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Lowering barriers to health

How to improve women's health - an example from Bangladesh

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Many examples can be found of advantages of a process-oriented approach above a focus on delivery of technologies or health services alone. What lacks, even in 2000, is examples of what these processes are and how they work. This article gives such an example.

"It was early 1998. A lady was brought to the village health post by her relatives. She was pregnant, she was anaemic, and she was swollen with oedema. Her husband was a rickshaw puller. He could not bear the cost of the treatment, so when she was sick, her husband took her to the mother in law's house. But she was a widow, and could also not pay for the treatment. So after we saw her in the village health post we saw that she was severely anaemic and she also had heart failure. We referred the case to the Chittagong Medical College Hospital. The Self-Help Organisations (SHOs) in the village collected money from the members and they took the lady to the Hospital. There she was treated. She needed some blood; the SHO members gave their own blood. After the treatment in the hospital she was cured, and after some days she delivered her baby. It was a nice, beautiful baby. And when she was cured, and after the delivery of the baby her husband came, and they settled the case. He took her to his house, and now they are a happy family."

This story was one of the many stories told by Dr Mohammed Iqbal, public health physician of the Chakaria Community Health Project** in Bangladesh. The story confirms that health is not just influenced by health services. Even though the health services did in the end improve the lady's condition and helped her to deliver the baby, the service itself did not make the difference. The project interventions – strengthening self help organisations and bringing health on their agenda – did make that difference.

In Bangladesh good quality health services are scarce in rural areas. There are some health services, but many women can not access them in times of need. Projects that focus on programs that introduce health services or technologies risk neglecting women. The Chakaria Community Health Project focuses on the processes that enable women and others to access and make use of health services. The process is one of community management and self help

promotion. Success in these areas means villagers get better at identifying their own problems and dealing with them, and thereby improve their socio-economic position. Once they have reached this point, the lives, lifestyles and health status of many of their members improve.

The Chakaria Community Health Project concentrates on self-help promotion. Project staff started by walking through the villages, getting to know people, and letting the people get used to them, in order to establish good relations between the villagers and the project staff. They identified resource persons and existing self-help organisations in villages and eventually started working with a selection of these organisations. The members of the Self-Help Organisation (SHO) became more aware of their own health situation, and eventually the SHO members put health related activities on the agenda of their organisation. Existing organisations included school, mosque, neighbourhood committees and the like and did not include women. Once the confidence of the SHOs was gained the members allowed women to be contacted and to come together to meet. For most women who were strictly confined to their houses and courtyards this was the first happening of this kind. Gradually women formed groups and started acting as self help groups in their own right. Eventually, they also joined wider networks by creating clusters of several local groups, made connections between the clusters, and participated in forums with men. The women were no longer invisible.

If a Self-Help Organisation expressed interest staff members would provide training to build leadership skills or other capacities within the SHOs. The project never provided any form of free material support. After an initial focus on preventive measures and health education on health problems selected by the SHO members, the organisations felt the need for some basic health services. Since then, many of them worked to establish health posts in their areas. At that point, the project recruited a public health physician, the first health professional in the project. The community mobilisation and capacity building of SHOs was done entirely by community organisers and facilitators, with management and research assistance.

As the village health posts are self financed by joint committees of the SHOs, they are keen to avoid duplication in services. Wherever there is a possibility of a government service in the area, for example EPI service, the SHOs link up with it. At the moment, two public health physicians are paid by the project, and they are available for consultation at the village health posts one day a week. SHOs have meanwhile trained up traditional birth attendants and paramedics from their village to provide additional services in their area (training service provided by the project). Current talks in the organisations concentrate on funding strategies for the project doctors: when the project finishes, they want to be able to finance visiting doctors themselves.

After five years, project staff feels that it is probably too early to draw firm conclusions about the impact of the project. Nevertheless, they see evidence that the project is working in the right direction because of the active involvement of the Self-Help Organisations, their large and increasing numbers, still without any material incentives from the project. They also note the increase in demand for quality health services, and in 1999 were able to make a long list of

initiatives taken by the SHOs including diarrhoea epidemic control, health fair, campaigns for promotion of safe latrines, village doctors training, a Poor Fund for those unable to pay for any of the activities, etc.

Evidence of the positive effects and impacts of process-oriented projects on health, and especially women's health, is mounting. The community management and self-help promotion processes address underlying socio-economic causes of bad health and help people lead healthier lives. For many women, these underlying causes are the most serious threat to their health.

This article is too short to highlight all the dimensions and the details of the processes of women's involvement, community mobilisation, transfer of skills and responsibilities from project staff to SHO members, impact on women's health to date, etc. That information is available and the implementing organisation ICDDR,B as well as the sponsors of the project are keen to share that information and lessons learnt for use in similar projects.

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**The Chakaria Community Health Project is implemented by the Centre for Health and Population Research (known as ICDDR,B) in Bangladesh. The first phase of five years was sponsored by a consortium of the German, Dutch and Swiss Red Cross, and addressed a population of approximately 140 000.*

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