CHAPTER III

Initiating Participatory Problem Solving in Health with the *Garo* Community in Bangladesh

Executive Summary

The *Garo* people in Bangladesh are an Indo-Tibetan tribe with a matriarchal culture and their own language. This people face a triple discrimination in Bangladesh based on the fact that they are an ethnic, a cultural, and a religious minority. This reality results in difficulties experienced in land occupation, job opportunities, accessibility to public sectors including health care services, housing and education. Analyzing the problems as presented by the *Garo* community leaders, I could summarize the situation to a three dimensional problem definition:

a) The assumed gap between the actual community health status of the *Garo* community and the desired status. This gap is influenced by factors such as: economic status, education, environment, religion, occupation, culture, nutrition, sanitation, the health care system, and intersectoral co-ordination and so forth.

b) The gap between the actual health services delivery and an acceptable service delivery. This gap is caused by factors as: availability of resources, capabilities, expertise, ethics, dedication, the degree of community participation and so forth. The gap is

further influenced by the availability of private sector and non-governmental organizations' initiatives.

c) The gap between the actual communication and co-operation of the public service sectors with the community and the desired communication and co-operation with the community. Based on the fact that health services operate mainly isolated from the other sectors, there is no effective co-ordination to meet community needs and its heavy top-down management. Also, this situation is influenced by the availability of private sector and non-governmental organizations' initiatives.

Of course these three problems are strongly interrelated and attempts to bridge the gap of one will have to take into account the interrelated aspects.

The study aims at the stimulation of community initiatives through participatory approaches, to improve the health status of the *Garo* community in the Dorgachola village of the Ausnara union at Madhupur *thana** in Bangladesh.

The general objectives are:

a) Initiate community-based participatory problem-solving in health for the *Garo* settlement in the Dorgachola village, Madhupur *thana*, Tangail District in Bangladesh.

b) Undertake initiatives planned, implemented and evaluated by the community to improve their quality of life.

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* Thana is the Bengali term for the smallest administrative unit in the country with an average population between 250 and 500,000.

c) Formulate recommendations related to participatory problem solving, based on the outcome of the research, to the various stakeholders.

The specific objectives are:

a) Initiate community based problem solving by: (1) Creating a village team for participatory problem-solving in health. (2) Defining problems affecting health from the *Garo* community's perspective. (3) Developing indicators and tools to assess the perceived problems.

b) Undertake initiatives to improve the quality of life by: (1) Assessing, with the local people, the problems affecting health in their area. (2)Formulating priority issues for the participatory problem solving program in the *Garo* settlement at Dorgachola village. (3) Designing an action program including monitoring and evaluation. (4) Estimating and mobilizing the required resources (internal and external) for implementing the planned action.

c) Formulate recommendations for the various stakeholders through a participatory evaluation of the research process and outcome.

Since the concern is expressed by the community leaders and members, there could be a viable opportunity to initiate participatory problem solving program(s) in health development. A community initiative can be justified in terms of answering the community needs on these levels where the public sector is unable to penetrate, based on administrative, strategic, operational and resource limitations.

The religious leaders of the *Garo* community are perceived as their only protectors and companions. The representatives of the Roman Catholic Church in the Mymensingh diocese* in Bangladesh, would welcome initiators of community based health programs, who share their concern for the *Garo* people.

A positive outcome, of the participatory action research, in terms of self-management and improvement of the community health status, could stimulate other *Garo* settlements for action to improve their quality of life. The total population of *Garo* people in Bangladesh is estimated to be 70,000 (BBS, 1994).

The essential feature of this study is the concept of 'participation'. The idea is that whatever form development may take, the active participation of people must be encouraged. The proposed study is based on the school of thought in participation which argues that:

> The direction of the development process is fundamentally misconceived. It is not the failure to take the human factor into account that is the fault and therefore the difficulties encountered in aiming at health for all, but rather the unreflecting way in which people have been left out of the development system and treated as passive recipients rather than active participants. The new approach, therefore, is to seek innovative and flexible procedures, taking into account the knowledge already possessed by local people. Participation, in this sense, is concerned with the production of knowledge, new directions and new modes of organization (Oakley, 1989, p. 2).

In the literature, authors including Fals-Borda (1991), Piyaratn (1990), Nondasuta and Chical (1988), Rahman (1991), Park, Brydon-Miller,

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*A diocese is a Roman Catholic religious District.

Hall, and Jackson (1993) stress the importance of this concept in 'health' development.

Participation in the context of this study means: Mobilizing community members to initiate definition, prioritization and analysis of problems, planning, implementing and evaluate the required actions with the active involvement of villagers, and linking this community initiatives with the existing public and non-governmental facilities and plans, aiming at improvement of the overall quality of life.

In short-term, capacity building in problem solving through a participatory action research with the *Garo* community in Dorgachola village, Madhupur *thana*, Tangail District in Bangladesh.

In mid-term, implementing participatory health development programs in the *Garo* community at Dorgachola village of the Madhupur *thana* in Bangladesh.

In long-term, to function as a catalyst for further development of the *Garo* community in Dorgachola village and to function as a stimulant for other *Garo* villages in the Arankhola, Ausnara and Sholakuri unions of Madhupur *thana* in developing community initiatives in health. This study could offer a base for future decision making on the planning and implementation of participatory health development programs within the *Garo* community of the Mymensingh diocese in Bangladesh.

This is a participatory prospective evaluation study to find ways in initiating health development activities by the community itself, to improve the quality of life, with respect to organizational, human resources and socio-economic and political constraints, and possible implications.

There will two stages to the research, each with a distinct approach: (1) Build consensus with the funding agency on the health and participation concepts, the research method, and the role of the funding agency and the researcher in the process. (2) Conduct a participatory action research including participatory appraisals, by using the soft systems inquiry method.

The proposed method aims at addressing simultaneous two aspects: (1) The human resource development, where people gain understanding, insight and learn in dealing with problems affecting the quality of their lives, and (2) the development of community initiatives complementary to the public services, addressing community health.

The basic principles of the proposed method can be summarized as the flexible use of methods, improvisation and iteration; multiple methods to cross check or triangulate; maximizing indigenous knowledge directly from local people; not trying to find out more than what is needed, not measuring more than is necessary for practical purposes; and critical self awareness, reflecting on what is being exposed and not exposed and admitting sources of error. The outcome is a more holistic picture about the situation, which could be cost-effective and very helpful in formulating activities but not to be generalized.

The study will be completed within a period of 12 months from the moment of commencement. A detailed outline of the time table is presented in table 3.

The study based on a participatory approach, will depend the community representatives assisted by one professional evaluator in the

field, and local manpower, and the feed-back of academic staff of the College of Public Health, Chulalongkorn University, Bangkok, Thailand.

It needs to be mentioned that in the absence of a work permit it is difficult to obtain a visa for a longer period (i.e. the maximum duration of stay with a tourist visa is 3 months.) Ways have to be explored on how to overcome this constraint.

In the absence of tele-communication, there is only the postal service to communicate with consultants. This constraint could be minimized by establishing cooperation with an agency, represented in the capital Dhaka, which would be willing to accept the role of communication agent between the evaluator and the College of Public Health of Chulalongkorn University in Bangkok.

At present Bangladesh is facing political turmoil, which result in frequent national strikes. These strikes paralyze the country, shops and offices are bound to close, as well as private and public transport. The fact that the study will take place in a rural setting, will minimize the impact of the political turmoil.

The study will focus on the *Garo* community as a specific group, which can be justified in terms of answering the perceived needs and concern of the community. The outcome of this study could offer valuable information for future study on *Garo* and non-*Garo* communities in Bangladesh.

The religious leaders in the *Garo* community are strong in terms of skills, attitude, insight of the problems and access to resources. Besides this they are highly respected and trusted by the *Garo* people. The

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Chairman of the parish council in Dorgachola village, is a layman. Although close co-operation with the religious leader and the local church will contribute to the sustainability, lay leadership would be preferable because of community membership and the continuity.

The *Garo* community has a history of participation and therefore required people with potentials will be available. It is a matter of creativity and innovative ways to address the problems.

Depending on the priorities defined and the actions considered, there could be a need for training of villagers. With the support from the religious leaders it should cause no serious constraints to organize required training and follow-up. There are several non-governmental organizations active in the area, having programs in human resource development and health promotion, prevention and care who could offer support in training of village volunteers.

At present there are very limited and poor health care services present in the neighborhood. It is not expected that the public sector can solve this situation in short term. It is my position that a lot can be taken over by villagers regarding promotion, prevention and even basic care, if proper training and feed-back are ensured. Villagers could consider creative solutions to stimulate cooperation with the governmental health workers to improve their situation. For the required training and feed-back, of villagers, I refer to the paragraph above.

The right attitude in whatever action planned would be to explore the possibility of self-financing or co-financing by villagers. This will not be

possible in all actions decided upon. Therefore single investments and short term program financing from external resources might be needed.

