UPPR

Urban Partnerships for Poverty Reduction
2008-2015

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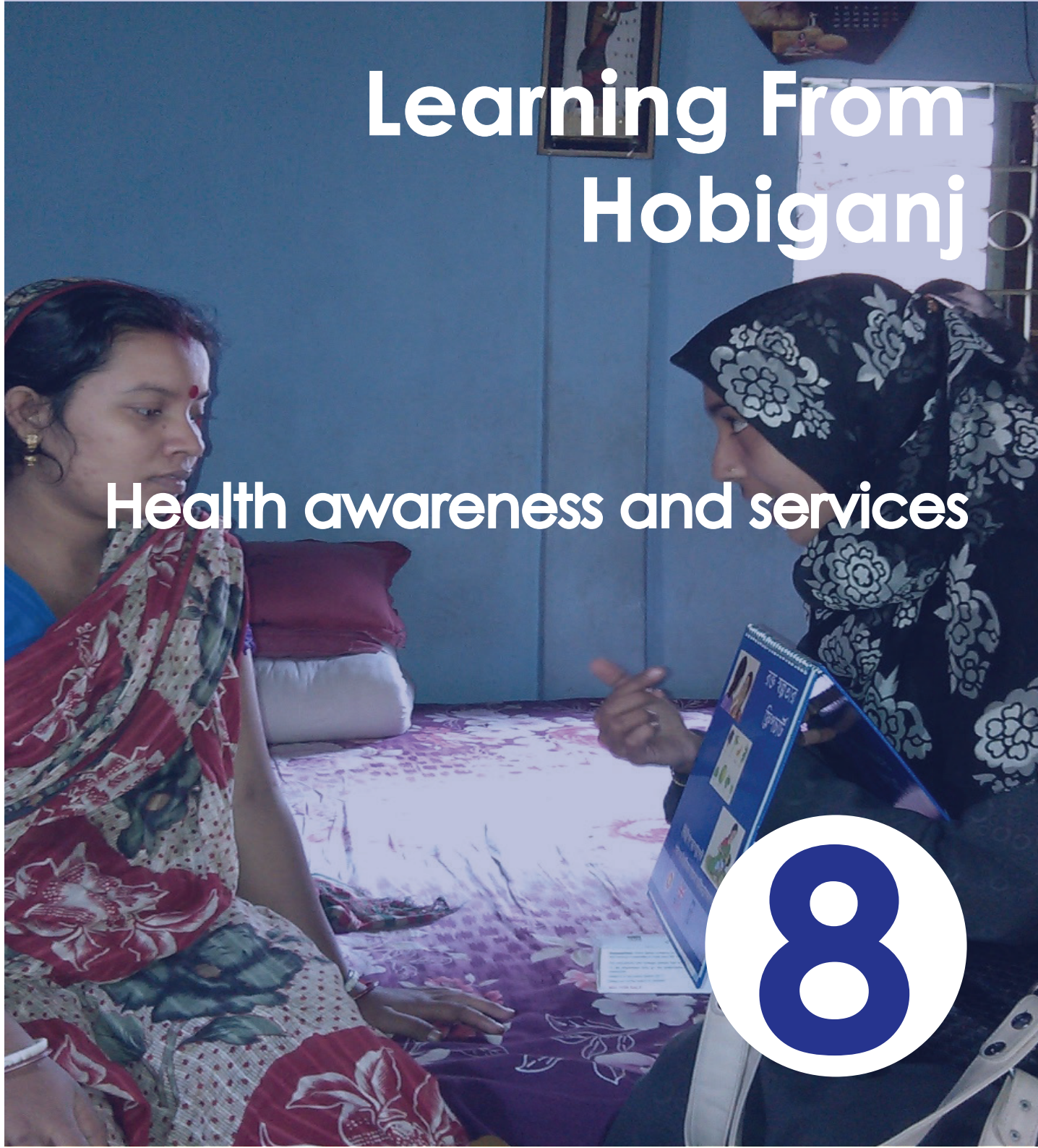
Learning From Hobiganj

