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DEFINING PRO POOR INTERVENTION IN URBAN HEALTH AND SANITATION WITH AN EMPHASIS ON NGOs EXPERIENCE: THE CASE OF DHAKA CITY

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It is now widely recognised that there is a need to take the scope of the population policy in Bangladesh beyond the confines of achieving population stabilisation through reduction of fertility. Although in recent years the approach to reduction of fertility has changed from narrow family planning to a broad based reproductive health approach, it is being increasingly felt that Bangladesh's population policy should encompass other equally important issues which have wide implications for the development process and the quality of life of people of Bangladesh. To address some of the related pertinent issues the Centre for Policy Dialogue has initiated a programme which aims at undertaking a series of studies covering the broad area of **Population and Sustainable Development.** The major objective of these studies is to enhance national capacity to formulate and implement population and development policies and programmes in Bangladesh, and through close interaction with the various stakeholder groups, to promote advocacy on critical related issues. The programme which is scheduled to be implemented by the CPD between 1999 and 2002 shall address, *inter alia*, such issues as population dynamics and population momentum and their implications for education and health services, the nexus between population correlates, poverty and environment, impacts of urbanisation and slummisation and migration, as well as human rights. The study has benefited from generous support provided by the United Nations Population Fund (UNFPA). The programme also envisages organisation of workshops and dialogues at divisional and national levels and also holding of international thematic conferences.

As part of the above mentioned CPD-UNFPA collaborative programme the CPD has planned to bring out a series of publications in order to facilitate wider dissemination of the findings of the various studies to be prepared under the aforementioned CPD-UNFPA programme. The present paper on the theme of ***Defining Pro Poor Intervention in Urban Health and Sanitation with an Emphasis on NGOs Experience: The Case of Dhaka City*** has been prepared by Dr. Quazi Towfiqul Islam, Development Adviser, PSU, Canadian International Development Agency (CIDA), Dhaka.

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I. Introduction

1.1 Background

Since independence in 1971 Bangladesh has been witnessing a steady growth of urban population, particularly, in the metropolitan cities of the country. The intercensal growth rate during 1981-1991 reveals that the growth in Dhaka City was more than 100 per cent i.e. 10 per cent per annum compared to 6 per cent in other cities and municipalities. Considering this trend estimated population of Dhaka City should now be more than 14 million (one of the most densely populated cities of the world). This number would also consist of more than 64 per cent of the total metropolitan population of Bangladesh, if population growth rate in other metropolitan cities is considered to remain at 6 per cent.

The most important reason of the above population growth is urban-oriented migration mainly taking place for major 'push effects', such as, river erosion and lack of employment opportunities in rural areas. These factors are pointing to the fact that bulk of the migrant population comprises very low-income poor households.

The consequences of increasing migrant population have, no doubt, triggered rapid urbanization in Bangladesh. However, this has very little to do with the positive trend of urban development. Urbanization has coupled here with rapid slummization, increase in income inequality and poverty, loss of cultural identity so on and so forth. It is to be noted that from one single slum in the 1950's the number of slums in Dhaka City has now grown, according to Dhaka Municipal Corporation, to 22,000. Therefore, it is quite natural that Dhaka has the largest share of slum population living in three metropolitan cities of the country. According to an earlier estimate about 30 per cent of Dhaka City's population live in slums.[1] Also, Dhaka is the place of highest number of floating population in Bangladesh.[2] Although having this explanation one should not miss the point that urban poor also live in non-slum areas but considering the conditions in slums, population living there are by all means categorized as poor.[3]

The excessive burden of city population has posed formidable difficulties for the urban public health, water and sanitation systems to provide normal services to the city dwellers. In slum public health, water and sanitation services are almost non-existent.[4] Whatever the extent of these services the poor get barely cover their needs in a true sense. As a result, prevalence of various diseases compounded with poor health of millions of slum population is very common, especially, amongst the women and children. The economic effects originating from health problems also have dire consequences in the long run. Because sustained illness

[1] Arifeen and Mookherji (1995).

[2] According to 1986 Slum Area Census (BBS, 1988) in three Statistical Metropolitan Areas (SMAs), Dhaka, Chittagong and Khulna, 69 per cent (more than half a million in absolute term) of slum population lived in Dhaka City, followed by Chittagong (17 per cent) and Khulna (14 per cent). Another study (URC, 1993) revealed that Dhaka City also shared nearly one-forth (0.1 million) of the country's floating population.

[3] For more detailed account of urban poor categorization, see Sen and Islam (1993).

[4] Depending on the size and concentration of slum population, Dhaka should be representative of population characteristics of slums of the whole country.

and poor health, especially, of the income-earners substantially erode income level and income potential of the households. This kind of situation further reduces households' capacity to access medical services. It is a vicious circle having serious health as well as economic consequences for the urban poor whose valuable contribution to the urban development and lives of other people can hardly be overemphasized in the present context.

To ameliorate the above situation it is obvious that urban health, safe water and sanitation services should be made available as well as accessible to the poor slum population at the first step. In this respect it is desirable that people at the policy and operational levels in both Government as well as NGO sectors need to have *correct perspectives, and implement pragmatic programs based on appropriate approaches* that make sustained impacts on the lives of urban poor. This has actually necessitated a study like this to help design policy options and programs in the relevant fields in both GO and NGO sectors.

In the above backdrop there is a need to review and analyze policies and programs designed and implemented by the government as well as NGOs in urban health, water and sanitation sectors. The government policies and programs in the relevant area are, in general, not targeted to poor as opposed to those of the NGOs targeting to poor and disadvantaged groups. Furthermore, review and analysis of the government policies and programs are, in general, readily accessible. On the other hand, various interventions and approaches adopted by the urban NGOs are relatively less highlighted, although some of these are much more innovative, effective and people-oriented than the government ones. Based on this hypothesis it was felt necessary to study and analyze in more detail NGO interventions and approaches in an urban location, for example, in the Dhaka City. Also, in this regard, an in-depth study of the perception of the household beneficiaries has critical importance to assessing the impact sustainability of various programs and approaches sponsored by the NGOs in the relevant field. Highlighting the comparative scenarios of the government/public agency sponsored programs and that of the NGOs is also relevant for any kind of future interventions aiming to bring measurable impacts on health and sanitation status of urban poor in Bangladesh.

1.2 Objectives of the Study

In the above background the study aimed at achieving the following objectives:

i. Documenting the various types of interventions and approaches of the Government and NGOs in the area of urban health, water and sanitation for the poor in Dhaka City slums.

ii. Focussing on the state of conditions of health, water and sanitation of urban poor as perceived by the slum households.

iii. Highlighting experience/benefits of the interventions made by NGOs and government/public agencies in the above service areas from the perspectives of beneficiaries.

iv. Suggesting policy options, programs and strategies of the Government and NGOs to effectively utilize available resources in urban health and sanitation sector for the benefits of urban poor.

1.3 Scope of the Study

Broadly, considering the Terms of Reference (Annex-1) and the purpose, the study has basically covered and is based on three main parts. First, it took into account types, growth and magnitude of health, water and sanitation programs, including their modes/approaches in implementation, mainly of the NGOs in Dhaka City, and, to a lesser extent, of government/public agencies and Municipal Corporation. Second, an in-depth study of perception of the beneficiary-households, covered by NGOs and others, in slums was carried out amongst different sizes of samples in distinct locations of Dhaka City. The locations were (1) Agargaon area (the biggest slum area of Dhaka City), (2) Tejgaon Industrial Area, and (3) Lalbag area. This was done to analyze health, water and sanitation conditions of the slum dwellers and, against this the background, benefits they get from programs of different actors in the relevant areas. Understanding of household perspectives with regard to health, water and sanitation services was also tried in the same exercise. Based on the above institutional information and survey findings and references to other relevant studies, observations and recommendations to address the needs of poor living in slums were made.

1.4 Methodology of the Study

The following methodologies were followed in the study:

- Relevant institution-level information was collated following a set of pre-designed formats and a checklist from the NGOs implementing health, water and sanitation programs in the Dhaka City slums.
- Interviews were held with the leadership and other staff (key informants) of the selected NGOs engaged in implementing the above programs.
- Review of relevant documents and literatures available at different organizations was made.
- Review of other relevant studies and documents, as available, was also made.
- For in-depth study of the perception of NGO beneficiary-population a structured and pre-tested questionnaire was administered amongst different sizes of sample households in Agargaon, Tejgaon, and Lalbag slum areas.

1.5 Sample Design of the Study

- Relevant institution-level information was collated from twenty-five NGOs implementing health, water and sanitation programs in different Dhaka City slums. They were divided under three categories based on their activity focus in these areas, such as, (a) Health NGOs (8), (b) Water and Sanitation NGOs (4), and (c) Health, Water and Sanitation NGOs (13). Identification of all these NGOs were collected from register of Coalition for Urban Poor (CUP) - a networking organization and a focal point of the NGOs working amongst the urban poor in Dhaka City.
- Verification of information regarding the relevant NGO programs from the knowledgeable persons was made in 10 randomly selected slums.
- For in-depth study of the perception of the slum households covered by the NGOs two most densely populated slum areas in northern part of the city located at Agargaon (highest concentration of slums) and Tejgaon industrial areas were selected. Another slum area of having less density of households was selected from Lalbag (old and southern part of the city) along the Dhaka City protection dam. In all these areas slums are situated in several clusters of having their own separate identities.[5]

[5] Distinguishing features of slums are discussed in Islam and Mahbub (1998) and Arifeen and Mahbub (1991).

- Sizes of the sample households in three slum areas were as follow: (1) Tejgaon industrial area = 255, (2) Agargaon area = 157, and (3) Lalbag area = 98. The variation in sample household sizes was dictated by two main considerations, such as, (a) density of households, and (b) concentration of program implementing NGOs in the slum areas. Adding together the total number of sample households for the study was 510.
- The questionnaire apart from collecting household information also gathered member-level information of 2,716 persons, comprising different age groups.

1.6 Organization of the Report

Including the background (Chapter - I) the study consists of six chapters. Chapter - II analyzes development and magnitude of NGO interventions in urban health, water and sanitation sectors for the poor. This will include specifically financial magnitude of different programs as reflected in the budgets in different years as well as area and population coverage of each of the programs in different slums of Dhaka City. In this chapter resources allocation by Dhaka City Corporation (DCC) in the relevant field for general and target population are also discussed. Modes and approaches in service deliveries of NGO health, water and sanitation programs are discussed in Chapter III to sift lessons and insights about the NGOs' system of operation. The in-depth perception analysis of the beneficiary-household population in the slums about health, water and sanitation services provided by the NGOs and, to a lesser extent by the public agencies, in the backdrop of overall health status of the same population are analyzed in chapter IV. Chapter V is devoted to making observations and developing recommendations for future policy options and operational framework in the field of health, water and sanitation for the poor. This is intended to making sustainable impacts on the quality of life of poor living in urban areas, in particular, and elsewhere, in general.

II. Development and Magnitude of NGO Interventions in Health, Water and Sanitation Sectors for Urban Poor

2.1 Development over the Years

Historically NGO programs and activities in Bangladesh have their roots in rural areas. Their target population and program coverage also include overwhelmingly the rural poor of which women constitute the single largest majority. Even today majority of NGOs of different categories and their programs are highly concentrated in rural areas with a major focus on micro credit.

