear if they could make their primary school teachers work before when the schools were run by them, why they now helplessly witness irregularities in schools now nationalized. There could be many examples of this kind where things were better run before than now.

Another example of recent origin is associated with trained TBAs in rural Bangladesh. They are often looked upon by the community as employees of the government or an organization, and not considered as

a community asset. This assessment is linked to the community member's experience that by extending training to their TBAs, the training providing organizations tend to alienate them from their traditional network of social relationships resulting in far less impact than optimum.

The above is a result of inappropriate approaches adopted in the recent past whereby people have been by-passed in designing and managing those activities. Thus if it is agreeable that things will be much better and more manageable if the community members have an effective role to play, then time has come to re-think how best a program can be designed to ensure optimum community participation for achieving sustainable health and development. The achievement of the above could be extremely difficult and might be impossible unless the strategy is based on sound research findings. Thus a need for serious operations research on community development oriented health programs is in order. The present proposal is precisely designed to serve this purpose.

IV. GOALS OF THE PROJECT

The main goals of this project are to:

(1) discover an effective strategy for organizing community members as self-help group;

(2) find appropriate and effective ways to cooperate with them to a stage of self-reliance such that, they are equipped to reduce their vulnerability to health and other crises; and

(3) train them to prevent and manage common health problems with an aim to improve their quality of life.

V. METHODOLOGY

The first step before identifying and/or forming self-help groups will be to establish relationship conditions with the community members. This is considered to be pre-requisite for giving any consultancy to the community members. The sole objective of this step is to listen to the language of the community members, their dreams, the challenges, aspirations, and build relationships of confidence.

For ensuring community participation the project will help strengthening traditional organizations centering mosques, clans, samaj, shallish, schools, clubs, Red Crescent grassroot level organizations if existant, etc., and will motivate them to act as self-help groups. Attempt will also be made to create new organizations such as, mother's club, neighbourhood committees, etc. if necessary. Depending on the situation in the study area there could be organizations formed for the most vulnerable groups following a target group approach.

After identifying or forming the self-help organizations a network among them will be established. They will be involved in problem diagnostics and in formulating strategy to address the problems identified. The members of the self-help organizations will be trained to help the community members to avoid and manage crises. A system will be developed such that the self-help organizations can share experience among themselves to make them more effective.

A monitoring and evaluation system will be established to assess the impact of the program. Process documentation will be done to better understand the strengths and weaknesses of the implementation procedures, and to understand the success and failure better. The self-help groups will be involved in every stage of the activities to ensure participation and to give them feed back for an improvement of their program. Utmost attention will be given to apply participatory rural appraisal, and/or other similar methods such that research skills to some extent could be transferred to the target population. Within this concept the ultimate ownership of the results of the scientific analysis will be made available and understandable to the target group.

At the beginning a baseline survey will be carried out in the study area to assess the current situation in terms of indicators amenable to the proposed interventions. The baseline will also include information about social groups and existing organizations to help better designing of the interventions and strategies for implementation. While the need for baseline data is well understood the baseline data collection is itself an intervention which often makes community aware of ceratin things and may even raise hopes for assistance. This may to some extent be a problem for the formation of self-help groups. In the absence of any ready-made solution to the problem, attempt will be made to clarify the intentions of the project with the target group/community members to minimize wrong hopes etc. Alternative strategy/methodology such as involving the community members in conducting baseline survey may also be tried. In fact various procedures and methods will be adopted to collect data from the community.

It is envisaged that the study area will be divided into various cells with the provision for comparison area to allow evaluation of the impact of various combination of interventions. In addition, small scale quantitative and qualitative research will be conducted on a continuous basis to understand the strength and weaknesses of the project eventually to enhance the performance of the program. These studies will also be helpful in understanding the mechanisms of influence of the programs. If resources permit provision to include area outside the program area will also be kept under the scope of the present project.

Selection of Study Area

At this stage it is planned to have the project started in a rural area preferably with less NGO activities in the past and without activities similar to the one proposed in this project. The area should

Ideally be a low performing one in terms of health and family planning performance. It should also be in a crises prone area in terms of natural calamities. Preferably it should be an area with a strong traditional social system in place. Chittagong district and its adjacent coastal areas to a great extent fulfill the above criteria. Thus, this pilot project will be implemented in the coastal belt areas such as, Banshkhali, Chokoria, and the like.

VI. PROGRAM INPUTS

Organizational Components

The local self-help organizations, representing the population at large and specifically the most vulnerable groups, will implement action programs to improve the living standards by focussing mainly on health issues in the broader sense of the word. They will also look after the social as well as environmental safety and protection measures determined on the basis of actual needs assessment.

The self-help groups are expected to form a platform or federation of common interests, which on local and regional levels will take up and formulate issues related to the health and survival requirements of the community members, especially of the poorest sector and will try to promote such issues. They will meet on a regular basis to share their experience among themselves.

The target population will be made aware of how the quality of life improves due to the betterment of the health status and living standards and because of new forms of social and community relationships which are likely to be developed during the process of implementation of the health oriented self help programs.

The target group will be made aware of the local resources and existing facilities both government and non-government at the village and union level to ensure access and maximum utilization of the facilities.

The self-help groups will determine how they can organize and implement the program inputs. The project will thus have the flexibility to accomodate community health workers and their training in the project plan and budget.

