UPPR

Urban Partnerships for Poverty Reduction
2008-2015

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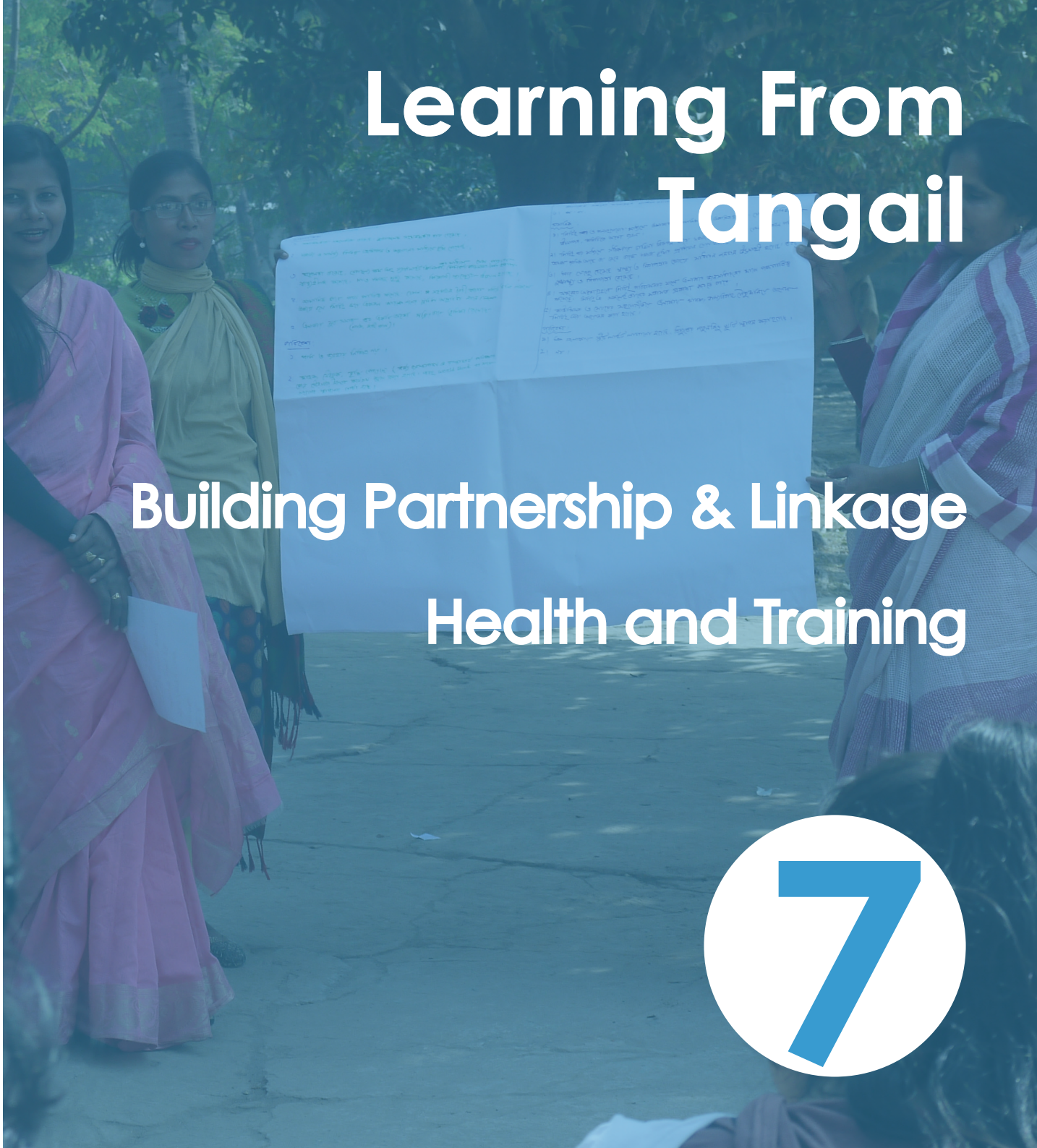