Only beginning from the late eighties NGO operations in urban areas, for example, in Dhaka City started taking a definite shape. This period also coincided with the inception of bringing the urban poor agenda in overall poverty alleviation programs and strategies of the government, NGOs as well as of many donors. Because, considering the magnitude of different poverty indicators, say, access to health, water and sanitation facilities, concern over urban poor vis-à-vis their counterpart in rural areas was regarded no less urgent and critical an issue. As a matter of fact, urban poverty manifested various new dimensions in overall poverty situation of the country, which ought to be addressed through different set of policies, programs and strategies.

Responding to the above need, growth of NGOs in Dhaka City, particularly, of those having health, water and sanitation programs (consisting of different activities and components discussed in the next chapter) was very significant in recent years. This has been presented in Table -1 for the period 1995-1999, which indicates that NGOs engaged in health, water and sanitation sectors increased from 9 in 1995 to 25 in 1999. The number in 1999 comprises 68 percent of total NGOs covered by the sample.

It is to be noted that the NGOs engaged in implementing health, water and sanitation activities under separate programs mostly began only with health activities. Many of these also at the same time undertook complementary activities like distribution and installation of water-sealed slab latrines at the beneficiary level. This type of NGOs also gradually included water component in their program through distribution and installation of tube wells. Recently, some of these NGOs have also added running water point component connected with DWASA main line. So, development of NGO activities in the fields of health, water and sanitation in Dhaka City has gone through several phases and experiments. This has helped classify them into two major categories i.e. health activity based NGOs (or health NGOs) and health, water and sanitation activity based NGOs (or health, water and sanitation NGOs). In between there is another category of NGOs of a smaller number, which emerged recently and do not have health component in the form of medical services provided by qualified personnel (doctors, nurses. paramedics, etc.), and operate only in the field of water and sanitation (or water and sanitation NGOs).[6]

In Table - 1 it is also seen that the growth of NGOs operating Health, Water and Sanitation in a package was much more significant (more than four times) compared to other two categories during the period under consideration. This underlies the fact that these three activities are very much inter-linked and should be addressed in a package to enable the poor get basic services from one source. This has better impacts on health improvement than if focussed on one or two components only.

[6] These categorizations are only for the analytical purpose and do not exclude individual NGOs involvement in other activities not attached with such categorizations.

Table - 1: Development of NGOs' Health, Water and Sanitation Programs (1995-1999)

Year	Number of NGOs working in Dhaka City (a)	Number of NGOs by Programs				
		Health (b)	Water and Sanitation (c)	Health, Water & Sanitation (d)	Total (e)	(e) as % of (a)
1995	35	5	Nil	3	9	25.7
1996	37	7	Nil	6	13	35.1
1997	37	7	2	8	17	45.9
1998	37	8	4	12	25	67.6
1999	37	8	4	13	25	67.6

Source: Coalition for Urban Poor (CUP), 1999.

2.2 Population and Slum Coverage in 1999

Against the above growth of NGOs information was collected to see how much population in slums was covered in 1999 by each of the NGOs in different categories (Table - 2). It was found that of the total number of NGOs operating in health sector, none half of them covered population exceeding 8,000 but each other half of them covered population more than 30,000. Population coverage of health, water and sanitation NGOs was also high. Each of the top one-fourth NGOs in this category covered population of more than 30,000.

With regard to the above there were certain degrees of overlapping of total population coverage between and within different categories of NGOs. Usually, this overlapping tends to be higher where number of NGOs is also higher in either one or other categories. However, the above population estimates give us indication about the extent of NGOs health, water and sanitation coverage in slum areas and highlights the need to cover more and more target population under health, water and sanitation services in slums.

As seen from the above, distribution of health NGOs in terms of population coverage were highly skewed vis-à-vis those in other two categories. Also the fact was that each of the top 50 per cent sampled health NGOs covered more than 40 slums in the city (Table - 3). On the other hand, any one of 90 per cent health, water and sanitation NGOs under study could not cover more than 30 slums. The positions of only water and sanitation NGOs in these regards (population and slum coverage) were not significant.

Table -2: Population Coverage of Programs by Number of NGOs, 1999

Program	Population coverage by number of NGOs							
	<2,000	2,001-4,000	4,001-6,000	6001-8,000	8,001-10,000	10,001-20,000	20001-30,000	> 30,000
Health	2	1	-	1	-	-	-	4
Water & Sanitation	-	1	1	1	-	-	1	-
Health, Water & Sanitation*	-	1	2	-	2	4	-	3

* BRAC's population coverage in this program not included.
Source: Survey, 1999.

Table - 3: Coverage of Slums by Program, 1999

Number of Slums	Program coverage by number of NGOs		
	Health	Water & Sanitation	Health, Water & Sanitation
<5	3	2	2
6-10	1	1	4*
11-15	-	-	1
16-20	-	1	2
21-30	-	-	2
31-40	-	-	-
41>	4	-	1

* Nari Maitry's slum coverage can not be given as they work in city wards as against slums taken into consideration in other cases.
Source: Survey, 1999.

2.3 Magnitude of budget expenditures over the years

Along with population and slum coverage there is also a need to know total budget expenditures of the NGOs in each category over the years. To this end, relevant information was collected at the institution level from as many surveyed NGOs as possible. The information so collected is presented in Table - 4. It should be mentioned here that, across the board, different foreign donors mostly provided funds to cover such expenditures.

Table - 4: Growth of NGOs' Health, Water and Sanitation Programs in Dhaka City (1995-1999)

Program Description	Year				
	1995	1996	1997	1998	1999
A. Health					
a. Number of NGOs	5	7	7	8	8
b. Budget Allocation (million Taka)	14.4	38.3	40.9	13.7	69.9
c. b as % of total program budget	23.1	20.8	24.2	15.5	16.8
B. Water & Sanitation					
a. Number of NGOs	Nil	Nil	2	4	4
b. Budget Allocation (million Taka)	-	-	0.4	1.9	1.9
c. b as % of total program budget	-	-	7.0	24.7	17.4
C. Health, Water & Sanitation					
a. Number of NGOs	3	6	8	12	13
b. Budget Allocation (million Taka)	2.2	8.2	10.0	15.9	27.2
c. b as % of total program budget	7.6	6.9	11.7	13.5	14.6
D. Total (A+B+C)					
a. Number of NGOs	8	13	17	24	25
b. Budget Allocation (million Taka)	16.6	46.5	51.3	31.5	99.0

Note: 1. Budget Allocations by Nari Maitry and CONCERN were not included.
2. BRAC's total number of beneficiaries was not included as the program is still being experimented in the surveyed areas.
3. CONCERN's beneficiaries in health program until 1998 were not available.

The budget expenditures[7] in health, water and sanitation services by the NGOs revealed the fact that health NGOs together spent much higher amount than any of the other categories over the period under consideration. For example, in 1999 total expenditure of health NGOs reached to an extraordinary high level compared to any of the earlier years' figures. Even in some comparable years, with an exception only in 1998, the total amount spent by the health NGOs is higher than by the amount spent by all other categories. In this respect it is also seen that health NGOs tend to be much bigger than others covered by the study. On the other hand, percentage of health expenditures in total program expenditures for health NGOs remained more or less the same in first three consecutive years with a noticeable decline in the last two years.[8] This situation can be explained by the fact that with the increase of volume of resources for health expenditures, health NGOs were also been engaged in diverting and diversifying their activities in other non-health programs.

There was a steady increase of budget expenditures over the years for health, water and sanitation NGOs together with an increase of their number. The range of budget expenditures of these NGOs signifies that they are mostly medium in size.

In this exercise it would have been interesting to draw budget expenditures by NGOs per beneficiary in different categories, which is possible with regard to individual NGOs. However, due to overlapping of beneficiary-population the above cannot be done at the aggregate level in any of the categories.

On the whole, it is seen in the above table that total budget expenditures of the NGOs, across the categories, increased by more than five times whilst their number increased by more than three times during the period under consideration.

2.4 Budget expenditures of Dhaka City Corporation for general and target population

In this section attempts have been made to discern DCC's[9] role and extent of involvement in the relevant fields. Recently, DCC has implemented some programs targeted to the slum dwellers in Dhaka City with financial assistance from some bi/multilateral development agencies. Side by side DCC has also other traditional interventions in the field of health, water, and sanitation mainly benefiting the poor population. This attempt, on the other hand, will also throw some light on a comparative assessment of the interventions made by DCC and NGOs in the relevant fields.

DCC's involvement in target programs for slum dwellers can be traced back to 1990/91. In this year DCC undertook Slum Improvement Project with financial support from UNICEF under the LGED. Till 1994, DCC did not get financial assistance from any source other than UNICEF. During this period DCC undertook some preliminary work in five slums and implemented in these slums various project activities till the beginning of 1996 from its own resources. Installation of slab latrines for the benefit of 2,729 slum households was one of the activities. Since 1996 UNICEF, ADB and DCC jointly started funding and implementing Urban Basic Service Delivery Project for a period of 4 years from 1996/97-2000/2001 under

[7] The resources spent for the programs cover salaries of the project staff and also organizational overheads that include salaries of the non-project staff, which are collected from each of the programs by certain percentages.
[8] In 1999 health expenditures increased to the highest level, attributable to only two to three large NGOs.
[9] In Dhaka City government channelizes its resources and implements different programs in the field of health, water and sanitation through DCC. The major interventions in, and maintenance for the latter two components are made through DWASA.

LGED of the Government. Until June 1999 the project implemented different components, including, installation of slab latrines and tube wells in 150 slums benefiting a total of 30,000 households. During the same period the project, with the assistance of UNICEF, also established 100 Urban Development Centers (UDCs). Each of these centers, apart from conducting skill training, credit disbursement and so on, should also provide primary health care, supply of safe water through construction of underground water reservoir, installation of slab latrines etc. It was envisaged that the centers altogether should cover a total of 200,000 slum-population i.e. 2,000 populations per center. The centers went on commencement during the period.

Apart from the above target programs DCC also traditionally implements some activities in the field of health, water and sanitation, which by scope and standard benefit the poor and low-income population of the city. A brief account of these activities and relevant issues, as gathered from the health department of the DCC, is in order.

DCC operates two hospitals, called Dhaka Mahanagar Shishu Hospital (Dhaka Metropolitan Children Hospital) and Dhaka Mahanagar (metropolitan) General Hospital and three MCH clinics. Also, DCC has in operation 17 dental cum primary health clinics in different areas of the city. Budget allocation for the Dhaka Metropolitan Children Hospital could be collected for the years of 1998/99 to 1999/2000. It was revealed that there has been a gradual increase in the budget allocation from Tk. 2.2 million to Tk. 4.9 million. Regarding allocation in the clinics, budget amount was about Tk. 11.5 million in 1995, which rose to Tk. 12.4 million in 1999. In addition, DCC maintains more than 24 points of public latrines and 6 bathing and washing places, consisting of mainly the ponds, in different places of the city.

III. Modes and Approaches of Service Deliveries of NGO Health, Water and Sanitation Programs

3.1 Introduction

It is generally known that NGOs follow different modes and approaches in the implementation of programs for the benefit of target population. Since in most cases NGOs programs are funded by external funding agencies their inputs as well as influences in program designing and implementation, including setting of modes and approaches, play a vital role. However, NGOs own perceptions and suggestions are no less important in this regard as long as they are directly involved in implementation activities.

