

# CORHI project

Bangladesh

The **CORHI** project – **Community ownership of reproductive health initiatives** – was designed to develop effective strategies for service delivery, empowerment of women, education of young people and community mobilisation. The emphasis on community participation is one of the most significant aspects of the project and essential to ensure its sustainability.

The aim of the project is to address the needs of under-served populations living in very remote areas, where general health care facilities are very limited and where sexual and reproductive health services are virtually non-existent. These include ethnic minorities, marginalised and disadvantaged populations, women with very low social and economic status, as well as people living in areas where the political situation is volatile.

The project was set up:

- to increase access to and use of quality, sustainable sexual and reproductive health services for under-served populations in six thanas in Chittagong and Sylhet divisions (thanas represent the lowest level in the administrative structure)
- to increase the contraceptive prevalence rate from 27% to 60% during the life of the project
- to empower women in low-income groups through women's development centres and to increase their status in the community
  - to improve the awareness of young people about sexual and reproductive health issues
  - to increase the ownership of the project by the community through the development and support of local level organisations, the involvement of community and religious leaders, and collaboration with government agencies and NGOs.

Project innovation and experimentation are key features for Vision 2000 Fund (V2F) projects. The CORHI project takes a comprehensive approach in tackling the six challenges set out in IPPF's Vision 2000 strategic plan: to address unmet needs in sexual and reproductive health, to broaden the scope of services provided, to deal with unsafe abortion, to target young people, to work with women to improve their status and to improve quality of care.

#### PROJECT TITLE

**Community ownership of reproductive health initiatives (the CORHI project)**

#### IMPLEMENTED BY

**Family Planning Association of Bangladesh (FPAB). The FPAB was set up in 1953 and provides reproductive health services to 1.5 million people annually.**

#### PROJECT AIM

**To enhance the sexual and reproductive health status of marginalised communities in Chittagong and Sylhet divisions.**

#### FUNDING

**IPPF Vision 2000 Fund**

#### BUDGET

**US\$2,495,967**

#### DURATION

**July 1997 to December 2003**





Information, education and communication sessions are an important part of mobile medical team visits. Here, information about contraceptive options is provided to women waiting to receive services.

The CORHI project set itself a number of challenges, and matches these with innovative approaches to achieve objectives and goals. The necessary infrastructure was developed to meet people's sexual and reproductive health needs in some of the most remote, marginalised and under-served communities which are generally not covered by qualified staff within the government health structure.

### SOUND NEEDS ASSESSMENT ... SOUND PROJECT DESIGN

The project was carefully developed using a thorough situation analysis, which included a comprehensive needs assessment followed by a wide-ranging baseline survey. This resulted in a sound project design based on the reality of the situation in the field.

The needs assessment identified a number of factors in the six study areas.

- The contraceptive prevalence rate was only 27% compared with 54% nationally.
- Reasons for non-use included the desire for more children, religious opposition, objections from husband and mothers-in-law, and fear of side-effects.
- Over 50% of women had no antenatal care during their last pregnancy.
- Almost 100% of births occurred at home.
- About 95% of all births were assisted by untrained attendants.
- Two-thirds of traditional birth attendants were untrained.
- The prevalence of sexually transmitted infections was high.
- Although government mother and child health/family planning committees existed in all the unions, most were inactive.
- Community leaders had little involvement in health and family planning activities, particularly religious leaders and schoolteachers.
- The literacy rate was 27% compared with 32% nationally.
- Young people had little or no access to accurate and reliable information on sexual and reproductive health.

### MEETING CHALLENGES WITH INNOVATION

The project provides an integrated service delivery approach offering a wide range of sexual and reproductive health services (including family planning) as well as curative services (including laboratory and general health services). Services are delivered through static clinics, mobile medical teams and the community-based distribution (CBD) programme. Efforts are concentrated in specific geographical areas to maximise impact.

A husband and wife team has been recruited in each thana, with the husband employed as project manager and the wife as the medical officer. This, in turn, ensures that female doctors can be recruited and retained in rural and remote areas.

Community mobilisation activities take place at grassroots level with community groups of 50-100 people, rather than at the higher union level where groups can number more than 5,000.

The project established a new governance system with steering committees at different levels: central, district, union and thana. This

has led to a highly professional approach and promotes community participation.

Gender violence issues and women's legal rights are included in the women's empowerment programme.