As mentioned above support from the public sector will remain difficult for a long time. This does not exclude that some progress can be achieved through hard work in liaison building. One of the final aims is to link villagers' initiatives with governmental plans and the public sector infrastructures.

Next to the public sector, there are the several non-governmental organizations active in different fields in the area, who could offer support by contributing in village programs, offering training, credit, scholarship, providing expertise and consult and so forth.

And last but not least the church whose force lays in being on stand by at any time. They can play a significant role in offering feed-back whenever the need is felt, they do have skilled people in development work, and they do have access to external resources.

The estimated budget to complete the proposed study is US $ 45,969. At the moment of completion, the report on the study will be presented during a meeting with the representatives of the Mymensingh diocese, the funding agency, the related agencies in Bangladesh and the evaluator.

A report of the study will be submitted to: (1) The funding agency, (2) Professor Chitr Sitthi-amorn, Dean of the College of Public Health, Chulalongkorn University, (3)the college of professors, of the College of Public Health, Chulalongkorn University, (4) Mgr. Francis Gomes, Bishop of the Mymensingh diocese, (5) the concerned persons of the Mymensingh

diocese, (6) the leaders of the *Garo* community in the Dorgachola village (7) the concerned agencies.

Bangladesh: An Overall View

Bangladesh gained its independence from Pakistan on March 26, 1971 after a heavy civil war in which almost the entire intelligence of the country was assassinated. This fact had a serious impact on the young nation. Even today, 24 years after independence, Bangladesh is still facing political instability, a serious constraint for the development of the country. Bangladesh is an agrarian country with limited industry mainly around the capital and the seaport.

The administrative set up of Bangladesh is as follows: The country is divided into 6 divisions (Dhaka, Chittagong, Khulna, Barisal, Sylhet and Rajshahi); the divisions are divided into districts (in total 64); while districts are divided into *thana* (in total 490 *thana*), with *thana* as the smallest administrative units. Each *thana* is further divided into unions (in total 4,451 unions). Unions are the smallest electoral units. Each union is further divided into *mauza** (in total 59,990 *mauza*). A *mauza* consists out of 2 to 3 villages, and villages are divided into 2 to 3 *para***. A *para* is the smallest community settlement (BBS, 1991). Figure 1 shows the map of Bangladesh including Tangail District where the study area is situated. Table 1 below gives an overview on the national revenues and expenditures

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* *Mauza* is the Bengali term for a cluster of villages, and considered as the smallest settlement by the National Bureau of Statistics in Bangladesh. Mauza is often used to indicate 'village' by the local administration, but the Bengali language has the word '*Gram*' which means literally village. So a *mauza* contains usually 2 to 3 *gram* or villages.

** *Para* is the Bengali word for hamlet or settlement.

by principle head during 1991, while Table 2 gives an overview of the health authorities per administrative level and the population served.

Table 1

National Revenues Bangladesh 1991

Principle head	%	Principle head	%
General administration	24.75	Agriculture	2.66
Justice & police	8.83	Industry	0.33
Foreign affairs	1.40	Civil works	4.93
Defense	16.51	Debt service	13.25
Education & sport	17.37	Others	4.06
Health & family planning	5.58	Total	99.67

Note. Source (BBS, 1991).

Table 2

Set-up Public Health Sector

Level & number of units	Health authority	Population served[a]
Central level (1)	Ministry of Health & Family Planning	120,000,000
	Director General of Health Services	
	Director for PHC	
Divisional level (6)	Divisional Director of Health	20,000,000
District level (64)	Civil Surgeon	2,000,000
Thana level (490)	*Thana* Health Center Officer	250,000
Union level (4,451)	Health Workers	30,000

Note. Source (Directorate MBDC Dhaka, 1995).

[a] The estimated mean is based on the assumption that the real total population is 120 million.

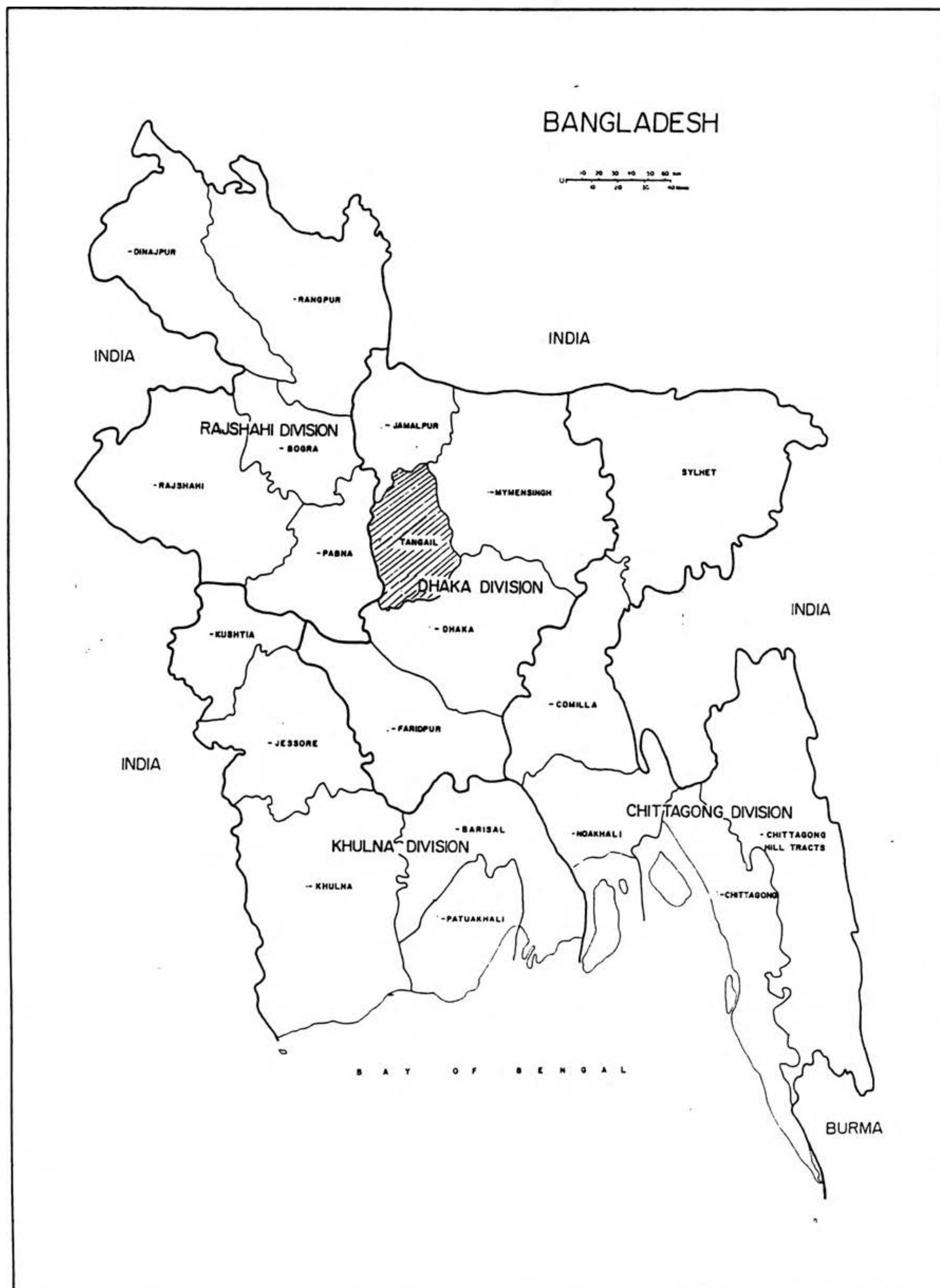

Figure 1. Map of Bangladesh including Tangail District.

The Bangladesh Bureau of Statistics, in its population census of 1991, estimates the total population to be about 111,400,000 with a density of 755 per sq. km. The country's population is dominantly Muslim (87%), while 10% of the population is Hindu, 2% are Buddhist and the remaining 1% consists of a whole range of Christian groups. Further, the population can be ethnically divided into the dominant Indo-Asian type, and more than thirty different tribes, ethnic minority groups, mostly located at the border districts of the country.

Although the country's constitution guarantees the rights of the different religious and ethnic groups, minorities do feel the threat of the dominant Muslim community in their daily life. Conflicts between Muslim and Hindu and Bengali and tribes are common (i.e. publications of Taslima Nasreen on the cruelties towards Hindus and the Amnesty International report on the genocide of the Chittagong Hill tribes).

The literacy rate estimated in the population census of 1991 is 32.4% for the whole country; 38.9% for males and 25.5% for females.

According to the WHO (SEARO* Regional Health Papers nr.7) and World Bank (Social Indicators of Development, 1994) about 38% (1994) of the population in Bangladesh have access to health care. Malnutrition, infectious diseases and rapid population growth are major problems confronting the country. Diarrhoeal diseases are very common, while other communicable diseases such as tuberculosis and leprosy continue to afflict the population.