Health Components

The following activities will be included under the health activities:

1. health education for the study population at large,

2. training of local health personnel such as, health care providers and TBAs,

3. health education and first aid training to primary and high school students, and teachers,

4. health education and training to all members of the self-help group, clubs, and religious leaders,

5. promote small family norms and ensure adoption of effective contraceptives by the members of the self-help groups,

6. activating satellite health clinics in the study area,

7. awareness building among women about their health and social status,

8. management capacity development among the members of the self-help groups,

9. development of community based disaster preparedness control.

10. development of networking with other NGOs, GOB, and other groups at the national level to share experiences and to influence the national policy decision.

Depending on the results of the baseline survey, needs assessment, and demand from the self-help groups additional feasible activities may be included in the project. Because of the innovative nature of the project it needs to be flexible and dynamic in terms of study design and methodology.

VII. EXPECTED OUTCOME

It is expected that the interventions will reduce child mortality, maternal mortality, and improve health status of the community members especially of mothers and children. The project will also improve the status of women and increase contraceptive acceptance. It is further expected that the vulnerability of the community members to various crises will be reduced and ability to cope with crises will be stronger. As such, it is anticipated that health related lossess and expenditures will be reduced resulting in higher investment in productive activities. Eventually the self-help groups will be able to maintain their activities by themselves and will sustain without any external support or minimal external support.

Improvement in some of the indicators (knowledge and awareness for eaxmple) is expected to be visible in a year time,

VIII. RELEVANCE AT ICDDR,B

ICDDR,B is an international health research institution. Since its beginning as a cholera research laboratory in 1960, the center has been

responsible for many major scientific developments in the field of diarrhoeal disease control, nutrition, population studies and community health, and has made significant contributions to knowledge.

ICDDR,B always recognizes the importance of social science in the context of health. In the recent past this realization has been much greater than before, and consequently, the center has undertaken a major collaborative research project on non-health intervention (social and economic development program) in its field area in Matlab. Through its demographic surveillance system and repetitive surveys the impact of the non-health intervention will be studied in Matlab. In fact the non-health intervention which has been implemented in Matlab is the Rural Development Program of BRAC (a national NGO). This is a target group oriented integrated package with minimum health orientation and at present not aimed to try out the possibility of sustainability through traditional social groups. In other words, currently it does not provide any scope to compare the efficiency of various models of organization development procedure in terms of sustainibility, community participation, and effectiveness.

The present project on the other hand will basically search for an appropriate strategy to develop community oriented sustainable organizations/institutions. Finding such strategy is crucial for Bangladesh to make the country ready to face various crises, some of which may result due to rapid population growth and its impact not only on health but also on such important issues as environment and society. Because the dimension of those crises could be so diverse and complex that no GO and/or NGO machineries will be adequate to manage them efficiently without full involvement of the community members. Thus, this project will complement our knowledge to be acquired from on-going research activities in Matlab in collaboration with BRAC.

IX. ASSUMPTIONS AND CONCEPTS

Assumptions

This pilot project is based on the assumption that it is possible to utilize local communities as units (self-help group) of action by combining outside assistance with organized local self-determination and effort for improvement of health and overall development. Through appropriate stimulation local initiatives and leadership can be developed as the primary instrument of change, which can eventually sustain as self-reliant groups, without external assistance or with minimum assistance to ensure continuing better health and development.

Concepts

The following is a description of important relevant concepts which will be used in the context of the present project.

Self-help

For practical purposes, self-help can be defined as any voluntary action undertaken by an individual or group of individuals which aims at the satisfaction of individual or collective needs or aspirations. The distinctive feature of a self-help initiative or activity is the substantial contribution made from the individual's or group's own resources in the form of labor, capital, land and/or entrepreneurial skills. At regional level which may include a number of villages, the concept of self-help finds its expression in 'movement building'.

Self-help Organization (SHO)

A self-help organization denotes the institutional framework for individuals or households who have agreed to cooperate on a continuing basis to pursue one or more objectives. A SHO is a membership organization which implies that its risks, costs and benefits are shared among its members on an equitable basis and that its leadership and/or management are liable to be called to account by the membership for their deeds.

Self-help Promotion (SHP)

Self-help promotion is any deliberate effort to facilitate the emergence and foster the functioning of SHOs. SHP signifies broader and more comprehensive approach to development than the narrower project approach. In SHP, identification, planning and implementation of activities are embedded in a multifaceted strategy which is put into practice through the deployment of a series of coherent initiatives and measures, called "self-help promotion instruments" (Verhagen 1987). SHP, thus conceived, can be broken down into a range of interrelated instruments or promotional services which are directed specifically to SHOs and their membership.

Self-help Promotion Instruments

There can be eight instruments of SHP. They are:

- identification of target population and target groups,
- identification of activities through participatory research and planning,
- education and mutual training,
- resource mobilization and resource provision,
- management consultancy,
- linkage building with third parties,
- process extension and movement building,

- monitoring and ongoing self-evaluation.

Self-help Promotion Institutions (SHPI)

Self-help promotion institution is an organization which has been charged with, or has set itself the task of self-help promotion. To achieve this goal the SHPI disposes of a series of instruments. Promotion becomes self-promotion when this task is fulfilled by federative organs of SHOs or by SHOs themselves.