Learning From Tangail

Building Partnership & Linkage

Health and Training

7

About these booklets

This series of booklets are case studies of good practice from the Urban Partnerships for Poverty Reduction (UPPR) Project in Bangladesh and form as part of the documentation of the UPPR Learning and Good Practices study conducted by Spora Synergies. The booklets follow a simple, clear structure reflecting on the practices that are seen as examplar and selected through a series of community based participatory workshops, focus group discussions and key interviews. Each case explains [1] The extent to which the practices or the processes developed through UPPR are innovative; [2] The extent to which they were and are sustainable [environmentally, socially and financially]; [3] The extent to which they are transferable and/or have been transferred locally or nationally and; [4] The key reasons explaining their sustainability and their transferability.

1 Savings and credits, Rajshahi

2 Women empowerment, Rajshahi

3 Community Housing Development Fund (CHDF), Gopalgonj

4 Water and sanitation access, Comilla

5 Water and sanitation, Khulna

6 Creation of a new fund for disaster management, Sirajganj

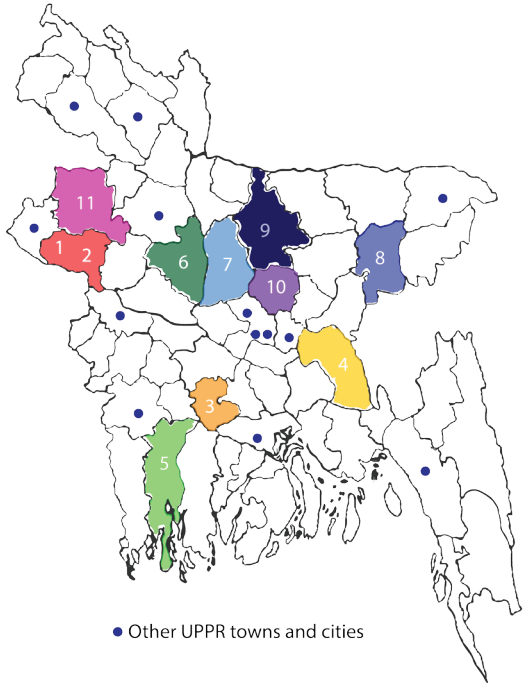
7 Health and apprenticeship, Tangail

8 Health awareness and services, Hobiganj

9 Improve child security and enabling employment of mothers, Mymensingh

10 School attendance improvement, Gazipur

11 Apprenticeship and skill building, Naogaon



Acknowledgements

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About the Urban Partnerships for Poverty Reduction (UPPR) Project, Bangladesh

By developing the capacity of three million urban poor to plan and manage their own development, the Urban Partnerships for Poverty Reduction (UPPR) project enabled the poorest within the nation's urban slums to break out of the cycle of poverty.

Urban poverty in Bangladesh is commonly understood as a chronic, complex and problematic phenomenon related firstly to a lack of skills and capacity for adaptation among a recently urbanized population and secondly, to the capacity and willingness of towns and cities to provide space for housing as well as public services appropriate to ever expanding number of urban citizens. From a local perspective, poverty is commonly understood as the acute absence of a 'social network' or 'social capital'. The lack of access to 'social network' as well as public goods and services, justifies the idea that communities within the urban slums in Bangladesh should be considered as 'excluded' from the essential components of urban wellbeing: land rights, opportunity for decent work, public goods and services, and formal representation in the government.

UPPR recognized that a single project alone cannot achieve all the institutional and infrastructural reforms that are needed in the cities of Bangladesh. Thus, UPPR supported poor urban communities to establish partnerships with other development actors, government institutions and the private sector. Capitalizing on this collective reach, slum dwellers were better able to access basic services as well as the job market.
UPPR began its work in 2008 in coordination with its institutional partner (and host) the Local Government Engineering Department (LGED) of the Government of Bangladesh. In the towns and cities in which UPPR worked, it did so jointly with the Municipality or City Corporation. The United Nations Development Programme (UNDP) managed the implementation of the project, and UN-Habitat supported the components that work on improving living conditions. Beyond the contributions of these actors, the majority of funding was provided by the UK Government.