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* Southeast Asian Regional Office.

The public health services reflect the predominantly centralized bureaucracy. Hospitals and programs are relatively centrally managed, with ministry appointed staff and centralized procurement procedures. The Ministry of Health and Family Welfare functions as the central planning and the co-ordinating body, while the Directorate of Health Services is the executive agency. In principle the Ministry of Public Health aims at delivery of services including primary health care and family planning down to the grassroots level. The reality is different: health services delivery do face serious constraints due to limited resources, lack of effective incentives, inability to cope with the huge demand for free services and constraints in intersectoral approaches. Bangladesh has 1 doctor available per 5,380 population, 1 hospital bed per 3,189 population, and an annual budget of 62 *Taka*[*] or 1.5 US dollar per capita for health and population control (BBS, 1991).

The *Garo* Tribe

The *Garo* people mainly settled in the central Northern districts, of the Dhaka Division of Bangladesh namely, Sherpur, Mymensingh, Netrakona and Tangail. *Garo* are a Indo-Tibetan ethnic minority, originally coming from the Assam hills and spread out to the present Bangladesh as the result of tribal wars in the past. Traditionally living from the forest, the majority of *Garo* people settled in the Northern forest areas in Bangladesh. The *Garo* tribe with a total population of 68,210 in Bangladesh, is the 5th large tribe

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[*] *Taka* is the monetary unit of Bangladesh.

in the country. 88.2% of the *Garo* population lives in the Northern districts of the Dhaka Division, while about 10% lives in the Chittagong Division and the remaining 1.8% in the Rajshahi Division (BBS, 1991).

The *Garo* culture is matriarchal, they have their own language and originally they practiced animism. About 100 year ago the first *Garo* people were converted to Christianity and at present the settlement in Bangladesh is mainly Christian. Due to progressive deforestation, *Garo* people are forced to give more emphasis on agriculture to maintain the family. This deforestation causes also the endless struggle for their land. What was once forest land, gradually transformed into agricultural land, although *Garo* people can not be held responsible for the deforestation, the authorities do not recognize the right of *Garo* people to posses the land.

The *Garo* community has to face a triple discrimination in Bangladesh: based on the fact that they are an ethnic and a religious minority. This reality results in difficulties experienced in land occupation, job opportunities, accessibility to public (health) services, housing and education.

The Problem

1. The perceived problem

The concern of the *Garo* community, their leaders as well as their religious leaders is based on the present situation regarding accessibility and quality of public (health) services in Bangladesh and the specific

discriminations experienced. The desire to find ways in ensuring basic good health services is strong, but the resources are limited.

The Mymensingh Roman Catholic diocese, represented by Monsignor Francis Gomes, expressed its concern on the health care for the *Garo* community and would be interested to examine possible ways to ensure proper health care within the diocese.

The problem as experienced by the *Garo* community and their leaders can be summarized as follows: public health services are poorly organized, and executed. Ineffective services, demoralized health professionals and discrimination is a daily reality for villagers in need for health services. Major segments of the community are poor and can not afford the available services. People do need accessible and affordable health promotive, preventive and care facilities to improve their quality of life. The religious leaders are concerned about the well being (spiritual, mental, economic and physical) of their community, although it is not always appropriate for the religious leaders to take initiative, they would like to see proper health programs organized for their community.

2. Problem definition

In my attempt to translate the problem as presented by the *Garo* community, and the Mymensigh diocese, I would like to make the distinction between health and health services. Health is an individual and community asset, affected by multiple systems (see Figure 2), while health service is a professional system to promote and restore health, only one of the systems affecting health. There might be problems in the health care

system, but a more holistic perspective, viewing the different systems affecting health will, contribute to an improved problem definition. Analyzing the presented problem I could summarize the situation to a three dimensional problem definition.

a) The assumed gap between the actual community health status of the *Garo* community and the desired status as defined by the participants. This gap is influenced by factors as: economic status, education, environment, religion, occupation, culture, nutrition, sanitation, the health care system, and intersectoral co-ordination and so forth, (see figure 3).

b) The gap between the actual health services delivery and an acceptable delivery. This gap is caused by factors as: availability of resources, capabilities, expertise, ethics, dedication, the degree of community participation and so forth. The gap is further influenced by the availability of private and non-governmental organization sector initiatives (see figure 3).

c) The gap between the actual communication and co-operation of the public service sectors with the community and the desired communication and co-operation with the community. Based on the fact that health services operate mainly isolated from the other sectors, there is no effective co-ordination to meet community needs and its heavy top-down management. Also, this situation is influenced by the availability of private and non-governmental organization sector initiatives.

Of course these three problems are strongly interrelated and attempts to bridge the gap of one will have to take into account the interrelated aspects (see figure 4).

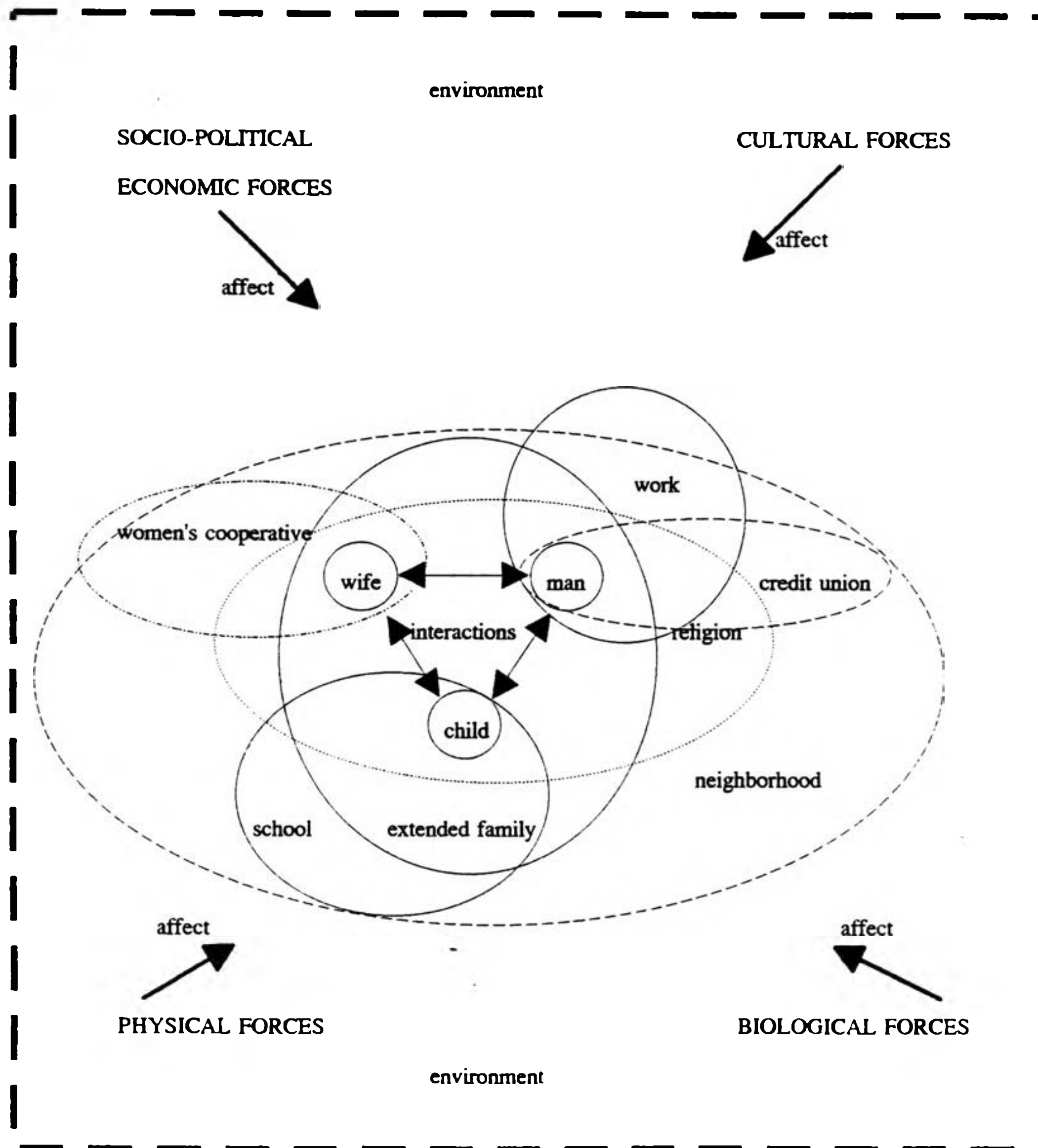

Figure 2. Community Health Affected by Multiple Systems.
The family system within multiple systems and their environment affecting health

