

Addressing Reproductive Health of the Urban Slum Population in Bangladesh: Innovative Experiences of Bangladesh Women's Health Coalition

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CHAPTER ONE

URBAN SLUMS IN BANGLADESH: POPULATION, HEALTH AND UNMET NEED FOR REPRODUCTIVE HEALTH

The current population size of Bangladesh is around 130 million (in 2000) with 100 million rural and 30 million urban. During the last fifty years, while the rural population size has doubled, the urban size has increased fifteen-times. With the increase in the urban population, the number of slums and slum dwellers are increasing rapidly. The extent of human misery and deprivation is unacceptably high among the slum population (Table 1).

The current annual average growth rate of urban population is about 6 percent compared to less than 2 percent of that of rural population. Medium term projection shows that urban population will share for 38 percent of the total population and will exceed 85 million in 2020, which is almost equivalent to the 1981 population of the whole country (Barkat A and S Akhter, 1999).^{1>}

The main reason for the rapid growth of population in the cities is the heavy inflow of migrants from rural areas. The vast majority of these migrants are extremely poor. Because of the interaction of rural push and urban pull factors, cities are being flooded with people looking for a job. Most of these people moving into the cities have no other places but only the slums and squatter settlements to reside. In fact, the slums and squatters are growing at an alarming rate. The estimated total number of slums and squatter settlements in the four metropolitan cities in Bangladesh is 3431 with about 88 percent in the Dhaka city alone.^{1>}

With the expansion of the urban centers and increase in the urban population, the number of slums and slum dwellers are also rapidly increasing. In the city area, migrated poor people preferred slum areas for their initial colony due to income scarcity and poverty of opportunity (Barkat A and S Akhter 1999). In Dhaka city alone, there are 3007 slums and squatters. The Dhaka population in 2010 will be about 17.6 million, up from about 10 million in 1998. The nature of urbanization is such that at least 50 percent of this Dhaka urban population will be living in the slums and squatters. The size of these population being so large and the rate of growth of slums and squatters being so high have important economic, social, demographic and public health implications.

The high extent of human deprivation of the dwellers of slum and squatter settlements is clearly evident in all dimensions of life, namely population, economy, education, access to health, child health and women's health status. Although the lack of human opportunity is highly pronounced for most of the people in Bangladesh, the relevant values are unacceptably high in case of the slum and squatter population. The scenario of urban slum as compared to the national situation is deplorable, and the gaps are significantly high and unacceptable in terms of the following indicators: population density, life expectancy at birth, level of poverty, prevalence of child labour, literacy, access to health facilities and sanitation, under 5 deaths due to diarrhea and prevalence of diarrhea, prevalence of acute respiratory infections, infant mortality rate, pregnant women's access to antenatal check-up, teenage fertility, and women's knowledge about STD/HIV/AIDS (Table 1). In view of the rapidly increasing slum population and high unmet need for multifaceted social, economic and public health services, any intervention aiming at minimizing the misery and deprivation of slum people should be studied on priority basis, and then efforts need to be made to replicate effective interventions on a wider scale. Keeping all the above stated in view, the

^{1>} Barkat A and S Akhter (1999), "Urbanization and Internal Migration in Bangladesh: the Onset of Massive Slumization", *Journal of the Refugee and Migratory Movements Research Unit/UNHCR*, Dhaka (forthcoming).

present study purports to review various aspects of the comprehensive reproductive health programme of the Bangladesh Women's Health Coalition (BWHC) in the Agargaon slum in Dhaka city.

Table 1: Comparative scenario of extent of human deprivation in the urban slums in Bangladesh: Selected indicators of population, economy, education, access to health, child health, women's health and structure of dwelling household.

Indicators	National	Urban slum	Indicators	National	Urban slum
Population			Child Health		
Total fertility Rate (1997)	3.03	4.4	% 12-23 mo's children fully immunized (1996)	46.9	38.5
Life expectancy at birth (1998)	60.8	51.6	% 12-23 mo's children taken measles (1996)	78.0	68.0
Economy			Prevalence of diarrhea (<3yrs old in the last 2 weeks) (1997)	13.0	20.0
Per-capita annual income: Urban (in Tk) (1996)	14,000	6,627	#under 5 deaths from diarrhea (1996)	110,000	36,300
Poverty level: Hard core poor (1998)	25.0	51.5	ORT use rate(+HH Solution) (1998)	96.0	79.8
\$1 a day (%) (1998)	30.0	62.0	% of children >3 yrs) with ARI (during last 2 weeks) (1996)	24.0	45.5
Child labour as % of total civilian labour force (1995)	11.7	50.5	Low birth weight (% of infants) 1996)	50.0	62.5
			Under weight children (% <5 yrs. who are under weight) (1997)	56.0	66.5
			Stunting-moderate & severe (% children <5 yrs) (1997)	55.0	66.0
			Vit A prevalence of children (1997)	59.0	55.0
			Infant mortality rate (1997)	66.0	124.0
Education			Women's Health		
Literacy rate (7 yrs+) (1997)	47.0	17.6	% Pregnant women receiving antenatal checkup (1996)	23.2	12.8
Adult literacy rate (15 yrs+) (1995)	49.0	19.5	Teenage (15-19 yrs) fertility (1997)	31.0	93.0
Primary school gross enrolment ratio (1997)	82.0	20.0	Contraceptive Prevalence Rate (1997)	49.2	39.8
Secondary school gross enrolment ratio (1997)	28.0	6.6	%married women of reproductive age who knew about 3 signs/ symptoms of HIV/AIDS/STD	33.1	11.0
Access to Health			% married women who know about atleast one means to prevent HIV/AIDS/STD	41.9	12.0
Access to health facilities (1995)	45.0	15.0	Structure of dwelling HH(%) (1997)	30.2	57.6
Access to safe drinking water (1997)	97.3	69.5		58.7	39.4
Access to adequate sanitation (1997)	30.5	9.5	Jhupri/Tong/Chhai	11.1	3.0
% HH use iodised salt (1998)	78.0	32.5	Tinshed		
			Semi-pucca and/or pucca		

Sources: Adopted from Barkat A and S Akhter (1999)

CHAPTER TWO

OBJECTIVES AND METHODOLOGY

Objectives

The Agargaon project of Bangladesh Women's Health Coalition^{1>} is one of the very few slum-based comprehensive reproductive health interventions in Bangladesh. In view of the alarming size of the rural pushed-migration, increasing size of the slum population, and huge unmet need for reproductive health in the urban slums it was considered worthwhile to study the innovative components of BWHC,A in its reproductive health and relevant developmental endeavour in Agargaon Slum.

The specific objectives of the study were as follows:

- To understand the mechanism of implementation and working of comprehensive reproductive health program in the context of urban slum.
- To identify the major problems of implementation of such program.
- To identify the innovative components of the program.
- To explore as how does BWHC,A tackles some of the less-explored and sensitive issues, such as adolescent RH, RH services to male, RH services to commercial sex workers, violence against women and children.
- To ascertain the nature and extent of RH-related behavioral changes that has taken place in the perception, attitude and practice of the slum people.
- To identify issues relating to the future success of the slum-based comprehensive RH program.
- To formulate lessons and issues for upscaling the BWHC,A innovations.

Methodology

The study was conducted during October 1999-March 2000. In compliance with the specific objectives of the study, the following were done: review of all relevant materials comprising of studies on urban slums, project documents, annual reports, brochures, leaflets, booklets, various IEC materials, and service statistics of BWHC,A.

Qualitative research methods were used extensively in the study. The tools used for data collection are: Key Informant Interviews (KII), Focus Group Discussion (FGD), Case Studies, Semi-structured Interviews (SSI), Observation, Sketch Map, Historical Profile, Transect Walk, Listing, Venn Diagram, Trend Analyses and Impact Flow Chart. Triangulation among various qualitative techniques was used to validate the information gathered. Some methodological notes about the qualitative tools used are described below:

^{1>} Henceforth will be abbreviated as BWHC, A

Key Informant Interviews included interviews of knowledgeable individuals having some first hand familiarity with the issues or settings to be studied to elicit their perceptions of the nature and extent of the problem under study. Three types of key informants were interviewed in this study namely, the program directors and managers, the outreach staffs, and the beneficiaries. In addition to queries about the program in general, questions on perceived intra household impact of the program were also included in these interviews.

Observation is important for cross checking information as well as for finding out new information. In this study the observer's role has been non-intrusive. The observer observed the meetings from a distance taking notes of what s/he observed.

Focus Group Discussion was used to obtain information from a group of people (4 to 8 individuals) having a common background, and were brought together, to discuss a particular topic of interest. A member of the core team acted as Moderator to lead and stimulate the conversation using a pre-determined guideline. Several FGDs were conducted in the study.

Case Studies included semi-structured open-ended interviews of program participants. The case studies included detailed background information of the program participant, involvement with the program, experiences with BWHC,A etc.

Historical Profile revealed important information for understanding the present situation of the project. It provided a summary overview of the key events in the project and their importance.

Venn Diagram method was used to understand various dimensions of the organizations operating in the program area and their perceived relationships and importance for the slum dwellers.

Mobility Map was drawn by the program participants, which show in general their spatial mobility. The mobility map prepared for this study was that which illustrates mobility of women for seeking health care. Several dimensions of mobility such as distance, purpose of visits etc. were discussed during the session and noted down.

Trend Analysis was used to identify changes over a particular period of time. In the session on Trend Analysis the program participants were requested to show the status of some indicators before and after the introduction of the program by putting beans or other tiny things in the boxes corresponding to the different periods.

Impact Flow Chart was used to know, diagrammatically, the effects of the program as perceived by the beneficiaries.

Incongruence with the ethical codes of research, and in order to ensure privacy, safety and security names of certain interviewees have not been disclosed. In such cases fictitious names were used.

CHAPTER THREE

WHAT BWHC, A IS

Bangladesh Women Health Coalition – Agargaon (BWHC,A) is a collaborative pilot project of BWHC and PLAN International Bangladesh (PLAN). Since its inception in April 1996 BWHC,A has been working exclusively with the slum dwellers of Agargaon slum with the aim to improve the health status of women and children.

The project is financially supported by PLAN and designed, implemented and managed by BWHC. There is partnership in monitoring and evaluation of the project activities and achievements. To understand BWHC,A project, it is relevant to know the background history of the organization BWHC.

Background History of BWHC

BWHC, a twenty years old organization was founded in 1980. The inception of this organization is very interesting. Based on the only center at Ramkrishna Mission, BWHC was running only one program called Menstrual Regulation Services (MRS) in Dhaka.

From the very beginning, the USAID population fund was directed towards family planning with some emphasis on maternal and child health. In order to support official and NGO led family planning program MRS was included. In Bangladesh, the very term 'menstrual regulation' is legally accepted for long time but there is a long controversy all over the world regarding the issue whether it is an abortion.

During Reagan's regime, a policy debate took place in America on this issue. The consummation of the debate went against abortion. As a result, funds were withdrawn from any kinds of MR or abortion programs. Consequently, a critical situation arose in Bangladesh: virtually, Government and concerned NGOs withdraw services for MR from its family planning package but demand for MRS remained alive in the society. Program beneficiaries continued demanding their unmet needs on MR. Right at this point of time, BWHC was founded as SIDA came forward with handful funds for this program. Need to mention that SIDA holds liberal position regarding abortion. BWHC just got involved to mitigate aforesaid unmet needs.

Being an NGO, it was not possible for BWHC to meet overall needs in this regard but it played a forefront role. Due to withdrawn fund, all efforts by government and other NGOs on MRS were adjourned. At this very moment Ms. Sandra Mustafa Kabir, the founder of BWHC, took the leading role. BWHC kept on going with the MRS program at Ramkrishna Mission.

Gradually based on customers' demand BWHC shifted from its single service program towards integrated program.

LOGICAL FRAMEWORK: shift from single service delivery towards integrated service delivery

The current service delivery package of BWHC has progressively been made based on women's demand and needs. Basically it comes up from their reproductive and sexual demand and needs.

The reality is a woman does not come to the service center only for menstrual regulation, rather she has many other complications regarding her health. Menstrual regulation is followed by family planning - so BWHC linked family planning with this program. Some times two or three months' pregnant women come to this centre - so it has to offer antenatal care to them. Thus BWHC introduced antenatal as well as postnatal care for all women under this program. Some women bring their sick children to the centre. In such cases, BWHC is situation bound to render services for both women and their children. So BWHC adds childcare and immunization components into its service delivery package.

Gradually the whole package covers mother and child health (MCH) and family planning (FP) - in brief MCH/FP services. Over time the package has been more extensive. Now BWHC included reproductive as well as sexual health of women into the program. Hence, the program itself expanded over time.

Likewise, the coverage of the program also expanded. In course of time, the number of centres has been increased. Initially BWHC ran the only centre at Ramkrishna Mission in Dhaka. Sequentially, it has been working in urban, then semi urban and finally in rural set up. Other than the head office at Dhaka, BWHC has now 12 centers covering 9 districts of this country.

BWHC provides all-important and essential services for reproductive and sexual health in each centre.

A BEGINNING FOR BWHC,A

In collaboration with PLAN, BWHC began this project on experimental basis in April 1996. That's why it is known as a pilot program of BWHC. Basically, PLAN is a child focused organization whereas BWHC is a reproductive health service provisioning organization. In order to carry out the partnership, both PLAN and BWHC agreed to work for children residing in the Agargaon slum but within the broader framework of reproductive health approach.

Reproductive health care in a slum context is completely a new and challenging task. In Bangladesh, hardly any full range of reproductive health care related services in a slum context could be found.

Most of the NGOs working in slum context are providing at best MCH-FP cares or general healthcare. But the project that BWHC designed for Agargaon slum is intended to provide a whole range of reproductive healthcare or comprehensive reproductive health care services. It also included public health based program to BWHC,A project.

Clinical services side by side public health services and also some efforts to change their behavior give the project the flavor of public health program. So the project is an effort to ensuring both preventive and curative supports to its target people through this project. In this context of course it is a unique program for BWHC.

BWHC designed this project underlying reasons given below:

First, based on experiences from Agargaon project, BWHC will incorporate all missing components to its other centers if those show any success.

Second, if BWHC gets succeed in handling whole range of reproductive health services in a slum context, then it can sell out this model to others beyond BWHC, even to Government of Bangladesh.

Third, it will promote this model in the other countries in Asia.

Project Goal and Objectives

BWHC Agargaon project started operating in February 1996 with the following goal and objectives:

PROJECT GOAL

To improve the health status of women and children in the Agargaon community (specifically within the project fixed working area and foster families outside the working area) by providing comprehensive reproductive healthcare and other basic developmental supports in a partnership with PLAN International.

PROJECT OBJECTIVES

1. Improve the health status and prevent unwanted death and illness of women in Reproductive age
2. Prevent the illness and death of under five children due to Acute Respiratory Infection and Diarrhea through appropriate interventions
3. Improve the nutritional status of under five children of the community
4. Prevent RTI/STD related illness of the men in the community
5. Address the Tuberculosis cases of the community through case detection, Referral and effective follow up
6. Develop community health and social volunteers for first line of referral, follow up, linkage with relevant institutions and sustainability of the program
7. Raise awareness of women of the community on basic health, social, legal, environmental and democratic issues
8. Provide functional literacy to the illiterate women of the community
9. Provide legal services to the people of the community

Subsequent to the mid-term evaluation of BWHC in general, in October 1997, the partners decided that the project period would be extended up to March 31, 1998 and an appraisal of BWHC, Agargaon project as well as an evaluation of Adolescent Club would be conducted. It was anticipated that the findings of the mid-term evaluation in general and appraisals, in specific, would be utilized to redesign the project.

Through continuous dialogues among different groups and fora of BWHC and PLAN as well as based on the findings of an participatory action research, which was conducted as a part of the appraisal by the external consultant, the partners came to an agreement that problems, which identified as the health problems of the country can be labeled as the important health problems of the Agargaon slums as well. Therefore it is reported in the project proposal of BWHC Agargaon for the period 1998 – 2003 that the project would address the following health problems:

- A. High maternal mortality
- B. High infant and child mortality and
- C. Severely Contaminated and Degenerating Sanitary Environment

BWHC, A Project: At a Glance	
Name of the Project	: Women and Child Health Development
Project Period	: April 1, 1998 – March 31, 2003
Location	: PLAN Dhaka Community at Agargaon slums. BWHC has fixed 6 pockets (bastis) in the Agargaon Slum. These are: <ol style="list-style-type: none"> 1. Karam Ali 2. Noor Mohammad 3. Tulatola 4. Motahar 5. Beltola 6. Shahider Tek
Implementing Agency	: Bangladesh Women's Health Coalition (BWHC) <p>Central Office: 10/2 Iqbal Road, Mohammadpur Dhaka – 1207</p> <p>Project office: 108/2 West Agargaon Dhaka – 1207</p>
Authorized Officials	: Anwarul Azim, Executive Director, BWHC
Partnering Agency	: PLAN International, Dhaka
Number of Beneficiaries	: Approximately 4000 households
Total Budget	: Taka 30,320,149 (Thirty Million Three hundred And Twenty thousand One hundred and Forty Nine only)
Budget for 1998 – 1999	: Taka 5,603,536 (Five million Six hundred and Three thousand Five hundred and Thirty Six Only)

Source: BWHC Agargaon Project Proposal, 1998 – 2003

Maternal mortality rate ranges from 4-6/1000 live births, one of the highest in the world.

Surrogate indicators show that:

1. only about 58% of women in the urban areas received any antenatal care and
2. only about 37% of pregnant women in urban areas were delivered by trained personnel (doctor, nurse, or midwife)

Infant and child mortality (and morbidity) rates remain alarmingly high.

The most recent preliminary findings of the Demographic and Health Survey (June, 1997) indicates that while Bangladesh has made positive strides in addressing these issues, nevertheless –

1. infant (0 – 12 months) mortality remains very high at 82/1000, a slight decrease from 87/1000 in the 1992 benchmark
2. child (13 – 60 months) mortality has decreased significantly from 50 to 37 per 1000 during same time period
3. total under 5 mortality is still a severe one: 116/1000, a decrease from 133/1000 during 1992 – 1996 time period.

National rates are mirrored or even exceeded in BWHC, Agargaon target populations.

Severely contaminated and degenerating sanitary environment, poverty, malnutrition, poor health, water resources and sanitation facilities, as well as crowded and poorly ventilated homes directly contribute to the health risks borne by BWHC, Agargaon target populations.

Women and children suffer disproportionately from environmentally influenced health problems. Lack of knowledge and awareness about health, hygiene, sanitation, environment and the social issues are the most influential factors aggravating health risks of the slum dwellers.

As mentioned earlier, BWHC took part in the strategic planning process of PLAN, and contributed in the issue-cause analysis of the important health problems in Bangladesh.