Main purpose and outputs of the UPPR Project

Purpose
Livelihoods and living conditions of three million poor and extremely poor, especially women and children, living in urban areas, sustainably improved

Outputs
1. Mobilisation: Urban poor communities mobilized to form representative and inclusive groups and prepare community action plans

2. Settlement Improvement Fund: Poor urban communities have healthy and secure living environments

3. Socio Economic Fund: Urban poor and extremely poor people acquire the resources, knowledge and skills to increase their income and asset

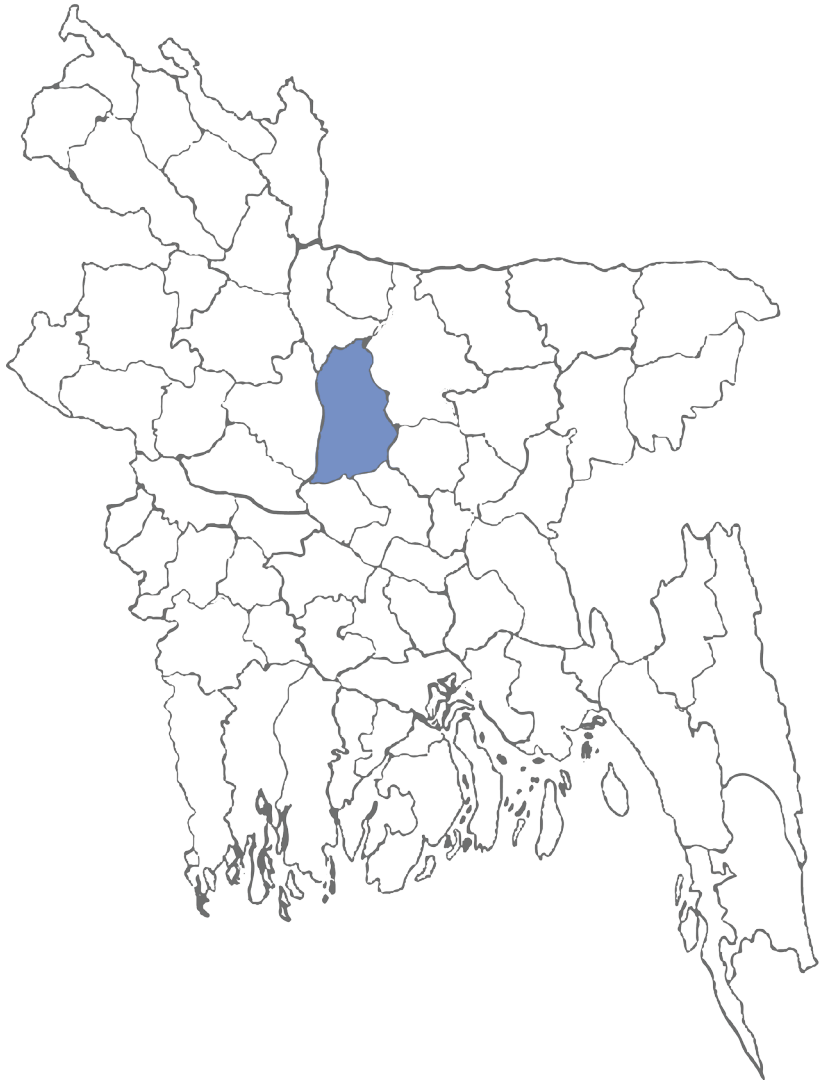
4. Policy Advocacy: Pro-poor urban policies and partnerships supported at the national and local levels