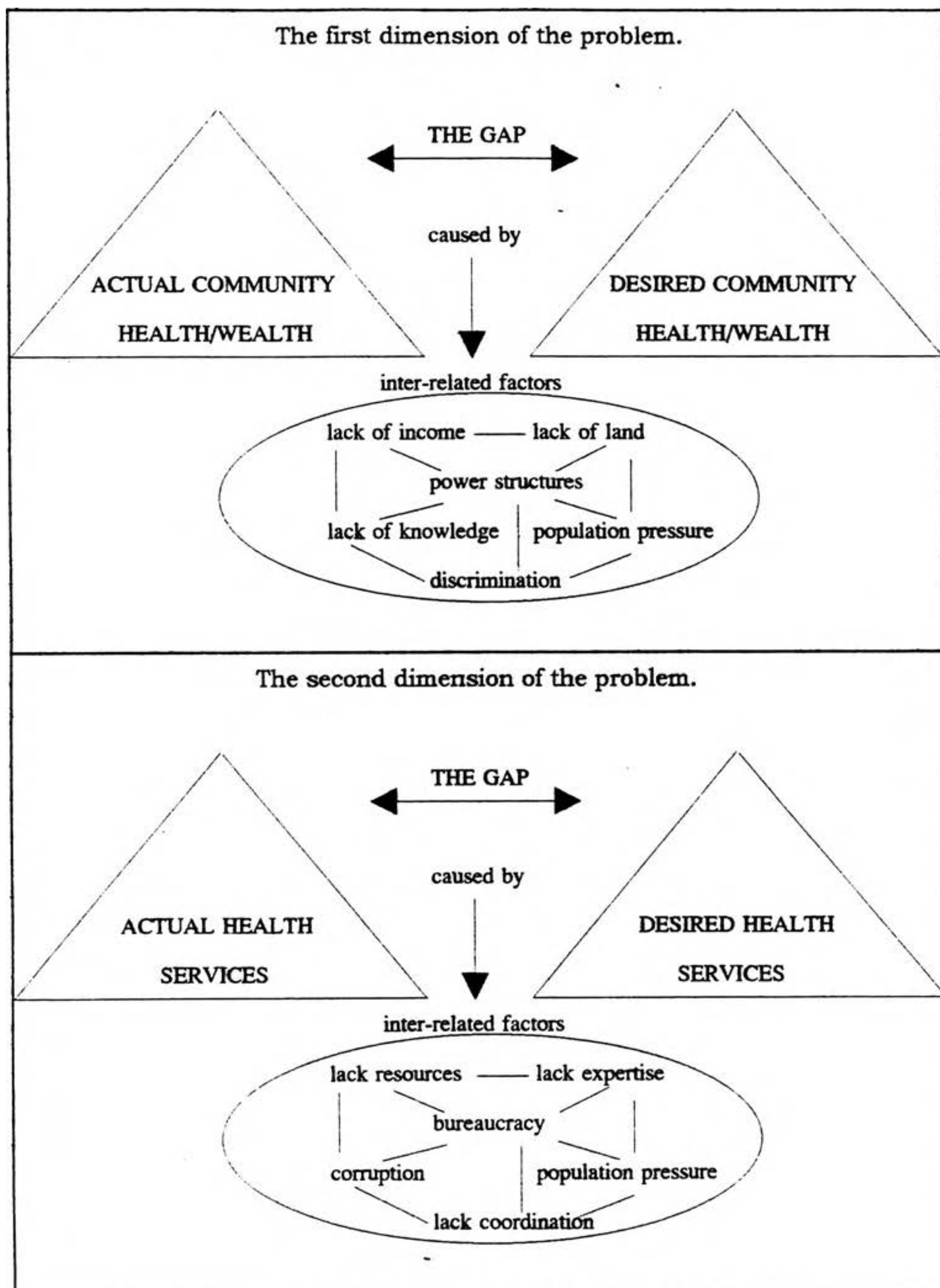

Figure 3. Problem Definition-1

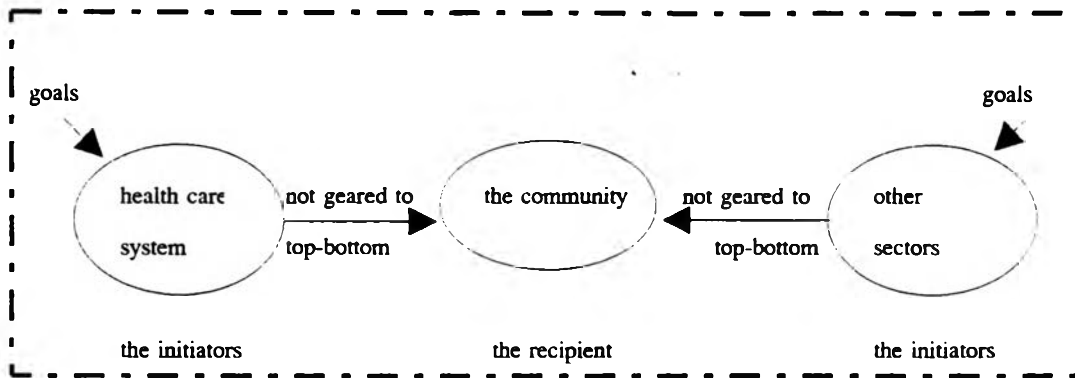

Figure 4. Problem Definition-2.
The third dimension of the problem: the conventional approach to development

The Study

1. The focus of the study

The concern is expressed by the *Garo* community, and the Roman Catholic church (Mymensingh diocese) and not by the (health) authorities of Bangladesh, therefore the study will focus mainly on opportunities within the community to initiate a participatory approach in problem solving and consider the governmental (health) services performance rather as an issue. This should not exclude the examination of possible opportunities to assist the local health care system and how to stimulate intersectoral co-operation, and linking up the people's goals with governmental plans.

The study will focus on a needs assessment on, and examine the feasibility of, initiating a community based health development program, including planning and estimating resources for actions required, through a participatory approach. This participatory problem solving must be seen in relation to intersectoral co-operation and the health care system, within the socio-political-economic reality of the environment. The study will further concentrate on describing the environmental context, assess the pre-set criteria for community participation, defining basic minimum needs priorities and their indicators, community oriented measurement, strategic choices for initiating a program, opportunities for community assistance to the local health care system as well as opportunities to stimulate intersectoral cooperation.

2. The study site

The *Garo* community is scattered over a quite large area. Considering the feasibility of studying the problems in terms of the geographic area, size of population groups, and environmental factors, the diocese area, which covers the Northern districts of the Dhaka Division, should be seen as the macro context, while a specific area will function as the study object.

Based on the outcome of a preliminary exploratory inquiry, which included an assessment on the relative degree of readiness for participatory approaches in problem solving of the *Garo* community under study, the study will take place in Dorgachola village of the Ausnara union, under the Madhupur *thana*, in Tangail District of the Dhaka Division. This area contains a settlement of 1,000 to 1,500 *Garo* people, next to *Mandai* people, Bengali Muslims and Bengali Hindus. Arankhola, Ausnara, and Sholakuri unions in Madhupur *thana*, a forest area, has been the homeland of *Garo* people for a few centuries. The three unions together have an estimated mixed population of about 111,000 (BBS, 1991).

Figure 5 shows the Madhupur *thana* of the Tangail District in Bangladesh including the Arankhola, Ausnara, and Sholakuri unions where *Garo* people settled, and the Dorgachola village as the proposed area for study.