### PROVIDING APPROPRIATE SERVICES ... REMOVING BARRIERS TO ACCESS

**By the end of 2001, the project had succeeded in recruiting 40,566 new acceptors. CORHI's unique approach – complementing static clinic services with mobile medical teams and community-based distribution – has been successful. The project reinforces the existing government CBD network and, in turn, the CBD network has become effective in promoting sexual and reproductive health.**

A broad and innovative range of services is offered by full-time static clinics and by mobile medical teams. Services include all family planning methods, including male and female sterilisation, screening and treatment of reproductive tract infections and sexually transmitted infections, breast and cervical cancer screening, menstrual regulation and infertility services. Child health and immunisation services are also offered, as well as antenatal care and general health services (mostly for respiratory ailments and diarrhoea). This package of complementary services has made the project attractive to clients.

**CORHI's unique approach – complementing static clinic services with mobile medical teams and community-based distribution – has been successful.**

Most family planning clients using oral contraceptives and condoms are served through community-based distribution. The main role of the clinics therefore is to complement and supplement existing services, and act as a back-up to provide clinical methods not offered by CBD volunteers as well as reproductive and curative health services.

The project identified important quality of care issues, including the right of clients to information, access, choice, safety, privacy, confidentiality, dignity, comfort and self-expression. In turn, providers identified

certain requirements which must be met to enable them to offer a quality service. These include training, up-to-date information, adequate physical infrastructure and contraceptive supplies, practical guidance and feedback on their performance.

### HELPING WOMEN TO TAKE CONTROL OVER THEIR OWN DESTINIES

**Through an appropriate combination of sexual and reproductive health services, skill training and income-generating activities, the project has been successful in empowering women from low-income groups to make decisions about family size and to improve their socio-economic status.**

The needs assessment survey showed that appropriate strategies were needed to allow women to play a greater part in the life of their family and community.

Forty-six women's development centres have been set up to provide women with information and education on sexual and reproductive health. Similar information is offered to men, mothers-in-law and religious leaders too.

Women can also learn skills at the centres such as sewing and basket-making. Small loans are available to enable them to engage in income-generating activities.

### YOUNG PEOPLE: TAKING POSITIVE STEPS TO UNDERSTAND THEIR SEXUALITY

**By the end of 2001, the project had worked with 41,262 in-school and out-of-school youth and school drop-outs, providing them with sexual and reproductive health information and education, and training a group of young people to become peer educators both in and out of school.**

The outreach project works closely with young people and youth groups and provides them with film shows and education sessions on population, health, family planning, sexually transmitted infections, issues surrounding early marriage, drug abuse and environmental protection issues.

The focus is on training peer educators to provide accurate sexual and reproductive health education and information to both in- and out-of-school youth.

### WORKING CO-OPERATIVELY WITH AN EXPANDED NETWORK ... SHARING A COMMON PURPOSE

**At mid-term, the project had succeeded in developing 46 locally-based organisations and training 2,350 community volunteers. Family planning and mother and child health services have become more accessible by linking them to facilities at thana, union and district levels, setting up a referral system to promote effective and longer-acting family planning methods and to manage method-related complications, and working with 600 religious leaders to tackle opposition to family planning.**

As its name implies, the project aims to ensure community ownership of its activities. The project therefore formed locally-based organisations in each union and trained volunteers to promote sexual and reproductive health services.

Community mobilisation also involves the participation of community volunteers, traditional birth attendants, traditional healers and promoters. Elected union council members have been enlisted to promote project activities and to reactivate union family planning committees.

## The project aims to ensure community ownership of its activities.

Traditional birth attendants are trained to conduct safe delivery, reduce unsafe abortion, provide antenatal services to a larger number of women and become service promoters. Traditional healers are trained to become part of the project delivery network.

### STRATEGIC THINKING, PLANNING, MANAGEMENT AND GOVERNANCE

The flexibility given to the project has enabled it to develop its own identity and try out fresh approaches, new management styles and new ways of working with communities. Relevant factors here focus on decentralisation and autonomy. While the project benefits from the experience and the financial discipline of FPAB, its separate geographical location allows it to function as an autonomous unit from FPAB. This has allowed the project to recruit specialised staff for its women, youth and community programmes, and to set up an evaluation unit which developed comprehensive management information systems for the project.