5. Management: Effective project management systems established and operational

Acronyms

BBS	Bangladesh Bureau of Statistics
BLAST	Bangladesh Legal Services and Trust
CAP	Community Action Plan
CBO	Community-Based Organization
CDC	Community Development Committee
CHDF	Communtiy Housing Development Fund
CRC	Community Resource Centre
CFs	Community Facilitators
Crore	1 crore = 10,000,000 BDT
DFID	Department For International Development, UK
GoB	Government of Bangladesh
JAP	Joint Action Plan
Lakh	1 lakh = 100,000 BDT
LGED	Local Government Engineering Department, Bangladesh
LGI	Local Government Institutions
LGRD	Local Government & Rural Development
LPUPAP	Local Partnerships for Urban Poverty Alleviation Project
MoU	Memorandum of Understanding
NGO	Non Governmental Organisation
PIP	Participatory Identification of the Poor
RECAP	Updating and continuity of CAP
SEF	Socio-Economic Fund
SIF	Settlement Improvement Fund
SLM	Settlement Land Mapping
UNDP	United Nations Development Program
UPPR	Urban Partnership for Poverty Reduction

Reference Map of Tangail DIstrict



ABOUT TANGAIL

Tangail Pourashava is the main town in Tangail District, in Dhaka Division. The city has a population (Urban) of 167412 [source: BBS census 2011], there are 1536 poor settlements containing 22370 Households across 18 Wards (source: SLM 2011).

As far as UPPR is concerned, it has organized 59 CDCs that represent 9735 members that are involved in the savings and credit scheme. Beyond the achievements in infrastructure development, UPPR dispersed 3678 block grants and 915 apprenticeship grants.

Linkage and partnership, Tangail

Communities from Tangail, under the umbrella of the UPPR project, had major achievements in the development of linkage and partnership with different organisations in the field of health and training. The project made it possible for all the social layers of the different communities to access health services and to get training in order to get into the local work market. This project has been spread throughout 16 of the 18 wards of the city of Tangail, and has procured special benefits for the extreme poor layer of the population.

Tangail CDC Federation

Submitting organisation: Tangail CDC Federation

Type of organisation: Community Development Committee

Key elements of the project:

- **Access to health rights and medical treatment for all**
  The work carried out through the establishment of 16 satellite clinics in the different wards of Tangail, together with the huge efforts developed by the CDCs in order to inform all of the community members, has allowed thousands of people to know their health rights and to get access to medical treatment. The project has beaten up one of the main cores of inequity, establishing a health system available for all and beyond their social position or possibilities.

- **Empowering women and girls to be economically active**
  The project provided specific training for women and girls of the different communities of Tangail, which has been addressed to get them a bigger access to long-standing sources of income. The project helps to cohesion the community through the empowering of women and girls, especially those being on the extreme poor lines of the communities.

- **Reduction of inequities and universalization of rights**
  A big effort has been put in the extension of two basic rights that the poor population, and more specifically the extreme poor, can not always access: health and work. The project has allowed to reduce inequities among the communities of Tangail, both making health more universal and opening the work market to those who could not have access to formal or informal education.

Linkage and partnership, Tangail

Background Information	
Organisation that led the process	**Tangail CDC Federation**
1. Type, size, and structure of the organisation	• The Tangail CDC Federation was created in 2011. In Tangail there are 18 wards, and 16 of them have a CDC. Each ward has 5 CDCs, with its respective leader. The CDC Federation has 5 CRCs (Community Resource Centre). Each CRC has 7 community members (6 of these CDC leaders and 1 IT person); each one is in charge of one topic, when the community needs information she/he has to deliver it. UPPR trains CRC members on how to collect information. The CRC team chooses one specific person, who will become the CRC facilitator. The different CDC collects information and transfers everything to the CRC facilitator, who gathers it all together. That is how every kind of information may become available for everybody. The information is documented but its transference is usually more verbal.
2. Previous and current activity	• The linkage and partnership project addressing health and training was one of the first actions developed by the Tangail CDC Federation, so no other activities were developed before. • They maintain linkage and partnerships with 28 organizations to create employment, access to health services, training facilities and other facilities corresponding to those organizations.
Context	
3. Brief description of prevailing neighbourhood conditions and the specific problems that the practice is designed to overcome,	• In Tangail, on the one hand, the poor people of the communities didn't have access to proper health follow-up and treatments. The really poor people did not know their health rights or basic information such as; that they can attend hospitals for free or how to access them; for other health needs they could not afford to go out of the community, and they were not aware of possible treatments that they had to follow at some point. • On the other hand, most of the poor people of Tangail, and more especially women, had no access to training in order to have the possibility to get a formal job. They did not have any means to get in touch with the market flow, in order to get access to the jobs in the formal private sector.