PLAN Dhaka and BWHC are in agreement with the identified issues and causes, and formulated project goals and objectives out of the similar exercises. The redesigned goals and objectives of the project became as follows:

RENEWED GOALS

1. reduce the measured incidence of maternal morbidity in the BWHC, Agargaon target population
2. reduce the measured incidence of infant and child morbidity in the BWHC, Agargaon target population

RENEWED OBJECTIVES

A. Reduce the measured incidence of maternal morbidity in the BWHC, Agargaon target population

- Increase access to and utilization of antenatal care and emergency obstetric services
- Reduce number of children born to adolescent girls
- Increase use of modern contraceptives in married women (15 – 49 years)
- Increase awareness among mothers and adolescents about STDs including HIV/AIDS
- Increase utilization of the male clinic for STD/RTI syndromic management care
- Increase use of condoms in adult males
- Increase awareness of males and their partners about STD/RTIs including HIV/AIDS
- Increase the rate of literacy of women (15 – 49 years) in the BWHC, Agargaon target population
- Increase awareness of women (15 – 49 years) on health, hygiene, sanitation, environment, legal and social issues
- Increase access of adolescent girls to AFLE

B. Reduce the measured incidence of infant and child morbidity in the BWHC, Agargaon target population

- Reduce and maintain diarrheal episodes and associated dehydration to less than 5%
- Reduce death reported/observed due to malnutrition to zero
- Increase complete immunization coverage to 100% by 2003
- Increased recognition of early symptoms and referral of ARI cases

Program Strategy

Program strategy for BWHC,A is designed as follows:

BWHC, Agargaon's program will address the issues and act upon the causes that lead to the identified problems. To this end, a three-pronged strategy is developed:

Create demand
Promote quality service
Facilitate community management

Creation of demand is being carried out through:

Health education

Awareness raising program

Campaigns for immunization, prevention of HIV/AIDS, detection and referral for treatment of TB

Dissemination of learning of periodic evaluation of the intervention program and

Other social mobilization activities

Population Covered

BWHC, Agargaon has six fixed pockets (*bastis*) in the Agargaon slum consisting of approximately 4,000 households as the project working area. These slums as shown in the sketch map are:

1. Karam Ali
2. Noor Mohammad
3. Tulatola
4. Motahar
5. Beltola
6. Shahider Tek

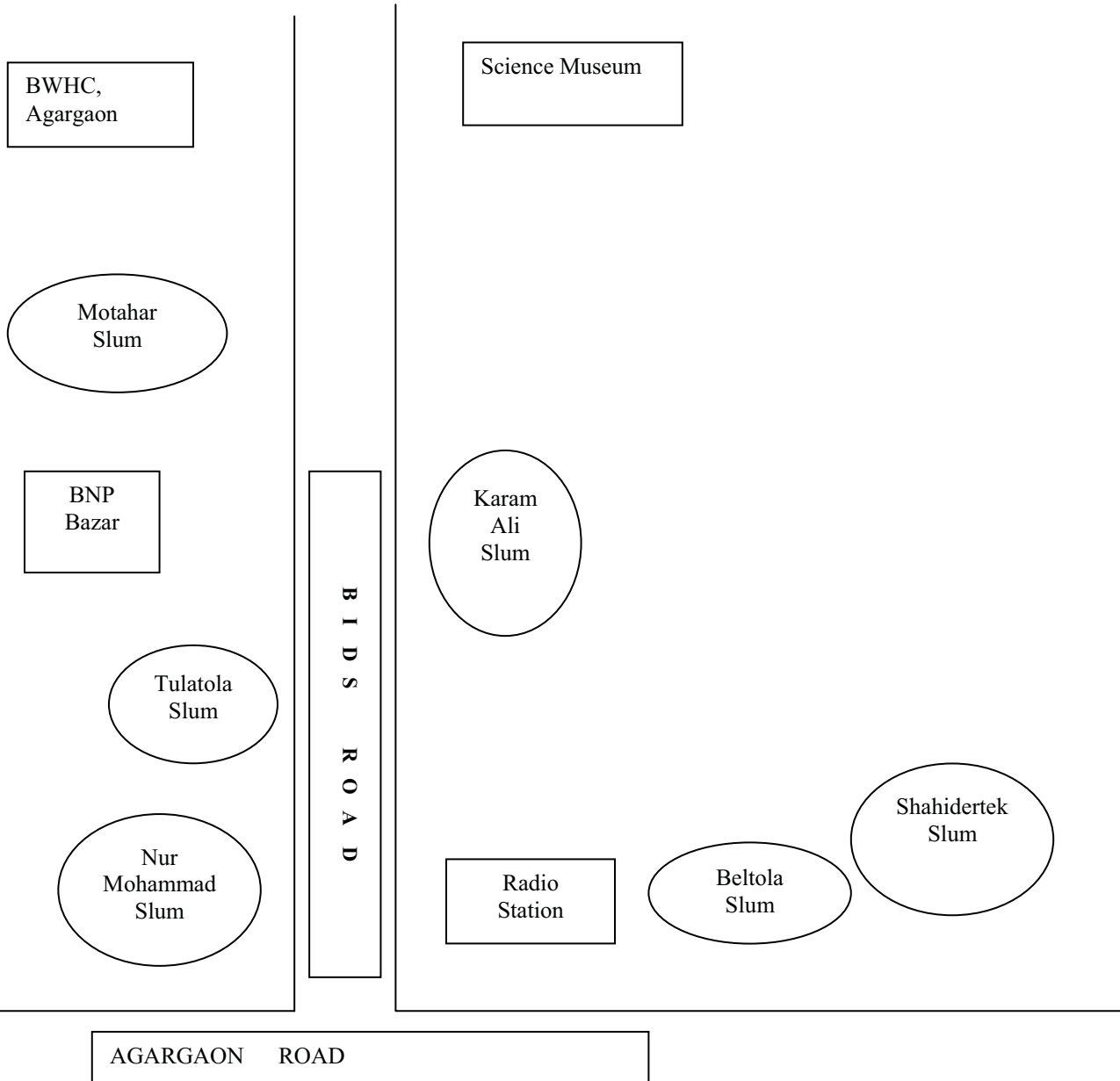
Potential beneficiaries are above-mentioned 4,000 households members of the fixed working area of the project (both clinical and community based development support services) and members of the Foster Families residing outside the working area (only clinical services).

Area Selection Criteria

These slums have been selected using the following selection criteria:

- Have large number of foster families
- Communication is relatively easy
- Less vulnerable to eviction
- Mostly remain accessible in the rainy season
- Absence of any NGO working in that slum with similar programs

Sketch Map* of BWHC, A Program Area



* This sketch map was prepared by Zinia, Basanti, Shamsad, Nasima, Maya, Momtaz, Shahin, Dil Afroz, Selina, Rabeya, Jahan Ara, Rawshan, and Yasmin, facilitated by TR Noor, November 23, 1999.

The sequence of major events of the project gave BWHC,A a dynamic panorama (see the table below).

BWHC,A started its journey comprising three units, namely Medical Unit, Community Development Program Unit and Nutritional Rehabilitation Unit in April, 1996. Medical unit consisted of a base clinic and two satellite clinics. Overtime it introduces some new components in this unit. Just after four months of its inception, BWHC,A developed a Male clinic for male counterparts of its clients. In order to get adolescents girls under this project, BWHC,A formed an Adolescent Club in Motahar slum in December 1996. Both Male clinic and Adolescent Club were included in the original project design, however 4-8 months time was needed to set the stage for actual implementation.

Because of community demand, it adds one more satellite clinic in the field after a year of its journey (April, 1997) and Medical unit was renamed as Health unit. To develop a formal accounting system, the project introduced a post of Accountant cum Administrative Assistant.

The year 1998 is very important for BWHC,A as several vital changes took place in this year. The pilot project turned to a permanent program as well as the project became centre-based. In order to run overall activities of BWHC,A, the office space was expanded. Coverage of the program became more focused: BWHC,A started working with dwellers in 28 slums in Agargaon of which 6 slums are of its own and the other 22 slums were picked from PLAN working areas.

Sequence of Major Events in BWHC,A Project

Year	Event	Remark
April, 1996	Pilot project starts at Agargaon	Medical Unit, Community Development Unit and Nutrition Rehabilitation Unit
August, 1996	Male clinic starts	
December, 1996	Formation of Adolescent Club (AC)	Center-based club in Motahar slum
April, 1997	Adds one more satellite clinic	Total no. of satellite clinic becomes 3
1997	Introduction of gratuity facility	
1997	Medical unit turns to Health unit	
1997	Formal post for an Accountant starts	Earlier PC has to maintain accounts
1998	Pilot project becomes permanent	
1998	BWHC turns from project to center	
1998	Office space extends	A new floor taken
1998	Coverage of satellite clinic changes	Focused on 28 slums
1998	Program Coordinator becomes Central Coordinator	
1999	Program Officer re-designated as Program Manager	
February, 1999	Adolescent Club burns	Shifted to base clinic
February, 1999	Boy group selected for AC	
March, 1999	Male clinic turns to Evening clinic	
March, 1999	Growth Monitoring starts	
March, 1999	Training for TBAs starts	
1999	Office hour changes	8 am to 4 pm becomes 9 am to 5 pm

At the beginning of 1999, BWHC,A experienced with a downhearted episode. The Adolescent club set on fire along with the whole campus of Agargaon slums. The club was temporarily shifted to base clinic and still it is being run under the premise of this clinic.

According to the Program Manager, the rehabilitation activities that took place by BWHC,A team just after the fire event basically won the hearts of slum-dwellers. It made the organization more trust-worthy to them. In March 1999, in order to provide services to working women under Agargaon slum – the Male clinic turned to Evening clinic, to ensure better health - field level growth monitoring for children as well as TBA training started.

Several times the designation of Head of the project was changed. Finally the Head is re-designated as Program Manager.

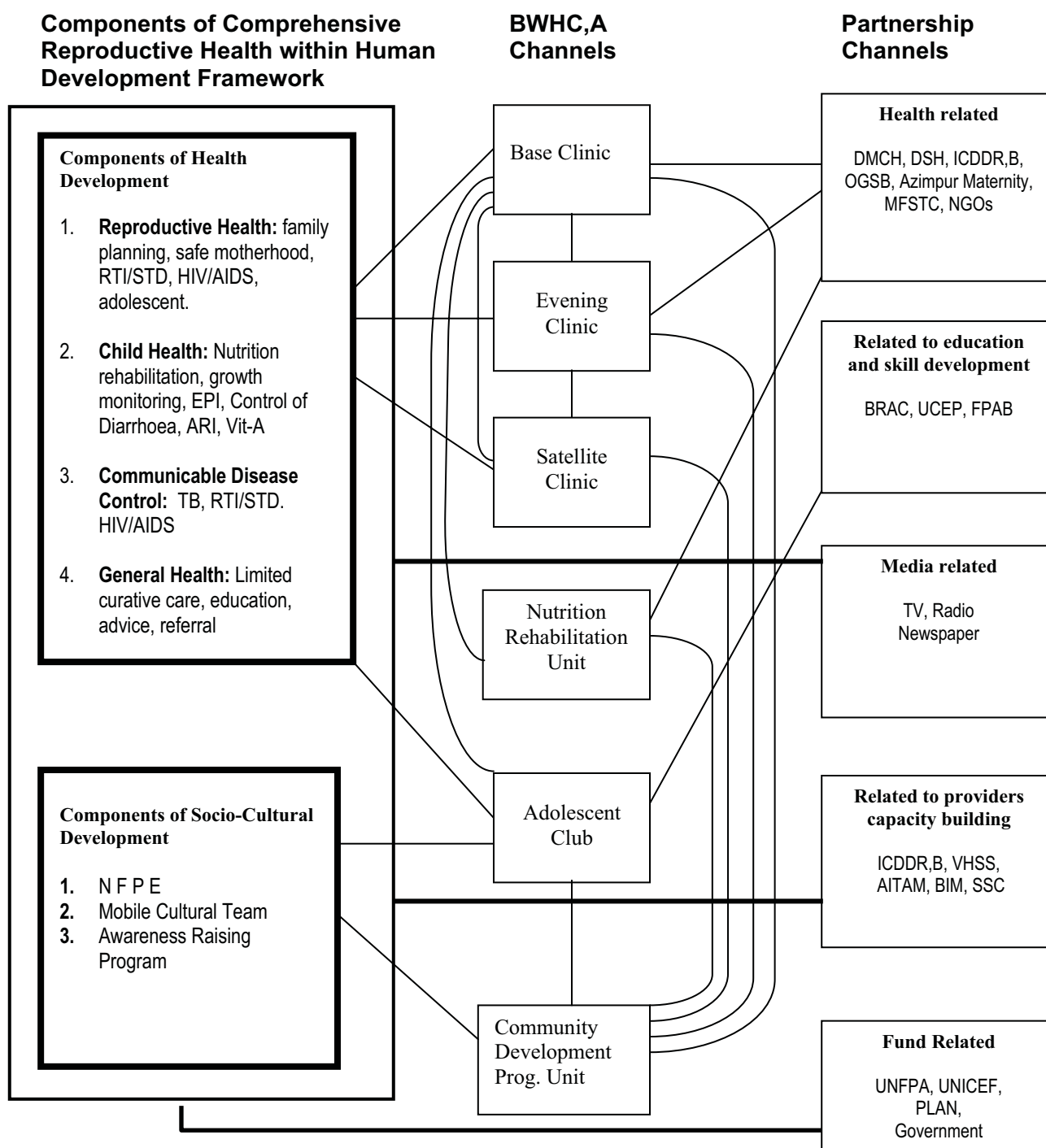
BWHC,A : the Model

The BWHC,A model of comprehensive reproductive health programme is essentially a human development model comprising of two broad building blocks: components of Health Development, and components of Socio-cultural Development. The components of health development consist of four major sub-blocks: Reproductive Health, Child Health, Communicable Disease Control, and General Health Care (shown in the diagram below). The Health Development Component is dominated by reproductive health with the following elements: family planning, safe motherhood, RTI/STD, HIV/AIDS, and adolescent health. The Child Health sub-block consists of services relating to nutrition rehabilitation (of moderately malnourished children), growth monitoring, EPI, control of diarrhoea, ARI and Vit-A. The sub-block of Communicable Disease Control comprises of elements such as TB, RTI/STD, HIV/AIDS. The General Health activities included are limited curative case, education, advice and referral.

BWHC,A provides both information and clinical services in compliance with the Health Development components listed above. At the same time, for those services which the providers of BWHC,A are not able to handle, it uses **partnership channels** and refer clients to various service delivery points, as appropriate. BWHC,A, clinic channels comprise of Base clinic, Evening Clinic and Satellite clinics. BWHC'A's other own set up - Adolescent Club and Community Development Program Unit – refers clients to the clinic set-up. The Nutrition Rehabilitation set up refers clients to both the base clinic and to health-related partnership channels (shown in the diagram below). All six channels of BWHC,A – Base Clinic, Evening Clinic, Satellite Clinic, NRU, Adolescent Club, and Community Development Program Unit – form an integrated unique network having close ties with each other.

In dealing with the components of Socio-cultural Development, the BWHC,A model has selected three sub-blocks, on priority basis: the NFPE (non-formal primary education), the mobile cultural team, and ARP (awareness raising programme). These are handled primarily by two channels: the Community Development Programme Unit and Adolescent club, which are intertwined. While the former has close ties with all the clinic channels of BWHC,A, the later maintains close link mainly with the Base Clinic. The BWHC channels dealing with the socio-cultural components have networks with the partnership channels outside BWHC (see diagram below).

BWHC Model of Comprehensive Reproductive Health Programme for Slum Population in Agargaon



In terms of linkages of the complete block (BWHC,A Model) with the partnership channels, the prominent ones are those related to providers' capacity building (ICDDR,B, VHSS, AITAM, BIM, SSC), media coverage (TV, radio, newspaper), and funds and resources (UNFPA, UNICEF, PLAN, Government). Thus, the BWHC,A model is intended to improve upon the slum dwellers overall health status, especially status of reproductive health using all possible available avenues which resembles a complex network of relationship.

CHAPTER FOUR

PROJECT MANAGEMENT

BWHC,A project is being implemented by thirty BWHC,A staffs under the supervision of BWHC central office management. The relationship between the BWHC central management and BWHC,A project management is shown in the organogram on the next page. Since it is a partnership program, personnel from PLAN International visits BWHC,A time to time and provide suggestions for further improvement of the program.

Staffing

The Program Manager is the overall in-charge of the project. Medical Officers are next to the PM. Supervisor of each unit holds the top-most position within the unit.

Only PM and 3 MOs are considered as manager level staff. Under overall supervision of PM, a dynamic team has been built for BWHC,A.

A total of 30 people are attached with the project as regular staff. Besides, there are 32 CHVs who receive monthly allowances and work under the direct supervision of CEs.

LINKAGES

With GOs

BWHC,A has close collaborative relationship with all relevant governmental bodies. It has to renew the official approval in every three years through NGO Affairs Bureau. BWHC,A believes NGO Affairs Bureau as an umbrella. Furthermore, it receives a constant support by government at program level. It gets all logistics for immunization from Directorate of EPI. The same is true in case of family planning. BWHC,A also procures IEC materials for behavioral change from Directorate of Family Planning as well as Directorate of EPI.

With Peer NGOs

As BWHC,A provides services for reproductive health, so in this field it has peer or like minded NGOs like Marie Stopes, Radda Barnen, Concerned Women for Family Planning (CWFP) ATTAM and some other NGOs. Actually it has connections with all NGOs those being operational in this field. Besides, it collaborates with other NGOs having identical programs. For example, it provides training or technical assistance to FWVs for Bangladesh Association for Prevention of Septic Abortion (BAPSA), a local NGO. It also provides technical assistance to Governmental

Total staff of BWHC,A:	33
PM	01
MO	03
[female: 02 and male:01]	
Paramedic	04
[all females]	
CA	01
CEd	01
NRUS	01
Counselor	01
Receptionist	01
AS	01
AE	01
SDT	01
CS	01
CE	05
MSW	02
Guards	03
Ayas	04
Accounts Assistant	01
Administration Assistant	01
*PM: Program Manager, MO: Medical Officer; CA: Clinic Assistant; CEd: Clinic Educator; NRUS: Nutrition Rehabilitation Unit Supervisor; AS: Adolescent Supervisor; AE: Adolescent Educator; SDT: Skill Development Trainer; CS: Community Supervisor; CE: Community Educator; MSW: Male Social Worker.	

FWVs on menstrual regulation. BAPSA selects FWVs through government and assign them to different NGOs. BWHC is one of there NGOs selected by BAPSA for the purpose.

In the field of imparting training, it has a relationship with CWFP. During training for Paramedics, CWFP sends its participants to BWHC,A for gaining practical knowledge.