Self-reliance

Self-help is a means to achieve self-reliance. Self-reliance is a state or condition whereby an individual or group of persons having achieved such a condition no longer depends on the benevolence or assistance of third parties to secure individual or group interests. By implication, a self-reliant group has developed sufficient analytical, productive and organizational capacity to design and implement a strategy which effectively contributes to the betterment of the conditions of life of its membership and the maintenance of its independent status.

Self-reliance should not be confused with autarky. In present society, no group or community can survive as a self-sufficient unit. Interaction with other groups has become as unavoidable as it is indispensable. Self-reliance, however, implies a style of interaction with third parties on the basis of equality.

Self-reliance like self-help does not exist in a pure undiluted form. SHOs or a group of SHOs having attained such a condition, are also capable of assuring their own promotion. The relationship between self-help promotion institutions, self-help promotion instruments, self-help organizations, and self-reliance as a self-propelling process is illustrated in Figure 1 and the overall system in Figure 2.

X. IMPLEMENTATION STRATEGY

The project will take the role of self-help promotion institution with its staff members as self-help promoters or facilitators. The first task for the self-help promoters will be to establish relationship with the community members. This will be done through frequent visits to the community and establishing informal dialogue with members through existing focal points such as, public representative, religious and social leader, school teacher, active members of club, student, etc. During this step a survey of existing groups and institutions (such as, village samaj, clubs, cooperatives, NGO groups, community library, formal and informal schools, mosque/temple, etc.) will be done by using key informant techniques of data gathering and participatory rural appraisal (PRA).

The next step will be to study the groups with special emphasis on group dynamics in relation to their movement towards goals (if the group has clear cut objectives and is adequately motivated towards the goal it means it is moving), speed (depending on the determination, attitude, resources and commitments of the group, decisions and implementations take place either slowly or quickly), and growth or direction (capacity of the group to achieve its objective with a high sense of oneness and commonness; as the group grows it obtains or attains a cohesion and maturity and such a group is able to take decisions relatively quickly and without any conflict or tension).

For mosques or schools attempt will be made to study who in the community are in close contact with them? To what extent the community members are involved/participating in school/mosque activities?

The third step will be to decide on the strategy to adopt in terms of using the existing groups or to build new groups to carry out the planned activities. As a principle every attempt will be made to take advantage of the existing organizations or groups. In case of non-existence of any group, formation of new groups will be considered.

Institutions or groups which are most common in the community and having highest community participation will be chosen as the first focal point to make contact with the community. In rural Bangladesh, mosque, temple, and school may fall under this category. These institutions will be used to discuss the health and related problems in a broader terms. Attempt will also be made to evolve strategies to alleviate the problems through participation of these institutions. The extent of participation may vary depending on the culture of the above institutions. For example, mosques can be used only to disseminate the information about new initiatives at the beginning.

The next step will be to identify or build active groups (self-help groups) to initiate health related programs/activities. As a general guideline the project will identify 'out-groups' (non-kinship) to start the process of self-help. However, the strength of 'in-groups' prevalent in the community will be fully exploited to strengthen the self-help initiatives. Existing institutions such as, village clubs, or other similar institutions (there may also be local committees formed under the auspices of local government) will be selected as self-help groups.

In some instances new groups will be formed with community representatives. Depending on community culture, women members will be included in the groups with man, or separate women groups will be formed sometime after activating groups mainly with man.

Thus there will be three types of self-help groups: existing clubs, local government committees, and newly formed groups with man or women, or both.

Then the self-help promotion instruments mentioned before will be

systematically applied to work towards self-reliance. A cadre of field workers trained in organization and promotion of self-help groups will work for the project to facilitate self-reliance.

The following is an account how the self-help promotion instruments mentioned earlier will be applied to progress the self-help groups to self-reliant groups.

Identification of target population and target groups

Unless felt otherwise during the exploratory phase, the project will adopt a community approach, i.e., the whole community will be targeted. However, existing social groups will be the first target to act as self-help group. These will include village clubs and local government committees (village population or development committees). In the absence of such clubs/committees villagers will be encouraged to form such groups. The project will not attempt to use political groups as self-help groups.

The self-help groups identified above, may of course during their program planning, decide to focus on any particular socioeconomic group or target groups for alleviating any specific health problem. These groups may include poors or otherwise most vulnerable, such as women especially women of reproductive age, underfive children etc.

Identification of activities through participatory research and planning

Participatory research refers to the active participation of the target population and groups in diagnostic and problem solving thinking about development constraints and their present condition. Its aim is to identify activities through which they could overcome such constraints and thus improve their condition. Participatory planning is the logical extension of participatory research and implies the target population's participation in the assessment of the feasibility of the proposed action and in the planning of operations.

Initial dialogue with the existing groups and key individuals including formal and informal leaders, school teachers, students, and other community members will be established very informally. Through key-informant interviewing the objective of these groups, character of the leaders, achievement so far, future plan, and extent of participation of the community members will be studied. Utmost care will be taken not to raise any expectation of community members in terms of getting relief or external financial assistance during the process of establishing linkage.