Practice or process description & lessons learned

4. What is the main purpose of the practice or the project?

It has a double purpose:

- Improving access to HEALTH rights and treatment.
- Improving access to TRAINING and job placement.

5. Who are the main groups benefiting from the project?

- No social class is especially prioritised. Anyone can access, since the services come to the community rather than the people going to the service.
- Women have a preferential access to the training activities, but men benefit from the project too.

t6. What are the main features?

For the health activities:

- The CDC project facilitated the establishment of 16 clinics in the communities. In 2013 the CDC Federation received a fund from the UPPR, allowing them to buy medicines, pressure machines, weight machines, and other medical instruments. Before that (from 2011 to 2013) the clinics provided the services for themselves. From then, health comes to the poor people of the community through these different satellite clinics.
- The CDC provides a room for visiting, and the clinics charge different fees according to the category of poverty in which the community has situated every family and every individual. Poor (marked in yellow) and extreme poor (marked in pink) have special discounts and prerogatives. In case that a person needs treatment or a prescribed medicine prices are the following:
  - Extreme poor: 10 BDT.
  - Poor: 20 BDT.
  - Non-poor: 40 BDT.
- The CDC project facilitated the establishment of 16 clinics in the communities. In 2013 the CDC Federation If the reason of the visit is to do a test then a 50% discount is applied for the extreme poor. 2 clinics offer one service for free every week to one patient, and it is the CDC who decides who can access it. If the CDC determines that a concrete treatment is very necessary and the person cannot afford it is given free. The poor are not allowed to get it for free, only the extreme poor, but they can also get 50% discount for test. The non-poor don not get any discount.

For the training activities:

- The CDC Federation develops contracts with several training organisations for a 3 month-long training program. The CDC Federation contacts the different CDC members for them to select or shortlist 30 members of their communities. And this 30 receive training related to different training sectors, such as: poultry farming, mobile service person, beauty services (hair dressing, make-up), mushroom farming, driving, electronics, garments, block printing, tailoring, embroidery, nursing and pathology training, handicraft, etc.

	• The community can now provide 3 to 6 months training to both female and male members. After they have completed this training they might have direct contracting opportunities in the formal market. The organisations might provide a job offer to the members of the community that they have trained. They can do that in their own organisations or in other companies that ask for trained work power. • If they whish to work on their own, do their own production and sell their products they might be given a loan so they can establish their own shop, or a platform to sell her/his products.
7. What other groups or organisations, if any, have been involved in the practice /project?	Several health organisations work in the communities now. The most stable ones are the following: • Smiling Sun • Saba Clinic • Joy Clinic • Matri Shodhon • Capital Clinic • Doctors Clinic • BLAST • Shodor Hospital Several training organisations work in the communities now. The most stable ones are the following: • Jubo Unnoyon • Mohila Odhidoptor • Chowa Garments • Shototа Electronics • Allauddin Textile Mill • BISC • Ishan Textile • Aduri Garments • Binoy Switch Factory • Ronger Tuli • SPL
8. What were the costs and how were they met?	• The costs were incurred as cost of transportation and meetings and these are met by the management cost of maintaining committees of federation, Clusters and CDCs
9. What is the involvement of the residents in the planning, design and management of the practice?	• Once in a year the CDC Federation organises an Annual General Meeting (AGM), where all the community members are invited, and where they share everything there. • For the specific case of health issues, there are community meetings with the CDCs every 15 days. They meet in an open space. When they have these meetings, the community members show their needs, desires, etc. and then the CDC members analyse it and look for solutions and for answers for the community.

