Why Things Work

in

BRAC's Health Programme in Bangladesh

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EXECUTIVE SUMMARY

This paper attempts to explain 'Why things work in BRAC's health programme in Bangladesh'. After describing the development of BRAC's major health programme, six key areas are identified as crucial to the success of BRAC's health work.

i) Sound project planning means knowing the target community, designing a small scale but replicable approach for pilot testing, and maintaining flexibility throughout the life of the project.

ii) As primary health care is about human development, personnel policy must be set so that the right health workers are selected, adequately trained and supervised, and given conditions of service conducive to responsible work.

iii) To elicit rural participation and encourage self-managed health care, Village Health Committees must be organised and supported. Successful field work means coordination with other organisations, and particularly for CSP, complementing and collaborating with government health workers.

iv) Continuous monitoring and evaluation at three levels - inside the project, inside BRAC, and external - allow problems to be resolved before they become serious. They also encourage constant project analysis.

v) Health education at the rural level demands appropriate communications at the inter-personal level. Spreading the health message to establish new norms means using the mass media effectively.

vi) Operating a nationwide programme requires skillful management by trained managers who know the field and who can communicate easily with and listen to their subordinates. The management style that works for BRAC is 'people-oriented'.

CONTENTS

1. Background: The Health Situation in Bangladesh

Bangladesh, with 103 million people, is the most densely populated country in the world. It is also one of the poorest nations, and the predominantly rural population, about half of which is now landless, enjoys little in the way of health and sanitation services. What services are available have a curative, urban bias, and are not well utilized by the poor because of lack of information and knowledge. The government's attempt to decentralise health services, with the objective of "health for all by the year 2000", has been hampered by the continuing curative approach as well as by insufficiently trained health staff with low motivation. The situation is beginning to improve, however, as primary health care, particularly immunization programmes, begin to become institutionalised at both government and non-government levels.

One of the major killers in Bangladesh is dehydration caused by diarrhoea, which accounts for over 50% of deaths in the 1-5 age group, and almost 64% in the 2-5 age group. In terms of morbidity, most children suffer 3 or 4 diarrhoea episodes a year, especially during the high infection seasons of April/May, and Nov/December.

Neo-natal tetanus is the principal cause of death among infants, and accounts for almost 50% of deaths during the first month of life. Of the 750,000 under-fives who die every year, 200,000 die of diarrhoea, 200,000 of tetanus, and another 100,000 of respiratory infections. BRAC estimates that 60% of mortality in the entire population is deaths of under-fives.

Other common but preventable diseases in Bangladesh, which are often fatal because of poor general health, are measles, diphtheria, TB, polio, and whooping cough. Half of all children suffer protein

malnutrition, and about 50,000 are estimated to be affected each year by Vitamin A deficiency, resulting in partial or total blindness.

UNICEF reports that over half of all infants are of low birthweight. Most rural deliveries take place at home with the help of a traditional birth attendant (TBA) whose practices are often unhygienic. Maternal mortality is high at 60 per 10,000, and the main causes are tetanus, infections, and eclampsia. Breast feeding is general in rural areas and is often prolonged for 2 years. However, colostrum is not given to newborns, and no supplementary food is given for the first 12 or even 18 months.

2. The Bangladesh Rural Advancement Committee (BRAC)

BRAC is a local non-government organisation involved in integrated development programmes to assist the disadvantaged rural population. It began as a small relief organisation in Sylhet district after the War of Liberation in 1972, but now has many district offices and over 2500 employees, all Bangladeshi.

BRAC works in organising and mobilizing people into cooperative groups which then plan, initiate, manage and control group activities in both social and economic development. After completing functional education courses, programmes in agriculture, pisciculture, animal husbandry, poultry raising, nutrition, health care and family planning services are implemented by the groups. BRAC supports the groups by providing training, credit and logistical assistance.

BRAC has attempted to make some health provision in its project areas, and has experience in community health care, including health education, mother and child care, preventive and curative services, and water and sanitation.

3. BRAC's major health work

In 1980, BRAC undertook a community based nationwide Oral Therapy Extension Programme (OTEP) to teach rural women how to combat diarrhoea. Later OTEP was modified to include a number of primary health care components, particularly an immunization programme for children under 5, and for women of childbearing age. OTEP has recently been integrated into a multi-faceted Child Survival Programme.

3.1 OTEP: The first phase 1980-83

During the late 70's, BRAC began to address the problem of rural diarrhoea management. In 1979 a pilot project was set up in Sylhet district to try to devise new methods for oral therapy, since clearly ORS packets could not be distributed on a vast scale throughout the country to a largely illiterate population.