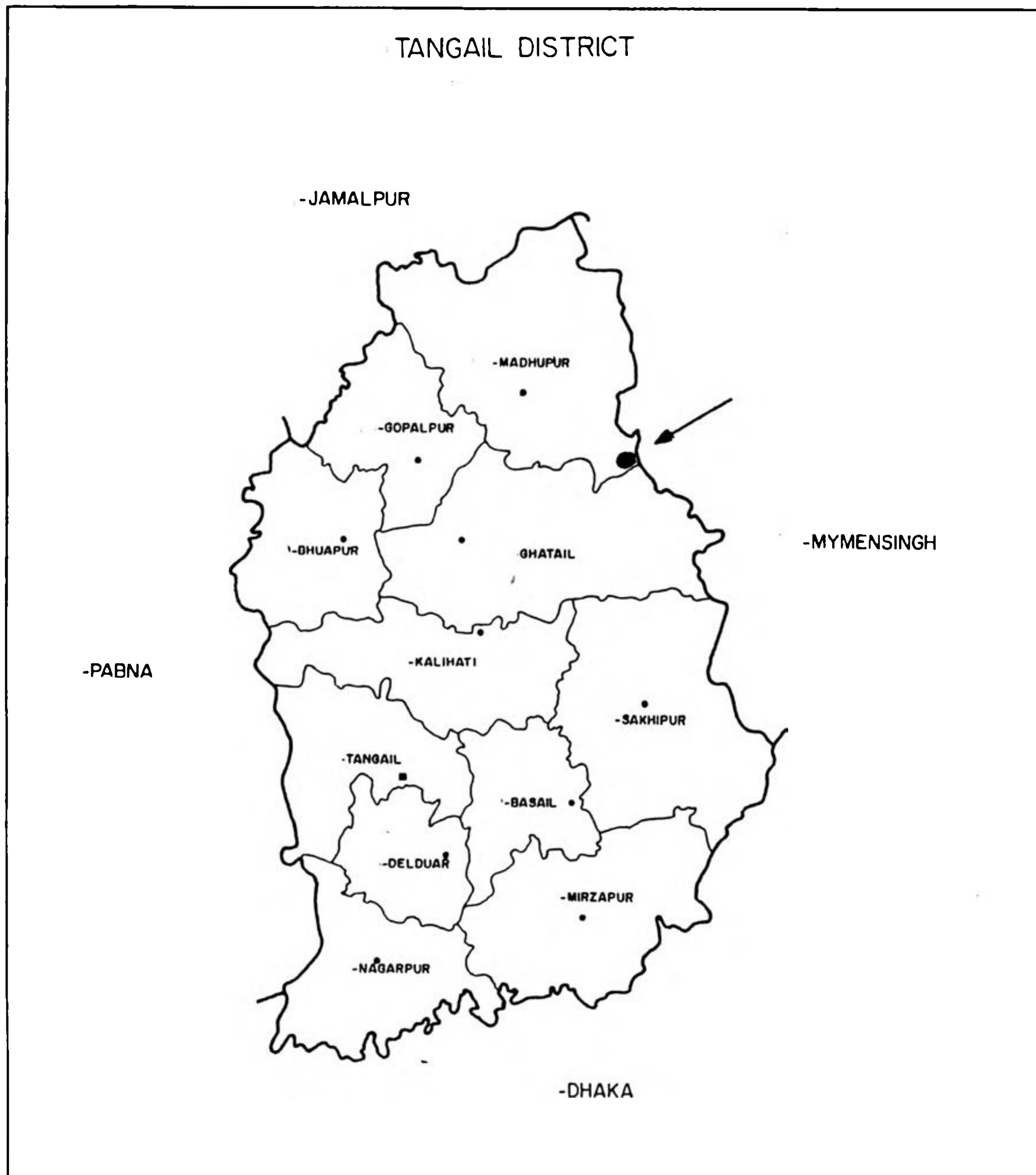

Figure 5. The Study Area: Dorgachola Village

Conceptual Framework

1. Importance of the study

The *Garo* people feel threatened in a predominantly Muslim environment. The discriminations experienced in their daily life, based on the fact that they are ethnically, cultural and religious different from the majority, makes them feel insecure. In public services they are treated as second class citizens, job opportunities are nil in the public sector, they have to face constant disputes on the occupation of their land and so forth. Having their own initiatives to ensure proper health for the community is something they are longing for. The present community health status as perceived by the *Garo* people, indicates possible improvements of the community health status and a need to implement a community health development program.

The representatives of the Roman Catholic church in the Mymensingh diocese, would welcome initiators of community based health programs, who share their concern for the *Garo* community. Finding a partner in exploring ways to improve community health among the *Garo* people is seen as an important contribution to the overall well being of the *Garo* community.

Since the concern and requests are expressed by the community leaders, there could be a viable opportunity to initiate a community based (self-managed) initiatives in health development. The preliminary exploratory inquiry pointed out that participatory approaches would be most appropriate in the *Garo* community. A community initiative can be

justified in terms of answering the community needs on these levels where the public sector is unable to penetrate, based on administrative, strategic, operational and resource limitations.

The performance of the governmental health care facilities, has to be seen as an issue. The *Garo* as a minority group, and the Roman Catholic church as a minority religion, are not in a position to influence significantly the functioning of governmental services. This does not exclude the search within the public sector for opportunities to assist the health care system and stimulate intersectoral co-operation, which would support community health development.

This study could function as a catalyst to stimulate other *Garo* settlements for action to improve their quality of life. In this way the study has an important potential to contribute to the development of the health system.

The purpose of this study can be summarized as follows:
(1) For the *Garo* community this study could offer them an answer on how to improve community health in general and more specific how to organize villagers and take initiatives to improve the quality of life. The learning process, through participatory problem solving, would make them less dependent and vulnerable. (2) For the Mymensingh diocese, this study could contribute in identifying whether a participatory problem solving approach in health is viable, which activities need to be initiated and what support is required. In long terms the participants could offer assistance and answers to other villages who would be interested to undertake similar initiatives. (3) Further this study could contribute in exploring ways to

develop the rural community health from the perspective of community participation in co-operation and the assistance of the efforts of the public sectors.

2. Rationale

Since the declaration of Alma Ata in 1978, experts in the field of community development, health development and primary health care stress continuously the importance of integration and community participation, but all working in the field of primary health care will admit that this goal is one of the most difficult aspects in realizing health for all. This because the principles of integration and community participation call for a change in the set-up and management of the public sectors including the health care system. Such process of change is a political issue, which takes time to be resolved.

The two concepts, integration and generation of UNICEF and delivery of services up to the grassroots level of WHO, are the fundamentals on which the declaration of Alma Ata is based. The literature offers a wide range of reports on the progress made and the lessons learned from programs aiming at one of the two concepts of the Alma Ata declaration (Reynolds and Stinson, 1991).

A literature review (Oakley, 1989; Fals-Borda, Rahman, 1991; Reynolds, Stinson, 1991; Freedman, 1994) indicates that community participation is important for sustainable success in community development. Community involvement in health care has a long tradition,

but it is only in the past two decades or so that community involvement in health developed as a systematic approach.

The essential feature of this study is the concept of 'participation'. Participation in the context of this study means: Mobilizing community members to initiate definition, prioritization and analysis of problems, planning, implementing and evaluate the required actions with the active involvement of villagers, and linking this community initiatives with the existing public and non-governmental facilities and plans, aiming at improvement of the overall quality of life.

The basic concept in participatory approaches is to improve self esteem and self reliance of communities, through active involvement in problem solving. Shifting the role of a community from the passive recipient to the active initiator. Health for all can become a reality if 'health' becomes a people's goal instead of a health care system goal only (Nondasuta and Chical, 1988).

If health is seen as the product of actions of people and the different sectors as there are: education, industry, agriculture, public works, health care services and so forth, it is evident that community health can only develop significantly if there is an integrated goal. Intersectoral co-operation and political commitment are the other keys to sustainable success. Therefore community development through participation needs to be linked with the other sectors affecting 'health'.

With the participatory approach, people can learn that they are not obliged to accept conventional solutions which do not address their needs and circumstances. They can learn to improvise and innovate based on

their own local conditions and resource constraints. Doing so they would acquire the capacity to appraise a situation, weigh the various possibilities, and estimate what their own contribution can and should be. The aim is to encourage people to take voluntary action to prevent disease and promote better health conditions and status's. The participatory approach could be defined as a socially oriented, community based, intersectoral problem solving process to be carried out by the people in the community with support from the local professional facilitators and aiming at fulfilling the basic human and community needs. It is a means to attain short-term quality of life benefits at the village level, while at the same time insuring long-term growth through intersectoral partnerships among various government sectors, agencies, non-governmental organizations, interest groups, people and their community (Piyaratn, 1990). Figure 6 and 7 show the conceptual framework for the participatory evaluation study.

Figure 6 demonstrates that: In the conventional approach to development, the government formulates a national socio-economic development policy with goals to be obtained by the country. In the national effort (health) professionals are the top to bottom providers of services to the people who are passive recipients of these services, in the hope that eventually, the goals can be reached. The participatory approach proposes that health professionals are facilitators helping the people to attain a set of goals and to plan and manage their own development projects. The people are both initiators and actors. The (health) professionals and the people are partners in development.

These changes require a transformation process. This change calls for a deep transformation of mentalities, behaviors, attitudes, relationships, leadership, methods and styles of work. A long, delicate and difficult process deserving all attention. There is no universal model for such change process and the basic concepts must be adapted to the socio-political and economic reality of the environment.

Figure 7 explains that: Based on the concept demonstrated in figure 6, effective co-operation between the people and the relevant public sectors requires that all parties have to practice this transformation process. At least a minimal credibility, mutual respect, trust and confidence between the sectors and the community is required to start participatory problem solving. The quality of the relationship between the parties concerned will develop and grow continuously along with successful achievements and the recognition of problems and failures and the joint effort to find solutions.

3. The goal

The study aims at the stimulation of community initiatives through participatory approaches, to improve the health status of the *Garo* community in the Dorgachola village of the Ausnara union at Madhupur *thana* in Bangladesh.

The study could function as a catalyst for other *Garo* settlements in the area. Therefore it could be a starting point in a long term process, where if participatory problem solving in the *Garo* settlement proves to be effective and sustainable, similar programs could be undertaken in other *Garo* areas

in Madhupur *thana* and in a later stage for the *Garo* settlements in the Mymensingh diocese where 88% of the Bangladeshi *Garo* people live.