In this chapter various modes and approaches of the NGOs in delivering health, water and sanitation services in Dhaka City are presented in a consolidated manner. The detailed separate account of these for each surveyed NGO is given in Annex - 2. In this regard it is important to note that, across the categories, target beneficiaries of the NGOs consist mostly of poor and disadvantaged women and children. Adult male (poor) population is considered secondary or indirect beneficiaries.

3.2 Salient features of modes and approaches followed in health, water and sanitation programs by NGOs

The above are identified and presented in the matrix below with respect to each category of NGO. It should be mentioned here that there are a few NGOs in Dhaka City registered with the Coalition of Urban Poor (CUP), which do not have any activities in the field of health, water and sanitation services[10].

[10] Out of total 37 NGOs from where information was gathered, only 12 (32%) were found falling into this group.

Categories of NGOs	Activities	Modes and Approaches of Service Deliveries
1. Health NGOs	• Counseling and limited curative treatment (including pathological testes) of various diseases. • Health, family planning, hygiene awareness training and education. • Referral and secondary treatment. • Antenatal and post-natal cares. • Training of TBA. • Limited supply of required medicines to the patients. • Immunization. • Installation of sanitary latrines. • Nutritional food and tablet distribution. • Different health services during emergencies.	• Group formation of the target beneficiaries through field survey. • Health education and awareness training are provided in-groups. • Treatment is provided through base (static) and satellite clinics on particular days or everyday a week, attended by qualified doctors and other qualified and semi qualified medical staff, only to the registered member-patients or credit group members in most cases. • Common medicines are provided to the registered patients at cost price. The health services are provided also to the non-beneficiaries women and children and family members of the beneficiaries in some areas and cases. • The doctors and health workers follow up the health services via home visits as per a time schedule. • For counseling and subsequent treatment nominal costs are charged for each patient and medicines are also supplied at cost price. • Distribution and installation of latrines are implemented through management committees consisting of the persons of the beneficiary groups with an emphasis on women. • In most cases latrines are provided under credit that is recovered in installments in a timeframe. • Credit members' savings and donors' contribution provide support for health loan fund. The loan is given based on verification and recommendation of a Committee, consisting of credit-group members, as per certain terms and conditions.
2. Water and Sanitation NGOs	• Installation of tube wells and slab latrines. • Health education and awareness training. • Solid waste collection and disposal. • Construction of water points with a legal arrangement with DWASA.	• Group formation of the target beneficiaries through field survey. • Committee formation consisting of female members from each group for overall operation and management of the service installations. • Advisory committees are also formed represented by the male members to make a balance in the community and assist the above management committee in need. • Latrines are provided to individuals or small groups (comprising 4-6 members) on credit, recoverable in installments in a given period of time. • Hygiene education and health awareness training are conducted in small groups.

Categories of NGOs	Activities	Modes and Approaches of Service Deliveries
3. Health, Water & Sanitation NGOs	• Combination of activities as outlined in case of above two categories of NGOs.	• Group formation of the target beneficiaries through field survey. • Base (static) and satellite and/or mobile clinics provide all types of health services as indicated in the activity column to registered and, in a fewer instances, to non-registered members, which are attended by qualified doctors and other medical staff. The clinics operate in some fixed days a week or round the week except for holidays. • Clinic-based curative cares are provided to only the registered members, also covered by the credit program. • In some NGOs the above registered beneficiaries are covered by a health insurance scheme under which every one deposits mandatory Tk.2.00 weekly. Against this deposit a beneficiary receives doctor's consultancy and full course of medicines (other than antibiotics) for herself and other 5 family-members (two children + husband + her or husbands parents). In case of antibiotic 50 per cent of the amount is provided. • There are 3-4 outreach clinics in each branch attended by qualified doctors, nurses and paramedics for six days a week. • The Community Health Workers conduct home visits. • Referral and hospital/center based secondary treatment are also in operation in case of a few NGOs. In such cases all kinds of secondary treatment to low-income population and referrals of outreach clinics are provided at low affordable prices. The medical center has certain bed-capacity and other facilities (personnel and logistics) to provide quality treatment round the clock. • Sanitary latrines and tube wells are provided in the form of loans that are recoverable in installments in a given period of time. • Costs for treatment and counseling are charged. • Tube well and sanitary latrine are installed and managed under the management committee comprising either female or female and male beneficiaries of varying numbers (5-7) so that cost recoveries and smooth operation of the installations are ensured. Advisory committee (4-5 member) consisted of the male population is also consisted to support activities of the women based management committee. • Tube wells are provided to small groups of beneficiaries (either credit group members or covered by the program) the size of which varies from NGO to NGO but remains between 60 - 100 beneficiaries per tube well to ensure proper operation and benefits of the installations. Sanitary latrines, on the other hand, are also given to individuals or small groups as above. • In some emerging instances NGO acts as an intermediary between the slum community (consumers) and DWASA to make running water available in a legal way (under a MOU signed between the NGO and DWASA) from the DWASA main line. Under this, the NGO is liable to pay water bills regularly to DWASA on behalf of the community. • The water is supplied through water points (WP) constructed with the initial investments of the NGO.

Categories of NGOs	Activities	Modes and Approaches of Service Deliveries
		• In some emerging instances NGO acts as an intermediary between the slum community (consumers) and DWASA to make running water available in a legal way (under a MOU signed between the NGO and DWASA) from the DWASA main line. Under this, the NGO is liable to pay water bills regularly to DWASA on behalf of the community. • The water is supplied through water points (WP) constructed with the initial investments of the NGO. • For each WP there is Pani Kal Samity (PKS) whose formation and activities are defined by a constitution. Each PKS consists of 50 -100 women beneficiaries to cover water supply, ideally, for 500 families. There are also a few exceptions where the entire community getting services of the WP form the PKS. • Mainly for site selection, operation, and maintenance of a WP and collection of bill for water use a 9 -member Management Committee (MC) is elected for a year by the PKS members. The members of the MC are usually the women leaders in the PKS. The responsibilities of the MC, amongst others, include paying water bills to DWASA, repaying construction cost of WP borne by DSK in fixed installments, appointing a caretaker for WP, and overall maintenance of the WP, etc. • In addition to MC consisting of only the women, an Advisory Committee of 5 male leaders of the community is also formed for one year. The main purpose of the Advisory Committee is to assist, protect and advice the MC in performing their regular activities. • The NGO keeps regular contact with the MCs and supervises their overall activities initially for two years during which MCs will, as believed, gather enough strength to work independently with DWASA without an inter-mediation of the supporting NGO.

IV. Perception Analysis of the Household Population

4.1 Introduction

This chapter analyzes perceptions of the beneficiary-household population about the activities of NGOs and others in the areas of health, water and sanitation in different slums. This has been done in the background of an overview of the health status of the same household population and practices followed by them during illness. The information for the entire exercise was drawn from the sample household surveys conducted in three big slum areas[11] in three geographically significant locations. The sample sizes for each of these slums varied according to the variations in density of households and the actual samples were sifted on random basis.

In the following sections and sub-sections findings and analyses of the information in relation to the above are provided with an introduction to demographic characteristics of the surveyed household-population.

4.2 Demographic characteristics of the households

The above is discussed with respect to age and gender distribution based on the information presented in table - 5.

It is seen from the table that children aged up to 5 and adolescent between 6-14 together constituted about 45 per cent of the total surveyed population. On the other hand, amongst the total population in age group 6 and above women were more than men, 42.3 and 40.9, respectively.

The above information is important to the extent that the total vulnerable population in the sample, comprising population up to 14 years of age and the females in other groups, was very high, 73 per cent. Vulnerability of this population was even more critical with respect to health cares because of their poor economic condition.

[11] The slums have been identified in the study as specific geographic areas where slum dwellers tend to concentrate for living. However, within this concentration there are several slums that are identified more accurately by names of different individuals or districts of origin the dwellers came from. According to a recent statistics of Dhaka City Corporation the total number of slums in Dhaka is 3007. This was 2,156 in 1991as per survey conducted by Center for Urban Studies (CUS), Dhaka University, under Urban Health Extension Project (UHEP) of ICDDR, B.

Table 5: Characteristics of Household-Population in Slums

(Age group in year)

Slum Area	Population Size by Age Group and Gender (%)												Total Population (%)			
	Children Up to 5	6-14		15-25		26-35		36-45		46 and above		Total	Children Up to 5 years	6 years and above		Total
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female			Male	Female	
Agargaon (Total H/H=255)	16.5	12.8	13.9	8.1	11.7	9.9	8.9	5.6	3.6	5.0	4.1	100	16.5	41.4	42.1	100
Tejgaon (Total H/H=158)	17.3	13.7	13.6	9.2	11.7	8.8	8.6	4.6	3.9	3.7	5.0	100	17.3	40.0	42.8	100
Lalbag (Total H/H=97)	17.2	17.0	15.0	6.1	7.4	6.3	10.5	6.8	4.1	4.9	4.7	100	17.2	41.0	41.8	100
Total (Total H/H=510)	16.8 (458)	13.9 (377)	14.0 (380)	8.1 (219)	10.9 (295)	8.8 (240)	9.1 (248)	5.5 (150)	3.8 (103)	4.6 (124)	4.5 (122)	100 (2716)	100 16.8 (458)	100 40.9 (1110)	100 42.3 (1148)	100 100 (2716)

Note: Figures in parentheses from column 2 onward represent total number of population.

4.3 Health status and practices of the population

The health status of the household population has been ascertained on the basis of some basic indicators, such as immunization status, incidence of diarrhoea, and some other serious and common diseases. The practices followed by them during illness are also illustrated here. These have been done as because activities of NGOs and others for health, water and sanitation services are basically aimed at improving overall health status of the target slum population.

Immunization status of the eligible children in the households has been presented in Table – 6. It was revealed that children of about 40 per cent of households, across the slum areas, were not covered by full doses, and that almost 33 per cent received only partial doses. This 33 per cent did not follow the program carefully. About 6 per cent of households did not get any of the doses.[12] The reason was 'lack of knowledge' according to 65 per cent of households. This situation is particularly significant for the NGOs and others implementing health programs with an emphasis on immunization of the target population in the slums.

Table 6: Immunization Status of Eligible Children*

Slum Area	All Doses	Partial	None	Total	Reasons for nor being immunized at all	
					Lack of knowledge	Non-availability
Agargaon	47.5	43.3	9.0	100	73.5	26.5
Tejgaon	56.5	40.0	3.5	100	78.8	21.7
Lalbag	73.4	24.5	2.2	100	44.4	55.6
Total	61.4	32.8	5.8	100	65.0	35.0

* Children aged 12-23 months by which they should be fully vaccinated.

Incidence of diarrhoea over the last three years experienced by the household population was recorded during the survey. It was revealed that one or more members of 58 per cent of total households, across the areas, were affected by diarrhoea during the last three years. On the other hand, the number of total population, comprising different age groups, affected in these households was 452. Their distribution amongst the surveyed areas is presented in Table- 7. It is seen in the table that amongst the total affected population, comprising more than 16 per cent of the total sample population, 34 per cent constituted children up to 5 years of age. Amongst population aged 6 years and above, no significant variation was observed between male and female.