One year of detailed research and exhaustive experimentation enabled BRAC to devise a safe oral saline which could be prepared at home using household ingredients (common salt and gur - a local molasses) and finger measurements. A field laboratory was set up to test sodium levels of samples taken randomly from households learning saline preparation.

The OTT message had to be devised in simple terms, encapsulated in a few poi which could be memorised, about the prevention and causes of diarrhoea, as well as about the accurate preparation of oral saline for its cure. The message (the 10, later 7, "points to remember" - see Annex I) had to be delivered orally in the home, and the pilot phase finally consolidated its approach as a one-to-one house-to-house teaching programme. Finding female field staff to

bring the message to one woman in every household was potentially difficult, in view of the custom of purdah in Bangladesh, which is especially strong in the conservative rural areas. However, women were found and trained to carry out the work, which is physically demanding (a lot of walking has to be done) as well as repetitive.

BRAC finally launched OTDP in 1980 after a thorough review of the pilot phase. Methods were systematised for recruitment and training of women workers and male coordinators, and mobile teams were deployed in 18 districts* with the objective of disseminating information on oral therapy to 2.5 million households in more than 20,000 villages in 3 years, so as to help reduce morbidity and mortality caused by diarrhoea.

Each woman worker visits about 10 households a day, spending about half an hour at each to teach the 7 points, demonstrate the preparation of oral saline, and observe the mother's preparation of it. The male coordinators are responsible for making prior contacts with the men in the community, without whose cooperation new knowledge addressed to the women would be unacceptable. They conduct meetings with village notables (opinion leaders) and at mosques, schools and market places, as well as with village doctors (herbalists, folk healers and quacks).

The women field workers are paid according to their 'scores' as assessed by a monitoring team of 3-4 men, which selects a 5% sample of households visited by each of them, and tests the mothers on what they have been taught. Performance is thus systematically monitored. 95%

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* Bangladesh is divided into 64 districts, 460 upazilas, and 4,760 unions. Each union has 3 wards; the population of a ward is about 7-10,000.

of workers score high and earn a monthly salary commensurate with that of other types of female employment in Bangladesh, both urban and rural.

A survey by BRAC's Research and Evaluation Division showed that the first phase of OTEP was largely successful: 2.5 million households were covered and after a month over 95% of women remembered the message, and how to prepare oral saline as taught. In addition, samples field tested, as well as those tested at ICDDR,B* in Dhaka, showed safe sodium concentration levels.

3.2 OTEP's Reinforcement 1983-86

OTEP was set up to promote a simple technical solution to a widespread health problem. Clearly, however, the promotion of a cure for diarrhoea, however simple, is insufficient without a simultaneous attack on the cause of the illness as well. The 7 point message delivered in one half-hour session would not necessarily be enough to explain disease vectors to mostly uneducated women, many of whose understanding of illness derives from superstition and traditional beliefs.

OTEP was therefore broadened to comprise a number of primary health care components to reinforce and complement the ORT teaching:-

- to promote ORT for diarrhoeal patients among all rural medical practitioners;
- the creation of women health cadres in the villages to promote health education;

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* International Centre for Diarrhoeal Disease Research, Bangladesh.

- to upgrade the skills of traditional birth attendants (TBAs): hygenic delivery, maternal nutrition, feeding colostrum to newborns;
- organisation of women's groups to discuss health issues;
- to promote supplementary feeding for infants over 4 months;
- TT (tetanus toxoid) immunization to women of childbearing age;
- organisation of village health committees.

During this phase, OTEP aimed to cover a further 4.4 million households in 24 districts. The programme area was divided into 3 regions with a regional manager in charge of each. Each region was further divided into 3 or 4 areas each under an Area Manager, who took charge of 9 or 10 field teams, 6 female worker teams and 3 primary health reinforcement teams. The expanded programme now comprised a field staff of 832 women field workers, 380 men field workers, and 13 field and head office managers.

The objectives of the second phase of OTEP were intrinsically the same as those of the first phase: to promote knowledge and use of ORT and thus, with the reinforcement of primary health activities, reduce morbidity and mortality caused by dehydration through diarrhoea.

All internal and external evaluation sources report almost universal knowledge about ORT in areas where BRAC teams have worked. However, accurate preparation by all those with the knowledge cannot be guaranteed as no study has been carried out. In addition, usage rates are variable, as people define 'diarrhoea' in different ways. BRAC continues to refine the 7 point message so that no confusion or doubt remains. It appears, however, that ORT treatment is becoming a new norm in Bangladesh for the treatment of diarrhoea, where

allopathic preparations (antibiotics etc.) were formerly resorted to, if any treatment was sought to all.