10. When did it start? When was it completed? What is its current status?	• The project started in 2011, as one of the first projects developed by the Tangail CDC Federation. • In 2013 it could grow in quality and quantity, when UPPR funded an important part of its activities. • The UPPR project finished in December 2015, but the project is still active in the communities, both with regard to the health service supply and to the training activities.
11. What were the concrete results achieved?	• Training. 1500 people trained • Establishment of 16 satellite clinics. • Support 55 disable children.
12. What barriers and challenges were encountered and how have they been overcome?	The project has basically faced problems in 2 stages: • An important part of the community didn't trust the value of the project on its beginnings. The CDC Federation proposed this project and at the beginning the community didn't want it, they didn't trust it but when they saw the results then the confidence was restored and now it is highly valued. • As for the contacting of the organisations (health and training), it was initially hard for the CDC Federation because these organisations didn't want to provide service in the communities. Once they could visit the communities these organisations understood that the project could work, and then they signed contracts with the CDC Federation. The strategy of the CDC Federation in order to facilitate this increase of confidence was to organise workshops in the neighbourhoods and invite the organisations, and then make them understand that the project was feasible for all of the parts. Training organisations accepted to provide services in within the communities from then on.
13. What lessons have been learned from the practice / process?	• The community, when they organise themselves (in this case through the CDC Federation) is able to lead a process of contacting and contracting different organisations from different sectors, more especially those related to the health sector and to the professional training sector. • The different companies and organisations can initially mistrust the capacity of the poor communities to manage their own services and to be reliable partners, but when they are invited into the communities to discuss and to know them, then new strands of trust and confidence appear and grow, and new social and economic relationships can be established.

Assessment	
Innovation and impact	
14. What are the key innovative features of the practice?	• The Tangail CDC Federation was registering a relevant amount of data on the members of the community that were receiving medical treatment, such as their age, the type of illness, the sort of treatment, etc. The UPPR project was not doing it in other cities, but its importance was quickly understood. A follow-up of the health of the members of the different communities is a very important issue in order to plan further actions. UPPR has transferred this practice to other cities of Bangladesh.
15. What impact have the project and its approach had on the residents and/ or the wider community?	• The community gained a stronger sense of identity. The members have become more aware of their rights and of their capacities. • Now the community know how to share relevant knowledge among its members. They have the capacity to ask for services of health or training because of this project.
16. What worked really well?	• The full health providing system is a big success of the project. Thousands of people have had direct access to treatments and medicines that have improved their general health and living conditions.
17. What did not work? Why did it not work?	• The training activities have not always been successful. Many of the times, the training organisations did not provide further opportunities to the trainees in order to have access to jobs. When these organisations did not look concerned about the job placement needs of the trainees, then the CDC demanded for explanations.
18. Have any local or national policy changes taken place as a result?	• The training activities have not always been successful. Many of the times, the training organisations did not provide further opportunities to the trainees in order to have access to jobs. When these organisations did not look concerned about the job placement needs of the trainees, then the CDC demanded for explanations.
18. Have any local or national policy changes taken place as a result?	• No policy changes have taken place up to the date.
19. Is any monitoring or evaluation process being carried out? When?	• The UPPR has carried out two evaluations of the linkage and partnership project in Tangail, a first one in 2012 and a second one in 2014. • Different workshops where organised, where the members from different CDCs talked about the project.