Once the link is established and mutual trust is built the project staff members will attempt to establish their role as partners in development. The importance of sound health in overall development will be subtly introduced among the group members. It is expected that once the group members are convinced about the importance of health, they

will come up with proposals for actions. Project staff will not rush at this stage to have a quick plan of actions rather they will wait with patience to give an opportunity to the group members to propose and design actions, however, crude they may be. The project staff may at most help explain the magnitude, nature, and causes of major health problems in the locality by following a participatory approach. This is a critical stage if not carefully handled will result in actions directed by the outsiders with most likely outcome of poor community participation and unexpected impact.

Education and mutual training

In common usage education and training denote essentially a one-way transmission of standardized packages of knowledge and skills from educated to non-educated, from skilled to unskilled. Against this, in self-help promotion, education and training refer to a synthesis of expertise brought in from outside and the experimental knowledge of the community members. The result of this process is new knowledge which is well adjusted to the local situation. Education and training in this conception are the purposeful creation of a learning situation which leaves ample room for the two-way communication of ideas and the transfer of skills. Because of their connotation with top-down forms of intervention the term 'education and training' might be considered inappropriate to indicate such a process and replaced by 'knowledge sharing and knowledge generation'.

A close contact and interaction of the project staff with group members and community people through formal and informal meetings will be the forum of mutual knowledge sharing. The sharing will be on issues related to group dynamics including identification and solution of problems in relation to group maintenance and sustainability. The other issues of knowledge sharing will be identification of individual and public health problems and searching for appropriate solutions.

Resource mobilization and resource provision

Resource mobilization is used to denote the process of pooling and putting to practical use the productive resources owned or possessed by (potential) members of SHOs. Resources can be natural (land, water), financial (money), material (seeds, grains, manure), non-material (know-how, entrepreneurial skills, claim making or bargaining power), and human (such as TBA, Quacks, charismatic leader, etc.). Through pooling of resources the villagers can achieve economies of scale and levels of knowledge or influence which are beyond the reach of the individual.

Resource provision refers to the acquisition of additional financial, material, non-material, and human resources from external sources. In self-help promotion external resource provision is complementary to the contributions made by the members of SHOs from their own resources. The question is how far resource provision should and can go to enable

the villagers to break through the vicious circle of poor health and under-development without destroying or undermining their self-help potential, as often happens with outside assistance.

Under this project, the self-help groups will use the local human resources such as TBAs, quacks, school teachers, students, other community members, and government health facilities for improvement of health. Provision for creation and expansion of local capacities to prevent and manage health problems will be made. Use of local resources will be made to ensure the program inputs mentioned earlier in Section VI. Apart from human resources financial contributions from the community will be raised to complement the outside assistance for implementing planned activities by the SHOs.

Management consultancy

Management consultancy denotes the assistance given in terms of advice with a view to ensuring the efficient use of resources by local SHOs or their higher level organizations, and in a direction consistent with the objectives of the organization. Consultancy can address itself to different aspects of management which are central to the performance and continuity of SHOs. It includes the management of resources (financial, human, and other resources) and conflicts (conflicts can arise in any organization between groups or persons in pursuing organizational objectives).

Management consultancy as a SH promotion instrument assumes that even when activities have been well prepared and planned, new and unforeseen financial, economic, operational and technical problems will emerge in the course of action, for which the SHO may need some outside advice and/or assistance. It can be viewed as a special, non-material form of resource provision and as such it carries the danger of imposition of ideas by an adviser on the SHO, leading to a feeling of inadequacy among SHO leaders and membership.

This service will be provided to the SHOs by trained project staff members who will visit them in a regular basis. Care will be taken such that it does not result in imposition of ideas on the SHOs from the consultants.

Linkage building with third parties

Linkage can be built in various levels such as, (1) within the SHPI/SHO sub-system or SH movement, and (2) within the large system of SH promotion including third parties such as government agencies, private banks, traders, social and religious organizations, etc. Linkage building with third parties denotes the build-up of a network of linkages between the SHPI-SHO subsystem on the one hand, and on the other hand between SHOs with various administrative or economic or other units whose support, service, collaboration or tolerance are necessary for the smooth functioning of the SHOs. The process of linkage building with third parties is of a dialectical nature and as such

its evolution also includes the severance or reduction of existing linkages which are no longer considered functional or are found to be counter-productive.

In this project the SHOs among themselves will build a link to share their experiences and resources. Apart from exchanging materials through correspondence a mechanism will be developed to have regular experience sharing meetings among various SHOs. There will be regional committee with representative from various SHOs to coordinate and maintain this link. The project will facilitate this linking building by way of providing technical and management consultancy.

Process extension and movement building

By process extension here it is meant the extension of self-help activities and self-help organizations over a wider geographical areas as a process which gradually covers a larger segment of the underprivileged strata of society.

Movement building is defined as the process of structuring the relationship between SHOs and the SHPI, and in particular between SHOs, both vertically and horizontally.

SH promotion implies a deliberate attempt to facilitate and speed up these two processes.

In process extension the main issue is how a process, once successfully started in few places e.g. villages can spread to other places without a proportionate increase in costs of promotion, viz number of project staff, costs of transport, etc. One strategy often practiced to keep cost of process extension low and make it more effective, is the involvement of local leaders who dispose of persuasive and motivating powers which normally exceed those of professional field staff.

Movement buildings implies the development of a network, both horizontally and vertically, between SHOs and their higher level organizations. At the same time it is true that SHOs, unless they work together in at least a second level structure, will not be able to undertake more complex types of activities which require a larger scale of operation.