3.3 Child Survival Programme (CSP) 1986-1990

The logic of OTEP's extension, including its broader fronted primary health care approach, was to build a complete child health programme upon its grassroots base. BRAC therefore designed the third phase of OTEP as CSP, with mothers and children as the principal focus, and in conformity with the government programme.

With the objective of reducing infant, child and maternal mortality, and of developing replicable primary health care models for rural Bangladesh, the CSP comprises two major projects.

The first is a large scale project to complement and supplement the government's primary health care work, and is to cover 30 million people in 19 districts (140 upazilas) of the country - the poorest areas in the noth west and south east. The major components of this project are ORT (a continuation of the OTEP work), immunization of children under 2 (DPT, polio, BCG and measles) and of women of childbearing age (TT), and the distribution of Vitamin A capsules to children between 6 months and 6 years of age.

BRAC's role is to assist the government in planning and organising its immunzation programme* by stationing 3 person teams in each upazila for a year to help with developing village registers, mobilising community support, the logistics of vaccine supply, cold chain maintenance, deployment of immunizers and training of government health and family planning workers on all aspects of immunization. A management team and an immunization trainer are stationed in each

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* EPI (Expanded Programme on Immunization); See below 4.3.2

district to provide additional support. BRAC district and upazila teams also assist in organising union and upazila committees to support the programme, comprising political leaders, teachers, village notables etc. Such committees are intended to help with mobilization of the community on immunization days and continuous updating of registers and records. The field work is carried out by teams of 5 women health workers, and 2 men coordinators, who remain in each upazila for a year. They also work in each union for 8 weeks doing the ORT (OTEP) and primary health activities. In the first two years, 80 teams work in 40 upazilas each year; in the third and fourth years, 60 teams will operate in 30 upazilas each year.

The second project is a partly experimental full scale health care project covering 3 million people in 15 upazilas (5 in the first 2 years, 10 more in the third and fourth years), whose starting point is that community participation is the key to successful primary health care. This approach requires that all health-related activities be carried out in conformity with the lifestyle, needs, priorities and capabilities of each community. Thus, communities are encouraged to mobilize their own human and material resources to supplement those provided by the government, in order to effectively improve local health and sanitation.

There are eight components to the primary health care (PHC) project, namely (i) ORT, (ii) immunization, (iii) nutrition education, (iv) upgrading the skills of TBAs, (v) safe drinking water (access to tubewells) and sanitation, (vi) health education, (vii) family planning (birth spacing), and (viii) basic curative services.

A basic strategy for this programme is the organisation of Village Health Committees (VHCs), to include the poorest villagers.

The VHCs play an important role as change agents, to define needs, and to serve as a conduit between the village and the government health system. Their effectiveness will be one of the important learning aspects of the work, especially to see if they will continue to operate after the 2 years the BRAC teams* spend in the areas.

Both CSP projects are being carefully monitored through detailed process documentation, from which analysis and models for successful strategies can be built.

The management structure of CSP has BRAC's Executive Director as its chief, and is headed by a Programme Coordinator at BRAC's head office. There is a manager in charge of field operations, and 4 regional managers. A Planning and Training Manager takes charge of the large training programme, and also liaises with the government offices. A medical coordinator and a chief medical officer manage all medical materials and activities, and a publicity manager is responsible for working with the mass media.

The CSP involves a massive training programme both for BRAC staff and for government health officials and field workers. Many staff have had to be specially trained as trainers. Fortunately, BRAC's OTEP already had 10 Area Managers, 400 men coordinators and some 560 women health workers available for redeployment as experienced field workers. BRAC's Training and Resource Centres (TARC) provide training tailored to the needs of each CSP worker, as well as special courses in management for medical doctors and other technical personnel.

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* In the first 2 years of the PHC project, 25 teams of 5 women health workers and 2 men coordinators are working in 5 upazilas. Each upazila team comprises an Area Manager, a medical doctor, a logistics organiser, an accountant and a process documentor. In the third and fourth years, there will be 10 such upazila teams operating.

4. Essentials for successful project implementation: BRAC's experience

BRAC considers itself to be a learning organisation which makes constructive use of mistakes and failed experiments. Its successful fieldwork today can mostly be explained by its open and undogmatic approach to rural development work, in which years of trial and error have produced tried, tested and reliable models for ongoing projects, and continue to produce challenges and alternatives to new projects such as CSP.