BWHC,A's reproductive health package is a comprehensive package. It needs hardly any help from other NGOs for service delivery, but it seeks help in case of referral. Excepting reproductive health service, it does seek help for other purposes from other NGOs. Such as, in case of literacy program it links with BRAC if there is any BRAC non-formal literacy program being functional over there. Similarly, it links its clients with other NGOs having credit program. BWHC,A just builds up legal awareness to the community people but do not provide any legal support directly. It also ties up the program with other legal aid giving NGO if there is any such NGO working in the catchment area.

The following table shows linkages of BWHC,A with other institutions/organizations. Second and Third columns of the table reveals extent of relationship and types of linkages, respectively.

LINKAGES OF BWHC, AGARGAON WITH OTHER ORGANIZATIONS

Linkages with	Rank	Type of linkages
INTERNAL		
Central Office	+++++++ 8	Overall plan comes from central office
PLAN International	+++++++ 8	Fund giving organization
EXTERNAL		
Local Committee	+++++ 7	Receives local support for the project
Dhaka City Corporation Zone no. 7	+++++ 5	EPI and TT; all necessary papers for NID, Polio. MNT, mop up
Family Planning Office	++++ 4	Provide contraceptives
National Library	+++ 3	Allows us to organize rally and other programs at National Library compound
Bangladesh Television	+++++ 5	Time to time covers the project
ICDDR,B	++ 2	Two-way linkage: our physicians receive orientation training at ICDDR,B and interested persons from ICDDR,B come to BWHC,A to collect data
FPAB	+++++ 5	Organize program for adolescent girls; the group won prize in the competition
VHSS	++++ 4	Two-way linkage for skill development. Provide training and training materials; send participants to BWHC,A for training on RTI/STD
AITAM	++++ 4	Two-way linkage for skill development. Provide training and training materials; send participants to BWHC,A for training on RTI/STD
OGSB	++++ 4	Two-way linkage for skill development. Provide training and training materials; send participants to BWHC,A for training on RTI/STD
BIM	+++ 3	Provides training to our staff
BSSIR	+++++ 5	Invited BWHC,A in Nutrition fair organized at BSSIR premise and we won the first prize in 1998 and the second prize in 1999; it brought BWHC,A in the limelight
BRAC	+++++ 6	Collaboration for NFPE program
BFF	+ 1	Invited BWHC,A to attend the rally on International Breast Feeding Day
Radda Barnen	+ 1	Provides posters, brochures, leaflets etc.
Newspapers	++++ 4	Time to time cover the project
Rotary Club	++++ 4	Provides three stitching machines to adolescents
UNFPA	++++ 4	Provides medicines for RTI/STD distributing concerned patient free of cost; also provides medical instruments
UNICEF	++++ 4	Provides medical instruments including MR set
SSC	+++++ 6	Provides training on Adolescent programme designing, promotion of adolescent programme, establish linkages with others.

Using qualitative tool explained by the authors the above table was constructed by BWHC,A staff.

According to them, the project is deeply linked with its central management as the overall plan of this project comes through central office. Same depth of linkage it has with PLAN as it provides necessary funds for this project.

For this project, local committee for Agargaon slum is vital. Without the direct support of this committee, it is not possible to run the project in a slum context. So, BWHC,A maintains a good relationship with the committee after its central management. From its program context, BWHC,A identified BRAC as the next actor for bearing a strong linkage as it collaborates NFPE (non-formal primary education) program of BWHC,A. The same level of linkage it has to maintain with the South South Centre (SSC) as it (SSC) provides training on Adolescent programme designing, promotion of adolescent programme, establish linkages with other relevant organizations.

After BRAC and SSC, BWHC,A identified four institutions having similar extent of linkages but nature of linkages with the project is not same. Institutions are: DCC, FPAB, BSSIR and BTV. Other than DCC, remaining three institutions are important to BWHC,A for campaigning. DCC provides all necessary supports for EPI and TT. Adolescent group of BWHC,A participates in programs organized by FPAB which heightens the image of BWHC,A as the group used to win prizes. The same is true in case of BSSIR where nutrition rehabilitation unit of BWHC,A participates in programs and used to win prizes. BTV covers BWHC,A time to time which ensures campaigning.

A bit lesser extent of link it maintains with newspapers for publicity. BWHC,A keeps same extent of link with Rotary Club as it provided three sewing machines to Adolescents under this project.

BWHC,A has almost same extent of linkages with UN organizations including UNICEF and UNFPA. Both UNICEF and UNFPA provide medical instruments including MR set to BWHC,A. Additionally UNFPA provides medicines for RTI/STDs for distributing concerned patients free of cost.

For training purposes, it has same extent as well as same nature of linkages with VHSS, AITAM and OGSB. Also it has a lesser extent of link with BIM for training purpose.

BWHC,A has minimum linkages with Bangladesh Breast Feeding Foundation (BFF) for inviting them in a rally on International Breast Feeding Day and with Radda Barnen as it provides posters, brochures, leaflets to BWHC,A.

Organogram

SERVICES BWHC,A OFFERS

BWHC,A includes all components in its service delivery package that Bangladesh Government already identified for rendering services in reproductive and sexual health known as essential service package (ESP).

<p>A. Base Clinic</p> <p>Registration Health Education Counseling Services</p> <ul style="list-style-type: none"> General Health (MCH) Family Planning (injections, pills, condoms and copper T) ANC PNC RTI/STD EPI TT MR Check-up Services for NRU Services for Adolescents' Health <p>Follow up Refer Drug distribution Monthly report</p> <p>Provide training For Traditional Birth Attendants (TBAs) For Community Health Volunteers (CHVs) Orientation training Training on Reproductive Health (AITAM, OGSB) Staff Training for skill development</p> <p>Monthly meeting (for all staff) Day observance Autoclave Incineration</p>	<p>It includes ANC, PNC for pregnant mothers. In case of childcare, it offers immunization as well as nutrition program. It also provides services to the children for preventing them from ARI, Diarrhea, and Malnutrition.</p>	<p>C. Evening Clinic</p> <p>Registration Health Education Counseling Services</p> <ul style="list-style-type: none"> General Health (MCH) RTI/STD ANC PNC Family Planning (injections, pills and condoms) MR check up and refer EPI TT <p>Drug Distribution</p> <p>Monthly report</p> <p>Case-wise Referral</p>
<p>B. Satellite Clinic</p> <p>Registration Health Education Counseling Services</p> <ul style="list-style-type: none"> General Health (MCH) Family Planning (injections, pills and condoms) ANC PNC RTI screening EPI TT Refer clients to base clinic for MR Case-wise Referral <p>Drug Distribution Monthly report</p>	<p>It designed program for adolescent groups for their safe livelihood.</p>	<p>D. Nutritional Rehabilitation Unit (NRU)</p> <p>Registration and Admission Health Education + Meeting with mothers Growth Monitoring Free Food Distribution (for child and mother) Cooking Demonstration Health Support Check-up and other services Follow up and refer Monthly report Field visit Training Weeklong Fair on Nutrition</p>
<p>BWHC,A works for women to keep them free from STD/RTI and HIV/AIDS. It also provides services to spouse of any woman for STD/RTIs.</p>		
<p>It provides clinic-based services and offers overall public health services. Unit-wise activities given in separate boxes will furnish a clear picture of BWHC,A.</p>		
<p>Unit-wise Activities and Services</p>		
<p>There are four different units under BWHC,A. They are: Health Unit, Administration cum Accounts Unit, Adolescent Club Unit and Community Development Program Unit. Health Unit is divided into four sub-units, namely Base Clinic, Satellite Clinic, Evening Clinic and Nutrition Rehabilitation Unit. Above two boxes cover main</p>		

activities and services under Health Unit of BWHC,A.

Dwellers in Tulatola slum identified Services that Coalition used to offer as follows:

- Treatment facilities for malnourished children
- Distribute medicines in half price
- Perform thorough check ups
- Immunize our children
- Perform door to door visit
- Help those who can not afford

They also said that Coalition is for all members of a family. ‘Adult males who are not of good character and used to suffer from bad diseases are also included in the program’ – said one slum dweller.

Main activities for Administration cum Accounts unit, Adolescent Club Unit and Community Development Program Unit are given below:

Administration cum Accounts Section
Office maintain Management
Meeting with Local Committee Coordinating meeting with PLAN Organize workshop Arrange training programs
Pay remuneration Deal all bills and vouchers Purchase House rent Audit Monthly report Maintain visitors Internal money deposit

Adolescent Club Unit
AFLE NFPE Skill development Cutting Embroidery Stitching Boutique Essay writing Drawing Recitation Other cultural activity
Day observation
Competition
Training Leadership Training
Meeting Parents Leaders Adolescents
Field based adolescent activities
Client referral
CHV

Community Development Program Unit
Fieldwork Awareness Raising Program (ARP) Growth Monitoring NID, MNT, Mopup
Day Observance <ul style="list-style-type: none"> • Breast Feeding Day • AIDS Day • Population Day • Sanitation Day • Nutrition Day • Environment Day • International Women’s Day • Any other international day
Follow up and referral
Baseline survey
Household Recording
Assistance of CHV for Satellite Clinic
Assistance of MSW in group meeting, social mobilization, adolescent group formation
CHV and CDU meeting
CHV training
Clinic education

CHAPTER FIVE

MANAGING THE PROJECT

Planning and Decision Making

Program Manager, the Head of the project, holds decision-making authority. Often some proposals come from field level to consider or reconsider. PM herself is responsible for solving problems that used to come from the field. At the same time, from the program perspective she decides whether any program needs to be redesigned.

Before making any decision, PM used to share the idea with manager level staff (Medical Officers). Then she brings it to the Supervisor level staff for their consent or feedback. Considering feedback from them, PM goes for implementation.

This is not all. Some programmatic decisions come from upper management from central office. PM has to incorporate different components to the project that come up as outcomes of any strategic planning meeting of overall organization. Besides, some times decision becomes donor driven. In that case, PM has to implement the decision based on criteria or changes made by donor.

It also takes into account the suggestions of target people. For example, it was scheduled that the duration for meeting of Awareness Raising Program will be of two hours and each group will be consisted of 20 members. But members of the group raised valid points such as keeping aside all household chores two hours are too long for them to manage and it is difficult to find out enough room for the meeting where 20 women can sit together in Agargaon slum. So BWHC,A had to redesign the program. It relaxed both duration of the meeting and size of the group. Now time duration goes down to an hour and the group size becomes 12 to 15.

The entire responsibility for the day-to-day planning and implementation of the program rests with the health workers. Each and every program runs under an annual plan. The plan clearly specifies objectives for the year, list of activities and the budget. Planning includes topic to discuss, materials required and methodology to adopt.

The annual plan is split into monthly plans. It specifies all activities for each month to fit into annual plan and objectives. Thus every staff in BWHC,A irrespective of designation has specific functional responsibilities and objectives.

How efficiently a staff is able to plan and implement as well as his/her capability to meet objectives depicted in the plan is a critical criterion for performance appraisal.

Major changes are discussed at an executive committee meeting and/or approved by the honorary Executive Director.

Human Resources Development

BWHC had a thorough strategic planning in 1999. This is for the first time BWHC introduced such a detailed planning program since its inception. Including managers from different centers, the top management from central office exercised thoroughly. Mr. Golam Samdani of BRAC facilitated the whole process. BWHC identified key issues and strategic directions in this process. Among them, skill development of staffs was identified as a very important component. BWHC designed an improved plan to meet all existing loopholes. To maximize

staff efficiency, BWHC designed where to render further efforts in future. The plan also includes the Agargaon project.

BWHC,A considers human resource development as one of its important tasks. Developing community health volunteers and TBA from field is a mentionable effort by BWHC,A. BWHC,A offers in-house need-based training. Also it sends participants to external training.

Recently the PM has obtained training on Community Managed Health Approach as BWHC,A is shifting towards this approach.

Management Information System

BWHC has a fairly strong centrally controlled MIS and Operations Research unit. Recently it has further developed. BWHC introduced MIS in 1984. An expatriate expert developed MIS for BWHC. It developed a package for reproductive health MIS. At that time rarely there was any MIS for reproductive health activities in this country.

Recently the whole MIS was reviewed by a US Consultant and he developed an MIS which is more utility based. Decision making process has become more decentralized and it is now more focused on clients. This system will indicate changes that are being brought to the life of a client or to his family members due to the program under consideration.

The unit is concerned with following kinds of database and reports:

a. clinical service database

these data sets contain pertinent information on all clients who receive clinical information and services at either the centre or satellite level.

b. community service database

the household permanent record card is the central repository and contains all critical household information in a summarized and readily accessible form.

c. group service level

these database consists of program specific records, which include Functional Literacy Program, Awareness Raising Program and Adolescent Family Life Education.

Notably, the MIS of BWHC has been a key issue for discussion in a recent governmental meeting. BWHC,A developed a format for group monitoring at the field level. To make it all useful, appropriate symbols are used for each indicator (see Appendix A).

Performance Review

Under chain supervising system, the immediate supervisor used to evaluate his/her subordinates directly. BWHC,A also have a similar supervision system to all staffs. Performance appraisal is done once a year. All staff, starting from the most junior worker to the Programme Manager, is appraised.

Incremental system implies the progress of a staff. A staff gets an increment if s/he does better. Annual increments or promotions, if any, are given on the basis of this appraisal.

Both supervision and evaluation play a role for this. Higher officials used to recommend for their lower tier staffs. BWHC,A also developed a form to evaluate a staff. It is a both way evaluation form to which a staff can also render his/her inputs.

At the level of health workers, the appraisal is based on their knowledge as well as on their effectiveness in the field as demonstrated by the performance of their respective working area on various outcome indicators.

Senior staff members who have functional and administrative responsibilities are assessed on how the programs for which they are responsible have performed as compared to the objectives established in the annual plan. In addition, other members also give feedback on how well the administrative responsibilities have been handled.

CHAPTER SIX

BASE CLINIC

Concept

BWHC,A provides most of its services in a clinic-setting. Alike all other BWHC projects, it has a base clinic (permanent clinic) - surrounded by three satellite clinics or outreach centers located within Agargaon slum area.

It provides same patterns of services in both the base clinic and satellite clinic. As satellite clinics are in a simpler form and less equipped, it provides mainly primary healthcare in these clinics. But in the base clinic, it offers a bit higher level and complicated services including MR.

In order to improve quality of services and render reproductive health services in general, and increase ANC and PNC in particular, BWHC,A promised that the number of general health patients would be limited up to 40 per day. Also it is committed not to ignore any patients deserving emergency services rather emphasis is given on educating and motivating the mothers to come for ANC and PNC. Official document says since its second year of execution, quality assurance measures like Client Oriented Provider Efficient (COPE) are supposed to be instituted.

Personnel of this clinic concentrate on the essential packages of services. However, this clinic also collaborates with other local NGOs, private and public health institutions so that through a network of referrals, the beneficiaries receive comprehensive services.

As for example: BWHC,A refers complicated pregnant mothers to Suhrawardy Hospital or Azimpur Maternity Clinic; ligation clients to Mohammadpur Fertility Service and Training; sick children to the Dhaka *Shishu* (Children) Hospital or Al-Marakajul, etc.

Anyway, if any of the clients from satellite centre come to base clinic (either referred or normally come for other services), one health file is opened against the satellite registration number. Separate registration book is maintained against each satellite centre.

Some data

Estimates based on service statistics of last two years (April 1996-March 1998) show a three-fold increase in the number of RTI clients. Family planning services increased almost 5 folds. Though number of clients for the ANC and PNC services are still not satisfactory, it almost doubled in the second year. Vaccination increased about 3 times and TT in non-pregnant women (about 5 years) increased 4 to 5 times. Night-blindness cases dropped to 1/4th in the

Description	
WORKING HOURS	9AM to 5PM
WORKING DAYS	5 days (Sunday through Thursday)
STAFF	
Medical Officer	2
Counselor	1
Paramedic	4
Clinic Assistant	1
Ayah	2
Receptionist	1
Clinic Educator	1
REGISTRATION TIME	9AM to 4PM
SERVICE DELIVERY TIME	9AM to 5PM
RECORD KEEPING	2 PM to 5PM
SERVICE PROVIDED	
Counseling	
Family Planning	
Menstrual Regulation	
STD/RTI- Syndromic management	
Ante and postnatal Care	
EPI	
Vitamin A distribution	
General Health Care	
Health Education	
Referral	

second year. Gynecological cases dropped to ½ but Obstetric cases increased 3 folds. Number of General Health services is still high but it remained static since the beginning.

Record Keeping

BWHC,A holds a systematic record keeping. It preserves a separate file for each client containing all necessary data including medical history. BWHC,A believes that this systematic record keeping is helpful in ensuring quality service and appropriate follow-up. Based on this, concerned health providers can decide the nature of treatment, course of future treatment or can consult with the client ins and outs of her/his disease.

Autoclave

After use, all syringes are poured to a container and these are boiled under a particular pressure and temperature to get that germ-free. It is called autoclave. This is for reusing those kits.

Incineration

To keep the health centre infections free, all used cottons and gauges are burnt at the end of the working day.

RATIONAL DRUG MANAGEMENT

Using drug formulary and treatment protocols

As per the rational drug management, BWHC,A adopts drug formulary and treatment protocols by the first year of the project period. Experiences of other partners of PLAN like GK and LAMB Hospital, and protocols of national programs have been utilized in this regard.

Introducing Monitoring Prescriptions

Regular monitoring of the prescriptions and quality audits ensures rational prescriptions and less treatment costs to the patients. The monitoring officer of BWHC monitors the prescriptions once the drug formulary and treatment protocols are set in.

Pricing Policy

BWHC,A introduces a pricing policy for recovery of the cost. There is a safety net for the poorest of the poor. Exemption criteria for them are also formulated.

This pricing policy is developed to recover substantial amount of medicine cost from the patient. At least 25% of the total medicine costs is supposed to be recovered in the first year of the project period, and by the end of the project period recovery rate of prices of medicines was 60%. Side by side, BWHC evolved a mechanism to provide safety net to the poorest section of the community by exempting them from paying for medicines.

The table given below tells about fees charged over time by BWHC,A for healthcare.

Fees for Health Care Under BWHC,A

Year	Registration Fee (tk.)		Service Charge (tk.)	Medicine Fee (tk.)
	New	Old		
1996	5	2	10	Free
1997	5	2	15	Free
July, 1998	5	2	15	Half Price charged*

* Half price charged from customers for general health care, ANC, PNC, RTI/STD and check ups.

For EPI and TT	:	Only registration fee is charged.
Fee for MR	:	Taka 200.
Fee for FP	:	Taka 5.
Fee for ANC pathology test	:	Taka 10.
Recompense taken for lost card	:	Taka 5.