With regard to the above attempt was made to estimating 'survival rate' of the diarrhoea patients in relation to the affected population. On the average this rate was very impressive, as high as 90 per cent, with some variations in children and adult age groups in one or two areas. This result was indicating a success of the promotional activities for Diarrhoeal treatment by various NGOs, organizations in government, and private social marketing sector.

Modes of treatment for diarrhoea (Table - 8) by the affected households were also captured during the survey. It was revealed that 'advice of pharmacy salesman' was followed by more than 48 per cent of the affected households. The second largest (about 33 per cent) mode of treatment was 'admission to government hospitals/clinics'. Admission to NGO clinics during

[12] These findings are quite comparable to national immunization coverage. As per Bangladesh Demographic and Health Survey, 1996-1997, the proportion of fully immunized among children aged 12-23 months was 54 per cent. The children received no vaccination was 12 per cent.

diarrhoea was expressed by less than 1 per cent of the households. Self-treatment, quack treatment or treatment by neighbors represented only around one per cent.

Like diarrhoea incidence of **other serious diseases** in the households in the past three years was also recorded. Based on the prevalence rate of these diseases in the period, only three were identified having the highest rate in two major age groups in this study. Thus, in the children age group (up to 5 years) *measles* was the highest prevalent disease followed by *pneumonia and jaundice.* In the age group 6 years and above little variation in the incidence of diseases between gender and age groups was witnessed. In this age group *jaundice* was the highest prevalent disease followed by *dental, asthma and chicken pox.*

Enquiry about of modes of treatment of the above serious diseases revealed that majority of households went for 'quack or traditional treatment' (35 per cent households) followed by 'advice of pharmacy salesman ' (28 per cent), 'MBBS doctor's treatment' (17 per cent) and so on (Table - 9). Dependence of the poor households on quack or traditional treatment can be explained by the prevailing confidence of the poor on this particular mode and also by lower cost of it.

With regard to incidence of common diseases there were commonalties amongst different slum areas and age groups. For example, high temperature (commonly termed as 'fever') was the most common disease of the household members followed by scabies, dental disease and gastric. The reasons of these diseases were mostly linked with the poor and unhealthy environment in the slums.

Table 7: Incidence of Diarrhoea in Last Three Years

Slum Area	Affected population by age group and gender											Total	Total affected population			Total
	Children up to 5	6-14		15-25		26-35		36-45		46 and above			Children up to 5	6 years and above		
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female			Male	Female	
Agargaon	31.5	10.0	13.9	6.1	8.1	6.5	8.9	8.1	3.1	1.2	2.7	100 (260)	31.5	31.9	36.5	100 (260)
Tejgaon	32.8	20.3	14.8	7.0	7.0	2.3	3.1	3.1	0.8	4.7	3.9	100 (128)	32.8	37.5	29.7	100 (128)
Lalbag	46.9	21.9	3.1	-	3.1	6.2	7.8	-	3.1	6.3	1.6	100 (64)	46.9	34.4	18.8	100 (64)
Total	34.1	14.6	12.6	5.5	7.1	5.3	7.1	5.5	2.4	2.9	2.9	100 (452)	34.1	33.8	32.1	100 (452)

Source: Survey, 1999.

Table 8: Modes of Treatment for Diarrhoea

Slum Area	MBBS Doctor's treatment	Advice of pharmacy salesman	Treatment by own decision	Quack treatment	Treatment advised by neighbors	Admission to govt. hospital	Admission to private hospital/clinic	Admission to NGO clinic	Total
Agargaon	21.2	44.7	2.2	0.7	0.4	28.6	0.7	1.5	100
Tejgaon	4.4	54.3	0.7	1.5	Nil	39.1	Nil	Nil	100
Lalbag	2.7	52.7	Nil	1.4	6.8	36.5	Nil	Nil	100
Total	13.6	48.7	1.4	1.0	1.3	32.8	0.4	0.8	100

Source: Survey, 1999.

Table 9: Modes of Treatment for Serious Diseases

Slum Area	MBBS Doctor's treatment	Advice of pharmacy salesman	Treatment by own decision	Quack treatment	Treatment advised by neighbors	Admission to govt. hospital	Admission to private hospital/clinic	Admission to NGO clinic	Homeopathic treatment	Total
Agargaon	21.6	29.0	2.9	28.1	0.5	10.7	0.9	3.7	2.6	100
Tejgaon	15.1	27.4	3.3	40.2	0.2	6.2	1.1	0.3	6.2	100
Lalbag	6.2	23.7	1.5	46.3	0.4	15.3	0.4	-	6.2	100
Total	17.2	27.7	2.8	34.7	0.4	9.9	0.9	2.1	4.3	100

Source: Survey, 1999.

discern the extent of households' affordability for treatment as well as their level of health awareness, their practices during common diseases were recorded in the survey. Thus, households' undergoing treatment 'in maximum cases' of illness comprised the majority (58 per cent), 'sometimes' comprised 21 per cent and 'not at all' comprised the lowest, one-fifth of a per cent (Table - 10).

Table 10: Practices by Households during Illness caused by Common Diseases

Slum Area	Practices during illness				
	Always undergo treatment	In maximum cases undergo treatment	Sometimes undergo treatment	Do not undergo treatment	Total
Agargaon	28.6	48.6	22.4	0.4	100
Tejgaon	17.1	67.7	15.2	Nil	100
Lalbag	6.2	66.0	27.8	Nil	100
Total	20.8	57.8	21.2	0.2	100

Source: Survey, 1999.

In relation to the treatment for common diseases, households were asked to rank amongst different available modes of treatment. The result showed that, across the areas, overwhelming majority of the households (about 70 per cent) identified 'advice of pharmacy salesman' as their first mode of treatment. For a sizeable number of households only one mode was tried, which was either 'advice of pharmacy salesman' or traditional 'quack treatment'. However, with respect to the second and third modes such ranking varied amongst the areas. For example, in Agargaon households ranked 'doctor's prescription' as their second as well as third priorities but in Tejgaon and Lalbag 'quack treatment' ranked as the second priority followed by 'doctor's prescription'. This ranking, as revealed during investigation, was determined by two critically important factors, viz., (1) cost of treatment, and (2) convenience of treatment in terms of having quick services in the easiest way. However, in many cases, the second factor outweighs the importance of the first one. As a whole, the question of the best and most appropriate treatment for a patient affected by common diseases is something less important for the households unless something serious with the patient is happened with the predominant mode of treatment i.e. 'advice of pharmacy salesman'.

4.4 Household perceptions about the health, water and sanitation services

Before elaborating the above from different perspectives it is imperative to highlight involvement of each household in the number of NGOs since the major focus of the study is on the NGOs. This has been presented in Table - 11. It is seen from the table that, on the whole, maximum households (about 40 per cent) in the cohort were simultaneously linked with two NGOs since one or two female members of the households were direct beneficiaries of the NGOs. In the same way about 6 per cent of the households were found involved in more than three NGOs at a time.

Table 11: Households' Involvement in NGOs

Slum Area	Number of households involved in number of NGOs					Number of household members involved in NGO activities					
	One NGO	Two NGOs	Three NGOs	>3 NGOs	Total	One	Two	Three	Four	Above four	Total
Agargaon	16.4	44.1	27.7	11.7	100	10.5	47.7	33.7	6.2	1.9	100
Tejgaon	60.5	34.4	5.1	-	100	54.1	37.6	7.0	0.6	0.6	100
Lalbag	57.1	37.8	5.1	-	100	66.3	26.5	7.1	-	-	100
Total	37.8	39.9	16.4	5.9	100	34.5	40.5	20.5	3.3	1.2	100

Source: Survey, 1999.

4.5 Perceptions about health services of NGOs and others

To the extent access to health services is concerned it was revealed (Table - 12) in the survey that majority of households (about 39 per cent), across the slums areas, had access to various forms of institutional health services being provided by different service providers for over 5 years. Against this only 4 per cent had access for one year. This variation in the time frame was a function of 'length (years) of stay' of the households in Dhaka City.

Although not reflected in the above table it was found that number of households accessed to institutional facilities was different in different areas. For example, in Agargaon 96.5 per cent of households tried for institutional services of different providers. The remaining was outside the realm of these providers and depended on the traditional modes of treatment. In Tejgaon institutional services were received by 91.1 per cent and they were lowest in Lalbag, only 82.7 per cent. The treatment in these service centers, including in those of NGOs, was for common diseases according to most of the households (98 per cent).

Table 12: Length of Access to Health Services by Households in Government, NGO and DCC Clinics

Slum Area	Years of health services being received				Total	Diseases being treated		
	Up to one	Up to three	Up to five	Above five		Common	Serious	Total
Agargaon	7.7	85.5	86.3	100	100	98.5	1.5	100
Govt.	0.9	4.3	14.5	80.3	100	96.6	3.4	100
NGO	3.8	45.2	40.0	11.0	100	99.5	0.5	100
DCC	-	-	-	-	-	-	-	-
Tejgaon	7.4	44.2	62.1	100	100	98.0	2.0	100
Govt.	1.7	8.7	19.1	70.4	100	98.3	1.7	100
NGO	4.5	43.9	43.9	7.6	100	98.5	1.5	100
DCC	13.0	13.0	34.8	39.1	100	95.7	4.3	100
Lalbag	33.3	119.4	52.8	100	100	96.4	3.6	100
Govt.	3.9	15.7	19.6	60.8	100	98.0	2.0	100
NGO	20.0	60.0	20.0	0.0	100	100.0	0.0	100
DCC	16.7	59.3	14.8	9.3	100	94.4	5.6	100
Total	4.4	28.9	27.9	38.7	100	98.0	2.0	100

Source: Survey, 1999.

The above Table-12 on a separate account for the NGOs revealed that maximum i.e. 45 per cent of households had access to NGO health services for three years, 41 per cent for 5 years, and 10 per cent for above 5 years (Table - 13). This variation in timeframe had a link with duration of the available NGO health services in the slums. On the other hand, according to a minority of households (15.3 per cent) services were available only to the registered member-beneficiaries.

Table 13: Availability of Health Services Provided by NGOs

Slum Area	Years of health services being received				Total	Persons being treated
	Up to one	Up to 3	Up to 5	Above five		Registered only
Agargaon	3.8	45.2	40.0	11.0	100	14.5
Tejgaon	4.5	43.9	43.9	7.6	100	25.8
Lalbag	20.0	60.0	20.0	-	100	0.0
Total	4.3	45.2	40.6	10.0	100	15.3

Source: Survey, 1999.

The health services accessible to the slum dwellers by different providers should also be viewed from the perspective of type of services households were really getting. To this end, households were asked to report their comments. According to the majority (about 40 per cent), across the areas and service providers, 'doctor's prescription' was the only type of service followed by 'prescription plus limited supply of required medicines' (36 per cent). Only about 10 per cent responded in favor of hospital/clinic based treatment (Table - 14).

For the above services **frequency of visits** by households to the facilities of different providers was captured on the basis of ranking done by individual households. It revealed that government hospitals were most frequently visited followed by NGO clinics. DCC clinics were visited the least as because basic services were not available in most of the clinics as opposed to the others.