This operation will be aided by the linkage building instruments mentioned earlier. This will be mostly important for extension of the SHOs after successful pilot operation. However, it will also have relevance even in this pilot phase of the project.

Monitoring and ongoing self-evaluation

Monitoring, as a part of a SH promotion system, can be defined as the periodic review by development actors and promoters of ongoing

activities at every level of the system, and the assessment of whether or not activities are proceeding efficiently according to operational plans, and reaching their specific objectives.

Ongoing self evaluation is a process whereby the development actors and their promoters determine systematically the relevance, effectiveness and impact of activities undertaken at every level of the SH promotion system, in the light of its long-term development objectives. It can be viewed as a dialogue over time and not as a static picture at one point of time.

The difference between monitoring and ongoing self-evaluation resides mainly in the time perspective from which the assessment takes place: the first, monitoring, is closely related to ongoing concrete activities; the second evaluation, implies an over-arching reflection on the development relevance and significance of the self-help activities and related promotional practice.

Monitoring and evaluation are widely accepted as valid components of program or project organization. However, in a conventional approach they are organized as separate activities entrusted to special staff or outsiders who can assess progress and performance objectively and in a detached manner. In a participatory approach, monitoring and evaluation activities are integrated in the working tasks of field workers, leaders of SHOs and other development agents, while special efforts are made to involve the target population itself (the development actors) in the process. The emphasis is thus on self-evaluation. However, in reality the executive staff of SHPIs and SHOs are often so overwhelmed by operational tasks that systematic and regular assessment of strategy, working methods and performance does not take place unless such a process is organized and receives the recognition and status of a useful instrument.

In this project monitoring and self-evaluation will be organized at three levels: SHO level, SHPI staff, and delegates from other supporting institutions. The methods adopted will mostly be RRA/PRA type. Periodic evaluation will also be carried out by independent teams by using traditional survey techniques.

XI. PROGRAM DESIGN

There will be three localities to have the three types of self-help groups mentioned above. The health program inputs outlined in Section VI will be implemented through the self-help groups. A fourth area will be chosen to serve as a comparison area for this study which will have no self-help group but will have some kind of monitoring of indicators amenable to program inputs.

XII. PROJECT MANAGEMENT

The Project Director (PD) will be responsible for the project and will be guided by a Self-help Promotion Committee (SHPC) and a Project Resource Group (PRG). There will also be Technical Advisor(s) to provide technical assistance to the project in matters related to the activities of the project.

The SHPC will consist of PD, Technical Advisor (TA), Field Coordinator, Director of ICDDR,B (or a person nominated by him/her) and three representatives from the SHOs. It will meet at least once in six months. The PD will act as a convenor of the first meeting, during which the committee will define its way of functioning. This committee will act in the role of a steering committee for the project. Its main function will be to achieve consensus on strategies targets and activities among all parties involved and benefitted.

The PRG will act/come together on request by the PD and will advise on subjects proposed by the project. The members of this committee will be volunteers with social science and development expertise with practical experiences in the fields of relevance.

Detail of the project staff members and the organizational structure of the project can be seen in the enclosed organizational chart of the project.

XIII. TIME FRAME AND DURATION

Achivement with regard to some aspects of the objectives is expected to be made in three years. However, the transformation of self-help groups to self reliancy may need longer time. Thus the pilot phase of the project may need to extend for five years. However, if some strategies are found to be effective, extension of the project to new areas will be considered before completetion of the pilot phase.

Depending on the availability of funding, project site identification will be carried out during September -October 1993. If SRC agrees, after detail negotiation, the activities of the project can start from 1 October 1993.