For Solvent Family

Service charge taken	:	Taka 30
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(To them, medicine not given - only prescribe)

Scenario of Introducing Money against Medicines

Initially, BWHC,A distributed required medicines to all of its clients free of cost. Only it takes registration fee taka 5 for new patients and taka 2 for old patients. Service charge was changed over time. In 1997, BWHC,A increased service charge to taka 15 from taka 10. Since July 1998, it charges half of the price for all medicines. But in case of medicinal price, BWHC,A considers all poorer clients. So it follows a 'zero to some amount' criteria. In other words, it follows some pre-service criteria. BWHC,A charges according to the services that are provided to any patient, but there is every provision to waive all charges (excepting registration fee) in case of valid reasons. It developed a 'free service criteria' format for financially worse-off patients. A destitute or financially unstable patient needs to fill up this format. To enjoy waiving required money, the format is verified by PLAN or volunteers of BWHC,A.

BWHC,A experiences a very upsetting scenario due to increment of service charge and introduction of price for medicines: there was a sharp drop in number of clients. Clients being habituated with 'relief-type' health services initially could not response with this price introduction. For BWHC,A, it took six months to witness an increasing tendency of the clients. Recently it covered up the gap. The number of clients is increasing day by day.

It indicates, patients are convinced with BWHC,A services and they are ready to purchase services from this centre despite of having governmental health service point in the locality (in Shahidertek slum).

Clients about Introduction of Charges for Medicines

One participant asked in a very confusing tone why the Coalition charges money against medicines. According to her, medicines to be distributed to all people residing in the slums

should be free of cost. Again she posed the question why the Coalition shifted from its initial arrangements where it used to give medicines to all patients free of charge.

Facilitator wanted knowing from them whether they were informed the reason behind taxing half of the charge for medicines. In reply they very confidently denied of hearing anything about this from anyone on behalf of Coalition.

Three of them suggested getting back to the initial arrangement that is charging no price at all for medicines for the sake of destitute residing in slums. Other (4 women) proposed to charge money following the ability to pay principle and suggested not taking any price from them whom could not afford in any way.

The topic did not get its end here. One of them again raised the question if some people have to pay for medicine and others do not then it will create some problem. 'If it is decided to take money for medicine then we must impose it to everyone irrespective of socio-economic status. As we know it is not possible for everyone to bear the cost, so what is the use to charge money to some of us? So it is better to waive this charge'.

All agreed that paying half of the price for medicine is not mandatory. Coalition considers those clients who can not afford. But they complained that in that case concerned Coalition person sometimes feels disturbed.

They want to avert charges that Coalition recently introduced in the program.

'Coalition did not charge any money for immunizing a baby or a pregnant mother earlier. Only we had to pay taka 5 for registration. That's all. But from last October 1999 it charges taka 2 for every single injection in addition to registration. Coalition people disagree to push any injection if we can not manage taka 2 for each injection. We feel bad, as we have to pay taka 2 against painstaking of our children (*amader polapain baether baethao paibo abar duida taekao dimu*).

Another participant said, "Again we have to pay taka 20 for each check up. It is too much for us." She continued, " I did the same check up from Radda Barnen at Mirpur by paying taka 12 only. Other than check up, they also provide us iron tablets, perform blood test within this amount".

One complained that Coalition does not consider emergency patient violating the serial number.

One (Noorjahan) made her understand that if we do not maintain the serial then the whole system will collapse. 'For the sake of quality service we must keep ample of patience. Besides, Coalition maintains a serial for each patient. So we must honor this'. She also disagreed that Coalition never ignored any serious patient.

Another participant pointed out with a very strong voice, "Say, we five came to Coalition's Satellite Clinic for treatment. If clients are treated serially, then it is possible for me to guess about the time of my turn. By that time I can come back to my hut for looking after my children or giving more fuel to my burner for cooking, if require and return to the clinic again on time. I don't need any transport cost for this. You see - along with my treatment I can continue my household chores. So I prefer Coalition the most."

One but everyone agreed to that.

They also added, "If we want to go anywhere other than Coalition for treatment, we have to give up all of our household chores for that day. It is somewhat botheration for us. At the same time we get quality service for our health from Coalition. So why do we care for other health centers far away from our place whereas we have a friend like Coalition at our doorsteps? For that reason we feel convenient attending Coalition's health center."

'We usually visit satellite clinic mainly for immunizing our babies, consulting some family planning problem and for general health problem. Satellite *apas* used to refer us to Coalition's base clinic - 5 minutes walk from here, if they feel. We try to follow their instructions'.

'I did not find any services given without taking money. I also did not go there without money. I had to give half of money charged once I went there'.

'I never went there with money. From the very beginning I have been treated there free of cost.'

'We did not ever hear anyone coming back from Coalition without proper treatment or advice for money. If anyone of us is not in a position to pay money for medicines, then she does a verbal appeal to Rabeya *Apa* (the CE). I saw Rabeya *apa* instantly issuing a slip to the concerned authority of Coalition for consideration. And at the same time I did not hear dishonoring any memo issued by Rabeya *apa*'.

Some of them remained reluctant on the point of paying money for medicines. They said that it is convenient for them to pay money for registration instead of medicine. But the others made them understand to share some money with Coalition as it is doing a lot for them. With a bit confusion finally they agreed to pay half price for medicine.

Medicine Use

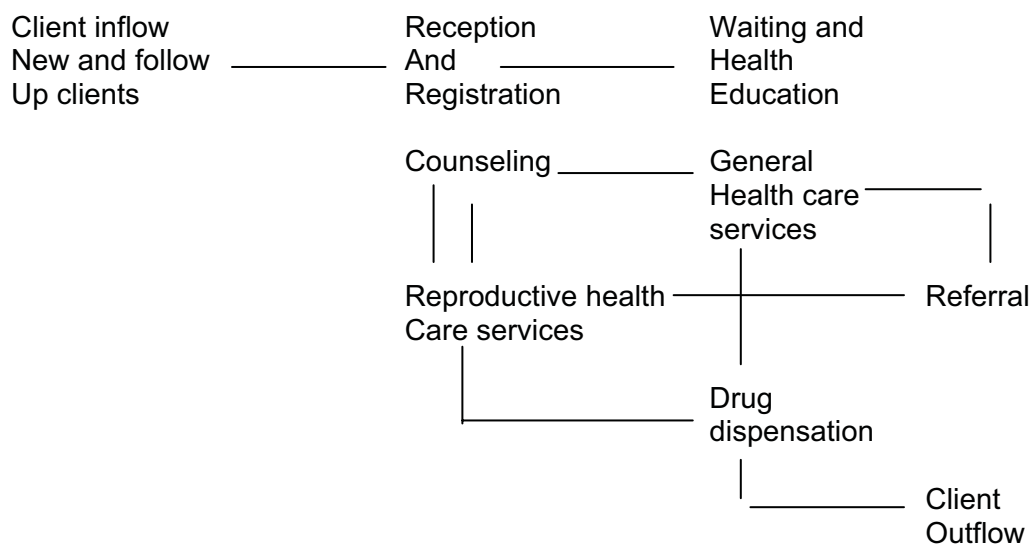
'Sometimes Coalition gives us half of the bottle of Syrup to take. If they are not giving us medicine in full, rather taking half price of that, then obviously we are being losers'.

'It is not good to waste additional medicine after use. *Apas* know quantity or doses of any medicine and they give us medicine as per our need. So why should they give you a full bottle if half of that is okay for you? '.

All agreed. Finally they come to a consensus that Vitamin or medicine is made for ensuring sound health. But taking medicines unnecessary is harmful. It is wise to take medicine as Doctor suggests.

'We think it is good to take medicine for health. But we don't know whether body needs any medicine. Doctor understands well. We do not understand. So we need to keep in touch with health centres like Coalition'.

Service Flow Chart : Base Clinic



In the Base Clinic, services are provided in a very systematic way following the above flow chart. All the staffs are always ready to render services to their clients. Patients are mostly mothers of different age groups and their children. Satisfied clients are the main actors for ensuring new patients in the base clinic. Shilpee and Farida, two clients, tell about this clinic as follows:

Shilpee

“I am of 12 years. I got married three years' back (at the age of 9 years). I gave birth a baby just two months' ago. I have 4 siblings. Of them three are sisters. I came to this clinic along with my younger sister. I got to know about this clinic from my sister-in-law.

I came here to listen what *apas* of this office say regarding my baby's care. I also heard I have to immunize my baby on time. *Bhabee* told me this health centre provides all services of this sort. So I am here with the desire if my baby is immunized.”

Only Because of Demeanor

Farida, a dweller of Karam Ali slum, took her baby to a non-BWHC health centre sometimes in 1996 as the baby had mild cold. The staffs on duty that day were very busy and shouted at Farida 'Do you want us to waste our time over a simple cold? Come back when we are less busy.'

Farida did not like being shouted at. This experience gave her a bad attitude toward the health staff of that centre. Still she does not like or respect them. This bad attitude discouraged Farida from attending the health centre next time her child was sick. One day she came to know about BWHC,A, another health centre within vicinity, sometimes in 1997 from her neighbor Parveen. She heard Parveen appreciating all arrangements and services that being rendered by BWHC,A. Farida remembered that Parveen's baby was successfully treated at BWHC,A. The positive attitude towards BWHC,A, which Farida had gained from neighbor's experience, encouraged her to go to BWHC,A next time her own baby was sick. Now Farida considers BWHC,A as a part of her family and goes there if she faces any health problems within the household.

Voices of Shilpee and Farida reveal clients' expectation and view towards this clinic. Confidence upon staffs of this health centre was not built in a day. Staffs of this centre are not merely service-holders rather they feel obligated in case of providing services to all destitute women. Probably formation of poor fund is the exact example of their commitment.

Formation of Poor Fund: An Innovation?

Service charge or medical charge can sometimes be given up. But to receive any services from BWHC,A, registration fee of Tk. 2 is mandatory for all irrespective of socio-economic status of clients. Common experience by Coalition staffs is that they used to face those patients who could not bear even the registration fee. Anisa, the Medical Officer, remembers a pregnant woman who came to this center two years' ago after being beaten brutally by her husband. 'She needed an ultrasonogram immediately as the heart bit of her baby inside was not found. Unfortunately this poor woman was lacking fund for this test. Other than this very test there was life risks for both mother and the baby. For the sake of their lives we had to collect fund and thus the test was done. Finally they were saved.

Similarly, many other patients used to come to this centre who need to do ultrasonogram, blood tests or urine tests, but they do not have fund for that. Even they do not have money to go other places (say, Dhaka Medical College Hospital) we generally refer. Considering all these we thought to organize a common fund, which will be used particularly for this type of cases. 'The name of this fund we selected as Poor Fund'.

Consequently in a monthly meeting the Medical Officers along with Non-Manager staffs raised the issue of developing a Poor Fund. All staffs, from Project Coordinator down to Guards, of this centre were present in the meeting. The Poor Fund agenda was unanimously accepted in the meeting. Project Coordinator made it clear that Poor Fund should not be considered as a component of the project. Rather, it is completely an effort by BWHC,A staffs.

For generating fund, a monthly non-mandatory subscription schedule for all workers was developed. Charges per month that fixed for staffs according to official position are as follows:

Project Coordinator/Medical officer	:	tk. 25
Counselor/Supervisor/Accounts Assistant/Paramedics	:	tk. 15
Receipcinist/Clinic Asst./Male Social Worker/Others in same rank	:	tk. 10
Aya/Messenger	:	tk. 05

All accepted the proposal cordially. Tk.220-240 is usually collected per month. There are some those are not able or willing to pay for the fund. In that case they are not bound to give money.

It was decided that the fund would belong to counselor. Now it becomes easier for staffs to deal with patients who come to this centre with empty hands. Required money for any particular cases are shouldered through this poor fund. Recently some employees donated their *jakat* in this poor fund. Hence the fund is enlarged. Current (December 1999) balance is Tk.986.

'When the adolescent girls are promoted from one class to another, they need new books and khatas. We help them to buy those books from this fund. Again, our non-formal education is up to class V only. We have some adolescent girls who are very much willing to continue their education, but are not able to provide their tuition fees' says the Counselor.

The Adolescent Supervisor requested whether she could have money from the poor fund to help all adolescent girls interested to continue their studies. Counselor says, 'We have provided financing to 4 or 5 girls from Poor Fund to continue their education. They got admitted in Taltola School'.

According to the Counselor, "Poor Fund concept of course an innovation, though it is no component of the project'. She expressed her deep concern over the self-generated Poor Fund as for its size and longevity. Instead, she dreamt an in-built poor fund within the whole mechanism where clients would also be a part generating the fund. 'And consequently, that will be an addition and of course an innovation of this project'.

Though Medical Officers took the initiative, now it becomes a collaborative effort of all staffs under this project. It also hints at innovativeness of the team, though not of the project itself, working in the centre.

CHAPTER SEVEN

HEALTH EDUCATION AND COUNSELING

a. Health Education

Concept

BWHC,A believes health education as the part of healthcare that is concerned with promoting healthy behavior. Once it is known what health is about, it is important to answer the question

Topics Covered in Health Education	
1. Personal hygiene	
2. Extra Cares for Pregnant Mothers	
3. Ante natal care	
4. Drinking Water	
5. Health Care System	
6. Tinned Milk is dangerous	
7. Weaning Food	
8. Diarrhea	
9. Care of ears	
10. Worm	
11. Preventing irritation	
12. Leprosy	
13. Care for eyes	
14. Care for any cuts	
15. EPI	
16. Primary Health Care	
17. Rural Health Education	
18. Use of safe water	
19. Flash cards on Health and Nutrition	
20. Measles	
21. Tube-wells	
22. Cleanliness of Environment	
23. AIDS	
24. Menstrual Regulation	
25. Reproductive Health Manual	
26. Prevention of Pneumonia and remedy	
27. Family Planning Manuals	
28. Responsibilities of mother	
29. Flip Charts on Family Planning, and Mother and Child health	
30. Diarrhea kit	
Sources of IEC Materials	
BWHC,A collected IEC materials from different sources. They are:	
• Bureau of Education	
• Concern, Bangladesh	
• VHSS	
• ICDDR,B	

'who is a health educator?' It is true that some people are specially trained to do health education work. We may refer them as specialists. In case of BWHC,A, it is

Clinic Educator who is playing this vital role. But since all health workers under this project are concerned with helping people to improve their health knowledge and skills, BWHC,A considers as true that all health workers should practise health education in their jobs. By carrying out health education activities, medical officers, paramedics, dispensers and of course community health workers, can make health more effective. Henceforth, BWHC,A emphasizes on health education.

In health education the educator is conducted about how people actually feel, not how s/he thinks they should feel. The educator is interested in how people look at their own problems. BWHC,A wants people to develop the confidence and skills to help themselves.

Process

In the Base Clinic, the health education session is designed at the entry point. Just entering the clinic the patient is supposed to sit for a while for registration and some other formalities. The Clinic Educator utilizes this very time getting them involved with relevant health issues.

Health Education session starts just after the patients gather in clinic in the morning and continues up to lunch hours.

To make it more organized, BWHC,A follows a systematic sitting arrangements for participants in the health education. It categorizes four types of patients according to the nature of health services they seek, namely general health, EPI,

Description

WORKING HOURS Utilise patients' waiting time (9:30 am – 12:30 pm)

WORKING DAYS Sunday - Thursday

STAFF Clinic Educator

MR and FP. So it is possible to count day loads of patients by nature of their problems just having a look on the sitting audience of the health education session.

Health education is also provided in different satellite clinics. CHVs are responsible for these sessions.

Materials used

Other than lectures, different materials are used to get patients involved in health education sessions. These are:

VIDEO Cassettes

1. ANC
2. PNC
3. Breast Feeding
4. AIDS
5. Special Care during delivery
6. Family Planning
7. Diarrhea
8. ARI
9. Beginning of a dream
10. *Chalan*
11. Tortures
12. Human Rights
13. Gender Discrimination

- Videos
- Flip charts
- Flash cards
- Demonstration materials

Clinical Health Education Guidelines developed by BWHC,A and sources of IEC materials are shown in a box on the previous leaf. BWHC,A has videos on different health issues. Video list shown in the box reveals other than health issues, BWHC,A deals with some other important topics including Human Rights, Gender Discrimination and Violence Against Women and Children.

Witnessing HE Session

Forty-five up Ms. Rawshan Ara Begum takes the responsibilities for health education in BWHC,A. She is educated up to higher secondary level. Her designation is Clinic Educator. She had training on health education. She says, "During my session, I try to follow approaches of health educators in TV programs 'Aapnar Shastho (Your Health)' and 'Maa O Shishu (Mother and Children)."

On the first half of any working day, she deals with patients for health education in the Base clinic and the other half of the day, she provides AFLE to Adolescent groups in two high schools under the locality.

On 29 November 1999, we visited Rawshan's morning session at Base Clinic. The session started at twenty past eleven in the morning and continued up to thirty minutes. There were seven patients sitting at the beginning of the session. Other five patients joined during the session. Rawshan delivers two different topics in each of her session. Additionally she covers a common topic -- the rules and regulations of the base clinic. At the end of the session, she gives time for meeting any queries. Rawshan selected topics for that session as follows:

Rules and Regulations of BWHC,A Base Clinic
EPI and Six Deadly Diseases
Cares for Pregnant Mothers
Queries

A brief description and analysis of the witnessing session is given below:

The topic chosen relates to the interests and needs of the target group.

BWHC,A provides HE before the health workers start to see patients. This is a time when people remain alert. There is fewer disturbances. More people are present.

Length of session is short, ranging up to 30 minutes, to prevent boredom. According to the Clinic Educator, "If the presentation lasts too long, mothers will become anxious about missing their turn with the health worker."

First of all, the Educator explained overall system of the clinic, including services BWHC,A offers and fees they need to pay. Then she get all participants involved in self-introduction.

To make the session more interesting, the educator uses a mixture of educational methods, like story telling and pictures. The educator repeats the same idea about six deadly diseases in different ways. This ensures people understand the ideas and make them remember.

She started the session with an opening comments like 'Good morning. We hope that all your families are well.' It establishes a good relationship and friendly atmosphere.

Also she used a simple, one-idea poster which helps to make points clear.

Time to time she kept asking questions. It encourages involvement and makes clients think.

She praised ideas from the audiences. It encourages them to continue participating and learning.

She considered local culture and the use of local words to communicate ideas. For example, in case of talking about six fatal diseases she called Measles as *lumti* (the local name). Finally she makes sure communication is clear and that everyone understands what is discussed.

She gathered information on mothers' knowledge, beliefs and experiences.

She encouraged participation in coming to understand the problem.

By making use of ideas from members of the group, thereby, involving them in solving their problems, the Educator shows that she respects and values their views.

She reviewed the topic with a visual aid, this helped them see the problem more clearly.

She praised them who answered correctly but didn't embarrass them who gave misleading answers.

She searched around for other opinions until she found the right one.

In the similar way, the Educator covered the topic extra cares for pregnant mothers.