Table 14: Types of Medical Services Received by Sources

Slum Area/ Service Provider	MBBS Doctor's treatment	Prescription and medicine	Hospital/ clinic based treatment	Referral	Follow-up	Pathological test	Total
Agargaon	37.7	32.4	15.6	0.3	3.7	10.3	100
Govt.	45.5	34.9	10.1	-	1.0	8.4	100
NGO	32.3	31.4	19.3	-	5.4	11.6	100
DCC	72.7	-	0.0	27.3	-	-	100
Tejgaon	43.0	42.6	0.2	-	13.5	0.7	100
Govt.	42.9	42.5	0.4	-	13.1	1.1	100
NGO	42.5	41.8	-	-	15.7	-	100
DCC	45.7	45.7	0.2	-	13.5	0.7	100
Lalbag	40.0	37.9	3.5	0.4	14.4	3.9	100
Govt.	41.6	38.2	5.8	-	9.2	5.2	100
NGO	29.4	29.4	-	-	29.4	11.8	100
DCC	38.9	38.9	3.5	0.4	14.4	3.9	100
Total	39.4	35.8	9.9	0.2	7.8	6.9	100

Source: Survey, 1999.

With regard to supply of life saving drugs 97 per cent of households expressed that it was 'not enough' in the government hospitals. Whilst it was 'enough' in supply in NGOs' health service centers according to 63 per cent of households. In case of **supply of common drugs** government hospitals were also lagging far behind the NGO clinics in the opinion of majority of households (Table - 15).

Table 15: Availability of Drugs in Health Service Delivery Centers

Availability of Drugs	Agargaon			Tejgaon			Lalbag			Total		
	Govt.	NGO	DCC	Govt.	NGO	DCC	Govt.	NGO	DCC	Govt.	NGO	DCC
Life Saving												
Enough	3.6	78.9	-	3.3	16.4	13.0	-	40.0	2.3	2.9	63.0	6.0
Not Enough	96.4	21.1	-	96.7	83.6	87.0	100	60.0	97.7	97.1	37.0	94.0
	100	100	-	100	100	100	100	100	100	100	100	100
Common			-									
Enough	26.3	95.1	-	29.0	61.8	77.3	1.6	100	25.0	23.2	86.9	42.4
Not Enough	73.7	4.9	-	71.0	38.2	22.7	98.4	-	75.0	76.8	13.1	57.6
Total	100	100	-	100	100	100	100	100	100	100	100	100

Source: Survey, 1999.

In order to discern the extent to which NGOs' efforts in the field were getting root at the beneficiary level household awareness about their health delivery system was measured during the survey. The findings, on average, suggested that around 90 per cent of households were aware of the health delivery system of the concerned NGOs. And out of them 90 per cent were aware about two important characteristics of the system of individual NGOs. Also, according to 74 per cent of them health services were not available to non-members (Table - 16).

Table 16: Awareness about Health Delivery Systems of the NGOs

Slum Area	Awareness of the system			Not aware	Is health delivery system available to non-members?		
	Aware of one	Aware of two	Total		Yes	No	Total
Agargaon	3.8	96.2	100	6.7	37.7	62.3	100
Tejgaon	24.2	75.8	100	15.0	0	100	100
Lalbag	0	0	0	100	NA	NA	NA
Total	10.0	90.0	100	10.7	26.3	73.7	100

Source: Survey, 1999.

Lastly, attempts were made to take note of households' overall assessment of health services being provided by different actors on two major accounts viz. 'quality of treatment' and 'influence on health improvement' (Table - 17). Regarding first account 70 per cent of households replied that it was 'satisfactory', while 15 per cent noted it to be good. Only 15 per cent said it to be poor. With regard to the second account, about 54 per cent commented that it was having moderate influence as against 29 per cent who said it was having good influence. Only 18 per cent said it had poor influence.

Table 17: Households' Assessment of Health Services Provided by Different Actors

Slum Area	Quality of treatment				Influence on health improvement			
	Good	Satisfactory	Poor	Total	Good	Moderate	Poor	Total
Agargaon	26.2	60.4	13.5	100	40.7	45.9	13.4	100
Tejgaon	3.3	79.7	17.0	100	19.4	66.8	13.7	100
Lalbag	1.7	82.8	15.5	100	7.0	53.9	39.1	100
Total	15.4	69.7	14.8	100	29.0	53.4	17.6	100

Source: Survey, 1999.

4.6 Perceptions about sanitation facilities of NGOs and others

Supply and installation of slab latrines (water sealed) by the NGOs and others are considered as sanitation services rendered to the community. The coverage of sanitary latrines in the slums was recorded in Table - 18 that showed 78 per cent of households in the slums used sanitary latrines and little more than 16 per cent used both sanitary and open (hanging) latrines. The NGOs, according to about 50 per cent of the households, provided the sanitary latrines, meaning that NGOs were the main providers of sanitary latrines in the slums (Table - 19). DCC happened to be the second largest source of sanitary latrines but in most cases their latrines were found not very user-friendly and technically faulty as opposed to the ones provided by NGOs.

Table 18: Coverage of Sanitary Latrines

Slum Area	Latrines used			
	Sanitary	Open	Both	Total
Agargaon	74.5	9.0	16.5	100
Tejgaon	70.1	4.5	25.5	100
Lalbag	100.0	-	-	100
Total	78.0	5.9	16.1	100

Source: Survey, 1999.

Table 19: Providers of Sanitary Latrines

Slum Area	Self	NGO	DCC	Others*	Total
Agargaon	4.1	30.8	41.0	24.1	100
Tejgaon	23.6	39.1	23.6	13.6	100
Lalbag	-	100.0	-	-	100
Total	8.4	49.9	26.3	15.4	100

Source: Survey, 1999.

Although various organizations are providing sanitary latrines but comparing to the need of the population the number of latrines was still not sufficient as per majority (66 per cent) of responding households (Table - 20). As to the extent of awareness about modes of delivery of sanitation services of the individual NGOs, 80 per cent of households reported that they knew about them. Of them 74 per cent knew about two important characteristics of the individual modes (Table - 21). About level of satisfaction with these modes, 29 per cent of households found them satisfactory, 43 per cent 'partly satisfactory', and 29 per cent 'not satisfactory' (Table - 22).

Table 20: Sufficiency of Sanitary latrines by Households

Slum Area	Sufficient	Not Sufficient	Total
Agargaon	27.9	72.1	100
Tejgaon	22.3	77.7	100
Lalbag	59.2	40.8	100
Total	34.0	66.0	100

Source: Survey, 1999.

Table 21: Awareness about Sanitation Systems of NGOs

Slum Area	Aware about the system			Not aware about the system	Total
	About one characteristic	About two characteristics	Total		
Agargaon	42.2	57.8	100	22.6	100
Tejgaon	18.8	81.2	100	37.3	100
Lalbag	6.1	93.9	100	-	100
Total	25.8	74.2	100	21.1	100

Source: Survey, 1999.

Table 22: Satisfaction about Mode of Delivery of Sanitation by NGOs

Slum Area	Satisfactory	Partly satisfactory	Not satisfactory	Total
Agargaon	20.7	51.7	27.6	100
Tejgaon	13.0	34.8	52.2	100
Lalbag	52.0	34.7	13.3	100
Total	28.8	42.6	28.5	100

Source: Survey, 1999.

4.7 Perceptions about water services of NGOs and others

The source of drinking water of majority (54 per cent) of households was tube well, whilst 38 per cent mentioned about pipe-water supplied by DWASA. 8 per cent used dirty supply water as available due to leakage of the water line for drinking purpose (Table - 23). The NGOs were the largest provider of safe water, as per 55 per cent of households, and the influential people who got illegal connections were the second largest providers, as per 31 per cent of households. The NGOs made safe water available mainly through installation of Tubewel, whilst connection with DWASA main pipeline is comparatively a recent trend (Table - 24).

Table 23: Sources of Drinking Water

Slum Area	Clean supply water	Dirty supply water	Tubewel	Total
Agargaon	18.8	11.4	69.8	100
Tejgaon	91.7	8.3	-	100
Lalbag	-	-	100	100
Total	37.6	8.2	54.1	100

Source: Survey, 1999.

Table 24: Safe Water Provider

Slum Area	Tap water provider							Tubewel			
	WASA	NGO	DCC	Legal private	Illegal private	Illegal influential	Total	NGO	DCC	Private	Total
Agargaon	-	-	-	16.7	1.4	81.9	100	82.0	14.4	3.6	100
Tejgaon	1.6	85.2	6.3	5.5	-	1.6	100	-	-	100	100
Lalbag	-	-	-	-	-	-	-	79.6	20.4	-	100
Total	1.0	54.5	4.0	9.5	0.5	30.5	100	74.9	14.8	10.3	100

Source: Survey, 1999.

The supply of water in different areas according to 36 per cent of households was 'fully available' but as per the majority (58 per cent) it was 'moderately available'. This categorization in individual slum areas has been shown in Table - 25.

Table 25: Availability of Safe Water as Per Need

Slum Area	Availability			
	Fully available	Moderately available	Poorly available	Total
Agargaon	29.4	61.6	9.0	100
Tejgaon	32.5	63.1	4.5	100
Lalbag	58.2	39.8	2.0	100
Total	35.7	58.0	6.3	100

Source: Survey, 1999.

Households' awareness about water supply system of the NGOs was also recorded. About 80 per cent of households responded that they knew about the system, amongst them 66 per cent knew about two of its main characteristics (Table - 26). The management system of water supply at the beneficiary level developed by the NGOs, across the board, promoted either community control in various organizational forms or direct NGO control. Keeping this in mind, during the survey it was tested if the actual control of the system was laid with the community management committee or the NGOs or with someone else not anticipated. The result has been presented in Table - 27. Maximum respondents (58 per cent) opined that control of the system was with the community management committee. However, control by the local influential people, not anticipated in the system, was also pointed out by a big margin (36 per cent) of households. These local influential people, according to 99 per cent of households, were also slum dwellers.

Table 26: Awareness about Two Main Characteristics of Water Supply System of NGO

Slum Area	Awareness about characteristics			Total
	Aware about one characteristic	Aware about two characteristics	Not aware of the characteristic	
Agargaon	16.1	65.9	18.0	100
Tejgaon	20.4	58.6	21.0	100
Lalbag	3.1	76.5	20.4	100
Total	14.9	65.7	19.4	100

Source: Survey, 1999.

Table 27: Actual Control of Operation and Management of Safe Water Provided by NGOs

Slum Area	Community committee (CC)	A few of CC	Direct provider	Local influential	Total	Local influential		
						Slum dweller	No-slum dweller	Total
Agargaon	47.3	7.4	-	45.2	100	100	-	100
Tejgaon	48.8	-	6.5	44.7	100	96.4	3.6	100
Lalbag	100.0	-	-	-	100	-	-	-
Total	58.4	3.6	2.1	36.0	100	98.6	1.4	100

Source: Survey, 1999.

Households' opinions about the above prevailing control mechanism for water supply management revealed that 90 per cent of them were satisfied with the community or NGO management (Table - 28). Against this, 72 per cent of households were satisfied with the

management control exercised by local influential group. This comparison provides a clear indication that management control exercised by the community or NGOs was more acceptable to the slum dwellers than that exercised by the influential local group. Regarding reasonability of cost structure of water supply implemented by NGOs but administered by management committees (including price of water, mainly for pipe water and maintenance of the installations, mainly for tube wells), 56 per cent opined it as reasonable.