A number of key features can be distinguished in BRAC's health programme which have been essential for making it work. These can be grouped under six headings - project planning, personnel policy, participation and coordination, monitoring and evaluation, communications and publicity, and management. The rest of this paper will comprise an analysis of each of these features in turn, in relation to BRAC's health work described in the previous section.

4.1 Project Planning

The design and planning of BRAC's health programme was based upon 4 crucial principles: knowing the community; being creative but realistic in approach; starting small; and being flexible.

4.1.1 Knowing the Community

BRAC's key to project planning is to have detailed knowledge of the community and its environs first. The pilot project for OTEP was conducted in Sylhet district, one of the most conservative parts of the country, but where BRAC could make use of 8 years of experience operating a village-based health programme, and the training and teaching methodologies it had developed in its functional education

programme. BRAC was thus in a good position to gain the cooperation and support of the local people in a project that might not benefit them if it failed*.

4.1.2 Approach

The approach adopted for OTEP was unique in Bangladesh, which is why the pilot project was so closely monitored. Having mobile teams of young women fieldworkers staying together away from their families, going in groups from village to village where they fan out to visit households invididually, 'woman-to-woman', is remarkable in a traditional male-dominated society. Many problems could have arisen. However, strict discipline in both work performance and in mores in the camps where the teams reside for 2 month periods, produced solidarity among the field workers as well as motivation for their work.

4.1.3 Small scale beginnings

OTEP started small, and was thoroughly analysed before being replicated on a larger scale. In addition, the extension of the project to other geographical areas did not create added layers of management or creeping bureaucracy. The key was to keep the operation simple, and only add more activities when the project was thoroughly established. Thus, OTEP's first phase ran for 3 years before any primary health components were added, even though it was known that a more complex MC programme was desireable from the start.

4.1.4 Flexibility

Plans for OTEP and CSP have always been flexible, so that changes

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* In areas where BRAC has not worked before, baseline surveys are either carried out by BRAC's research division, or else existing surveys are used.

can be made as and when necessary without disruption. This trial and error approach, for example, allowed BRAC to suspend the upgrading training of Traditional Birth Attendants (TBAs), when it was found that the trainers (the women field workers) had not been adequately trained for this function; either their training should be made more thorough, or professional midwives (or other medical professionals) should carry out TBA training instead.

It was also found that the training of village health cadres was not effective because they were not offering health education to their 'constituents' (first, 20 households, later only 5 households), which was the objective of the exercise. This was because of certain social constraints (a very poor cadre feeling unable to visit a better off household with health advice), as well as low motivation (the cadres were expected to work for no payment or compensation at all). BRAC therefore decided to drop this part of the programme except in a few places, until an improved strategy could be made viable.

In the early stages, OTEP teams were 20 strong, and spent only 2 weeks in each area teaching the ORT message. This period was found too short, so teams were halved to 10 people staying 4 weeks; then the teams were of 7 people spending 6 weeks in an area. By 1987, BRAC settled with the optimum team size of 5, spending 8 or 9 weeks in an area. In addition, ORT teaching is now being done in a group forum of two to five women, instead of on a one-to-one basis, which has been found to be more conducive to better ORT learning as well as more cost effective. In this way, implementation methods are continually under scrutiny and refinement.

4.2 Personnel Policy

Well over half of BRAC's 2500 employees are now engaged in primary health field work (CSP). Personnel policy is therefore of key importance in the programme, and concerns selection and training of field workers, supervision and monitoring of staff performance, and the work style of field teams.

4.2.1 Selection and Training

The women field workers are the front line of BRAC's health work. Basic selection criteria include age between 20 and 35, no children under 2 years old, religious tolerance, having husband's or guardian's permission to work, 10 years of schooling (fluent in reading and writing Bengali), and stamina. Press advertisements draw hundreds of applicants, so BRAC is able to handpick outstanding candidates on the basis of performance during pre-selection training which lasts 5 days. Of those recurited, 20% drop out after 2 months, and another 10% by the end of the first year. The remaining workers form a strong group of women.

The teams work 6 days a week for 3 1/2 months, then take 2 weeks off. Before resuming work, they receive 2 days of refresher training.

The male coordinators are carefully selected. Most are graduates, and a few have had 12 years schooling, and are aged in their late twenties. They receive pre-service training in leadership and communications, para-medical skills and programme management. Again, about 50% have dropped out by the end of the first year, but the rest remain with BRAC many years.

4.2.2 Supervision

BRAC's experience is that close supervision of field workers not

only gives them encouragement and support in a difficult job, but also identifies and solves problems before they become detrimental. The women field workers keep detailed records of household visits in their work diaries, which are examined regularly by the male team coordinators, thus giving opportunities for collective discussion.