Health awareness and services

8



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

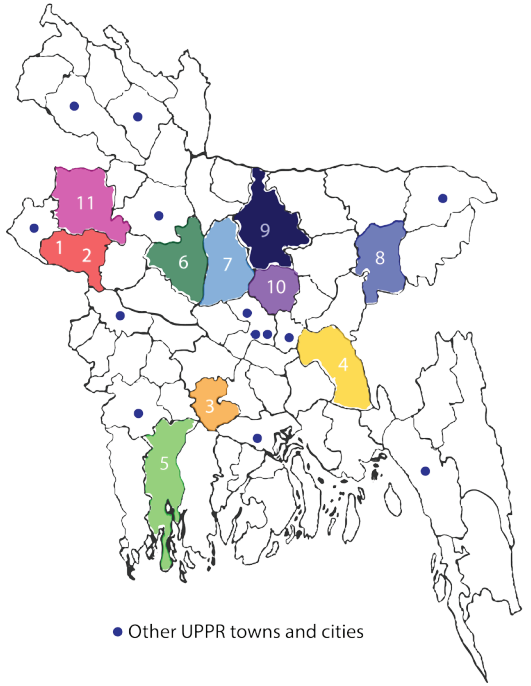
7 Health and apprenticeship, Tangail

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



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Spora Social Consultancy paraa

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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

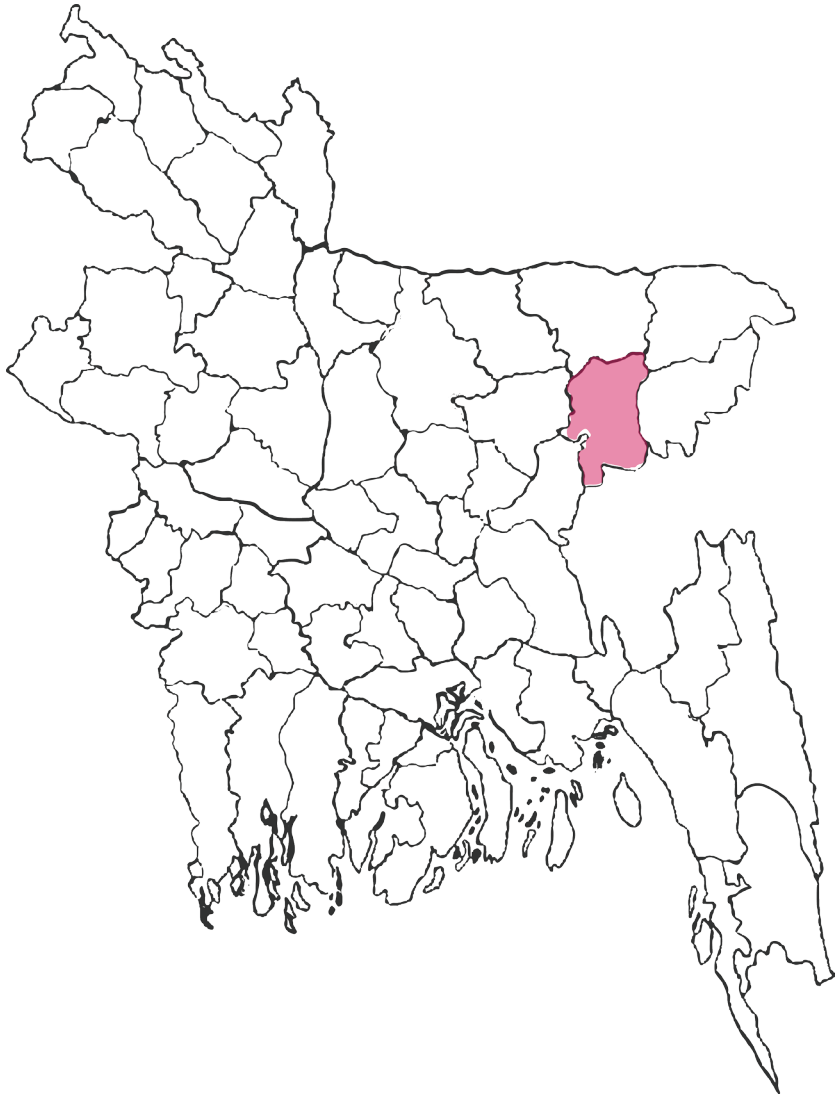
4. Policy Advocacy: Pro-poor urban policies and partnerships supported at the national and local levels

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 Hobiganj



ABOUT Hobiganj

Hobiganj Pourashava is the main town in Hobiganj District, in Sylhet Division. The city has a population (Urban) of 244966 [source: BBS census 2011], there are 589 poor settlements containing 11389 Households across 9 Wards (source: SLM 2011).

As far as UPPR is concerned, it has organized 22 CDCs that represent 4286 members that are involved in the savings and credit scheme. Main tangible physical achievements are the construction of 305 latrines, over 14.283 kms of roads and ways with footpaths,.3 kms of drains, and 109 water facilities. UPPR also dispersed 1460 education grants, 1555 block grants and 545 apprenticeship grants.