Table 29: Opinion about Management of Water Supply and Price Charged by NGOs

Slum Area	Is management by CC or the NGO satisfactory?		Total	Is management by local influential satisfactory?		Total	Is price for water charged by NGO reasonable?		Total
	Yes	No		Yes	No		Yes	No	
Agargaon	85.2	14.8	100	83.3	16.7	100	33.3	66.7	100
Tejgaon	89.9	10.1	100	51.4	48.6	100	26.5	73.5	100
Lalbag	94.8	5.2	100	-	100.0	100	97.7	2.3	100
Total	89.3	10.7	100	71.6	28.4	100	56.2	43.8	100

Source: Survey, 1999.

4.8 Contribution of water and sanitation services to household health improvement

An assessment of overall contribution of the water and sanitation services to household health improvement was also done from the perspective of the households. Thus, according to majority of households (78 per cent) this contribution was moderate (Table - 30).

Table 30: Contribution of Water and Sanitation Services to Household Health Improvement

Slum Area	Great contribution	Moderate contributing	Poor contribution	No contribution	Total
Agargaon	0.4	69.9	23.3	6.4	100
Tejgaon	1.3	81.3	17.4	-	100
Lalbag	-	91.8	8.2	-	100
Total	0.6	77.7	18.5	3.2	100

Source: Survey, 1999.

In the above context, it seemed important to point out the effects of a collapse of NGO supports for the above services on the household health status. To this end, households were asked to give their opinions. The exercise showed that 6 per cent of the households did not believe that NGO support would ever come to an end. From amongst the remaining, 60 per cent opined that the collapse of NGO supports would have terrible effects on their overall health and sanitation status. However, according to 39 per cent of households this would have little effects (Table - 31).

Table 31: Effects of a Collapse of NGO Supports

Slum Area	Effects				
	Terrible effects	Little effects	No effects	Do not know	Total
Agargaon	66.4	32.4	0.4	0.8	100
Tejgaon	32.9	66.4	0.0	0.7	100
Lalbag	86.7	13.3	0.0	0.0	100
Total	60.0	39.2	0.2	0.6	100

V. Observations and Recommendations

Overall observations and recommendations have been developed in this chapter based primarily on the findings and analysis of the main tasks carried out in the study. In addition, review of relevant literature on the subject and interviews with the key informants in slum areas also provided valuable inputs to this chapter.

Observations

- NGOs in Dhaka City started to emerge in late eighties with the rapid slummization in the city having a focus on health and sanitation activities. Beginning from the nineties their numbers started to increase with new comers incorporating diverse activities in the field of health, water and sanitation and micro credit.

- NGOs emphasizing on health program, although smaller in number, tended to be larger compared to other categories of NGOs engaged in all three fronts i.e. health, water and sanitation. However, there was a significant increase of the latter category over the last five years with a larger coverage of population, indicating the urgent need in this area by population living in the slums.

- The magnitude of NGOs interventions in the relevant fields was still inadequate compared to the actual need and problems faced by the slum dwellers.

- There were obvious overlapping of beneficiaries and areas covered by different categories of NGOs. This overlapping was higher where number of NGOs was also higher.

- NGOs' programs were highly dependent on donor assistance, provided mostly by foreign donors. Donors' guidelines and priorities have had important bearing for design and implementation of concrete project activities implemented by NGOs. The programs in the public sector, run by DCC, were also largely dependent on foreign assistance.

- There was a lack of coordination amongst the NGOs resulting in wastage of resources as well as gap in understanding amongst the NGO community about the problems faced by the slum dwellers. This problem had also a direct link with the lack of coordination amongst the donors' whilst they response to individual projects.

- Methods and approaches applied by the concerned NGOs in the field of health, water and sanitation were more or less the same as well as very typical. They were designed based on NGOs' own experience and lessons as well as on the same of others, including, the donors and government. In this overall context, there was a recent trend suggesting that active community participation in operation and maintenance of service deliveries was slowly getting a root on some institutional framework and dominating role of women in the community. The implication of this trend was very important, notably, with regard to supply of tap water in the community. The community was assured of having tap water on a sustainable basis, whilst government was also earning its revenue from water supply.

- The privately managed systems were, on the other hand not accountable to anybody, being operated illegally in most cases. It was learned during the survey that recently WASA had connected some of the illegal water taps with meter and permitted other individuals to do water business in the same way to minimize revenue/system loss in water supply. However, in this arrangement under-dealing with the revenue collectors to pay less to the authority through under-billing was reported. The loss of revenue of the authority was jointly shared between the revenue collectors and the private connection holders. The implication of this kind of operation had an adverse effect on the popularity of Community Managed water points in some areas, as long as the services of the latter appeared to be costlier to the users.

- NGOs had obviously serious stakes both in terms of providing services to the beneficiaries and surviving their own entities. This was particularly true for the medium and small NGOs working mainly in urban setting.

- The long-term sustainability of the NGO programs critically depended on their capacity to coordinate amongst them as well as integrate the programs with the government ones to get much needed institutional as well as infrastructural support.

- The people living in the slums were barely meeting their needs for health, water and sanitation in spite of the interventions made by NGOs and others. It was because basic service deliveries for the poor did not have any coverage of well-formulated policies, strategies, and concrete steps at the macro level.

- Slum dwellers' problems became much more complicated and serious as they were always exposed to evictions sponsored by the government and groups of vested interest.

- The purely government institution-based services in the field were not target-oriented. This was true for the population living in the slums. Only DCC had the mandate and some ongoing target programs for the slum dwellers. The services provided by them were not responsive to the need of the population both in terms of coverage and quality of services.

- Hitherto, DCC's efforts in addressing slum dwellers' problems were also on purely adhoc basis with some support from multi- and bilateral donors. There was no serious thought and well-designed plan to respond to the needs of slum dwellers in the relevant fields. Government attitude and actions, no doubt, had a link with this kind of situation.

- Despite many limitations and low coverage in terms of inputs, services of the NGOs in health, water and sanitation areas for the beneficiaries had, indeed, benefited them to a great extent and impacted positively on their health improvement.

- The accessibility to NGO health services by poor was much better than to those provided by the government sector. However, due to the scale and institutional strength government services were still covering larger population for all types of health services, particularly, for serious diseases. With regard to water supply, public organization like DWASA could still provide better services, if planned and jointly implemented by the NGOs. In sanitation public sector intervention is negligible.

- The magnitude and diversity of the problems associated with health, water and sanitation facilities in the slums were so vast that any kind of partial and isolated efforts by any organization would not have a significant impact on overall improvement of the prevailing situation. In this regard, the question of ensuring bold and effective community participation, emphasizing on women, was considered to be very critical.
- In the overall context it was revealed that people living in slums would be seriously affected if obstacles were created to the implementation of NGO activities.

Recommendations

- There should be a national consensus on the broad policy framework of urbanization in the country. In this regard, opinions and experience sharing with different stakeholders, including NGOs and community people, are very much needed.

- Based on long-term policies concrete steps in consultation with participation of the community, notably of women, and other stakeholders, including NGOs, should be developed and implemented for resettlement of slum as well as other displaced and floating population of the country.

- Policies, programs and strategies in the field of health, water and sanitation targeting the urban poor should be formulated based on meaningful dialogue and coordination amongst the public sector organizations, donors, NGOs and other private organizations willing to contribute in the sector. The same spirit should also prevail during implementation of program activities. As stated above, active community participation, emphasizing women, should be crucially important to determining appropriateness and sustainability of the program activities in the long run.

- Government machinery should view NGO activities to be complimentary to government target programs and utilize existing NGO networks to deliver services efficiently at the grass roots.

- Inter NGO collaboration and cooperation should be developed with more emphasis on general principles and specific activities to be carried out in the field.

- To be guided by pragmatic policies and programs, NGO interventions in the fields of health, water and sanitation for the benefit of poor population, across the country, should be placed in their true perspective at the national level where appropriate coordination has to be achieved.

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Institution level information and documents of the surveyed NGOs in the relevant fields.

Annex-1

Terms of Reference of the Study

1. To assess magnitude of the health and sanitation programs and activities of selected NGOs in health, water and sanitation sector for the disadvantaged population living in the slums in the Dhaka City.

2. To review main characteristic features of the above program interventions incorporating beneficiary profile, nature of interventions, delivery mode of respective actors etc.

3. To highlight major results achieved through implementation of the programs from the viewpoint of beneficiaries.

4. To analyze perspectives of the NGOs as well as beneficiaries with respect to health, water and sanitation programs.

5. To develop recommendations for sustained improvements in health, water and sanitation for the urban poor in future.

Annex-2

Matrix of Salient Features of Health, Water and Sanitation Programs of NGOs in Dhaka City Slums

Name of NGO	Name of Health, Water and Sanitation Program	Target group(s) of the Program	Activities of the Program(s)	Modes/Approaches of Service Deliveries	Cost Recovery of the Programs/Components	Financial Sustainability of Program/Components	Impact monitoring of Program/Components
HEALTH NGOs							
1. CONCERN - Bangladesh	Health & Nutrition Program	• Women of reproductive age. • Children aged below 5 years.	• Treatment and prevention of malnutrition. • Immunization. • Antenatal care. • Post- natal care. • Health education & growth monitoring. • Training of traditional birth attendants.	• Group formation of the beneficiaries based on survey. • Health education is provided in-groups. • Satellite- clinic based treatment of the group members by the qualified doctors and other medical staff. • TBA training is also conducted at the clinics. • Use of contact women from the community to work as a link between CONCERN and the community in providing health care services.	• All medical services are provided to the beneficiaries free of cost.	• Sponsorship and grants from abroad.	• Regular field visits. • Special visits by senior personnel. • Treatment records of the beneficiaries. • Follow-up health training sessions. • Observation and recording of health practices of the beneficiaries at the household levels. • Monthly meting of the staff. • Activity-reporting in written form. • For measuring target-achievements of individual activities objectively verifiable indicators are used.
2. Bangladesh Women's Health Coalition (BWHC)	Clinical Program	• Women, adolescent, and children.	• Counseling. • Immunization. • General health cares for women and children. • Family planning. • Menstrual regulation (MR) services • Obstetric care • RTI/STD/HIV. • Health education. • Vitamin A distribution. • Referral. • Pathological test. • Nutritional and required medical care of the malnourished babies of less than 5 years. • Collaborative activities of different nature for the target population with different public bodies (including DCC) and other NGOs.	• Integrated reproductive health care of registered women and children through a center in Agargaon slum encompassing static clinic, satellite clinic and male evening clinic. • The center is capacitated with one Medical Officer, three Paramedics, one counselor, one Clinic Assistant, one Clinic Health Educator, and one Educator.	• Nominal fees for the services paid by the registered members of the programs.	• Sponsored by the donors • Partly by the service charges paid by the beneficiaries.	• Periodic operation research and evaluative studies are undertaken to review performance of the programs as well as enrich MIS of the organization.
3. GHORANI	Health and Nutrition	• Men, women and children of all ages living in the slums.	• Treatment and supply of medicines. • Health awareness training. • EPI • Vitamin distribution. • Supply of oral saline and water purifying tablets.	• Weekly visits of doctor to slums for delivering health services. • Health workers organize patients prior to the above visits by doctor.	• No mechanism of cost recovery of the services.	• Donations from mainly local sources.	• No system is yet been in practice.