As mentioned in 3.1 above, the women's pay is determined by performance, as monitored by special teams. This not only serves as an incentive to do good work, but also detects poor performance, and enables any worker's problems to be identified and remedied quickly.

4.2.3 Work Style

BRAC is an organisation that over the years has developed its own identifiable work style and spirit: it is a special balance of discipline, morale, and a social service ethos which is rare in Bangladesh.

Discipline is important, for example, in the field workers' living situation. Unmarried men and women live and work together (though occupying separate quarters) in one place, then move on to another. 'Camp'* rules are strict and conform with traditional norms. BRAC signs a formal agreement that it is responsible for each woman worker's personal safety, and the male team coordinators take on this responsibility. The women must move around together, dressed in simple blue s ees, and carrying umbrellas, symbolic of purdah.

High morale comes from team work and the habit of rapid personal and professional conflict resolution. The work is hard and potential for discontent is great, particularly the necessity of living away

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* All BRAC field workers are provided with appropriate housing and office facilities at or near project sites.

from the family, and often far from the home district. However, all workers (especially the men) are motivated by the need for employment and the women by a desire to contribute to the cash income of their families.

Social commitment grows as the workers gain experience and see the tangible results of their efforts: gradual but real change in attitudes and practice regarding health in the villages.

Fieldworker morale is also maintained by regular and appropriate training, both refresher courses and training for new functions in the CSP, such as on immunization and the public health system. Bringing large numbers of field workers together in the training centres thus facilitates both professional and recreational mixing, and nurtures the ethos of social service.

4.3 Participation and Coordination

BRAC's health objective is prevention, and therefore self-help health management is essential. This means that village people must obtain health education and then learn to participate in or demand the health services they require. The formation of Village Health Committees (VHCs) aims to foster such participation.

Very often NGOs work on similar projects with little or no communication among them, so that overlapping and confusion can arise in the field. BRAC tries to bridge such gaps, by coordinating its work, especially in health, with other organisations, and more recently with CSP, with government health departments.

4.3.1 Village Health Committees

In BRAC's integrated development programmes, in which health is

one of many facets, rural institution building is an important activity, and starts with tiny village groups, which clump into larger village organisations, which in turn federate into union and upazilla level representative committees. Such institutions take years to consolidate, and need constant support, but BRAC has shown that they can and do empower the rural poor, and give them confidence to know and demand their rights in terms of rural development resources.

In the second stage of OTEP, VHCs were instituted in the areas where the primary health components were added to the programme. Their two main functions were to prepare the local people for some health interventions from outsiders, and to promote and legitimise such activities. These committees ceased to function after BRAC's departure. Since CSP, however, in which BRAC is assisting in carrying out official government policy, the role of the VHCs is much more important, as mentioned above in 3.3, and attention is being given to how the VHCs will be activated on a long-term basis to achieve community 'empowerment'.

The VHC's in CSP are not mere pressure groups, however, but have specific functions to perform in a reliable manner: maintaining registers of families, births, girls reaching childbearing age, and their immunizations; preparing lists for immunization days; and motivating families to return for second and third doses. This active role by the community is considered essential to obtain reasonable coverage rates, and efforts are being made to include women in the committees.

Another way of ensuring the participation of women in health management is the selection and training of a new cadre ('Mother Volunteer') in some CSP areas. Selection is based on the

identification of mothers who have recognised leadership qualities and are already consulted by neighbours for social, economic and other reasons. Each Mother Volunteer is trained on various aspects of health management, and is expected to disseminate relevant health messages to 10 households. Such participation brings health care right into the village home.

4.3.2 NGO and government coordination

To reduce morbidity, disability and mortality associated with vaccine-preventable diseases*, the Expanded Programme on Immunization (EPI) was formally launched in Bangladesh in April 1979. However, through lack of efficient infrastructure and trained personnel, by 1985, only 3% of those eligible were being immunised. With the objective of universal child immunization (80% coverage) by 1990, therefore, the government has intensified its efforts and encouraged all organisations (NGO, bilateral and multilateral) with relevant capacity, to assist in this work.

As BRAC's capacity lies in the mobilisation and organisation of rural people, as well as in grassroots health education (OTEP), it has been in a position to assist with EPI in the Child Survival Programme launched in October 1986. As explained in 3.3 above, BRAC is trying to assist the government health machinery to gain experience and develop systems to cope with the immunization backlog and to set up continuing programmes for immunization and TBA training after BRAC leaves the area.