This study could offer a base for future negotiation and decision making on the planning and implementation of a participatory health development programs within the *Garo* community of the Mymensingh diocese in Bangladesh.

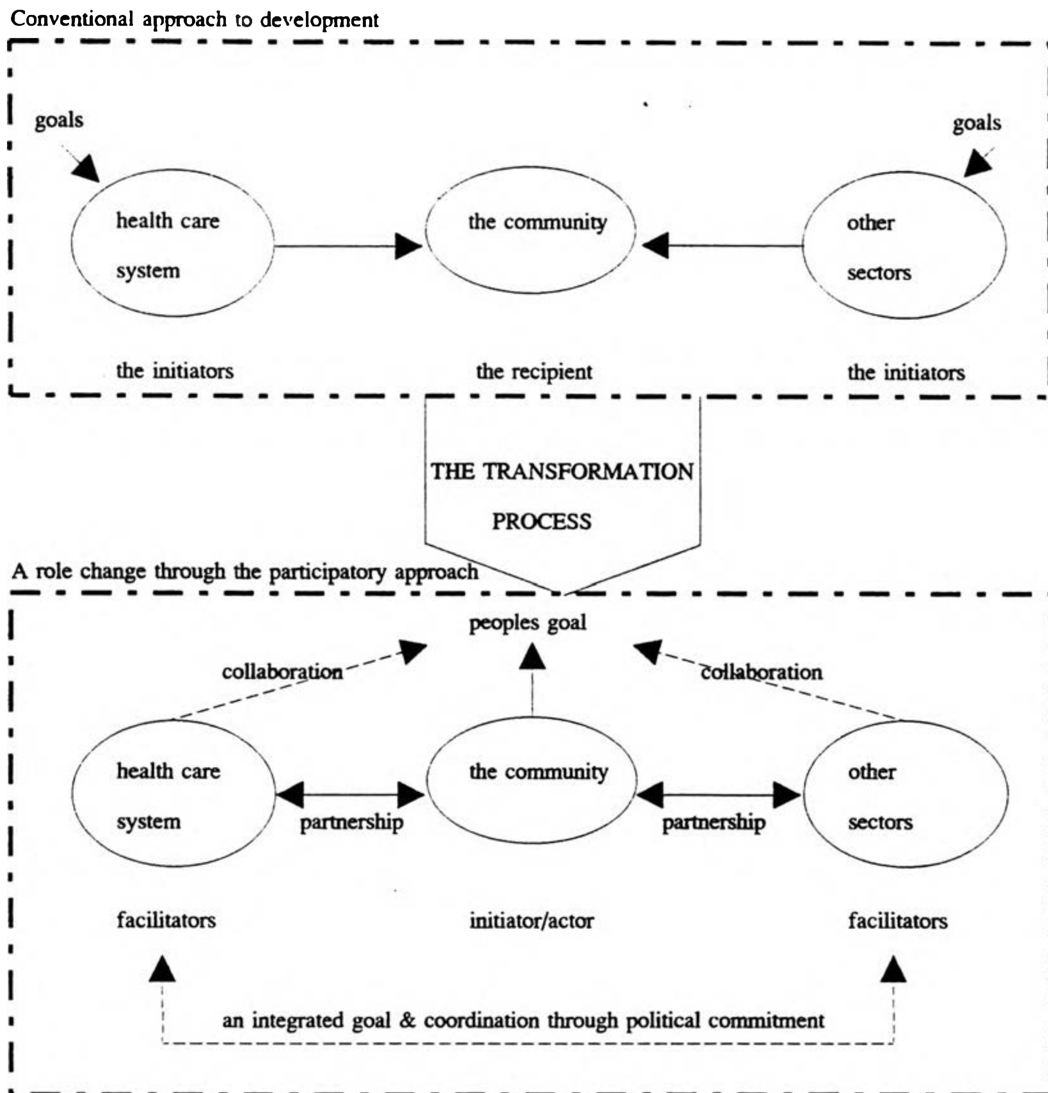

Figure 6. Conceptual Framework-1.

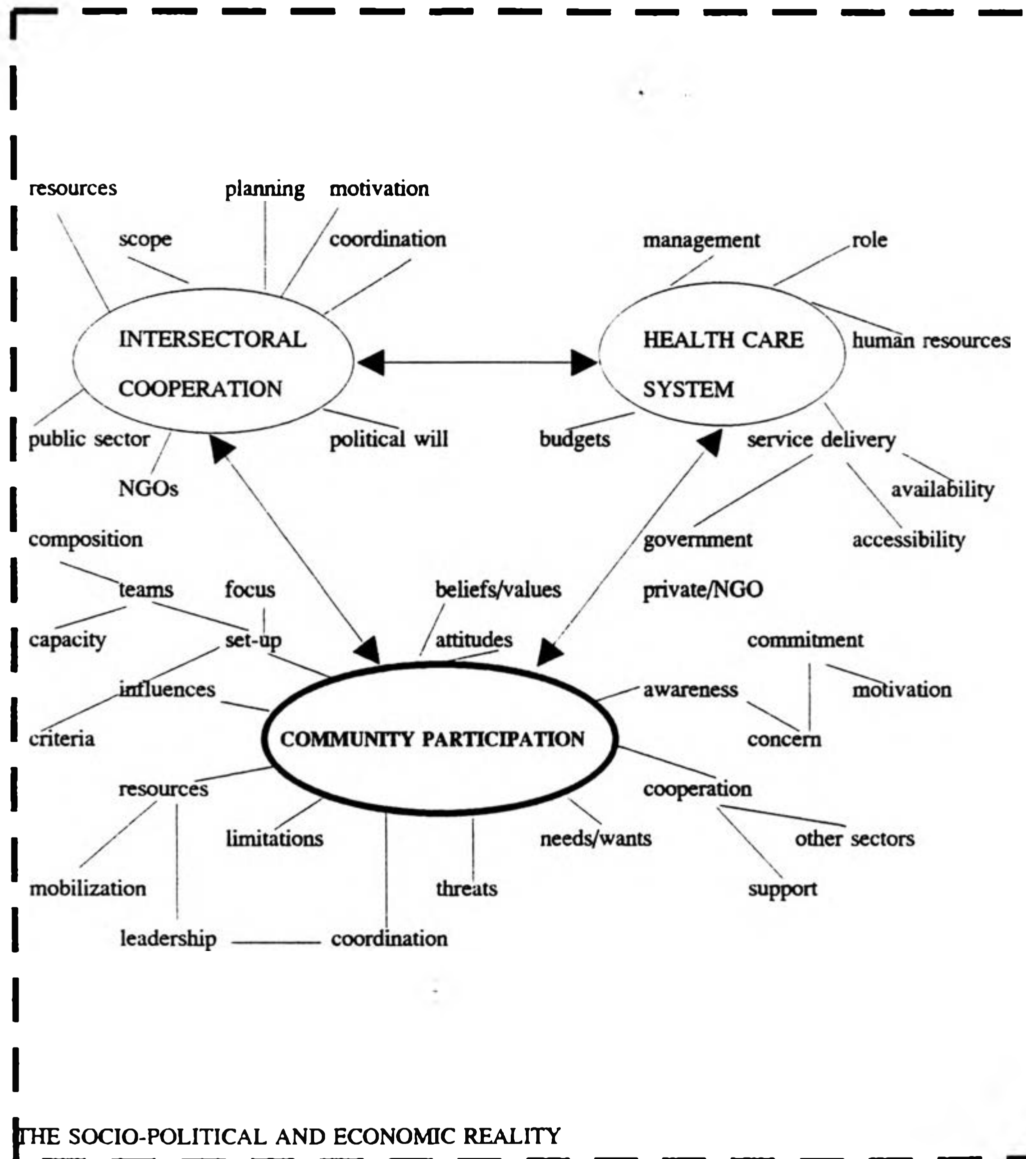

Figure 7. Conceptual Framework-2.
The web of causal forces at work in sustainable community health development.

3.1 Study objectives

3.1.1 General objectives

a) Initiate community-based participatory problem-solving in health for the *Garo* settlement in the Dorgachola village, Madhupur *thana*, Tangail District in Bangladesh.

b) Undertake initiatives planned, implemented and evaluated by the community to improve their quality of life.

c) Formulate recommendations related to participatory problem solving, based on the outcome of the research, to the various stakeholders.

3.1.2 Specific objectives

a) Initiate community based problem solving by: (1) Creating a village team for participatory problem-solving in health. (2) Defining problems affecting health from the *Garo* community 's perspective. (3) Developing indicators and tools to assess the perceived problems.

b) Undertake initiatives to improve tha quality of life by: (1) Assessing, with the local people, the problems affecting health in their area. (2)Formulating priority issues for the participatory problem solving program in the *Garo* settlement at Dorgachola village. (3) Designing an action program including monitoring and evaluation. (4) Estimating and mobilizing the required resources (internal and external) for implementing the planned action.

c) Formulate recommendations for the various stakeholders through a participatory evaluation of the research process and outcome.