At the end of the session, the educator reminds all participants to bring all of their children up to 5 years to this clinic for Polio on coming 2 December as the day will be observed as National Immunization Day.

Point to mention

During the session, one by one participants were called to the Reception for registration and to the Counselor for counseling. It hampers quality HE session as it breaks concentration of both participants and the Educator.

b. Counseling

Concept

Counseling is one of the approaches most frequently used in Health Education to help individuals and families. BWHC,A considers counseling as the most important vehicle for providing reproductive health services.

BWHC,A believes during counseling, a person with a need and a person who provides support and encouragement (the counselor) meet and discuss in such a way that the person with a need gains confidence in his or her ability to find solutions to the problems.

According to Ms. Nasima, the Counselor of BWHC,A, "Counseling relies heavily on communication and relationship skills. Opportunities for counseling arise whenever we work with individuals and families: with patients at the health centre (base clinic or satellite clinic), with pupils at school or during a home visit, to name a few."

BWHC,A also considers counseling as a part of the treatment and care given to a sick and troubled person. "It is also an important aspect of disease prevention and health promotion because it helps people to understand what they can do, through their own efforts, to avoid illness and to overcome health risks improving their lives" – says Nasima.

Process

After registration, the receptionist sorts out the patients for counseling. Not all patients are entitled for counseling. Only patients who come to this centre with problems related to FP, MR, STD/AIDS, ANC and PNC are selected for counseling.

During counseling, the Counselor not only uses lectures rather uses pictures, posters, dummy sexual organs, flip charts and flash cards.

After counseling if the patient is agreed to receive expected services from this centre then the counselor fills up a form, which is developed separately for each problem. The patients needs to sign it up to express her complete confidence on this centre.

Description

WORKING HOURS

8:00 AM to 4:00 PM (in day clinic)

4:30 PM to 8:30 PM (in evening clinic)

WORKING DAYS

5 days (Sunday through Thursday)

STAFF

Counselor 1 (day clinic)

1 (male clinic)

COUNSELING GIVEN

On FP methods

Advantages

Disadvantages

Complications

Helping to choose an appropriate method

On MR

Pre-counseling

Reason for MR

Idea about MR

Informed consent

Physical check up

Post-counseling

Ensure follow up

Advice

FP method

On RTI/STD

Pre-counseling

Source of Risk factor

Detection signs

Complications

Post-counseling

Advice

Condom protection

Couple counseling-

On ANC

Advice

Ensure follow up

On PNC

FP method

Breast feeding

EPI

Having a complete session, the Counselor refers the patient to the Paramedics or Clinic Assistant. Paramedic seeks assistance of Medical Officers if required.

In case of MR or STD/RTI cases, post counseling is offered.

Counseling is rendered both in Base clinic and Evening clinic during whole of its working hours.

Sample of Counseling

During visit BWHC,A – we got an opportunity to witness a counseling session.

A young lady named Yasmin alone came to the health centre for MR. She is 23 years of age. Resides in a slum outside BWHC,A working area. Her husband Wadud is a rickshaw trader. She is the second wife of her husband. She did not get any formal education. She can sign her name only. She is a housewife. First visited this centre seven months ago. Came to know about this centre from satisfied clients. She has a son of 2 years age. She performed one spontaneous abortion and one MR. She did the MR in her last pregnancy from this centre. So she has a confidence over this centre and plans to perform another MR here. She takes pills for contraception. She gives her son breast milk along with weaning foods. She had her last menstruation almost two months ago. During her previous menstruation her flow was normal. It continued for five days. She did not face with any intermenstrual bleeding. Yasmin wished to have another MR from this centre. Let's see a part of the conversation that took place between Yasmin and the Counselor:

- Counselor : Are you sure that you want to have a MR?
- Yasmin : Yes, I am.
- Counselor : You did a MR last time. Again you want another MR. Do you know this time you have life risk?
- Yasmin : Yes, I know but I have every confidence on you.
- Counselor : That's okay. Would you mind asking you the reason behind your decision for another MR?
- Yasmin : My husband does not want child any more.
- Counselor : I see. But does your husband know your decision?
- Yasmin : Yes, he does. Please keep it secret of my coming here this time.
- Counselor : You keep all confidence on us. You didn't face any problem for your last MR, did you?
- Yasmin : Not at all. Thank you very much for that.
- Counselor : It's a compliment for us. Now tell me, are you determined to do another MR despite of life risk? Sorry to ask the question again.
- Yasmin : Yes, I am. That's why I am here.

Counselor : Okay. You are already experienced with MR. But again I remind you the process.

[The counselor narrated clearly the whole process using a dummy of female reproductive organs. She also showed Yasmin several pictures]

Remember, you must be abstaining from intercourse with your husband for subsequent 6 days of MR. You must be careful not to perform any heavy work at least for two days. You have to see us again just after 2 weeks the MR is performed.

Yasmin : Yes, I agree.

Counselor : If the MR is done, what method do you prefer for contraception?

Yasmin : You know, I am now having pills. Can you tell me options?

Counselor : Of course. Other than pills, you can have

[Counselor depicted a clear picture of FP methods including consequences of each method before Yasmin. For this, the Counselor used different pictures. Learning all this, Yasmin did stick on pills.]

Counselor : It is not guaranteed that you will get a MR. First of all you have to go under a check up. If you conceive of less than 10 weeks, only then MR will be performed.

Yasmin : I agree.

Counselor gave her a clear idea about necessary costs for MR. Finally the Counselor filled up an agreement form and put before Yasmin for her signature. Yasmin responded quickly. Place for signature of her husband remained unfilled as he was absent right at that moment. Counselor reminds Yasmin that the signature of her husband will be necessary if the MR takes place after the checkup. She agreed. Counselor sent her to the Paramedics for checkup.

Examination report suggests her breasts were free from any complication. She weighs 40 kg. Her blood pressure was in normal range (100/70 mm of Hg). Uterus size suggests that she has been carrying a baby for more than 10 weeks. So after consultation with the medical officer, the paramedics rejected performing any MR and advised her to go for ANC under this health centre.

It is appreciated that during the whole counseling session, the counselor kept in mind the rules. The above mentioned experience also implies BWHC,A abiding by its principle of not performing any MR in case of conception exceeding 10 weeks. It refers to the commitment of quality service by BWHC,A.

CHAPTER EIGHT

NUTRITION PROGRAMME

A. Nutrition Rehabilitation Unit

Concept

In order to render first hand assistance to malnourished children, BWHC, A since its inception introduced NRU on experimental basis. The scope here is very limited with little space and only 2 people to run it but it has been playing its part in giving a comprehensive service to the community. This unit provides nutrition and required medical care to the malnourished babies under 5 age. In addition, this unit provides cooking demonstration and nutrition health education to mothers.

Some Data

Previous document says since its inception, 252 children attended the unit and out of them 132 were admitted into it. Only 5 of them needed re-admission, which shows that the nutrition education and the cooking demonstrations for the attending mothers are having positive influence on them. Total number of dropouts before the first discharge was 27, which means the follow-up activities should be strengthened.

The biggest draw back of the unit is its inability to measure impact in the community and relative small coverage.

Process

Malnourished children are mainly selected from community following growth monitoring or day clinic. A child is referred to the NRU if his/her weight for age is seen less than 60% of reference value. The same is true in case of base clinic.

NRU accommodates six target children at a time. They are kept for 10 working days in this unit (from 9 am to 4:30 pm and Sunday through Thursday).

If a child fulfills admission criteria (see the box), then NRU Supervisor explains overall rules and services to the mother. She makes it clear that it is nothing mandatory but for the sake of her children's health she (the mother) should think positively about services that NRU offers. After mother of the child is convinced, the Supervisor gets all formalities done. By rule, if it is not possible for a mother to stay, there must be an attendant, either sister or grand ma or aunt, with the child in NRU.

Description	
WORKING HOURS	9 AM to 4:30PM
WORKING DAYS	5 days (Sunday through Thursday)
STAFFS	:
NRU Supervisor	1
Ayah	1
ADMINISTRATION	logistics and supplies and other coordination with day clinic NRU Supervisor all responsibilities of the unit Project Coordinator direct supervision of the NRU Supervisor
CAPACITY OF THE UNIT	6 babies/day
ADMISSION CRITERIA	Weight for Age < 60% Without Oedema Age-5 months-5 years Staying in the unit-working hours of 10 working days
FINAL DISCHARGE CRITERION	Weight for Age-75% or more
MANAGEMENT OF PATIENTS IN THE UNIT	a. Dietary b. Medical c. Health education for mothers d. Cooking demonstration for mothers e. Recreational
FOLLOW-UP	Fortnightly after 10 working days in the unit- for 1 month and then every month until final discharge.
SOURCE OF CLIENT	Referred by From Community : CHVs, MSWs, CEs From Day Clinic : all staffs

NRU Supervisor takes an hour-long class on health and nutrition to all attendants. Topics used to cover in these sessions are mainly Nutrition, General Health, Safe Water, and Cooking Process. In case of mother having many children, the Supervisor advises on FP and MR. Also refers them to Base clinic. NRU supervisor campaigns for breast-feeding and immunizations.

Children and attendants under NRU are served food twice a day. Children are given Vegetables *khichuri*, a banana with a seasonal fruit (either an orange or an apple), milk and an egg as breakfast. An egg and vegetables are served to all attendants for breakfast. Sometimes fruit is added to them (the attendants), if there are adequate quantities.

For lunch, NRU serves either fish or flesh of meat. In case of meat, either chicken or beef is provided. Additionally, vegetables and pulses are given with rice.

Everyday weight of each child is measured. Anti-biotic and required vitamins are given to diseased children, if there is any. NRU-served medicines usually include components like Folic Acid, B50 Forte, Iron, vitamin C, and riboflavin. It also serves medicines for de-worming.

A child is discharged after 10 working days but a follow up visit is a must until its weight for age comes to 75 percent or more of reference value.

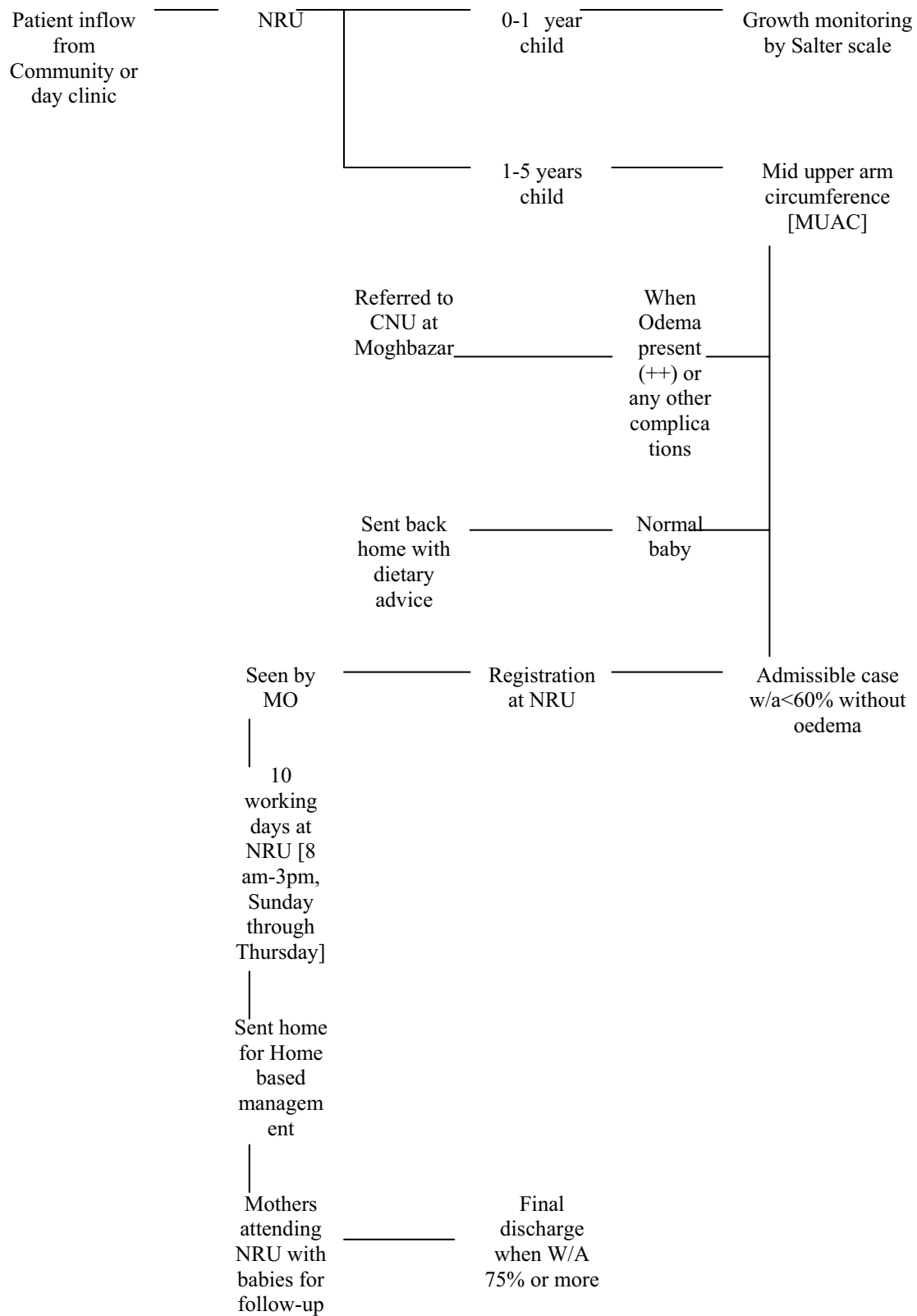
An Exceptional Effort

During fieldwork the concerned CE identified one lean and thin adolescent girl standing beside a hut in Motahar slum. Her name is Salma. Aged 15-16 years. She got married at her 12 years of age. She gave birth a child but it died afterwards. She is now separated from her husband and lives with her parents in Motahar slum. CE officially informed about Salma if NRU can play any role for her nutritional improvement. Salma was invited to have a lunch with BWHC,A people. She narrated everything of her life. Medical Officer declared her suffering from third degree malnutrition after taking weight.

Though NRU does not have any provision to provide support for overcoming malnutrition other than children up to 5 years, but this unit took initiative to motivate other staffs of this health centre to raise a fund for Salma out of humanitarian ground. BWHC,A arranged lunches for her on a regular basis for subsequent 3 months with that generated fund. She was given an egg and milk in addition to routine menu for lunch. Good news - she gained weight and got improved over time.

Service flow chart given below will make the overall process of NRU under BWHC,A more clear.

Service flow chart: Nutritional Rehabilitation Unit



Rina and Yasmin, two attendants of children under NRU say their experiences and feelings as follows:

‘I Love to Come Here’: Rina

Coalition has been formed while we stayed at Lasker Mistree Slum. Apa(s) from Coalition came to our house and advised my mother to participate in our program. My parents came here leaving my sister Rozina to my Grandma. She was almost dying. People advised to bring her here. Since then my sister is better. According to doctors opinion she has been suffering due to severe mal-nourishment resulting tastelessness towards food. She did not at all get breast-feed. Apa wanted to know from us whether we got her admitted there. We agreed to their proposal. We used to regular bring her here 7 months at a stress. In the meantime we brought her to our house but again took her to Coalition due to malnutrition. Apa (s) used to look after Rozina properly. They fed Rozina an egg, khichuri, milk, banana everyday. I also ate rice here. My sister has improved a lot than before after bringing here. She does not walk still but she is now able to sit, talk and eat . At present she is at the house of Shekhertek. 6 more children were with her. I loved to stay here. I have come here for my mother’s treatment. She has ache in her leg. After my sisters admission here, I attend AFLE here. I have come to know about diarrhea, early marriage and sexual diseases. We have been advised to be clean, to clear our sexual organ and also to eat nutritious food. I have been benefited knowing this. I have also learnt how to cook nutritious khichuri. [She can explain the process of cooking khichuri]. I have also learnt that we should clean green leafy vegetables before cutting it. I also get others know about the things I learnt here. My neighbors of my age do not know so many thing as they do not attend AFLE. It is better to learn and also it is our moral responsibility to let them know all this things. I always try to let them know. I advised many mothers not to feed their children the tinned milk. I told them to feed them colostrum and after having that milk their children can be free from many diseases. At first they ignored me. According to some of them colostrum is treated as rotten milk but I told them not to do that but many of them have now stopped to feed their children the tinned milk. I did not ever hear about any case of early marriage. Till date no one at my house discussed about my marriage. I do not support early marriage. My friends also want to study. They want to get married later. It is not wise to get one married before 18 years. It is not possible to tolerate different types of problems due to marriage at this stage. An adolescent girl is not in a position to face all the problems relating to her children, husband and parents-in-law. Her health will be *bhenge jabe* (at stake) soon. I came to know this after coming here. We can easily communicate with them who used to teach us.

They advised to bring Rozina fortnightly. They also helped my mother. They referred her to another hospital. They arranged a big amount for my brother’s operation (through PLAN). They gave me money to purchase mosquito net and sandal. They give us free treatment. They also gifted a frock to Rozina. They arranged food for Rozina while she was sick. They used to give medicines whenever I bring Rozina here. I love to come here.

'Apas Did a Lot for My Child' Yasmin

I came to know about this clinic before my first son was born. I heard from *apas* of BWHC,A. Initially we could not put on faith to them. But I heard from some of my neighbors that they received proper treatment from this clinic in a cheaper rate. So I got interested of coming here. Most of the costs are carried out by the clinic. We share only a little portion of that. As I believe, BWHC,A tries its best to do for a patient. If the case is beyond their reach, the authority used to refer the patient to a proper place for further treatment. Representative of this clinic visits our slum at least once a week. They used to look around the slum to search out whether physically we are in good condition.

I had been suffering from fever for a long time. Hearing from others I came to this place. After a thorough check up I was given some medicines to continue for next three months. Then I got admitted in Mohakhali Cholera Hospital for 6 months but no disease was diagnosed. After the birth of my first child, again I came to this clinic. This time my disease was discovered – it was Tuberculosis. Unfortunately my child was also got affected with the same disease.

My second child was suffering from malnutrition. He got admitted in the NRU. He was supposed to enjoy all facilities for two weeks. But as he was not recovered by that time period, *apas* extended his duration for another two weeks. *Apas* did a lot for my child. They provided foods and medicines to him. Finally they sent my child to Al-Markajul Clinic for further treatment. NRU also did all arrangements for my treatment along with my child. We stayed there for one month. Al-Markajul does not provide food to any patient. So it was a problem for me to arrange food. Out of generosity, *apas* from BWHC,A specially arranged food for us for long one month. Really it was a big help for me! Besides, when I went back to my house from Al-Markajul, I was not in a position to arrange my regular intake. I will appreciate NRU *apa* as I saw them not giving her back to me at that very moment rather she continued providing food for both of us (me and my child) for next three months. I used to collect food from BWHC,A as I was to bring my child there everyday for pushing an injection everyday. Now both of us are in good health.