It is a challenge to BRAC to instill the motivation of its own

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* Diphtheria, pertussis, tetanus, measles, poliomyelitis and tuberculosis

fieldworkers into government workers, and it is still too early to identify what features of BRAC's collaboration techniques are most effective. However, emphasis has been laid on training government health workers and their administrators, as well as on developing VHCs to sustain demand on the latter for continuing immunization and vitamin A distribution.

Meanwhile, BRAC has representation at the National Steering Committee meetings for EPI, as well as at weekly EPI meetings.

4.3.3 Other organisations

Although communications are not always easy in Bangladesh, BRAC tries to keep lines open to other organisations, particularly those whose knowledge or expertise complement it own. The International Centre for Diarrhoeal Disease Research, Bangladesh (ICCDR,B), for example, provided valuable technical assistance to OTEP both during the pilot phase and since, including training, laboratory testing, and simple technology transfer.

A Technical Advisory Committee comprising members with a range of expertise from different local and international organisations was set up to advise OTEP on diverse aspects of its work. Such inter-agency coordination was crucial to the success of the programme. A similar consultative body is intended to be set up for CSP. Meanwhile, teams of process documenters are recording detail of the CSP field work as part of primary health care model planning.

4.4 Continuous Monitoring and Evaluation

As mentioned above in 4.1.4, BRAC likes to maintain flexibility in its approach. However, flexibility must be distinguished from

structurelessness or lack of planning, in which ad hoc changes could create confusion. BRAC's health work has been working well because of the operation of three levels of monitoring: internal to the project; internal to BRAC; and external.

4.4.1 Monitoring inside the project

It is through BRAC's inbuilt monitoring systems that need for change or adaptation can be detected as soon as difficulties arise. As mentioned in 3.1 above, OTEP field workers are supervised constantly by work diary checking as well as by salary assessment*. Their work is also observed personally by the coordinators, and by the frequent visits of Area and Regional Managers. In addition, random samples of household prepared ORS are spot tested at 5 field laboratories to check the sodium content, and some of these samples are further tested at ICCDR,B in Dhaka.

As CSP consolidates itself, detailed process documentation is being collected and used for record and statistics keeping, and also as the raw material for programme analysis. It is an exhaustive process, but one which should produce results in time; it is too early to comment on its efficacity at present.

4.4.2 BRAC'S Research and Evaluation Division (RED)

BRAC's RED now employs 70 members. This includes 45 in the field and 20 coders in Dhaka. RED has a number of roles: to carry out baseline surveys of communities and their resources before BRAC begins any activities with them; to monitor BRAC projects and evaluate their major phases; to carry out feasibility studies on projeect expansion or diversification, and to undertake studies on certain issues of

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* Such assesment has been discontinued; see below 4.6.

general interest in rural development, not necessarily directly related to BRAC's work.

While monitoring within the project itself can identify certain problem areas, RED can stand back and objectify such problems, then clarify and explain them. RED has continuously monitored and also carried out a number of detailed studies in the course of OTEP**, which have assisted managers in planning and decision making.

Studies currently underway by RED on CSP are a comparative study on group vs individual ORT teaching, a Rice-ORS study, a study on the way immunizable disease are perceived in the village, and how immunization is accepted, and a study on the effectiveness of TBA training. The findings of such studies will determine how the continuation of the programme will be carried out.

4.4.3 External Evaluations

Because OTEP was an innovative programme with implications that stretched beyond its national boundaries, external evaluations have been carried out at internals throughout its course, and CSP will also be similarly evaluated. Despite BRAC's internal monitoring and evaluation systems, external teams with international experience help to focus and conceptualise certain issues, and also bring reports of BRAC's health programme to a wider audience. Thus, learning takes

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** These include studies on the women field workers' motivation; the performance of coordinators; the availability of ORS ingredients; ORS usage rates. A major study to measure the impact of OTEP on mortality was also undertaken in cooperation with ICCDR,B; baseline data on a population of 70,000 where collected in OTEP areas, and on a similar number in non-OTEP areas. The same households were followed up every six months for three years. Age specific mortality and causes of death were determined for each area and compared.

place on both sides, and improvements are brought to the programme. Annex II lists the evaluation reports produced on OTEP.

4.5 Communications and Publicity

Skillful communications are essential when trying to convey pedagogic health messages. BRAC has paid great attention to the training of the women health workers in such skills, and the ORT message is delivered as a dialogue with each rural woman. Mass media communication, clearly, is delivered as a monologue, but BRAC has been careful to design straightforward messages for constant repetition.