3.2 Research questions

3.2.1 Creating a village team

What are for the Dorgachola village the appropriate choices in composing a village team? Should a new team be created or can we use existing groups? Is an affiliation with the local church desirable? What is a workable group size? Should different strata be included or is it preferable to go for one specific strata only?

3.2.2 Define problems affecting health and their indicators

What are the problems which influence community health? What are the roles of the individual, the village, and the public sector in relation to this factors? What are the basic minimum requirements to ensure community health? How can each basic minimum requirement be best measured? How frequently must measurement be done? Who will measure the community health status? To whom will results be reported?

3.2.3 Formulate the priority issues for the area under study

What is the required intensity of needs to become priority? What is the required frequency of needs to become a priority? What are the other requirements to become a priority need?

3.2.4 Design an action plan and evaluation

What is needed to be done and what are the alternatives? What can be done? Who should do it? When should it be done? How should it be done? How do we ensure that planned actions are realized? How do we measure whether the actions improve the situation? How do we deal with problems and failures? Who should be involved in evaluation?

3.2.5 Estimate and mobilize the required resources

What manpower is needed? To which extend is assistance available from existing services? What are the incentives in terms of money and or rewards needed? What training is needed for whom? Who will offer training? Is local expertise available? What materials, accommodation and funds are needed? Is there support and feed-back in long term available? Who could be interested to provide resources?

Methodology

1. Method

This is a participatory prospective evaluation study to find ways in initiating health development activities by the community itself, to improve the quality of life, with respect to organizational, human resources and socio-economic and political constraints, and possible implications.

There will two stages to the research, each with a distinct approach:

a) Build consensus with the funding agency on the health and participation concepts, the research method, and the role of the funding agency and the researcher in the process.

b) Conduct a participatory action research including participatory appraisals, by using the soft systems inquiry method.

The proposed method aims at addressing simultaneous two aspects: (1) The human resource development, where people gain understanding, insight and learn in dealing with problems affecting the quality of their lives, and (2) the development of community initiatives complementary to the public services, addressing community health.

The basic principles of the proposed method can be summarized as the flexible use of methods, improvisation and iteration; multiple methods to cross check or triangulate; maximizing indigenous knowledge directly from local people; not trying to find out more than what is needed, not measuring more than is necessary for practical purposes; and critical self awareness, reflecting on what is being exposed and not exposed and admitting sources of error. The outcome is a more holistic picture about the situation, which could be cost-effective and very helpful in formulating activities but not to be generalized.

2. Approach

2.1 Create a team

Participatory action preferably starts by building on existing affinities, based on the experience that any group has to comfort the local elite. In the Dorgachola village there are two options: (1) working with the

existing parish council or (2) creating a new group with members having affiliation with the present organizations and groups. Initial negotiations with the religious leaders and the key persons in the locality will answer the question which option is preferable.

The group should start small that is, between 5 and 10 people, in order to facilitate management and commitment. With exception of the religious leaders, the group will operate independent from authorities. With regard to the local church, consensus must be established on the role and position of religious leaders as stakeholders.

Flexibility on membership will be practiced by allowing different strata as long as contrasts do not indicate serious obstacles for the poor segments of the community to have a voice in the process. Criteria for membership will include, next to affiliation with the existing structures, type of leadership, motivation, and basic literacy. With respect to the matriarchal culture of the *Garo* people, the group should aim at 50% female members.

2.2 Identifying problems

The initial meetings will be used to identify problems. The preliminary exploratory inquiry revealed that villagers strongly emphasize the need for promotive, preventive and care facilities and programs in health. This findings could be used as entry point. Although in principle aiming at an open ended approach the facilitator will assist the group in offering direction were needed, using the basic minimum needs approach of Thailand and the Philippines and reports on other participatory approaches

as resource material. The specific problems felt will be explored and analyzed to identify the underlying web of causes. Next to discussions, techniques as village mapping and mind mapping on the blackboard will be used to demonstrate the problems and the complexity of causal networks. The techniques used will assist in describing the complexity of the situation rather than isolating 'the' problem or prioritize problems.

2.3 Information and data collection

Once the list of problems is generated and important causes defined, participants will have a closer look to what they want to know and which techniques will be needed to obtain this knowledge. The questions to be answered, each with their specific technique, will be reviewed in terms of skills to acquire and commitments in time and labor.

Based on the questions to be answered and what participants can learn and can do, following techniques could be used: secondary data review, surveys, direct observation, focus group discussions, key informant interviews, case studies, mapping and diagrams and so forth.

2.4 Describing the situation

A description will be made of the structure, processes and status of the actual situation based on the participatory inquiry. The principal concerns and issues will be defined and the primary tasks associated. Further the group will discuss the range of possible and relevant choices for improvement. A report in appropriate form will be made to document the above.

2.5 Defining the human activity system

Transformation statements will be developed for each primary concern, task, structure and process in such way that it is clear what the transformations are and the improved states are. The group will discuss with the different stakeholders involved which system definition needs to be developed in models for action. There were appropriate, recommendations will be formulated for the concerned sectors (professionals) to work on specific aspects of the improved state of affairs. For example the public health sector or a non-governmental organization could be asked to assist in realizing specific aspects of the improved state of affairs.

2.6 Conceptual modeling

Skilled group members, guided by the facilitator, will develop concept models for each system definition, as learning experiences to build skills in projecting the further potential changes needed. The conceptual models will be discussed with the group members.

2.7 Comparison

As mentioned above the human activity system models will be prepared to debate the change with the group. The group discussion will concentrate on questions as: Is the proposed change addressing the real problem? Do the models help to improve insight? Do models fit in existing structures or require abolition of former structures? Do the models call for less costly and less divisive problem solving? Do models present scenarios, uncertainties and expected outcomes? Is the change desirable, presents it

what they really want to be? Is the proposed change feasible, can they really implement the change to reach the goal? At this stage group discussions within the community will be organized to disseminate the information, to further debate the proposed change and to start the process of mobilization of community resources.

2.8 Proposals for change

Based on the problem statements, the formulated goal with objectives and operational targets an operational plan will be designed by the group. The required community, local and external resources will be estimated, and the appropriate evaluation methods will be defined in terms of input, process and results, for the proposed program as a whole and for the external financed components. The program proposal will be submitted to the important stakeholders in order to obtain support and the required local and external resources.

2.9 Evaluation of the action research

Prior to termination of the facilitator's involvement, the participatory action research itself will be evaluated in terms of the objectives. The evaluator of the funding agency will assist the facilitator and the group members to conduct the participatory evaluation. The focus will be on the process of participatory problem solving and on the outcome in terms capacity building and of the proposed actions.

a) Process: The aim is to identify defects in the procedural design of the participatory action research. The actual process will be

described in terms of selection of the area, creation of the group, group dynamics, the learning process, and the role of the facilitator.

b) Outcome: The outcome of the participatory action research will be evaluated in relation to the gained skills and capacities of participants, the action plans for change, the context, the input and process information.

c) Recommendations: Next to the recommendations on research design and process in this specific context, the aspect of follow-up and support of the group should be addressed as well.

2.10 Implementation

At this stage the facilitator will leave the process. The group will communicate the details of the action plan with all active involved villagers, and organize open sessions to inform the community on the program. The group will implement the change stepwise according to the plan of action. The group will continue to meet in order to monitor the process, modifying certain aspects where needed and evaluate the results.

3. Time Table for the Study Implementation

Table 3.

Time Table proposed Research

Activity / month	Jun-96	Jul-96	Aug-96	Sep-96	Oct-96	Nov-96	Dec-96	Jan-97	Feb-97	Mar-97	Apr-97	May-97
Literature review	■	■	■	■	■	■	■					
Consensus funding agency	■	■										
Criteria pilot area	■	■										
Consultancy CPH	■				■			■			■	
Interviews			■	■	■							
Selection pilot area			■									
Participatory research				■	■	■	■	■	■	■	■	■
Survey HCS utilization						■	■					
Analysis findings							■	■	■	■	■	
Progress report					■				■			
Final Report											■	■

Note. Period June 1996 till May 1997.

Feasibility and Ethical Issues

1. Resource constraints

The study will explore the needs, requirements and feasibility of planning and implementing a health development program initiated by the community. The scope of the study will depend on the availability of funding. The total estimated expenditure for this study as demonstrated in the table below, is US $ 45,969. Provided that a funding agency approves the budget as estimated, the study can be implemented as planned.

The study based on a participatory approach, will depend on the community representatives assisted by one professional evaluator in the field, and local manpower, and the feed-back of the academic staff of the College of Public Health, Chulalongkorn University, Bangkok, Thailand.

The time to complete the study and submit the report is estimated to be 12 months from the moment of implementation. The proposed commencement would be June 1996.