Economic sustainability	
20. To what extent is this practice/ project reliant on a funding stream that may cease in the future?	• The project was over in December 2015 • It ended from the UPPR side. The CDC Federation is studying now how to make the project sustainable in time. They have found methods to continue the project on their own, basically through a continuation of the services provided by the different organisations. • The capability of the CDC Federation is not as strong when there is not external financing, and it has different effects depending on the type of activity developed: • Health. The system is now not subsidized for the extreme poor, but the clinics keep offering different rates according to the poverty category of each person (extreme poor, poor, non-poor). • Training. The number of participation has decreased dramatically (from 30 to 5). Some organisations stopped the service. Others will continue with less number of people. Some others will continue at the same level.
21. Does the program help people have long-lasting source of income or increase the wealth of their community?	• The project has promoted long-lasting sources of income to a numerous amount of people of the communities, who received specific training and who could get a job or develop their own micro-business. • The project has provided health services to thousands of persons in the communities, increasing indeed the wealth of the community and of its members, especially of the poorest ones.
Social sustainability	
22. Does [or did] the practice facilitate greater community cooperation and integration?	• The project promoted an increase of interaction and trust in different levels. • Inside the CDC members. • Between different CDC's • Between the CDCs and the community members.
23. Have the skills and abilities of people [primarily women and young girls] increase as a result?	• The training activities have clearly increased the skills and abilities of the members of the communities who have participated in the project. • Women and girls were more beneficiated. UPPR targeted women and girls, so the training was more clearly directed to this population.
24. Are people healthier and safer as a result?	• Improving of health of the community members has been the main aspect of this project, and it has worked.

25. Has the practice resulted in social inequities being reduced?	• Access to health or to training is usually higher according to the economic capability of every family. The implementation of this project has allowed the extreme poor and the poor to access the same health and training opportunities that the non-poor population of the communities. • The different groups socialize more among them after the implementation of the project, as far as they find each other sharing the same services within the community.
26. Are individuals [and which ones?] empowered to take a more active role in society?	• This project is directed towards all of the persons and family members of the different communities of Tingail. Nevertheless, the project has been an important tool for the empowerment of those individuals making part of the extreme poor strand. This project has allowed a significant amount of extreme poor individuals to have access to specific training, and to get jobs at the same level than other the other members of the community.

Environmental sustainability [Give evidence]

27. Does the practice / project ensures a more appropriate use of energy and water resources?	• No relevant observations on this matter.
28. Are there any other environment impacts of the practice [for instance, climate change adaptation]?	• No relevant observations on this matter.

Transfer and scaling up

29. To what extent has there been any scaling up of the practice?	• This practice has been scaled up to 9 clusters covering 18 Wards and 59 CDCs.

30. To what extent has the practice / project been transferred?	**Locally** • Every month, 59 CDC leaders share the knowledge and results of this project and they learn from each other. **Nationally** • The project exists in other cities, and its innovations are transferred from one city to another (such as the development of a patients register). **Internationally** • People from India and Nepal have visited the Tangail CDC Federation in order to learn from the different projects developed, and more especially to learn about their approach on early marriage prevention. The linkage and partnership project created big interest among these delegations.
31. What were the most important dissemination channels that explain the transfer and / or the scaling up?	• Horizontal transferring of the practice was developed through the monthly meetings developed by the 59 CDC leaders of the Tangail CDC Federation, together with the regular meetings with the several communities. • The UPPR team has worked on the transferring and scaling up of the project towards other cities of the country. • Regular meeting with community organization, NGOs and other service providers to maintain communication and relationship is essential dissemination channel that explain the transfer and the scaling up. • Community leaders (Federation and Cluster) maintain regular response when these organization need help from community. • They keep up all the requirements and direction of these organizations to get services from them

1. The community takes care of the girls belonging to the extreme poor layers.

2. The rudimentary school is the first step towards the newly modern high-school building where the children can go.

3. UPPR provides opportunities to women to open their own business.

4. UPPR provides opportunities to women to open their own business

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5. Empowerment of girls is essential in the community to avoid early motherhood