Health awareness and services, Hobiganj

Hobiganj is located in the Sylhet Division of Bangladesh and, as part of the UPPR project, it has shown notable improvement in health and nutrition, especially for mothers and children of the CDCs. Monitoring and care for the pregnant, post natal cares and support in adolescence were notable and ensured through access to urgent treatments, distribution of medicines and nutrition and hygiene education. Environmental health of the community has also been taken into consideration by developing a waste collection system.

Hobiganj CDC Federation

Submitting organisation: Hobiganj CDC Federation

Type of organisation: Community Development Committee

Key elements of the project:

- **Nutritional and health awarenesss**
  One of the key elements has been awareness-building programs on health and nutrition, especially among women and adolescents. Dissemination of the benefits of health awareness and developing a caring mentality towards mothers and children have been crucial for the community's significant improvement in health.

- **Access to health services**
  The federation has always focused on communicating and establishing linkages with various public health service providers as well as mother and childcare organisations. This has been crucial for rendering services to mother, child and adolescent, otherwise could not be possible to improve access to treatments and services for the wider community.

- **Income generating Waste Management System**
  The CDC federation initiated the waste management system in 2003 and since then has been covering all the wards of the municipality. Under monitoring by the federation committee the initiative has been employing community workers to collect wastes from households, clinics, hotels and restaurants and dumping in municipal allocated zone

Health awareness and services

Background Information	
Organisation that led the process	**Hobiganj CDC Federation**
1. Type, size, and structure of the organisation	• The Federation registration is under progress. As a result, CDC registration is ongoing under the authorization of the Federation. Though the activities started in 2002 under LPUPAP –but after formation of the Community Development Committee (CDC) in 2009–, Health awareness and services were boosted up by UPPR. There are 22 CDCs within 9 Wards of Pourashava. At present 20 CDCs are active. Four elected persons direct the CDC and their designations are Chairperson, Vice chairperson, Secretary, Cashier. At first they conducted a survey regarding the health status of the member of Primary Groups (PG). They communicated with other heath service providers to manage health service for their PG members.
2. Previous and current activity	• Previous activities were directing saving and credit scheme, implementation of SIF and SEF services, monitoring the activities of the Primary Groups, reducing costs in availing health services like doctors' advices, medical check-up, medicines, vaccinations and awareness raising in every level of communities were major activities previously done under this practice. • These initiatives are still ongoing by coordination and communication with other organization dealing with health services. Community waste management system and employment of community workers.
Context	
3. Brief description of prevailing neighbourhood conditions and the specific problems that the practice is designed to overcome,	• Health services are a component that should be offered by the Government in such a way that poor and extreme poor could afford it, but in their common reality such services are not existent. Poor and extreme poor people in Hobiganj city were in vulnerable as for health awareness and services. Due to lack of proper awareness regarding sanitation and hygienic practice they faced several water and air borne diseases. • Malnutrition is a common phenomenon in urban poor settlements. Different health clinic offered Health Care for their convenience of getting health services, but they were unable to afford those services due to financial constraints and lack of information dissemination.

Practice or process description & lessons learned

4. What is the main purpose of the practice or the project?	• Care and health services in complex vulnerable stages. • Health and nutritional awareness building and monitoring by community promoters. a) A community promoter per CDC to monitor and aware the mothers, and provide reports to nutrition officer. b) Educating to follow prescription. • Distribution of medicines, nutritional foods and vegetables. a) Drugs and medicines for common health complications and complex stages of physiology (pregnancy, childhood, adolescence). b) Vegetables, seeds and seedlings. c) Protein sources (eggs, chickens). • Community waste management in maintaining cleanliness of the physical environment. a) Fund from waste management has been as a fixed source of financial support. They are planning to establish a community clinic in and already allocated space. b) Twenty community vans regularly collect household wastes from all the 9 wards, while maintaining cleanliness of the physical environment.
5. Who are the main groups benefiting from the project?	• Pregnant mothers. • Children. • Adolescents (both male and female).
6. What are the main features?	• Care for pregnant mothers: regular checkups, blood pressure counting, documenting and informing delivery time, volunteer and promoters employed by UPPR. • Post natal care: awareness in mothers for breast-feeding; immunization activities are governed by the municipality. • Puberty: iron tablet distribution, awareness of hygiene are also provided by volunteer and promoters employed by UPPR. • Discussion regarding healthcare service and awareness are regularly carried on a PG meeting, which is held twice in a month. • UPPR wash programs were promoted in Nirodomi and Ranmcholon primary schools by drama activities. • The CDC federation initiated the waste management system in 2003. The service has been covering all 9 wards of Hobiganj Pourashava collecting wastes from around 4,000 households, hotels, and clinics. 20 people at a time have been working regularly by rotating shifts, employing a total of 30 community workers. Federation overlooked the entire practice and municipality allocated the dumping zone (Goyain riverside). • Charging CDC members 50 BDT per household. • All of these activities are currently continuing in Surma Cluster.