It need to be mentioned that in absence of a work permit it is difficult to obtain a visa for a longer period (i.e. the maximum duration of stay with a tourist visa is 3 months.) Ways have to be explored on how to overcome this constraint.

2. Technical constraints

In absence of tele-communication, there is only the postal service to communicate with the forum of experts. This constraint could be minimized by establishing cooperation with an agency, represented in the capital

Dhaka, which would be willing to accept the role of communication agent between the evaluator and the College of Public Health of the Chulalongkorn University in Bangkok.

At present Bangladesh is facing political turmoil, which result in frequent national strikes. These strikes paralyze the country, shops and offices are bound to close, as well as private and public transport. This political turmoil could cause constraints in terms of mobility during the study. The fact that the study will take place in a rural setting, will minimize the impact of the political turmoil.

Finally the scope of the study will depend on the cooperation within the *Garo* community, the Mymensingh diocese, the (health) authorities of Bangladesh as well as the concerned representatives of local and international agencies and the advisors of the Chulalongkorn University.

3. Ethical issues

The study is intended to explore possibilities for improvement of the community health among the *Garo* people, as a specific group, which can be justified in terms of answering the perceived needs and concern of this community. The outcome of this study could offer valuable information for future study on *Garo* and non-*Garo* communities in Bangladesh.

This study based on a participatory approach, will guarantee the right of people to participate in decisions and proposals affecting their society.

Sustainability

1. Leadership

The religious leaders in the *Garo* community are strong in terms of skills, attitude, insight of the problems and access to resources. Besides this they are highly respected and trusted by the *Garo* people. The village, proposed for study, is under the supervision of the religious leader residing 25 km away. The religious leader visits the village regularly, but there is no priest living in the close neighborhood. The Chairman of the parish council is a layman. Although close co-operation with the religious leader and the local church will contribute to the sustainability, lay leadership would be preferable because of community membership and the continuity. Attention must be paid to select the right leaders, in terms of potentials, support in the village, and support of the religious leaders. Taking into account the cultural values and norms, the facilitator should handle with care the role of leadership imposed on him. Even when it would be appropriate in the initial stage to accept this role, the facilitator should step back as leader as soon as possible and restrict his role to facilitator.

2. Human resources

The *Garo* community has a history of participation and therefore required people with potentials will be available. It is a matter of creativity and innovative ways to address the problems. An example, the village has several teachers working in the primary and high school who could be motivated to take other responsibilities in the village as well. There are

traditional birth attendants who could fulfill an extended role in mother and child care and so forth. It will be important to pay attention for incentives. This does not necessarily mean financial incentives. Incentives should be defined in terms of responsibility and workload of the functions involved in the action plans.

3. Technical resources

Depending on the priorities defined and the actions considered, there could be a need for training of villagers. With the support from the religious leaders it should cause no serious constraints to organize required training and follow-up. The local church does have capable trainers in different disciplines. There are several non-governmental organizations active in the area, having programs in human resource development. There are at least two to three non-governmental organizations within a radius of 30 km with expertise in health promotion, prevention and care who could offer support in training of village volunteers. Also the limited opportunities in specific technical support from the public sector should not be excluded.

4. Basic minimum health care

This might be the point which need attention. At present there are very limited and poor health care services present in the neighborhood. It is not expected that the public sector can solve this situation in short term. Health care, even basic, is a non-profit sector and will need for a long time significant resources if organized. It is my position that a lot can be taken over by villagers regarding promotion, prevention and even basic care, if

proper training and feed-back are ensured. Negotiations with the local public health services should bring a clear understanding on the governmental planning in health and the constraints experienced. Villagers could consider creative solutions to stimulate cooperation with the governmental health workers to improve their situation. For the required training and feed-back, of villagers, I refer to the above under technical support. Notwithstanding this there might be a need for a qualified nurse-midwife or even doctor in the area. In that case the villagers should negotiate with the church and non-governmental organizations in the area to explore the possibilities.

5. Financial resources

The right attitude in whatever action planned would be to explore the possibility of self-financing or co-financing by villagers. This will not be possible in all actions decided upon. Therefore single investments and short term program financing from external resources might be needed. An important principle here is that villagers have to change their attitude from being grateful recipients to negotiators with self esteem. Whatever external financial resource needed the terms agreed upon evaluation of the proposed action or program should be on a participatory basis. In the first place the church, within the scope of their limitations, could consider financing. In absence of this possibility the religious leaders could fulfill the role of intermediator to search for funding agencies. Also village leaders themselves could contact agencies active in the area. Finally the agency

funding this research could decide to finance or co-finance certain aspects of the proposed actions.

6. Support and feed-back

As mentioned above support from the public sector will remain difficult for a long time. This does not exclude that some progress can be achieved through hard work in liaison building. One of the final aims is to link villagers' initiatives with governmental plans and the public sector infrastructures. In respect to this it is important to create leadership with strong social skills and to utilize political brokers in establishing co-operation.

Next to the public sector, there are the several non-governmental organizations active in different fields in the area, who could offer support by contributing in village programs, offering training, credit, scholarship, providing expertise and consult and so forth.

And last but not least the church whose force lays in being on stand by at any time. They can play a significant role in offering feed-back whenever the need is felt, they do have skilled people in development work, and they do have access to external resources.

Resources

1. Manpower

Table 4 below gives an overview on the required manpower. Consultancy with the academic staff of the College of Public Health of Chulalongkorn University is the feed-back possibility of the evaluator/facilitator whenever the need is felt. This consultancy will be restricted to short visits of the evaluator to the College of Public Health during the research process. I provided four community members as surveyors for the health care service utilization survey. They are mentioned separately because this survey is a single effort spread over a larger area and therefore a compensation must be paid. The number of local participants, members of the problem solving village team, is difficult to define in advance. One house personnel is foreseen for the evaluator/facilitator throughout the research period based on my prior experience in the area under study. This person will carry out all the basic house keeping activities.

Table 4

Required Manpower PAR

Function	Participation	Quantity
Evaluator/facilitator	Full-time	1
Consultants CPH-CU	As per need	-
Local surveyors	Part-time	4
Local participants	Part-time	-
House personnel	Full-time	1

2. Budget

The total estimated expense for the proposed research is US $ 45,969.00. The breakdown of the expenses is given in table 5 below. This estimation include four return flights from Bangkok to Dhaka, doing so I will be able to visit the College of Public Health for consultation three times during the research period, starting from Bangkok at the time of commencement and returning to Bangkok at the moment of completion of the research.

For the consultation visits to Bangkok I estimated a duration of 5 days per visit at a rate of 50 US $ per day for hotel costs. A forfeit is estimated to meet transport costs in Bangladesh as well as in Bangkok.

The salary for the evaluator/facilitator is a gross salary cost, including medical-social security, pension scheme and revenue tax contributions. The salary cost for the local house personnel is based on the salary-scale of a non-governmental organization working in the same area.

A portable computer is included to facilitate the research process in the field, as well as an estimated forfeit for paper, printing, copies, fax, telecommunication and other administrative costs.

Table 5

Estimated Budget PAR

Ledger item	Quantity	Cost in US $
Air ticket BKK-DHK-BKK[a]	4	1,000
Airport tax	8	107
Visa cost	1	67
Hotel BKK[b]	15	750
Transport	forfeit	335
Salary evaluator (gross)	12	40,000
House personnel	1	1,200
Surveyors	4	535
Computer	1	1500
Administrative cost	forfeit	475
Grand Total	-	45,969

Note. BKK-DHK-BKK[a] = Bangkok, Dhaka, Bangkok; BKK[b] = Bangkok.

Report on the Outcome

The proposal for this study is based on: (1) The suggestions of Monsignor Francis Gomes, the representative of the Roman Catholic diocese of Mymensingh, and (2) the *Garo* community leaders of the Dorgachola village, and the Arankhola, Ausnara and Sholakuri unions of Madhupur *thana*, Tangail District in Bangladesh. (3) The funding agency agreeing to provide the required budget for this study. (4) The concerned agencies, represented in Bangladesh, with interest in Primary Health Care and community development initiatives.

After evaluation of the participatory action research, a presentation of the findings will be given and the significance of different outcomes will be formulated in a study report. In conclusion statements on the need for

improvement of the research design will be given, and approaches will be formulated which could optimize the capacity building, group dynamics and sustainability in the specific social setting. In support of the conclusion, specific recommendations will be formulated per type of stakeholder. At the moment of completion the report on the study will be presented during a meeting with the representatives of the Mymensingh diocese, the funding agency, the related agencies in Bangladesh and the facilitator.

A report of the study will be submitted to:

a) Professor Chitr Sitthi-amorn, Dean of the College of Public Health, Chulalongkorn University.

b) The college of professors, of the College of Public Health, Chulalongkorn University.

c) Mgr. Francis Gomes, Bishop of the Mymensingh diocese.

d) The leaders of the *Garo* community in the Dorgachola village and the Aronkhola, Ausnara and Sholakuri unions.

e) The concerned agencies.

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