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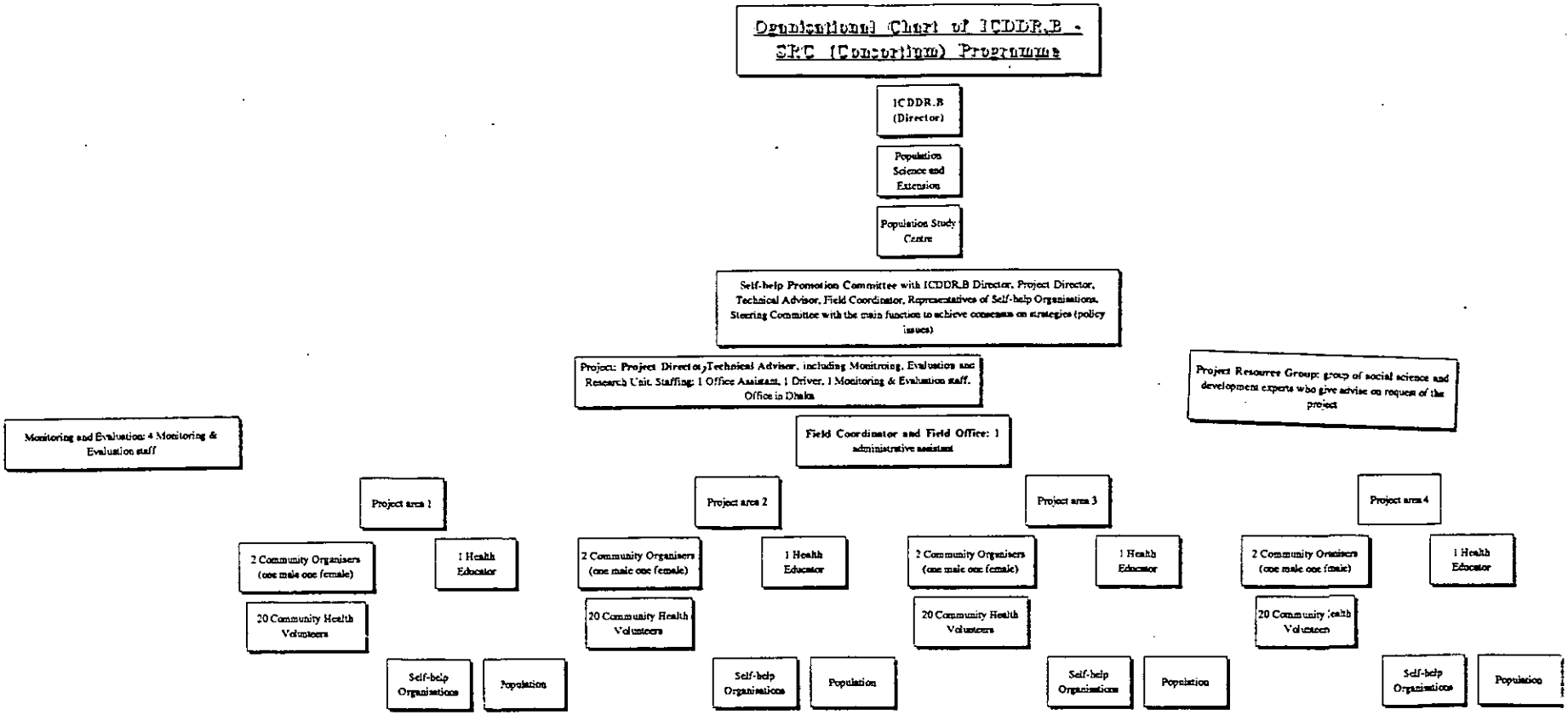
Organizational Chart of ICDDR,B - SFC (Concortium) Programme
ICDDR,B (Director)
Population Science and Extension
Population Study Centre
Self-help Promotion Committee with ICDDR,B Director, Project Director, Technical Advisor, Field Coordinator, Representatives of Self-help Organizations. Steering Committee with the main function to achieve consensus on strategies (policy issues)
Project: Project Director,Technical Advisor, including Monitoring, Evaluation and Research Unit. Staffing: 1 Office Assistant, 1 Driver, 1 Monitoring & Evaluation staff. Office in Dhaka
Project Resource Group: group of social science and development experts who give advise on request of the project
Monitoring and Evaluation: 4 Monitoring & Evaluation staff
Field Coordinator and Field Office: 1 administrative assistant
Project area 1
2 Community Organisers (one male one female)
1 Health Educator
20 Community Health Volunteers
Self-help Organisations
Population
Project area 2
2 Community Organisers (one male one female)
1 Health Educator
20 Community Health Volunteers
Self-help Organisations
Population
Project area 3
2 Community Organisers (one male one female)
1 Health Educator
20 Community Health Volunteers
Self-help Organisations
Population
Project area 4
2 Community Organisers (one male one female)
1 Health Educator
20 Community Health Volunteers
Self-help Organisations
Population

Explanations on the organisational chart

Project Committees

Project Resource Group

This is a committee which will act/come together on request by the Project Director and will give advise on subjects proposed by the project. The members of this committee will be volunteers with social science and development expertise with practical experiences in the fields of relevance.

Self-help Promotion Committee

This committee acts in the role of a Steering Committee for the programme. Its main function is to achieve consensus on strategies, targets and activities among all parties involved and benefitted. The Project Director, the Expatriate Technical Advisor, the Field Coordinator, the Director of ICDDR,B (or person nominated by him) and three Representatives from the Self-help Organisations are the members of the committee which meets at least once in six months. The Project Director acts as a convenor of the first meeting, during which the committee members define their way of functioning.

Role of Technical Advisor

The TA will be put at the disposal of the programme by the donor organisation (SRC). His/her appointment will be mutually agreed upon by the partners. A precise job description will be worked out prior to posting.

XV. BUDGET

A. Summary Budget

Items	First year project requirement US $
Personnel	
Project Director* & office support	39,000
Field Operation	86,000
Baseline survey	20,000
Qualitative studies	15,000
Equipments	19,400
Vehicle	40,000
Supply	9,000
Communication	1,000
Rent & utilities	3,600
Workshop & training	10,000
Travel (Local+International)	5,000
Contingency	5,000
Total	253,000
Add 18% local project implementation cost	45,540
Grand total	298,540

* - 50% of Project Director's time; overhead charge will be 15% when the Project Director's time-effort will be increased in subsequent years.