4. Community Health Care Program (CHCP)	Community Health and Family Welfare	• Primarily women and children of the slums.	• Health, family planning and nutrition education. • Immunization. • Control and treatment of TB. • Reproductive health care services. • Ante natal and post natal care of pregnant mother. • Prevention and control of water born diseases. • Control of STD/AIDS/HIV. • Water supply and sanitation. • Curative services specially to mothers and children for simple ailments. • Assistance to physically handicapped etc.	• Medical services are provided through base clinic, health posts (satellite clinic) and mobile clinic as far as practicable attended by fulltime medical officer.	NA	NA	NA
5. Shakti Foundation for Disadvantaged Women	Health Program	• Women and children of the slum covered by the credit program.	• Preventive health education. • Curative treatment. • Loan for emergency treatment. • Additional services.	• In the weekly center meetings of credit groups discussions are held about personal hygiene, prevention of communicable diseases (including HIV), family planning, safe motherhood, immunization, etc. • Own female doctors are engaged for check up and primary treatment of the members through four health centers. • Creation of health loan fund with the members' savings and grants of donors. In each branch a Health Committee is constituted with seven members from the beneficiaries. This committee verifies and recommends Health Loan Applications, fixes terms and conditions for disbursement and repayment of loans as well as follows up utilization of loans. • In additional services common medicines are provided to the members at cost price. The services of the health center are also open to non- beneficiaries (female patients of all ages and boys up to 12 years of age) and family members of the beneficiaries.	• One-time registration fees of Tk. 25.00 per member for health services. • Tk. 1.00 weekly fee is also charged per member for health service. • For each doctor's consultancy Tk. 5.00 is charged.	• Contributions of the beneficiaries and donors.	• Register book of the patients, monthly reports, periodic disease-wise report, etc.
6. Bangladesh Association of Women for Self-Empowerment	Health Education	• Slum dwellers of all ages and sexes.	• Education in health and hygiene practices for prevention of diarrhea.	• Beneficiaries of the credit groups are provided health education in smaller groups.	• This program was provided free of cost only for the project period.	• Did not continue after termination of the project support.	• Monitored during the implementation period both by the NGO staff as well as by the sponsoring organization.

7. Participatory Development Action Program (PDAP)	Program - I • Health Program Program - II • Environment Program	• Slum dwellers of all ages and sexes.	Program - I • EPI • Outdoor treatment. • Contraceptive distribution. • Ante natal and postnatal care. • Health awareness for adolescents. • Health education. Program - II • Garbage management. • Construction of water point. • Installation of sanitary latrines. • Health awareness.	Program - I • The doctors and health workers provide central and satellite clinic based outdoor services. • Medicine is provided partly free of cost. • Health awareness and education provided through small groups of beneficiaries and their children, including, adolescents. Program - II • Management committees from amongst the beneficiaries are formed through which installations are provided. • Health awareness is conducted in-groups separately for different focus groups.	Program - I • Medical services are provided for the beneficiaries with a registration fees of Tk. 5.00 for each. • In addition to the above each patient is charged Tk. 2.00 for outdoor consultancy. Program - II • Provided free of cost.	• Community contribution and grants. • Local peoples' donation.	• Observations during field visits and group discussions with the beneficiaries.
WATER & SANITATION NGOs							
8. Center for Development Services (CDS)	Water and Sanitation Program	• Slum dwellers of all ages and sexes.	• Tube well installation. • Slab latrine installation. • Health education. • Solid waste management.	• User's group formation. • Committee formation, consisting of the members from each group, for overall operation and management of the service-installations. • Health education is provided through sessions in small groups.	• 25% of the cost of service installations is recovered from the users own contribution paid to the organization in 12 monthly installments.	• Sponsorship and grants from abroad. • Income from the economic empowerment program.	• Regular field visits. • Meeting with the community people. • Monthly project meeting. • Various reports, including annual report, highlighting status and achievement of the program activities.
9. ARBAN	Program -1 Water Supply and Hygiene Education Program Program -II Water Environment Service Program	Program - I • Slum dwellers of all ages and sexes. Program - II • Women of the slum.	Program - I • Construction of water points with a legal arrangement with DWASA for maintenance and payment of water bills. • Hygiene education. Program - II • Tube wells and slab latrine installation. • Hygiene education.	• For each water point beneficiary group is formed consisting of women members. They elect a Management Committee for day to day operation and management of water supply in the community. In addition, an Advisory Committee consisting of the male leaders of the community is also formed in order to integrate and ensure males participation and assistance to the whole operation of water supply and management. • Hygiene education is conducted through groups.	Program -I • Construction costs of the water points are provided to the community as credit that is recovered through monthly installments in two years with a 6-month grace period. Program - II • Provided without any type of cost recovery.	Program - I • Community bears the responsibility of making the water service facilities financially viable in the log run. Program - II • Grant support of the donors and the beneficiaries' own contribution.	• Meeting with community people, field-visits, weekly and monthly meetings, monthly and annual/annual reports. • Follow-up heath sessions for the health services.

10. Bangladesh Agricultural Working Peoples' Organization (BAWPA)	Water and Sanitation	• Slum dwellers of all ages and sexes focussing on women and children.	• Construction of water supply points connected with running water under an agreement with DWASA. • Installation of tube wells, slab latrine and hygiene education. • Solid waste management. • Construction of sanitation block having both latrines and bathing spaces separately for women and male under one shed. The waste of this block is connected with the DWASA mains, where possible, or with a septic tank attached with the block. • Hygiene education.	• Sanitary latrines are mostly provided through small groups; each group consists of 4-6 beneficiaries. Latrines are also provided to individuals, to a lower extent. In this way sanitary latrines cover the whole community. • For each tube well installation, the female beneficiaries, representing 25 families, form a management committee consisting of one Chairperson and 4 members. • Hygiene education is conducted for the beneficiaries of slab latrines and tube well, in- groups. • For water point construction and services, BAWPA plays the role of an intermediary (so called social inter-mediation) between DWASA and the community to enable the community people getting access to safe water. In this regard female community population is organized in a forum for each water point, which undergoes an agreement with BAWPA for financing and repayment of the construction costs of water points. • An elected management committee comprising women beneficiaries is constituted for day-to-day operation, maintenance and management of each water point. Mainly to support this committee an advisory committee comprising male leaders of the community is also formed. • Installation of slab latrine and tube wells is also made through the above committee. The installations are provided to the community as loan. • Doctors and health workers provide hygiene education in-groups.	• Construction costs of the water points and sanitary blocks are recovered in 18 monthly installments having a grace period of 3 months. • Costs of tube well installation are recovered fully in 18 monthly installments. • Costs of sanitary latrines are repaid by the user(s) in full in 50 weeks.	• Community contribution.	• Observations, regular contact and meeting with the community etc. • Follow up sessions for hygiene education and feed back of the health workers.
11. SEP-Bangladesh	Water and Sanitation (CUP/UNICEF)	• Slum population of all ages and sexes.	• Health education. • Tube well and sanitary latrine installation.	• Installations are provided through groups consisting of 5-10 female beneficiaries. A committee is also constituted for each group headed by a President and all others as members.	• Tube well cost is recovered in full through monthly installments within a flexible timeframe. • For one slab latrine the group members pay a total of Taka 200.00 at the time of procurement.	• Grants, contribution of the beneficiaries, and income of the credit program.	• Observations, groups members' meetings and reporting of the monitoring team (CUP).

HEALTH, WATER & SANITATION NGOs							
12. PRODIPON	Program - I Working Children Welfare Program Program - II Water, Sanitation and Health Services Program in the Slums	Program - I • Children aged below 14 years working in the factory. Program - II • Slum dwellers of all ages and sexes.	Program - I • Organization and awareness building. • Literacy campaign. • Health services, including, medical check up, treatment, medicine supplies and health education. Program - II • Hygiene education • Tube well installation. • Slab latrine installation. • Solid waste management.	Program - I • Clinic based activities staffed with qualified doctors and nurses. Program - II • Health education provided through sessions in small groups. • Tube well and sanitary latrine installations are done though committees to ensure cost recovery as well as operation and maintenance of the installations. Thus, for each tubewl members of 2-3 beneficiary-groups (each group consists of 20 - 30 female members) elect a 5-member committee. This committee includes a minimum number of male representations from the community. On the other, one slab latrine is installed for 100 families in a cluster. For each latrine a 5-member committee is also formed from the users where a balance is made between the male and female representation. Further, for each type of the installations a 5-member central committee is also formed taking one member from each of the primary committees for overall management and operation of the installations at the community level.	Program - I • Annual registration fees per child to the amount of Tk. 20.00. Against this all services are provided without costs. Program - II • Full recovery of costs by monthly installments in a period of two and half years with a grace period of six months. • 25% cost recovery of the slab latrines in a two-year period through weekly installments.	• Continuous financial support of the donors and through the beneficiaries' own contribution.	• Continuous dialogue with the beneficiaries, reporting of the field staff, and monthly coordination meetings.
13. Jubo-Jiban Advancement Committee (JAC)	Program - I Sanitation Program Program - II Water Supply Program	• Slum dwellers of all ages and sexes.	Program I & II • Slab latrine and tube well installation. • Health education.	• Each tube well is installed for a group of 20-25 female beneficiaries who also are the members of credit groups. For day-to-day operation and repayment of the cost of installations a Management Committee comprising 5-7 female members of the above group is formed. Further, a 4 to 5-member Advisory Committee consisting of male leaders of the community assist this committee. • Each family belonging to the credit program is provided one slab latrine under a separate arrangement reached with the beneficiary families. • Health education is conducted in small groups.	Program -I • 25 % cost of the sanitary latrines is recovered through weekly installments in ten weeks. • Costs of tube well installations are recovered in full amount in 30 monthly-installments. Program - II • Conducted free of costs.	• Grants and the beneficiaries' own contribution.	• Meetings with the community people and observations.