I have three kids. But I am expecting another one. It is my fault. So I keep on touch with this centre for my regular check up. I can not afford costs for medicines. So I used to surrender myself not to pay the charge for medicines in full. *Apas* always consider my ability and give me all medicines that I require.

My husband is a rickshaw puller. I used to sell local cakes (pithas), banana, eggs, cookies, tea etc. by the side of the street. I earn nearly taka 50 a day. I rented a shop that costs taka 500 a month. I work there from morning to mid night till 12 o'clock. My children used to help me in this affair. I started this business with taka 100 in my hand. I used to take products on credit from suppliers.

I believe God is almighty. I am now okay, as He wanted me recovered. But it is also true I must need an *uchhila* (media) through which god's wills will be fulfilled. I will say it is BWHC,A in this context. I am very satisfied with this organization.

I used to say others to come here for their health problem. I don't like other health centers or hospitals, as those are very expensive. To push an injection, I need at least taka 10 or so if I want to receive this service from anywhere other than this center. But here it is almost free of cost. So I prefer to come here in case of any health problem of my family. *Apas* treat us as sisters. You see these kids are not ours, it is theirs. We just gave them births but could not give them sound health. It is *apas* who are getting our children healthier.

Apas always give us good advice but we are skeptical to follow those. So we do suffer, otherwise we could maintain sound health. We can not keep clean our surrounding as *Apas* used to suggest. So I will say the fault is ours. *Apas* used to come to our slum ignoring all troubles but we are so penny pincher paying a ten-taka note for them.

I had problem of white discharges. I am now cured by their treatment. I am continuing medicines.

They used to suggest keeping clean our kids. They also said to cut nails, to have a shower a day etc. are good for child health.

'The child of Yasmin was suggested to take high anti-biotic but we found no progress. So referred him to Al-Markajul as we lack pathological instruments. They diagnosed the child was attacked by TB. Mother was also found affected with TB. After she came to us we sent her to TB Clinic. Some tests including cough test, X-ray etc. were performed there and it was confirmed that both of them had been suffering from TB. The doctor of TB clinic gave them some medicines free of cost and advised to push some injections. BWHC,A provided them all injections' - Dil Afroz: NRU Supervisor

Points to Mention

- The room where the children are taken care of is not that spacious. It is very congested.
- Age-specific recreational facilities are lacking.
- There must be a game room where the children at least can move around.

B. Field-based Growth Monitoring

Concept

In order to monitor nutritional status of children up to 3 years, BWHC,A introduces field-based growth monitoring system at field since March 1999. Growth card is used for monitoring each child. Growth monitoring component is added with other activities of Satellite clinic. Basically it becomes an entry point for NRU. With this program, BWHC,A suggests what a child should take as food, what type of diseases it does suffer, what remedial measures should parents of a child should adopt etc.

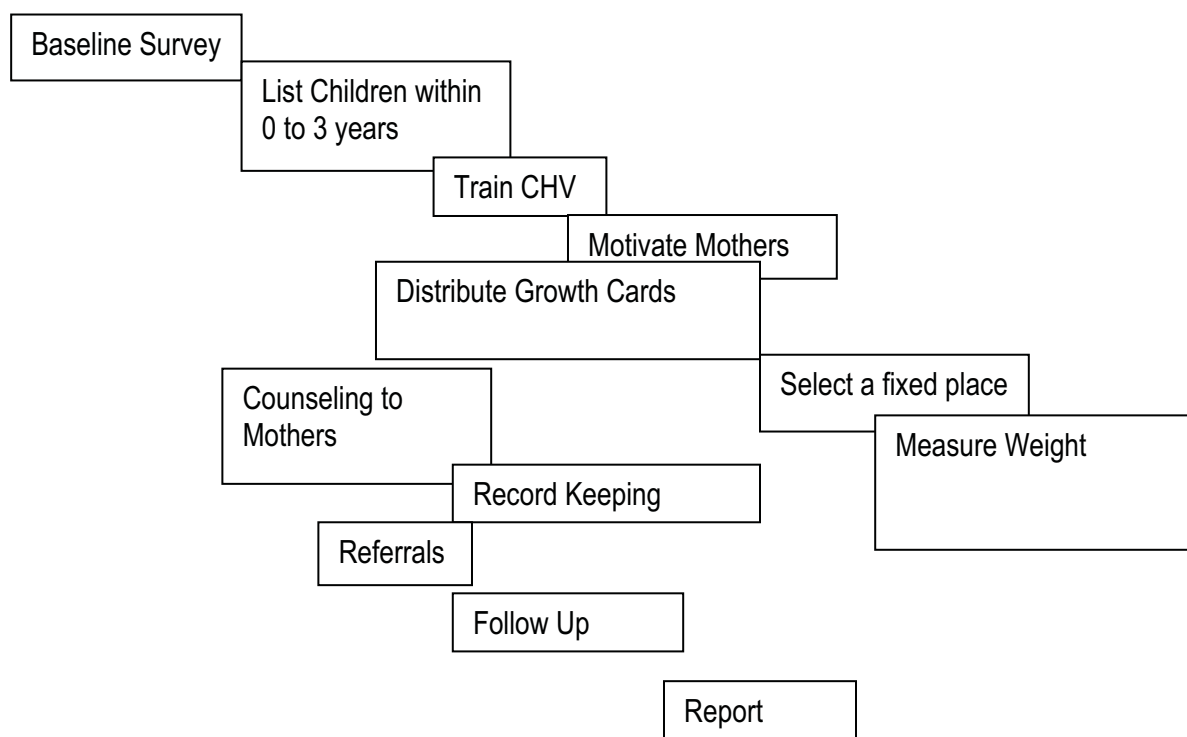
Coverage

Conceptually all children up to 3 years residing in six BWHC,A slums are brought under this growth monitoring system but due to misconception many parents still keep aside their children from weighing. According to BWHC,A staff, the number of children for growth monitoring is increasing day by day.

Process

Each CE with assistance from CHVs makes a list of children up to 3 years in her working area. CHV s are trained to deal with growth monitoring system. CHVs motivate mothers and distribute cards to each mother having target children. They select a fixed place (usually the Satellite clinic where it has) and measure weights of children using salter scale. Paramedics are responsible in taking weights. On-the-spot counseling is given to mothers if required.

Record keeping, referrals, follow up and report writing are the next steps. CS and CEs supervise this whole system.



A Day with Growth Monitoring

On our arriving there, we saw 6 mothers putting children on their laps and sitting on benches inside the Satellite clinic at Karam Ali slum. Concerned Paramedics along with CHVs was engaged in managing Salter scale. Weight measuring kept going on a 'first come, first serve' basis.

Simultaneously with yelling by kids, both counseling and record keeping process took place for each and every child up to 3 years who are brought there. Small space for satellite clinic and limited benches for mothers did not hamper sitting, as all mothers were not present altogether at a time. Rather there was a continuous flow of mothers. So Coalition people could perform their task systematically. The thing that hampered was scant supply of light. Paramedics had to squeeze her eyes to count the exact reading from the scale. More dangerous, the whole effort may go wrong if the Paramedics fails to set the zero scale (0) correctly. Oh God! Better to say – *let there be light*.

When all this was happening, some conversations off the satellite clinic by two neighboring women came into our ears. Of them, one (W1) was saying to other (W2) in a very choked voice, 'Unnecessary they take weights of our children. Instead of betterment of their health, it hampers their normal up growing'.

W2: Exactly so.

It made us curious to dig out their minds a bit. Getting out from there we found them cutting vegetables with a sharpened weapon just in front of the clinic door which is risky for any one's, especially for attendants with children, movement.

While asked why they thought measuring weight is hampering for child's health, first they got shy – then keep going as follows:

W1: Oh Sir, you have already heard what we said! Okay, I tell you - actually without any help from outside it is we used to feed our babies and make their health sound. We give food to them by working hard. But people like you just come to us and concentrate to our kids as if you are doing a lot for our children. Some times you used to blame us saying that our babies are getting over weight. Suggest us not to feed the baby much. Another fine morning you again come to us and used to say, "Oh! No, your baby is malnourished. S/he is under weight. Don't you feed them what you used to take?" You see we are illiterate people. We don't know so much calculation like you, we only know parents must provide food to their children to make their stomach full. Otherwise I believe it will affect health status of a baby. If you from outside interfere, take weight hanging them in a bowl – they used to get afraid of which made them sick. It can not be of anything healthy.

W2: Measuring weight is completely bad for health. Besides, BWHC, A charges money for that. You see I will have to bring my child to this centre – keeping all my necessary household chores aside, my child has to bear all hassles but eventually it is I who have to pay. I don't like this at all. I know I don't need to spend any money if I take governmental health service.

[By this time, a male person (M1) appeared over there and willingly took part in conversation]

M1: O fool! Don't you know BWHC does charge half of the amount that you should have to pay? Say, if you were to pay taka 50 for any service from BWHC, finally it will charge you taka 25, just the half of the amount. It is only for the betterment of poor people like us. You see we are ignorant of many things as we came here directly from rural areas. So still we believe in prejudices. Some believe that weighing hinders normal growth of a child. But I will say weighing is a must to understand body growth of a child.

Do you think weighing does not hamper the health of a child?

M1: Yes, I believe there is no harm in weighing any child.

So you will not bring your baby here for weighing, will you? (Question to W1)

W1: My baby will get fever if I bring him here for weighing. Once I brought my daughter here for weighing but he got scared and suffered from fever for few days. So I gave up my interest on it.

(Please see over leaf)

(Contd. A Day with Growth Monitoring)

Do you think all of the babies weighing here get on fever?

W1: No that's not the case. But my daughter got fever.

If everyone does not get sick, then will you still blame weight measuring for causing your kid sick?

W1: I am a bit confused.

M1: Come on, try to get out from fools' world. Mothers from extreme corners of this slum are coming here for measuring growth of their children – but you being nearby resident ignoring facilities like this.

W1: Okay, let me talk it with my husband.

W2: I will also ask my husband to rethink.

[Spot Visit, 12 December 1999, 10:30 am to 12:00 pm]

CHAPTER NINE

ADOLESCENT CLUB UNIT

Adolescent Club

Adolescents are the most vulnerable section of the society. They are also the most neglected ones in the community. The idea of setting a club or centre for the adolescent in the slum area is of most recent origin in Bangladesh. The concept is for effectively communicating and working with this 'hard to reach' group.

The Adolescent Club program was added to the BWHC, A in October 1996 on a pilot basis. The idea of the program was to effectively communicate and work with adolescent girls. With that purpose in mind, a club was established in the 'Motahar slum' of Agargaon slum area. The main goal of the Adolescent Club program, according to the BWHC Program Proposal, was "to help adolescents in becoming responsible citizens of the country". More specifically, it was set up to realize the following objectives:

1. To raise their self esteem
2. To improve their health status
3. To increase their literacy rate
4. To develop their awareness on health, social, legal and family life
5. To help them in earning a better livelihood
6. To help them manage the club by themselves and thereby teach them about management, planning, etc.

Though the infrastructure of the club was destroyed by the incidence of fire on 27 February 1999, activities of the club are being carried out at the base centre for the time being.

The club provides a wide range of services relating to: preventive and curative health, legal issues, family life education, safe recreation, functional literacy/numeracy, and skill development of its members. The members of the club are girls, both married and unmarried, are within the age limit of 9-16 years, live with their families in the Agargaon slum area, and within 10 minutes' walking distance to the club and clinic.

In the past, the Adolescent Club ran as a self-standing (separate) program. PLAN and BWHC were in dialogue about its possible integration in the overall gamut of BWHC Agargaon Health Program. Recently an independent consultant has done a critical review to evaluate the program of the club. According to the recommendations of the evaluator, and per discussion among the partners, Adolescent Club program has been incorporated in the BWHC Agargaon project. Besides, the evaluator made several other recommendations,

Description	
WORKING DAYS	5 days a week (Sunday – Thursday)
WORKING HOURS	9:00 AM to 5:00 PM
STAFFS	Adolescent Supervisor Adolescent Educator Skill Development Trainer Guards-2
MEMBERS	100 registered adolescent girls from the community
SELECTION CRITERIA	age 9-16 years eagerness to join the club lived in Agargaon for minimum 6 months attended three BWHC meetings girls with no education got preference.
ACTIVITIES	AFLE NFPE Skill Development
TRAINING	Leadership training Health Care Recreation

which BWHC has planned to pursue in phases over the next year. Following important activities will be carried out in line with the recommendations:

- An outside consultant will be engaged to conduct a highly participatory planning process for redesigning the program
- 'Cost Effectiveness' issue will be addressed
- Membership fees will be introduced to establish the club concept
- Initiative for greater involvement of parents and the community will be taken
- AFLE curriculum will be reviewed to streamline the topics and to make it appropriate for the Agargaon community. Age-specific AFLE group formation and curriculum selection will be done.

Facilities

Other than AFLE classes, the learners are entitled to play in-door games including Carom Board, Ludoo, and Chess. Newspapers, storybooks and other IEC materials are supplied to them. A black and white television and a Cassette player are available for them.

Besides, they are taken to National Museum, National Zoo, Science Museum and some other places as study tours.

A. Working with Adolescent Girls

a. Adolescent Family Life Education through CLUB

Concept

In order to make adolescents conscious about personal hygiene and other important topics, BWHC, A introduced Adolescent Family Life Education (AFLE) through the Adolescent club. Adolescent Educator conducts all classes using the AFLE curriculum development by VHSS.

Criteria

All the adolescent club members are granted as learners of AFLE.

Major Topics covered in AFLE

- Personal Hygiene
- Responsible parenting
- Safety in the home
- Domestic violence
- Violence amongst friends and neighbours
- Decision making and negotiation skills
- Positive role model
- Gender issues
- Age at Marriage
- Childbearing
- Concept of FP
- Fatal Diseases: STD/RTI and HIV/AIDS

Description
<p>STAFF Adolescent Educator</p>
<p>MATERIAL AFLE curriculum developed by VHSS (reviewed version)</p>
<p>LEARNERS Adolescent Club members</p>

Stories

Being aware of safe livelihood, three adolescent club members – Maya, Jui and Neela – overcome some unwanted situations. Maya escaped herself from being abused by her own brother, Jui skipped the early marriage trap and Ruby did recover from STD. Masuma, another girl, of Adolescent club got experienced with some positive changes in her life. Stories narrated by these four pubescent girls are given below:

Beware of Your Own Brother Too!

Maya ages 13 years. Lives in Montu's slum. Reads in class V under NFPE of BWHC, Agargaon. Her father ferries vegetables. She has 6 siblings. Of them 3 are sisters. She involved with the adolescent club in December 1996.

There are 3 rooms in our squatter. In one room me along with Reba apa, my eldest brother, Rubel *bhaiya* and my youngest sister used to sleep in the same *chowki* (bed). My parents and two other brothers reside in other two rooms. I faced a lot of problems while go for sleep on the same bed with my brothers. Rubel *bhaiya* used to sleep just beside me. He is senior to me of 4 years. One night I woke up from sleep and realized that something was happening over my body. Instantly I discovered it was Rubel *bhaiya* pushing his body towards me and also keeping his hands here and there of my body in an irregular manner. I got puzzled to that. It was completely a new experience for me. I understand the experience I was facing is something shameful. That's why I could not share it with any body, even with my friends. I just kept mum. The same incident used to repeat almost every night. It shoved me indeed to an unwanted hollow from where I guessed not to be rescued ever.

As I could not express my unbearable feelings, I used to break everything that comes to my hands. The problem lasted for 3 or 4 months. Eventually I could not but selected Selina apa and Sanjida apa of Adolescent Club to share my bitter experiences with them as they used to provide us family life education. They listened to all of my words very carefully and summoned my mother to the club. They talked a lot with my mother and made her understand many things about my ongoing problem. Hearing everything, my mother was about to loss her senses. They encouraged her not to loss her confidence rather suggested to change the sleeping arrangement in our house. From then on I have been sleeping with my mother. Selina apa and Sanjida apa sent Rokib mama to consult with my brother. Rokib mama discussed with Rubel for a long time. Probably Rubel *bhai* realized everything as I will say since then I have not been facing any problem.

Currently my Rubel *bhai* is engaged with income generating activity. He ferries vegetables. As far I know my other sisters did not face any problem of this sort. Considering our family condition, apas of BWHC,A got my mother involved in an income generating affair.

I feel very happy after being involved with this club. I can spend my times here playing indoor games with other girls. I used to attend AFLE classes.

Till date, my parents did not ever take any initiative for my marriage. If they do, I will not agree with their initiative. Rather I will say, "I am not a woman of 18 years. So I am not fit for getting married." I learnt this from our AFLE class. I also learnt that if any woman gets married before 18 years both she and her kids will suffer a lot. Body construction of the lady may be broken down, the children may be malnourished etc.

Only two months ago I experienced with menstruation. No menses were withdrawn from my body during the problem that I faced with my brother.

I know what to do during menstruation. A female person should buy a panty from a neighboring marketplace and wear it. In order to soak the blood, she should pour some clean cotton cloth into it. She has to change the cloth after it is completely soaked off. She needs to wash the cloth and dry it up in secret under direct sun light. During menstruation, a woman must take adequate food. I used to take nutritious food during menstruation. If I face any problem, I just rush to apas of BWHC,A. Really they are unquestionably caring to us. I feel them as someone who is very close to me!

OVERCOMING THE EARLY MARRIAGE TRAP

Jui is of 12 years. Reads in class V under adolescent club of BWHC,A. Father is a Rickshaw puller and mother is a housewife. Hails from Bholra due to river erosion. She has 5 siblings. Of them 3 are sisters. She is third among her brothers and sisters. She helps a lot to her mother in household chores. She learnt embroidery works from BWHC,A.

At first one Farida took me to this place. Farida resides by our house in Motahar slum. She has been a member of this adolescent club before I joined with this group. BWHC,A hired a room in our Motahar slum for adolescent club. I found Apa and Rokib mama conducting the music class. They recorded my name in a registration book. Hence I got involved with this organization.

I used to go for singing and attend classes over there. Besides, I also learn embroidery works from them. Girls older than me learn carpenter works.

I became a regular student of AFLE class. One day while I was in the class, a close friend of mine went to our house. She heard some noisy conversation from our house as soon as she reached there. It was my father saying something to my mother in a loud voice. She gave her ear to that and heard my father talking about my marriage. He was saying to my mom that would be groom's family would come to our house very soon. He suggested her to get prepared for that. My friend rushed to me and demanded sweets as she conveyed good news for me. Hearing the news from her, I got angered. You know that in my AFLE classes I learnt not to get married before 18 years where as I was a girl of 10 years. I understand it would be suicidal for me if I get married at this age. I know all demerits of early marriage from my apa, then how could I agree with the decision of my father? Really at that moment I experienced a stormy feeling in my mind. I could not but ran away to my house.