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Detail Budget for the First Year Improvement of Health through Community Oriented Development Program ICDDR,B			
Items	Annual Salary	% Effort	Project Cost in US $
A. Personnel			
Management			
1 Project Director	70,000	50	35,000
1 Office Assistant	4,000	50	2,000
1 Driver	2,000	100	2,000
Sub-total			39,000
Field Activities			
1 Coordinator	6,000	100	6,000
1 Administrative Assistant	2,000	100	2,000
8 Community Organizer/Trainer	3,000	100	24,000
80 Community Health Volunteer	300	100	24,000
Sub-total			56,000
B. Training			
4 Health Educator	3,000	100	12,000
C. Monitoring and Evaluation			
1 Anthropologist	4,000	100	4,000
1 Demographer-Statistician	4,000	100	4,000
1 Sociologist	4,000	100	4,000
1 Computer Programmer	6,000	50	3,000
1 Data Entry Technician	3,000	100	3,000
Sub-total			18,000
D. Survey			
Baseline Survey			20,000
Indepth Surveys			15,000
Sub-total			35,000
E. Equipments			
Computing			
3 Personal Computers @ 3000 each			9,000
1 Dot Matrix Printer @ 700 each			700
1 Laser Printer @ 2500			2,500
Softwares (Stat , spreadsheet, dbase, word pr)			3,500
Supplies and Accessories (disk, paper etc)			2,000
Health Assessment			
8 Weighing scales, @ 100 each			800
8 Stadiometer, @ 100 each			800
144 MUAC Tape, @ 100 for 12 dozens			100
Sub-total			19,400
F. Vehicle			
1 Jeep, @ 26,000			26,000
9 Motor Cycles, @ 1,500 each			13,500
Maintenance and Insurance			1,500
Sub-total			40,000
G. Supply			
Stationary			1,500
Training Material			1,000
Petrol			1,500
Office Furniture and Maintenance			5,000
Sub-total			9,000

Detail Budget- contd.			
Items	Annual Salary	% Effort	Project Cost in US $
H. Communication			
Mail, Fax Telephone			1,000
I. Rent and Utilities			
Office Rent, Field, @ 250 per month			3,000
Utilities (Water, electricity etc.) @ 50 per month			600
Sub-total			3,600
G. Workshop and Training (Home and Abroad)			10,000
K. Travel			
Local			1,000
International			4,000
Sub-total			5,000
L. Contingency (Unforseen items)			5,000
Total			253,000
M. Local Project Implementation Cost 18%			45,540
Grand Total			298,540