7. What other groups or organisations, if any, have been involved in the practice /project?	• Smiling Sun. • Marie Stopes. • Ma-moni. • Matri mongol. • Government Hospital. • BRAC. • Mayor of Hobiganj Pourashava (who personally assisted and donate money). • American life insurance.
8. What were the costs and how were they met?	The CDCs managed to bear the expenses, besides collaborating with other organisations (for relevant services, treatments, medicines). The expenses were mainly for awareness building programs and following up, and were carried out through: • Volunteer contributions. • Personal expenses. • 6 community facilitators each paid with 4,000 BDT per month by UPPR. • Waste management committee also supported with their fund. Currently they are planning to form health fund.
9. What is the involvement of the residents in the planning, design and management of the practice?	• There was active involvement from the residents in assisting the CDCs and enabling public service providers. • Appreciating and accepting the approaches and supporting accordingly. • Participating in community meetings and approving to support from their disaster management fund. • Random cases of financial supports from community leaders. • Mayor was involved in special cases in managing large expenses for treatments and surgery.
10. When did it start? When was it completed? What is its current status?	• The practice started in 2008 and is still followed up. The service providers in linkage are committed to the services they agreed and were providing during the project phase.
11. What were the concrete results achieved?	• Access to emergency delivery: more than 700 pregnant women got the facilities. • Secured and healthy motherhood, childhood and puberty: more than 2000 were benefitted. • Nutritional supports and care during pregnancy and childhood: more than 10000 had nutrition supports. • Medical cards with discounts: more than 500 households got these facilities.
12. What barriers and challenges were encountered and how have they been overcome?	• Not possible to cover all kind of medicines. • Trust building. • The women felt shy at initial stage as a question of privacy.

13. What lessons have been learned from the practice / process?	The practice throughout the project timeline have been successful to educate the communities on the importance of nutritional and health precautions, services and cares. As a result: • Mothers are aware of their own and their children's health. • Adolescents are concerned about health and hygiene. • Service providers respond to specific demands.

Assessment

Innovation and impact

14. What are the key innovative features of the practice?	• Alongside improving mother and child health and the community health in large, innovation was addressing the health risks of disaster-affected people in crisis periods. They have been providing medical facilities during and after disasters, mainly flood and others. • Waste management fund has been able to fund the nutrition support for the pregnant mothers. They are currently planning of establishing a community clinic, allocated space and progressing forward. • Vehicular collection of community waste has been able to employ thirty community workers per day.
15. What impact have the project and its approach had on the residents and/ or the wider community?	• Care and monitoring in pregnancy and security of childbirth to the mothers have been the greatest achievements of the community. • Young girls (adolescents) became aware of and communicated freely about their complications and practical hygiene. • Immunization and nutritional support had a crucial impact in healthy and secured community childhood. • The community in general developed a sense of importance and a caring mentality towards mothers and children. The community are more aware of family planning and prohibition of early marriage.
16. What worked really well?	Among the different components of the practice, two major approaches were widely appreciated and followed: • Medical check up and blood pressure counting of pregnant women as prescribed. • Distributing iron tablets and educating the adolescents about necessary hygiene.
17. What did not work? Why did it not work?	• Although achievements in improving awareness and access to health services, the one that could not be addressed was the prevention of drug addiction among the community youths. Since the practice mainly targeted women and children, male members and youths seemed fell out of concern. Unemployment and lack of awareness among the parents. Currently they are campaigning strongly against addiction
18. Have any local or national policy changes taken place as a result?	• No policy has been taken by local or national policy makers. This is one major field of concern yet to be explored, especially for waste management and treatment.
19. Is any monitoring or evaluation process being carried out? When?	• PG and CDC leaders have worked throughout the practice adaptation mainly in monitoring and following up. • Monthly monitoring has been done by cluster and federation leaders. It was in their regular schedule and was crucial in following up, though structured evaluation processes were absent. • Scheduled monitoring by the promoters, especially to the pregnant mothers on priority basis.