4.5.1 The Message

BRAC's health work goal is to give basic health education so that common diseases such as diarrhoea can be avoided and managed. The primary health care components are intended to widen prevention of other illnesses mentioned in point 1 above. The key to success is good interpersonal communication between women field workers and village mothers, who are responsible for the level of hygiene and sanitation maintained in the home. The delivery of the right messages in the right manner by the right people is thus crucial to helping rural women participate in their own and their families' health care.

But health messages, however obvious to educated urban dwellers, may be completely meaningless to rural women who have never been out of their villages. BRAC's OTEP message and the style of its delivery (the 7 points, see Annex I) is still under refinement as ambiguities and misunderstandings continue to be exposed. Teaching aids (flip charts and books) are also under continual scrutiny, and new materials for CSP are rigorously field-tested before being produced.

Creating and delivering a health message is only one side of the

equation, however. The message has to be received and understood. Further, the recommendations carried in the message have to be adopted and used regularly; in other words, understanding (and accepting) the message is intended to modify or completely change traditional beliefs and behaviour about health. This is very difficult to do in half an hour, particularly when concepts such as 'germs' or 'disease vectors' have to be used to explain the cause of diarrhoea.

When it is appreciated that evil spirits are usually blamed for illness, especially by women, the almost universal knowledge of ORT for diarrhoea treatment in OTEP areas, and the high knowledge in non-OTEP areas, demonstrate the effectiveness of BRAC's communication strategy. A study on BRAC's campaign showed that rural knowledge of ORT was mostly accounted for by individual health workers spreading the information in person (Mitra, see Annex II).

4.5.2 Mass Media

Since OTEP began, BRAC has run a widespread multi-media publicity campaign on ORT through radio, TV and the press. In addition, posters are distributed and pasted up at schools, shops and markets; leaflets on the '7 points' have extensive distribution, and special information packs/folders go to local influentials and officials; hoardings and billboards have been erected at road junctions, bus stations and ferry ports. Moreover, BRAC frequently receives requests from other educational and health organisations for supplies of materials on ORT and diarrhoea management.

Although the mass media campaign reaches a predominantly urban audience, the objective has also been to influence 'opinion leaders' and thus enhance the credibility of OTEP's work. When BRAC

commissioned an external study of its publicity campaign on ORT, it was surprised to find that radio was the predominant source of information on ORT for all groups of the public. BRAC had underestimated the access of rural people to radio, and has adapted its campaign accordingly. The mass media, especially radio, have proved invaluable as a means of reinforcing and 'universalising' the ORT message.

4.6 Management

Like most organisations in Bangldesh, BRAC has a hierarchical management structure, and each programme (including OTEP/CSP) has its own hierarchy. A large organisation and a multi-faceted field programme demand clear lines of authority and responsibility, but BRAC tries to keep these lines open and 'listening'. This is done through appropriate management training, regular meetings, staff promotion policy, and the style of management which BRAC calls 'people-oriented'.

4.6.1 Training managers

BRAC attributes much of its success in health work to the acumen and experience of its field managers, most of whom have undergone formal management training appropriate to their jobs, as well as having the right field experience.

BRAC's health programme (OTEP) was designed according to the experienced staff available to run it, and could not have been undertaken by any new organisation. BRAC's Training and Resource Centres (TARC) provide essential training for field workers in all aspects of project management, from communication skills to planning

and accountancy, according to their levels of responsibility. BRAC finds it has a high turnover of staff at first, then people stay many years, and are posted to different projects to obtain progressive experience.

4.6.2 Two-way communication

BRAC's programme keeps its 'lines' open mainly through regular staff meetings. Field workers in the health programme meet weekly with their coordinators; monthly meetings take place in the field with Area and Regional Managers present; Area and Regional Managers meet together at the head office every three to six months with BRAC's Executive Director. All these meetings allow feedback to come in, plans to be made, and overall decisions to be taken in an informed manner and with relevant consultation. In addition, managers from different programmes meet informally at TARC during training periods, and discuss each others' work.

Because BRAC is very large and complex, a 3 day annual convention is now held in order to bring all BRAC's field and head office managers (about 100 people) together to discuss all BRAC's programmes and to invite questions, comments and opinions to be openly aired on any issues relevant to BRAC.

4.6.3 The managers

Only exceptionally is a BRAC manager brought in from outside. Most begin in the field, working as coordinators for five years or more, before being promoted to managerial positions. BRAC's policy is that no manager should be managing work of which he does not have first hand experience himself. In this way, misunderstandings are reduced, and management remains field rather than desk oriented, which

is essential for a rural programme.