ICDDR,B

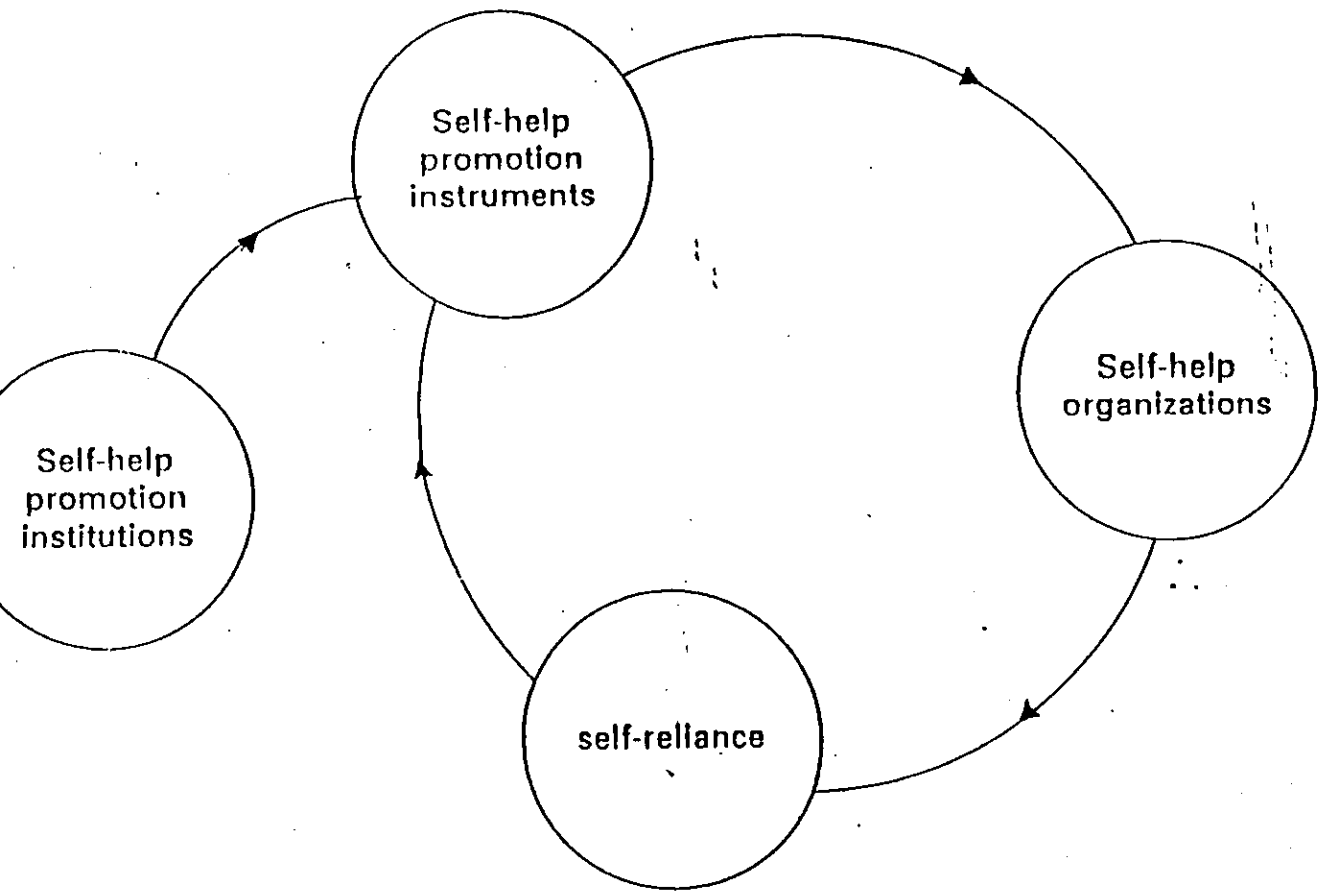
SELF HELP FOR HEALTH PROJECT

Time Schedule of Activities

1994

Activities	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Selection of Field Site												
Establishment of Field Office												
Recruitment of Staff												
Baseline Surveys												
Processing of Baseline Data												
Identification of Local Organizations.												
Establishing Relation with Organizations and Communities												
Development/procurement of SH Materials												
Training of Core Staff												
Establishment of a Monitoring System												
Review of Activities with SHPC												
Training of Health Promoters, nominees by SHOs												

SELF-HELP PROMOTION AS PART OF A PROCESS



(concept after: Kaenroad Verhagen; self-help promotion, a challenge to the NGO community, Amsterdam 1987)

figure : 1

THE OVERALL SYSTEM

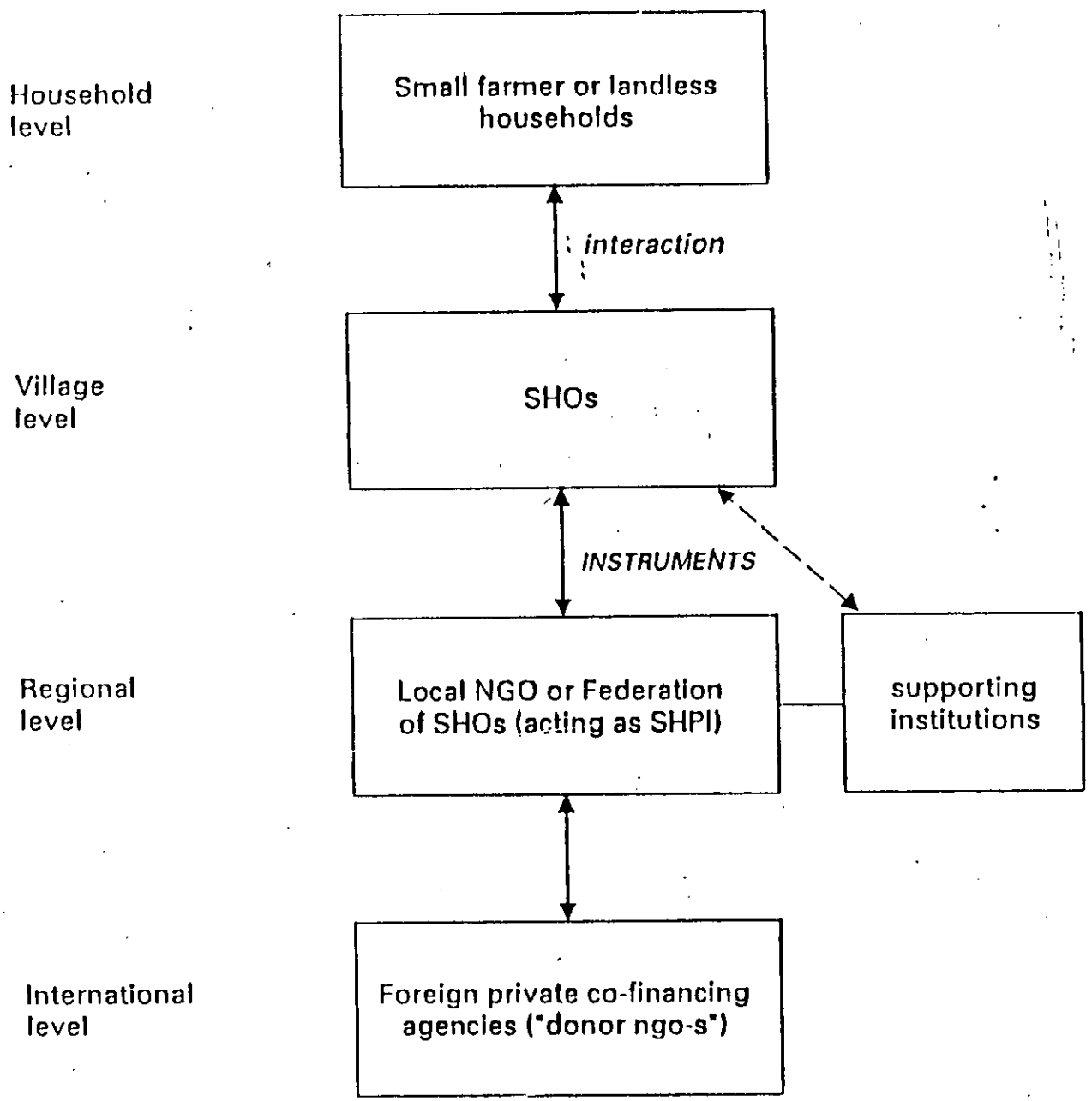


Figure 2