14. Action Aid	Program -I Health Program Program - II Water and Sanitation Program	Program - I & II • Slum dwellers with an emphasis on women and children.	Program -I • EPI • Pre- and Post-natal care. • Child health cares. • Consultancy. • Health education to schoolchildren. • Emergency medical fund or heath loan. • TBA training. • Nutritional food distribution during emergencies. Program - II • Tube well and slab latrine installation.	Program - I • Medical services are provided through satellite clinic attended by the qualified doctors and nurses 4 days a week. • Interest free health loan is provided to only the credit members from their own savings in the group. Program - II • Groups are provided tube wells and slab latrines managed and supervised by committees formed by the beneficiaries.	Program - I • One time registration fees of Tk. 50.00 per member. • For each consultancy registered members also pay Tk. 10.00. • Non-registered patients should pay Tk. 15.00 for each consultancy. • In the above cases no additional costs are paid for other services. • Health loan is repaid based on the individual capacity of the borrowers, governed by the group. Program - II • Totally free of cost.	Program - II • Cost sharing by the beneficiaries and outside grants. Program - II • Totally supported by grants.	• Field and door to door visits, and monthly, quarterly and annual reports.
15. Assistance for Slum Dwellers (ASD)	Program - I Health & Hygiene Program Program - II Water and Sanitation Program	• Women, girl adolescents & children.	Program - I • Clinical service. • Pathological tests. • Health education. Program - II • Tube well installation. • Hygiene education. • Behavioral change. • Training of staff, peer educator, caretaker. • Community mobilization.	Program - I • Health workers undertake awareness and motivational activities amongst the girl adolescents groups. • Patients are received at the organizational clinic attended by the doctors. Necessary consultancy and medicines are provided and, if necessary, patients are referred to hospital and other treatment. • Doctor's field visits to follow up the clinic-based treatment are also made twice a week. • Some pathological tests are done at the pathological laboratory of the clinic. Program - II • Management committee is formed for a group of beneficiaries comprising 15 - 20 women to take decisions on taking loans for installation of tube wells. • Following the decision of the committee agreement with ASD is signed for the receipt of loan and installation of tube wells.	Program - II • Nominal charges for consultancy, medicines and pathological tests. Program - II • Weekly or monthly installments for recovery of total costs in 2 years time.	• Donor's support and community contribution.	• Weekly, quarterly and monthly meetings. • Follow-up sessions for health education.

16. Organization for Mother and Children (OMI)	Program I Water and Sanitation Program Program - II Day Care Center & Adolescent Skill Training Program	• Women and children of the slums survey.	Program - I • Tube well and slab latrine installation. • Health education. Program - II • Treatment of patients. • Health education.	Program - I • Committee consisting of 10 members (5 males and 5 females) is formed from the group-beneficiaries. • Installations of tube well and slab latrines are done through the above committee. Program - II • Registered patients of the target population are treated in the daycare center 3 days a week, attended by the doctors and nurses. Available medicines required by the patients are provided at prices lower than 75% in the market. • Health education is provided to target as well as adult male population in-groups.	Program - I • 25% of the costs is recovered by monthly installments in 2-6 months. Program - II • Partly covered by the fees of medicine. • Service charge of Tk. 2.00 for each time at day care center.	Program - I • Entirely based on outside grant support. Program - II • Beneficiary contribution. • Cross subsidy from other income earning programs.	• No systematic efforts at the organizational level, so far.
17. Dushtha Shasthya Kendra (DSK)	Program - I • Primary Health Care Program - II • Water supply and sanitation Program - III • Communit y Hospital	Program - I & Program - II • Slum population with an emphasis on women and children. Program - III • Low-income population of slums and in other areas.	Program - I • Clinic-based curative services. • Outreach services in the form of home visits at individual beneficiary level for delivering health messages and monitoring health practices by the beneficiaries. • Training in health awareness and for TBAs. • Installation of tube wells and sanitary latrines. Program - II • Construction of water points. • Hygiene education and health awareness training. • Installation of tube wells and sanitary latrines. Program - III • Health center (hospital) based secondary treatment.	Program – I • Clinic-based curative cares are provided to only the registered members who are also covered by the credit program. • The above registered beneficiaries are covered by a health insurance scheme under which each has to deposit Tk.2.00 every week on compulsory basis. Against this deposit each beneficiary and other 5 members (two children + husband + her or husbands parents) of her family are entitled to have doctor's consultancy and full dose of medicines other than the antibiotics. In this case 50 per cent of the required amount is provided. • There are 3-4 such clinics at each branch, which are attended by qualified doctors, nurses and paramedics for the services six days a week. • The Community Health Workers conduct home visits to follow up of treatment and also deliver and monitor application of health messages. • Sanitary latrines and tube wells are provided in loan. Program - II • DSK acts as an intermediary between the slum community (consumers) and DWASA to make running water available in a legal way (under a MOU signed between DSK and DWASA) from the DWASA main line. Under this, DSK is liable to pay water bills regularly to DWASA on behalf f the community. • The water is supplied through water points (WP) constructed with the initial investments of DSK. • For each WP there is a Pani Kal Samity (PKS) whose formation and activities are defined by a constitution. Each PKS is composed of 50 -100 women beneficiaries of DSK's other ongoing programs to cover water supply, ideally, for 500 families. There are also a few exceptions where the entire community forms the PKS since it is getting services of the WP. • Mainly for site selection, operation, and maintenance of a WP and collection of bills for water use a 9 -member Management Committee (MC) is elected for every one year by the PKS members. The members of the MC are usually the women leaders in the PKS. The responsibilities of the MC, amongst others, include paying of water bill to DWASA, repaying of construction cost of WP borne by DSK in 30 installments, appointment of caretaker for WP, overall	Program - I • Weekly premium deposits by the beneficiaries. • Repayment of costs for latrines and tube wells in installments. Program -I I • Water tariff collected by the community management committee, which include also costs of construction of water points for the repayment period. • Repayment of costs for latrines and tube wells in installments. Program - III • Treatment fees at structured rates for different services.	Program - I • Community and donor's contribution. • Cross subsidy from the credit program. Program - II • Water bills collected by the community management committee. Program - III • Patients fees and donors contribution.	Program - I & Program - II • Work of central monitoring and evaluation team. • Periodic reporting and community meetings. Program -III • Separate structures for administration and monitoring. • Periodic staff meetings.

				maintenance of the WP, etc. • In addition to MC consisting of only the woman, an Advisory Committee of 5 male leaders of the community is also formed for one year. The main purpose of the Advisory Committee is to assist, protect and advice the MC in performing their activities. • DSK keeps regular contact with the MCs and supervises their overall activities initially for two years during which (as believed) MCs will be strengthened enough to work independently with DWASA without an inter-mediation of DSK. • Sanitary latrines and tube wells are provided in loan. <u>Program - III</u> • Provide all sorts of secondary treatment to low-income population and referrals of DSK's clinics and outreach services at prices affordable to the beneficiaries. The center has a 12-bed capacity equipped with required manpower and logistics to provide quality treatment to the patients for round the clock.			
18. Rural Health and Development Society (RHDS)	Health, Water and Sanitation (LIFE/UNDP)	• Slum dwellers of all ages and sexes.	• Health Training and Hygiene Education • Installation of twin pit latrines and deep tube well. • Construction of water point. • Emergency water supplies. • Solid waste disposal.	• Community mobilization and activity implementation through groups and management committees formed by the community.	• Cost recovery of different installations through installments within a mutually agreed timeframe.	• Community and donors' contribution.	• Field visits, follow-up, workshops, management committee and general meetings of the community people.
19. PLAN-International	<u>Program - I</u> • Environment-al Health Program <u>Program - II</u> • Community Health Program	• Children and women.	<u>Program - I</u> • Installation of tube wells. • Installation of sanitary latrines and bio-gas plant. • By-lane and drainage improvement. • Solid waste management. • Information, education and communication. <u>Program - II</u> • Health awareness. • Base clinic services. • Satellite clinic services. • Hospitalization. • Adolescent club.	<u>Program - I</u> • Household registration, group formation of the beneficiaries. • Formation of three tire committees, namely, (1) Management Committee comprising representatives of Plan International, technical persons and community people; (2) Selection Committee; and (3) Maintenance Committee. The latter two are wholly composed of the people selected by the community. <u>Program - II</u> • Health services are provided through two permanent satellite clinics at the working slum area. • Since it is a child-focus NGO, the youngest child of a family is given an identity card to become a **Foster Child (FC)** member against a registration fee of Tk 20.00. • The above FC member and through him/her all other children and women of a family get health services. In this respect FC member sometime gets full and all kinds of treatment/health services, whereby, other members get only partial services. Across the board, each time services are provided with a fee of Tk 17.00 per patient. • For medicines and necessary pathological tests half of the total costs are borne by the patients. <u>Work via Partner Organizations</u> Plan International also work through other organizations to implement the above programs focussing on the children in the slums.	• All activities in either of the programs are highly subsidized at the moment. This is mainly because that the activities of the organization are still regarded as new and undergoing continuous modifications and adaptation.	• Absolutely dependent on own financial contribution that is mobilized though international fund raising network.	• In-house program specific monitoring teams equipped with different techniques and tools do their jobs. They are stationed in the program implementation area. • Central monitoring teams are also active in this area. • Outside consultants carry out periodic evaluation of program activities.

20. Initiative for Peoples' Development (IPD)	Program - I • Primary Health Care Program - II • Water and Sanitation	• Slum dwellers of all ages and sexes.	Program - I • Outdoor consultancy Program - II • Tube wells and sanitary latrine installation. • Health education.	Program - I • Clinic based weekly consultancy for the patients. Program - II • One tube well is provided for 15-20 families. • One slab latrine is given per family. • Health education is provided in-groups. Each group consists of 20 - 25 beneficiaries.	Program – I • Each time Tk. 2.00 is charged per patient. Program - II • 50% costs of tube well and sanitary latrines are recovered through weekly installments in one year.	Program - I • Consultancy fees. Program - II • Community contribution and grants.	• Observations and group discussions.
21. Aparajeyo Bangla	Slum and Street Children's Program (Healthcare Services Component)	• Slum and street children between 6 months to 18 years of age. • Mothers of the slum children.	• Clinical and consultancy services including medicine supply and pathological tests, for the in- and out-door patients. • Advice on personal health and hygiene education. • Vaccinations. • Health education in-groups. • 50% treatment cost, including, advice on health and family planning services to the mothers of the slum children. • Medicine supplies. • If necessary, referral to the government hospitals or specialized clinics.	• The qualified medical team operates one 20-bed clinic at Arambag under which mobile clinic is also in operation in the area. These facilities are open to registered slum and non-registered street children. Another non-bed clinic is in operation at Kamrangir char of old Dhaka providing services to the registered slum children. • Medical services are provided to the mothers of slum children. • Health education is provided via small children groups by the qualified medical team, including doctors, paramedics and nurses.	• For treatment at Arambag clinic Tk. 1.00 registration fees is charged once for each of the registered children in the slum. No more charges have to pay by the children for the services of the clinic. However, street children in need of treatment have to pay each time Take 1.00 as registration fees. • At Kamrangir Char clinic every time each patient has to pay Taka 5.00 for getting health services at the clinic.	• Ensured mainly through sponsorship and grants from abroad. A small part is covered from the charges paid by the patients.	• Special monitoring team in charge of monitoring of activities as well as assessing impacts on the beneficiaries work based on predefined indicators. • Field visits, monthly meeting, monthly and annual reports, monitoring reports.
22. Prottoy	Program - I • Water and Sanitation. Program - II • Health Service	• Women and children of the slum.	Program - I • Installation of slab latrines and tube wells. Program - II • Outdoor consultancy. • Limited medicine supply. • Health education.	Program - I • Tube wells and slab latrines are provided through committees consisting of members drawn from the beneficiaries. Program - II • Medical services are provided to the credit group-members and also to the members of their families through satellite clinics. They work three days a week and run by the doctors and paramedics. • Health education is provided in-groups.	Program - I • 50% of the costs of the slab latrines and tube wells is recovered from the users through monthly installments in nine months. Program - II • Every time each patient is charged Tk. 2.00 for consultancy. • The patients also pay 50% of the costs of the supplied medicines.	• Community contribution and grants/donation.	• Field visits, community meetings, monthly reports, records of the attended patients (in case of health services), etc.