The head office, which is where most managers are expected to be found, is regarded by BRAC managers as the place where reports are written and meetings held. Even top managers make frequent field trips, staying for days at a time in the 'camps', as does the Executive Director. Management in BRAC is thus not equated with distancing from the field activity.

4.6.4 How BRAC managers manage

BRAC field workers receive training using participatory methods: they are expected to feed-in to what the group is learning. They are trained to help organise and mobilise groups of landless people in the villages by getting the latter to speak out in group meetings about issues that concern them. Thus BRAC workers at all levels operate using the same kind of participatory approach.

BRAC managers are able to respond to demands or grievances that are made by those under their responsibility because of the open lines of communication. For example, the women health workers became discontented with the incentive system of payment, mainly because there was no allowance for seniority for those who had worked for many years, and also they received none of the other benefits of BRAC field staff. The issue was discussed at the different levels and finally it was agreed to pay them as BRAC staff as they demanded. In this way, grassroots workers have a voice at top level, and grievances can be resolved quickly by referral up.

5. Summary

This paper has attempted to explain what makes BRAC's major health activities work. A nationwide Oral Therapy Extension Programme (OTEP) ran for 3 years as such, for another 3 with added primary health components, and currently collaborates with the government as the Child Survival Programme (CSP). Six features were distinguished which are of key importance to making the programme succeed:

i) sound project planning

ii) careful personnel policy

iii) participation and coordination

iv) continuous monitoring and evaluation

v) appropriate communications and effective use of mass media

vi) 'people-oriented' management style.

Annex I

SEVEN POINTS TO REMEMBER

1. Loose motions, watery diarrhoea, infantile diarrhoea, cholera and dysentry, all these are called DIARRHOEA in general. Water and salt contents drain out from the body with each loose motion. If such loose motions continue for sometime, symptoms like thirst, loss of appetite, vomiting, indigestion and spasms of hands or legs etc. may set in. Diarrhoea leads to malnutrition and sometimes to death. So necessary measures should be taken in time to save the diarrhoea patients.

2. To avoid this disease, we should drink tubewell or tap water; water from other sources should be boiled and then cooled before use. Rotten food should not be eaten. All food should be covered well so that flies can not sit on it. Hands and mouth should be washed with soap or pure water before eating. Hands should be washed with soap or ash after using the latrine. Remember that breast-milk is harmless. Children who suck breast-milk from birth rarely suffer from diarrhoea, but nipples must be kept clean.

3. The treatment of loose motions/diarrhoea is to replenish by any means the water and salt lost. The easiest treatment is to administer oral saline. One can easily prepare this saline at home by using water, salt, and molasses or sugar. In case of dysentery, consultation with a doctor is advised.

4. Oral saline is prepared by mixing a 3 finger pinch of salt and a fistful of molasses in half a litre (seer) of water, and well stirred. Care could be taken to mix salt, molasses and water in the right proportions. A fistful of sugar can be used if molasses is not available.

5. Oral saline should be administered immediately after the first loose motion. It may be difficult to replenish the lost water and salt if saline is administered after 2/3 loose motions, when the patient will be more dehydrated i.e. the eyes will become sunken, tongue dry, fontanelle of children sunken. When the patient has become very weak in such cases, s/he should be referred to a doctor.

6. Adults should be given oral saline at the rate of half a seer at a time after each loose motion. Children should be given only as much as they want, but at frequent intervals. Once saline is prepared, it should be kept no more than 6 hours.

7. Advice on nutrition: During diarrhoea, the patient should drink plenty of water and eat food like rice and curry, along with oral saline. In case of children, breast milk/normal diet should be continued. An increased amount of food at least for seven days after recovery should be given. This will prevent malnutrition and weakness of the patient and minimise the risk of his/her falling victim to the disease again.

DIARRHOEA IS A DANGEROUS DISEASE, PREVENT IT.

Annex II

External Evaluation Reports on OTEP

Shushun Bhatia, R.A. Cash, I. Cornaz: "Evaluation of the Oral Therapy Extension Programme (OTEP) of the Bangladesh Rural Advancement Committee (BRAC)". Jan 24-Feb 12, 1983; Swiss Development Cooperation.

Mitra & Associates: "Impact Study of BRAC's LGS (ORS) Campaign", Dhaka, July 1985-Feb. 1986

I. Carnaz, D.F. Pyle: "Evaluation of the Oral Therapy Extension Programme (OTEP) of BRAC". Jan 12-Feb 13, 1986.

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A.M.R. Chowdhury: "Evaluation of a Community Based Oral Rehydration Programme in Rural Bangladesh". London School of Hygiene and Tropical Medicine, 1986.