Economic sustainability	
20. To what extent is this practice/ project reliant on a funding stream that may cease in the future?	• Health knowledge and education does not depend on any particular funding stream, which was carried out through meetings and programs in the CDCs. The little expenses for this purpose were managed through collective contribution. Hence the practice is not solely reliant on funding, as long as the service providers are committed. • The capacity for purchasing medical equipments among the poor is a challenge to some extent requiring to rely on fixed funding stream. • Currently they are struggling in funding to establish a community clinic. • Community waste management system at its current scale does not require further funding unless the approach is extended to treating the collected waste for composts or biogas.
21. Does the program help people have long-lasting source of income or increase the wealth of their community?	• More than 500 families have provided with special health cards that helped their affordability of services with discounts and urgent cares. • As a by-product Improvement in community health certainly has an impact in employing human potential and healthy workforce, especially women to contribute to local economy. Beside, healthy childhood offers a potential and efficient future to a new generation to take over responsibilities on their own health in coming days.
Social sustainability	
22. Does [or did] the practice facilitate greater community cooperation and integration?	• Success essentially required integrating all community components to serve the purpose that has been significantly achieved. The members and leaders through the PG to federation chain were committed in their roles to ensure cooperation from other relevant service providers operating in the communities. Municipality ensured that the public health services are delivered sincerely as required. • Hobiganj Unnayan Sangstha, a local NGO for legal supports and consultancy were activly involved in dealing 162 social cases and helped in reducing domestic violence and harassment of women, especially housewives.
23. Have the skills and abilities of people [primarily women and young girls] increase as a result?	• Nutrition department have been providing health education to mothers. • Mother and childcare organization ‘Maa-moni’ trained the CDC leaders on pregnancy and post natal care and knowledge which were later transmitted to their communities through yard meetings.
24. Are people healthier and safer as a result?	• Pregnancy is safe and mortality rate in childbirth is reduced significantly. • Malnutrition –especially among children–has been eradicated to a great extent and immunization ensured. • Hygiene and dignity during puberty is restored. • Secured and healthy motherhood, childhood and puberty that benefitted more than 2,000 members and children.

25. Has the practice resulted in social inequities being reduced?	Inequalities in giving importance and access to care and services are addressed both in terms of gender as well as socio economic status. • The wider community realized the importance of taking care of their women. This fact satisfactorily restored equality to access health services among women and most importantly among the poor, who were ignorant and deprived of such necessities. • Health complications during adolescence are now given importance to be addressed in equal terms, not to be neglected as they used to be previously.
26. Are individuals [and which ones?] empowered to take a more active role in society?	• CDC and cluster leaders have been active in improving community health. The CDCs were able to monitor and holding the service providers committed to their roles, and their efficiency is well appreciated in the wider community.
Environmental sustainability [Give evidence]	
27. Does the practice / project ensures a more appropriate use of energy and water resources?	• The practice is yet to relate to appropriate use of resources for energy and water, suggesting that there are still gaps in understanding the holistic approach of the practice intended by the program.
28. Are there any other environment impacts of the practice [for instance, climate change adaptation]?	• Other than securing healthy household environment no notable impact is yet to experience.
Transfer and scaling up	
29. To what extent has there been any scaling up of the practice?	• Other than securing healthy household environment no notable impact is yet to experience. Locally scale up in 9 wards of LG.
30. To what extent has the practice / project been transferred?	**Locally** • Transferring has been achieved in all of the nine wards where UPPR CDCs exist. PG and CDCs were active in this. **Nationally** • Leaders of the CDCs and clusters visited Rajshahi, Sirajganj, Gopalganj, Khulna, Chittagong, Sylhet and Narayanganj **Internationally** • Four CDC leaders visited Thailand during LPUPAP, later visiting to Thailand and Cambodia during UPPR.
31. What were the most important dissemination channels that explain the transfer and / or the scaling up?	• The most important disseminating strategies have been: • City visits: Rajshahi, Sirajganj, Gopalganj, Khulna, Chittagong, Sylhet and Narayanganj. • Scheduled community meetings and improved relation and communication among the primary groups. • Regular visits of successful cities in this field is an important dissemination channels for transfer and scaling up knowledge.

Counseling for a pregnant mother

Counselling for Complementary Feeding

Video Show on IYCF

Iron and Folic Acid tablet (IFA) distribution

Counselling for Complementary Feeding

School Level hand washing practice