I found my mother arguing with my father in a strong voice. She forewarned him not to do the same mistake that he exercised to his eldest daughter. My brother was also against my early marriage. But who listens to whom? My dad was adamant, as it was his prestige concern. On my behalf, he already gave his word to groom's family. So he was not in a position to listen any word from anyone against this initiative.

I threatened my mother saying that if you arrange the marriage without my consent both of you (parents) will be taken under custody. I also asked her whether she would feel happy if sent to the jail and mausher kamar khey. My mum started crying and assured me that she was against my marriage at this age. She also informed me that other than my father everyone is against this initiative. Finding no other way I decided to seek help from apas of BWHC,A and narrated the whole story to them. Some days later, I brought Selina apa and Sanjida apa to our house. At that time, my father was in sleep. Seeing apas at house, my mummy woke my father up. Apas talked a lot with my pa. They made him understand all negative consequences for early marriage. My father got convinced to that. Then he told to the proposed groom's family that he would not get her daughter married so early. Still they proposed my father to perform the akhd and also proposed not to take me to their house before I was of 18 years. My dad disagreed the proposal with a strong voice. Rather he raised the valid question: what if my daughter does not agree with this marriage at her age of 18 years? Since then on my father did not ever force me for marriage. Instead, he refused several proposals for my wedlock.

The eldest sister of mine got married when she was of 14 years. I want to get married after 18 years of my age. I learnt this from Sanjida apa and Selina apa. I came to know many useful things after I involved with this club. I learnt how to make my surroundings pollution free, how to keep my body clean, how to tailor a cloth etc. If I did not join here, I could not learn these things. Now I can stitch my cloths during different festive. This way I can save money of my family for my clothing. Even occasionally I earn some money by stitching for others. I can contribute money for my education purpose from my own fund. Just recently I earned taka 350 for stitching a *kantha*.

I used to share all lessons that I learnt from this club along with my friends as well as neighbors. Till date I brought five girls here from the slum I reside.

I want to share another incidence in my life. One day my friend Abeda and me went to collect green leafy vegetables from a small pond half a mile away from our slum. All on a sudden a stranger appeared before us. He was a young man. Handing over taka four to Abeda's hand, he said, "Please bring me a cigarette by the half of this amount and buy some baked rice for you with the other half." Abeda called me to follow her but the man brought himself before me and said, "No, no – you don't go. You stay with me." Abeda went away leaving me alone. I got scared. The man caught hold of me and took me to a room near by the pond. He shut the door at once and threw me off to the bed. I asked him in fierce voice, "Why did you bring me here?" He replied, "I brought you here just to spend some time with you. Your friend will come back soon, so don't get scared" I got up and sat on the bed. He sat beside me and slowly started coming nearer to me. I attempted to run off the room but he again caught me off and threw me to the bed. He became very furious of me and by force got over my body. At that time I found him nude, without wearing the *lungi*. He attempted to press over my chest but I tried to knock him off with my hands. Finally I kicked him off. He fell down on the floor and I fled away from that dead house at once! I saw Abeda coming back with stuffs in her hands. I got annoyed with her and threw all of them to the ground. I rushed to our Club with Abeda and narrated my scaring experience to Selina apa. She shared it with Rokib mama, who teaches us song in the club. Rokib mama brought me to that very place again but we found no trace of that guy.

Neela: the STD victim

Aged 14 years. She has two brothers and three sisters. She is the eldest child of her parents. The youngest sibling is of one year. Lives in Motahar slum. Father is involved with liquor business. Mother is a housewife. Earlier her father was a rickshaw puller. He possesses three rickshaws of his own. He runs his family with the stable income from these vehicles. Father used to misbehave with all of the family members. He is a gambler and a drunk.

Before I involved here, I was basically a leaf picker. I used to collect leaves to meet the in-house fuel need. I saw Sanjida apa moving over slums for collecting names of adolescent girls. Out of curiosity I appeared before her in the Club and got informed everything about this program. When I entered into the club I saw some girls singing, some playing Carom Board, Chess and some other playing Loodu. I wished if I were one of them! Sanjida apa registered my name as I showed her my interests. All these happened five years ago.

I am now a student of class V of NFPE under BWHC,A and participates AFLE classes regularly. I got admitted in class II. I learnt many things from this. I came to know about diarrheal diseases, about water, negative consequences of early marriage and also about sexual diseases. I learnt early marriage is called if anyone gets married before s/he is of 18 years. As I understand from the class that a girl should not get married before she complete 18 years of age.

When she was asked about sexual diseases, she got shy. Finally she denied saying that she does not know anything about sexual diseases.

I visited the National Zoo, Shishu Mela (Children's Park) and Ahsan Manzil along with other girls.

One day I was occupied in leaf picking somewhere near Shamoli. Suddenly a male stranger appeared before me and said, "Hey kid, do you want much more leaves? If so, follow me." I gave assertive response and followed him. As soon as I reached nearer to him, he all at once put his hands on my mouth (mukh chepey dhorechhey) as though I could not make any sound. Thank lord, hands of that guy once got misplaced and I could cry like anything. A lady heard my screaming and came forward to rescue me from that beast. And finally I was released. Since then I stopped going so far for picking leaves.

She again got shy when asked whether she came here for seeking treatment of any kind of disease. She remained wordless for a while.

I came here for fever and cold.

On behalf of BWHC,A, I do many works. Say, I can feed Polio to the children, I send mothers to this center to feed their children Polio and inspired mothers to visit this center in case of their any kind of illness.

While asked about her aim in life, Neela stared at the white brick wall against her in very gloomy eyes and said in a soft voice, "Nothing, I don't have any aim in my life. Nothing attracts me at all." She continues - my father always discourages my schooling. He used to say, "What's the use of going to school? Don't go there." But my mother sends me here hiding my dad. I guess I can not continue my education after class V. You know BWHC,A offer education up to class V. As I know I will not be able to continue my education in future, so I lost my aim in life.

Recently I got an offer from UCEP for vocational training. Apas of BWHC,A arranged this for me. The training will start from next April (after 4 months from now).

I hate my familial atmosphere. It is completely unhealthy. Abba always calls bad names to everyone of our family. Even sometimes he calls me in such names which a father is not supposed to utter. Our neighbors also hate my father. They used to suggest him not to call bad names in presence of kids like us.

Neela developed RTI diseases over time. Examined by the BWHC,A paramedics, she has been given anti-biotic and tablets for vaginal diseases for three times. According to the Adolescent Supervisor, her vagina was found open during examination. Though surprising but the fact is the paramedic could pour all five of her fingers into Neela's vagina at a time. It is confirmed that Neela has been penetrated several times.

Neela got shy during conversation.

Masuma's New Life

Aged 12 years. Her father passed away few years ago. Mother is working in a garment factory. She has only one brother and 2 sisters. She is the third child of her parents. She has been in touch with BWHC, Agargaon since 1995. Basically she was a leaf picker. But BWHC, Aapa has opened her eyes and with that vision she could dream for a prospective nice life in future.

We lived in Motahar slum. Currently we are staying in Taltola slum— one mile away from this place. I used to come here only to study. I am very fond of studying. I believe if I become an educated person I can learn many things and I will really be a human being (*manusher moto manush hotey parbo*). Before I involved here I read in some other schools but I like the most only this school. I like it as *apas* used to teach here are very nice and caring to us. They also provide healthcare free of cost. They give us medicines when required. Besides, I have to pay all of my fees in the school I studied before. You know my father passed away. It is very difficult for my family to bear my educational expenses. Administration of this office is so kind that till I am here I have been studying free of cost. I stood second place in the last examination. I was eighth in my previous class.

I like studying English and Bengali the most. I want to be a Physician in future. I want to serve my country. I wish to be a Physician as I used to see my neighbors suffer from various diseases. People can not afford money for proper treatment. So I want to dedicate my life for them.

I learnt a lot from AFLE classes. As for example, no female should be married off before she attains 18 years of her age, negative consequences of early marriage, about diarrhea, about nutritious food etc.

I try to share my knowledge with other people. Before I involve here, my mother used to clean vegetables after cutting. I informed her the proper way to clean vegetables. Now she cleans all vegetables before cut them into pieces.

If anyone suffers from Diarrhea I suggest offering oral saline to the patient. I know how to prepare this at home. We have to mix a packet of oral saline to half a liter clean water. In case of hand made oral saline, one has to add salt and molasses in half liter boiled water. The quantity of salt and molasses are(she continues correctly).

When I get sick I obtain health services from Base Clinic of this office. My mother also visited this clinic twice due to some of her personal complains.

Sabina, Momtaz and Nazma – three members of adolescent club got an opportunity to receive a vocational training in UCEP. BWHC, A arranges all for them in this context. Living in Kashem Chairman's slum they came in contact with this organization about two and half years' back. They earn some money by their embroidery work. Some conversations took place while they came to see their beloved club before returning home from UCEP sessions. Very smartly they participated in chatting. They say as follows:

Conversation with Adolescent Girls

Sabina Akhter, Momtaz Akhter, Nazma Akhter.

'We learned embroidery works and attended health classes. Other than education, we got opportunities to play indoor games and read storybooks. We enjoyed here very much - that is why we used to come here.'

Sabina said, "I earned taka 55 from embroidery work."

Nazma said, "Me too."

'We are very happy on receipt the amount.'

'We have come here to read storybooks and to visit our *Apa* also.'

Momtaz said, "We learnt a lot of things from here. Such as, many thing about family affairs, If we stayed at home we could not learn many things, we have learnt mainly embroidery and cutting.'

'We came to know about women repression, dowry, and sexual abuse.'

"Yes, we did. Before we did not know how to take proper care of ourselves. *Apa* has taught us many things in this regard. Now we know so many things, which we can implement in future. Now we can make our family member conscious about health. We learnt a lot from them."

While asked about their future plan, they replied:

Sabina: I like to be an operator in sewing.

Nazma : I like to be an engineer.

Momtaz: I also like to be an operator.

Sabina says, "We will not get married before age 20. If my father tries, I will not agree".

She continues, "Early marriage causes a lot problem to one's health. Such as, we will loose our health due to giving birth a child. We do not want that."

While asked what they will do if their parents pressure them for getting married, they answered -

Momtaz: I believe they will not pressure us as they also attend the Coalition meeting held each month. Now all of them understand the bad sides of early marriage.

Nazma and Sabina: We do agree.

b. AFLE through SCHOOL

Concept

The school based Adolescent Family Life Education is conducted in NGOs, government/private schools of the community catchment area. BWHC, A selected students of Sher-e-Bangla Girls' High School and Taltola Girls' High School.

Criteria

Students of class VII to class X.

Messages Given

Same curriculum developed by VHSS is followed.

According to the convenient timing of the school, Clinic Educator is responsible to conduct AFLE classes.

Description
<p>TIMING according to the convenience of the school</p>
<p>STAFF Clinic Educator</p>
<p>MATERIAL AFLE curriculum developed by VHSS</p>
<p>LEARNERS Students of class VII to X</p>

c. NFPE

Concept

School going adolescents are supposed to continue their education in their respective schools and enjoy all facilities of adolescent club. The non School-going adolescents under this club are provided with non-formal primary education (NFPE). BWHC, A follows BRAC model for NFPE.

Criteria

All non-school going members of Adolescent club.

Facilities

Learners under NFPE enjoy all facilities under this club.

Syllabus covered

NFPE curriculum developed by BRAC is followed. BRAC Educator is responsible for conducting sessions in NFPE program.

With all positive efforts by BWHC, A, Hasina – a student under NFPE – eventually fails to uphold her desires. It is not any success story, rather a story of disappointment. Hasina says as follows:

Description
Done in collaboration with BRAC
<p>STAFF NFPE Educator (BRAC)</p>
<p>MATERIAL NFPE curriculum</p>
<p>LEARNERS non-school going members of the club</p>

Hasina's Broken Dream

I am now running 14 years. My father is a drunk as well as a gambler and mother is a sweeper.

I joined the adolescent club five years' ago. I am also a learner of NFPE program under this centre. In my days with BWHC,A I got an opportunity to participate in a photo competition on Our Daily Life, jointly organized by JOICFP and FPAB. Got seventh prize competing all over Bangladesh. It is a pride not only for me, but also for BWHC,A.

Last year I passed class V. I like studying very much. But there is no scope to continue my studies in BWHC,A after class V. Seeing my keen interest for further study, Selina Apa (the Adolescent Supervisor) of BWHC,A gets me admitted in class VI under *Suravi* school.

I witnessed how people do suffer in a slum area. It inspired me to be a Doctor in future. But or struck by hard life I have to give up my studies and join in a garment factory soon.

Here is BRAC Educator Selina Khatun says about on-going NFPE program under BWHC,A.

Priority: Education-friendly Atmosphere

I am Selina Khatun. Working here as an Educator on behalf of BRAC for NFPE program under BWHC,A Adolescent Club. I have 23 students in my class. Of them, 15 to 16 girls regularly attend school. Due to Ramadan, the number of attendants has been reduced. Some of my students are currently involved in preparing and selling iftaar. I hope all of students will attend classes after Ramadan.

This school is for adolescent girls under Agargaon slums. Being slum-dwellers, each of them is engaged in different type of activities. So they are not able to give time regularly. The situation is like this: if they come to school one day, the other day they go for job. They have to engage in household chores because their parents also go for job. Due to this, this school faces more difficulty compared to other general schools.

I take classes 6 days a week from 8:00 am to 11:00 am. I teach students of Class V.

In my class, I have both types of students who are very attentive and who are not. It is my duty to make all of them attentive in education but due to lack of conducive environment I am not able to do that. They need playgrounds for games, separate room for cultural activities. Extra curricular activities are completely absent here because it is not like a school building.

From my teaching experiences in other BRAC schools, I will say this education program with adolescent girls is lacking education-friendly atmosphere. You see the classroom is within the Adolescent Club office. As a result, office staff and visitors every now and then enter into the room without prior notice while I take my scheduled class. The presence of others while taking classes creates difficulty for us. It hampers students' attention. I am unable to give them a favorable atmosphere. This is one of the difficulties that I face.

Again, the kitchen is just adjacent to this classroom. Foods are being cooked there. All the smoke and smell comes into our classroom. It is also hampering education.

My opinion is - a School should be like a School. This school does not lack any material or input support. It is only atmosphere that creates problem for us.

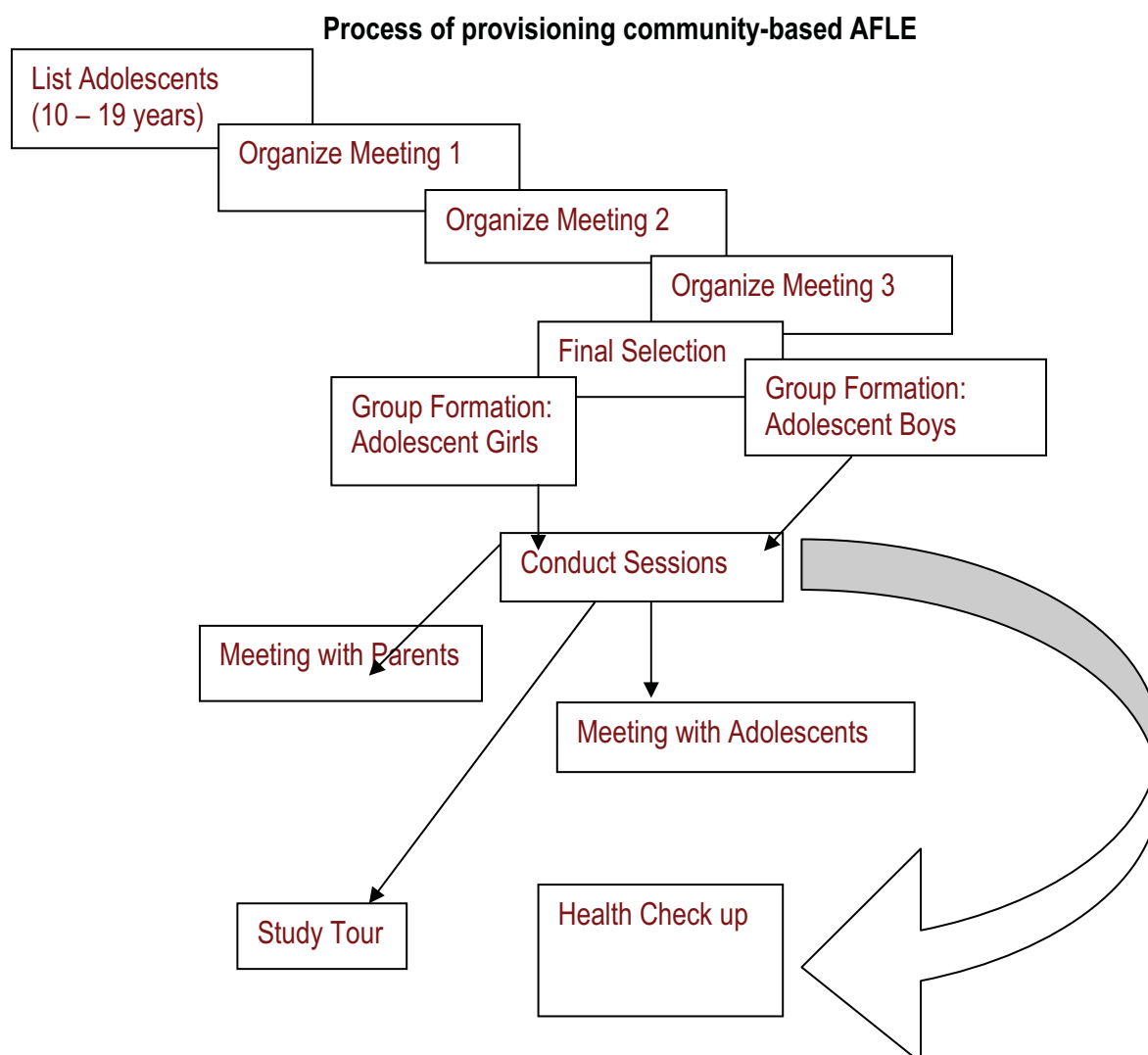
c. Community-based AFLE

Concept

In order to disseminate health messages at community level adolescent group, BWHC,A introduced community-based AFLE program. Community Development Program unit and Adolescent Club unit jointly run this program. The community based approach has been applied to three slums namely Karam Ali slum, Shahider Tek slum and Nur Mohammad slum.

Process

The whole community based AFLE program is supervised by a team of BWHC,A staff. It includes AS, CS, MO and Paramedics. IEC materials are used during sessions. CHV and CE are responsible for preliminary listing of adolescents at field. After the list is done, three subsequent meetings are held with target adolescents. Usually MO, CE, AS, AE, and Clinic Educator remain present in these meetings. Final selection is done after three meetings are over (the whole process is shown below).