The project has experimented with an innovative governance system: this fosters good governance through a range of project advisory committees at central, district, union and thana levels.

CORHI is able to attract high calibre volunteers to its committees, drawing membership widely from different fields and from those with a high level of professional expertise, including volunteers from government departments and NGOs.

The close involvement of government means that the project can focus on meeting the needs of particularly under-served communities.

**Dr Ziaul Matin describes the barriers he and his wife encountered when they took up their posts as project manager and medical officer in Kawkhali.**

'Violent political unrest and economic constraints were common, and there were the inevitable misconceptions. But within a few months we were able to gain the trust of the community. We became known as the Vision Clinic in Kawkhali and everybody called my wife "Daktar Apa", literally meaning doctor/elder sister, a term of friendly respect.'

(Source: *Real Lives* Issue 6, IPPF South Asia Region, 2001)

**The CORHI project reaches under-served populations living in very remote areas, where general health care facilities are very limited and where SRH services are virtually non-existent.**



# profile

## Bangladesh

### GIVING VILLAGERS OPPORTUNITIES TO DEFINE THEIR OWN AGENDA

**By September 2000, the project had developed the managerial capabilities of 46 local organisations to run the project on a self-help basis once the project funding has ended.**

One aim of developing local groups is to increase self-reliance by giving villagers the opportunity to define, plan and co-ordinate implementation of their own development agenda. This is a key part of the participatory and democratic nature of the project. It is hoped that effective groups will find ways to collaborate with other agencies operating in their area to maximise and build on the effectiveness of their own scarce human and financial resources. In the long run, successful groups will learn to provide and maintain community facilities, introduce realistic service charges for sustainability, and self-finance development activities at the community or household level.

### MOVING FORWARD ... PROGRESS TOWARDS SUSTAINABILITY

Many FPAs face a difficult dilemma resulting from the apparent contradiction between their mandate to provide services to the poorest of the poor and the objective of achieving financial sustainability. Nevertheless, various elements are expected to contribute towards the overall sustainability of this project. These include development of local level community organisations, human resource development, co-ordination with the government, demand creation for family planning and sexual and reproductive health services, local resource mobilisation and integration of project activities into the overall FPAB programme.

In the long run, groups will learn to provide and maintain community facilities and self-finance development activities.

Cost recovery is another important factor. The general policy is to charge service users, except in cases of severe hardship. Only 5% of clients are unable to pay the consultation fee and, by the end of 2000, the six project sites were recovering 6-10% of their costs.

### SHARING EXPERIENCE ... BUILDING ON LESSONS LEARNT

The project has served as a demonstration model for FPAB, which has replicated the integrated approach used by CORHI in its other projects. For example, FPAB has created a similar model for its governance system, as well as replicating its youth programme and mobile medical teams approach. Other FPAB clinics are considering using female service providers who are preferred by clients in the project. Three other important principles have emerged.

- Firstly, an integrated approach is necessary for behaviour change, and is also likely to be more sustainable.
- Secondly, the project has been allowed to evolve relatively independently. As a result it has been able to pilot new strategies and approaches which can eventually become part of the main programme.
- Thirdly, community ownership is a long-term process, which may take longer than five years. Some elements of the project can be handed over to the community, while other aspects need additional work and inputs to prepare the community.

For more information on Vision 2000 Fund projects, please contact us at the address given on the right.



The CORHI project is based in six areas in the eastern part of Bangladesh: **Comilla Sadar** (Comilla District), **Sitakunda** (Chittagong District), **Ajmiriganj** (Hobiganj District), **Kawkhali** (Rangamati District), **Senbagh** (Noakali District) and **Jamalgang** (Sunamganj District).

- **Bangladesh is the most densely populated country in the world: it has a total population of 133 million, with 36% aged 10-24.**
- **Population growth is 2.2% per year.**
- **Human Development Index ranking: 145 out of 173 countries.** (Source: UNDP 2002)
- **Socio-demographic and health indicators are well below the South Asia average.**
- **Average life expectancy at birth is 59 years.**
- **The infant mortality rate is high at 66 per thousand live births.**
- **The maternal mortality rate is very high at 600 per hundred thousand live births.**
- **The contraceptive prevalence rate among married women (15-49) is 54% (all methods).**
- **The number of women per 100 men is 94.**

(Source: PRB 2002)

## contact

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