BWHC,A developed adolescent girl groups in two slums, namely Karam Ali slum and Shahider Tek slum. There are four adolescent girl groups in each slum. Each group comprises of 15 adolescent girls.

On the other hand, BWHC,A developed one adolescent boys' group consisting of 20 members in Nur Mohammad slum.

Two sessions are held per week. MOs and Paramedics perform a regular health check up for these groups. Members of these groups are taken many places for study tour.

B. Working with Adolescent Boys

Group Formation for AFLE

According to Adolescent Supervisor, Selina Newaz, the formation of adolescent group comprising boys is the outcome of reality. Initially BWHC,A did not have any plan to deal with boys group in the slum.

'Till now, we completed two adolescent girl groups.' Some of them told me, "Apa, we learnt a lot from you but you know boys whom we will marry one day are not aware of this. They used to tease us here and there. So what is the use of being conscious if our expected life partners are not aware of?" It made us thinking about the boys group. We formed a boy group comprising of 20 adolescent boys. We selected the Satellite Clinic at Nur Mohammad slum as the school for this group. Rokib runs this school. Community Supervisor, Zohra, and me used to supervise this program.

Participants of this group gathered here being experienced with many bitter situations (*shaat ghaat paani kheyey eshechhey*). Some of them involved in liquor business. They acted as mediators. Sometimes they also took liquor. Some other worked in Film Development Corporation (FDC) and became derailed. They were involved in crimes like pick pocketing or storing arms.

'When we started looking for adolescent boys for the group some of them came to us and expressed their feeling that they want to get rid of these notorious circle. We started our journey with this group from July 1999. We conduct educational classes for them regularly. We also selected some of them and sent to UCEP and Bangladesh German Technical Centre for vocational training over there. Other than educational facilities, we also provide them logistic support for recreation. They play carom board, Chess and loodu and read storybooks.'

'We used to organize a monthly meeting with parents. They commented that general conducts of boys under this program have been improved. Some of them reported that their sons have been getting rid of smoking. They do not go to the notorious circle (*taara kharap loker shathey mishena*). The project has been running since last July, so we expect much more improvements of all participants over time.'

Dealing a Difficult Group: Iron turns to Gold

Says Social and Cultural Educator Rokib

Some young boys at Motaher slum and Nur Mohammad slum were addicted to heroine, pathedrine and other drugs and it was their common practice to disturb others. They used to tease our adolescent girls. One day they teased our Adolescent Supervisor Selina Apa. She informed it to the office. We suggested her not to be broken mentally or annoyed with them. To get them in track I adopted a polite strategy. First of all I tried to build a rapport with them and show my willingness to talk. They agreed to sit with me.

I tried to look at what they like to do the most. I observed their movement for a week and found that they preferred to make fun by singing and dancing as well as taking *ganja* and other drugs. I told that I liked them very much. Again I showed my interest to mix with them more closely. I proposed to do something jointly. They got inspired. They informed me that they are going to arrange a program, so I can take a part to that. To become closer, I wanted to give them subscription willingly. Only to gain their trust I used to accompany them even at night. Keeping the same goal in my mind I attended the program and also sang a song. They appreciated my song very much. They allowed me to stay with them. I watched they spent a little amount that was collected for the program and the lion portion of the amount they spent in drinking and taking drugs. It made me understand that the program is just an excuse, their ultimate aim is to drink and take drugs.

I proposed them to form a group combinedly to do some cultural activities. They agreed to that. I took the privilege of my seniority. I told them in order to develop a cultural team they needed to listen to what I say. I preferred to utilize our office premise. I started to bring them at clinic. Some of them became suspicious of going there. On the other hand some of our staffs became reluctant and already complained to Dipumoni apa (the then Project Coordinator) against me that I was polluting the office premise. I did not face any problem from the authority as I already informed apa about my strategy.

I handled everything very carefully. I gave them an idea that for singing, rehearsal is a must. They agreed. I asked them whether they like to take cigarette, which might be harmful for practice singing. They decided not to take cigarette at office. I repeatedly suggested them to give up cigarette totally, as it will create problem otherwise. Then they agreed saying that they will give up cigarette gradually. Since then they stopped taking heroine and pathedrine. Their smoking habit also got reduced. They do not smoke at all within this centre. If they do, it is out of this office premise.

I formed a **social volunteer group** with them. Another group has been formed with the adolescent boys of Nur Mohammad slum who assisted selling and smuggling heroine and other drugs. Over time we rendered them health messages and they got convinced to that. They also started thinking themselves as a part of this clinic. Being motivated, some of them got admitted into school.

These boys now become our safe guard. They used to protect our female staffs as well as our adolescent girls and protest, if any incident takes place to disturb any females of this locality. They response immediately, if we call them any time. So they are devoted!

CHAPTER TEN

SATELLITE CLINIC

Concept

Satellite Clinic (SC) was established keeping in view the following objectives:

- To ensure access to basic reproductive health care service at grass root level
- To establish and maintain a referral linkage between satellite centre and base clinic
- To sensitize the community about early health seeking behavior

SC started functioning since April 1997. SC takes services to the clients' doorsteps and lessens the burden on the day clinic.

For SC, BWHC,A intends to ensure optimum utilization of existing community resources through establishing an essential minimum health care system that is accessible, affordable and acceptable to slum-dwellers.

The aim of developing SC is to improve health status of women and children at grassroots level. Clients are coming for the FP, ANC/PNC, EPI and Vitamin A supplementation and General Health care services. Though BWHC,A wants to give emphasis on Reproductive Health in these centers, but due to lack of space and privacy STD/RTI management cares is not being given here. However, screening of RTI/STD, MR and IUD clients are done by the concerned Paramedic.

Criteria of SC

- Availability of good accommodation
- Away from similar type of service delivery centre of other NGO and/or GoB to avoid duplication
- Availability of water and sanitation facilities
- Acceptability of the landlord in the community

Process

A team consisting of a trained Paramedic and two CHVs run a satellite clinic. CHVs are adequately trained to carry on their assigned task. During working hours, one CHV always remains involved in rendering health education to mothers. The other CHV keeps all necessary records in a register book as well as assists the Paramedic. Clinical hour ranges from 9 am to 1 pm.

Description

NUMBER OF CENTERS 3
(1 in Motahar slum, 1 in Karam Ali slum and 1 in Shahider Tek slum)

WORKING HOURS 9 AM to 1 PM

WORKING DAYS 2 days/SC
(Tuesday and Thursday)

STAFFS

Paramedic 1
CHV 2

SERVICE PROVIDED

Ante natal care
Post natal care
Family Planning
EPI and Vitamin Supplementation
General health-care
Referral
Follow up

After returning back from SC, the Paramedic is supposed to complete her daily record keeping, such as registration fees, service charge, daily medicine consumption etc.

The client at first is registered by a CHV. Basic information is noted for the client. It includes serial number, name, address, age, registration number, registration fee, service charge and remarks.

After registration, the client is referred to the Paramedic for required health care. Paramedic also records some information like name, reg. Number, complains, physical findings, medicine prescribed, where to refer and remarks.

If any client is referred to base clinic after registration and if she reports within two days to base clinic for that specific problem she needs to pay only the service charge.

To avoid discrepancy, BWHC,A follows the same schedule for different fees as it is in the base clinic.

General health service seekers attending the SC get only a prescription, no health file is opened. For ANC clients, an ANC register is maintained, as they need continuous services.

It is a tough job to deal with people in the field. Here is an example the way BWHC,A personnel handle situations at the Satellite Clinics. Box within the following text reveals an opposite scenario which is completely in favor of BWHC,A activities.

Tackling Situations

'When the father of this child (your son in law) will come back from his work, you just try to make him understand the importance of child immunization. If he does not understand - you just let us inform, we will send Rabeya, our CE, to your house and she will discuss with him' -- says Zinia – the on-duty Paramedic of Karam Ali slum in response to an old maid. According to the old lady main objection of the kid's papa is that the clinic is located beneath a Banyan tree. So some gruesome things may affect his child. In reply, Zinia consoled the maid saying that children are angels, so her son-in-law should not get afraid of any uncanny things. She continued, "You see we used to serve a number of children every week. Till date no complain we received from any mother who told her child got affected for coming under this Banyan tree."

Grandma was a bit confused about immunization for her grand son who was born only eight days' ago. She wanted to know whether it is a must to immunize the baby by that day. Paramedic very clearly explained all about child immunization. She also suggested to convince her son-in-law first and then to come here for immunization. Otherwise, situation may get complicated if the father is not convinced.

'My name is Lovely. Here is my son Naim. His father is a rickshaw puller. I heard from another maid who resides in our slum that I can get my child weighted if I come to this hut under the Banyan tree. My husband is very cooperating. He instructed me to bring my baby here after getting my son a good shower and wearing him nice dresses'.

Kamal, the son-in-law, is a small trader. He studied up to class V. Eventually the lady

understands all. Zinia also seeks helps from other clients sitting before her in the satellite clinic. She requested them to tell Kamal that their children are okay.

During conversation with clients, Zinia talked with a very communicating as well as polite voice. She addressed clients as *maa* (mother) which get them free from any hesitation to talk about their problems in detail.

An Important Note

People residing beside the Satellite clinic in Karam Ali slum are seen cooking food just at the door side of the clinic. Smoke and smell of food surround the whole clinic. Naturally normal activities get hampered of this. Tears get out not only from the eyes of children but also from adults due to this unwelcome smoke. Spicy smell irritates everyone's nose who gather at the centre. Moreover, it aggravates the chances of fire incidence. To be free from all risks, BWHC,A must find a remedy of this.

Not well-informed about BWHC,A Services: Farida

I am Farida – a housewife. I am now 15. Got married when I was only 8 years' old. My husband is a baby taxi driver. I don't have any education. My husband can only sign his name. I have two kids. Of them, one is of two and half years and the other one of 10 months.

I first came to this satellite clinic just after my youngest child was born. Rabeya apa told me about this clinic during her door to door visit. She suggested me to bring my child to this clinic for Polio and other vaccines. My husband willingly sent me to this satellite clinic to get our child immunized after I informed him about this.

Unfortunately my son got Pneumonia just two months' ago. I visited a local doctor closed by to our slum. He referred my son to Shishu Hospital (Hospital for Children). I went there for his treatment. Did his chest X-ray and pushed seven injections over there. Eventually he recovered.

I don't have any clear idea whether BWHC,A gives any treatment for Pneumonia. But I heard it serves children for some other diseases. Also heard they provide treatment at a cheaper rate. Some of my neighbors told me that BWHC,A renders quality service. A number of children in this locality are being benefited having treatment from them. I yet to go there if my child gets any other complications in future.

The lady is confused about overall service package that BWHC,A offers. Even she doesn't know whether she could visit BWHC,A for herself or any other member of her family. She knows BWHC,A provides services only for children.

CHAPTER ELEVEN

COMMUNITY DEVELOPMENT PROGRAM UNIT

CDP Unit: As a Whole

Concept

BWHC,A strongly believes that real development in a community will not occur unless the people themselves are actively involved in the process. In this context, BWHC,A works as a catalyst while it prepares all volunteers as development agents to carry forward the task of social upliftment .

Structure and Activities

Community Supervisor (CS) is the Head of this unit. Along with five Community Educators (CEs) and two male social workers, CS run the unit. Multi-faceted activities are done through this unit. They are:

Volunteer Development Program
Community-based Health Promotion
Awareness Raising Program
Formation of TBAs
Community-based AFLE
Community-based Growth Monitoring
Cultural Team

Volunteer Development Program

BWHC,A motivates and encourages volunteer approach rendered by community people to assist in the overall development process initiated by it. Usually volunteer activities are mainly undertaken in the field of conducting functional literacy and awareness raising sessions, involvement of TBA in safe delivery, and assisting satellite clinics.

BWHC,A develops three types of volunteers namely literacy volunteers, health and social volunteers and cultural volunteers.

Volunteer-wise responsibilities are given in the box on the right.

Developing CHVs

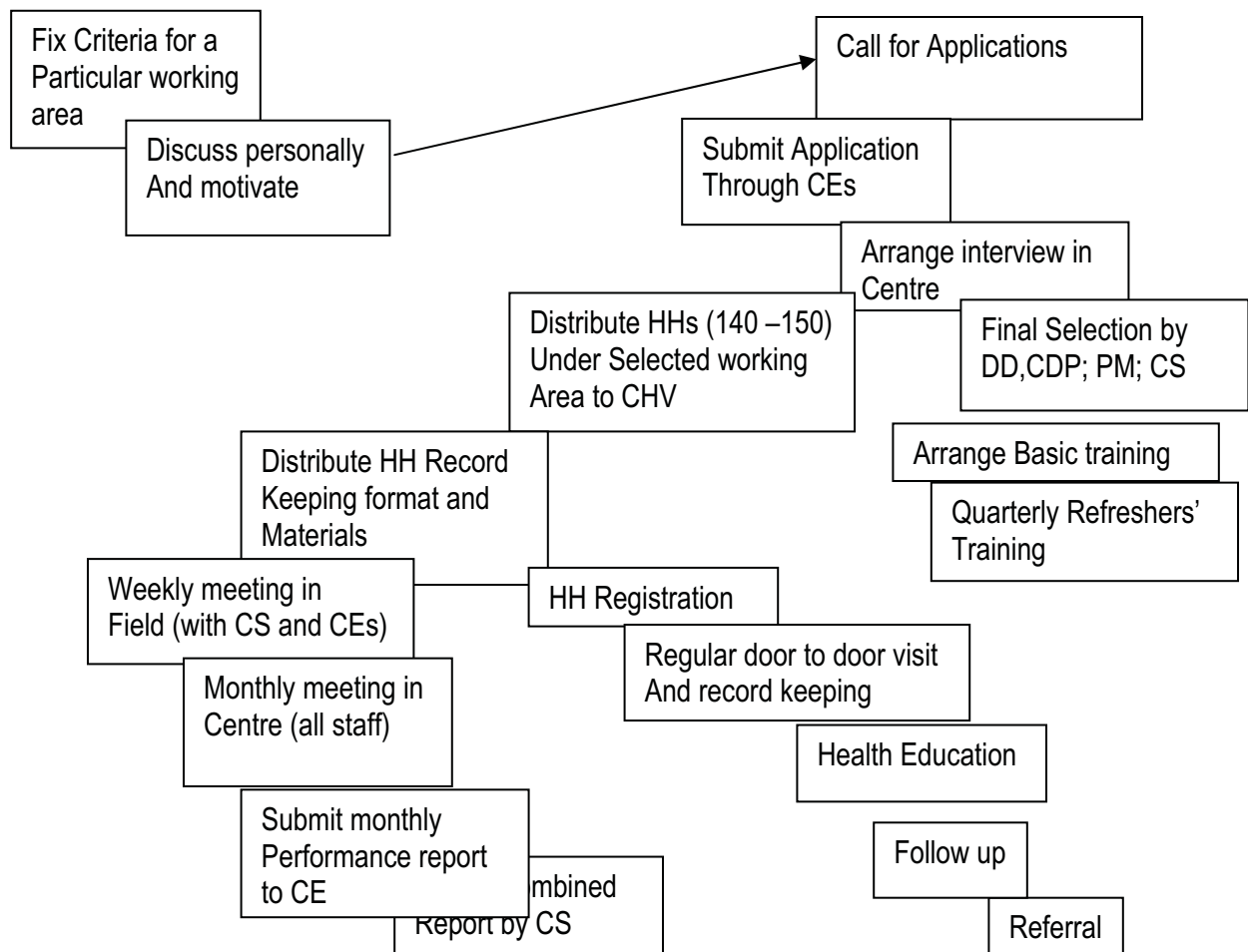
People must see a health worker at work if s/he wants to establish a good relationship with them. In other words, the health worker must be visible to them.

BWHC,A develops health volunteers from the field.

Description
<p>STAFF Community Supervisor Community Educators - 5 Project management</p>
<p>SELECTION CRITERIA education-at least up to class five eager to work as volunteer acceptable to the community</p>
<p>ACTIVITIES Selection of volunteers Training of volunteers Assignment of works Supervision and monitoring</p>
<p>TYPES OF VOLUNTEERS Literacy Volunteers help in literacy program and IEC Health and Social Volunteers help in health, social, democratic, legal works and in integration of local resources (e.g. GO/NGO or Private) with community Cultural Volunteer help in dissemination of messages through cultural programs for raising awareness of the community</p>
<p>ACTIVITIES OF A CHV</p> <ul style="list-style-type: none"> • Base line information collection of 130-140 households by each CHV • First line referral by CHVs to the clinics • Follow up of clinical cases in the community

Process

Developing a CHV and the overall responsibilities borne by her is shown below:



Community based health promotion

CEs and CHVs work under the supervision of CS for the prevention of

- ARI
- Diarrhea
- Malnutrition
- Tuberculosis
- Unwanted pregnancy

Activities of CHV

- Motivation
- Screening
- Health Education
- Referral and Follow- up
- Demonstration; practicing ORS preparation,
- Integration with local service centers

Shorifunnahar: the CHV

Sharifunnahar, one of six CHVs, works under Rabeya apa at Karam Ali slum. She used to cover 140 *ghars* (households) of this slum. Her husband prepares optical lenses. She got married in 1989. She has one son, born in 1991 reading in class III and a daughter of 4 years old. She did not get admitted into school yet. She has been living in this slum for the last 12 years.

Shorifunnahar remembers like this pointing her finger towards the satellite clinic: About 5 years' back the Satellite Clinic has been set up in this house. I did not get involved in any job prior to joining BWHC,A.

She keep continuing: I was suffering from RTI disease. Apa from Coalition used to come to our slum. I shared my problem with her. According to her suggestion I went to Coalition office. I was under treatment over there for 2 months. At present I am free from RTI. I recovered having proper treatment from them. This is about 3 years' back. Since then I had my confidence on Coalition. I work here based on trust over them. If I do not have faith on Coalition then my clients will also not be convinced as well. I motivate and counsel them from my own experience.

Two or three months after my recovery, apas from Coalition came to our house and asked me whether I am willing to work for the development of slum dwellers on behalf of BWHC,A. Finally they proposed me to join here as a CHV.

Then I discussed it with my husband. He agreed. Since then I am working here.

I get Tk. 300/- per month as an honorarium. The amount is not that attractive. We would be benefited if the amount could be raised more. We informed Coalition about this. I think the amount should be at least Tk.700. Sometimes I face difficulty in my family while performing my duties. It happens they call me to Coalition office while I remain busy with my work at house. Then I have to go there sacrificing my household chores.

Sometimes I perform my duties according to my convenient time. If I do not feel good at field then I just come back home and report to office or perform door to door visit in the afternoon after completing my work at home.

We are assigned to motivate target people in keeping the slum clean so that diseases like diarrhea, pneumonia may not occur and also let them inform the causes of various diseases. At the same time we take necessary actions if find anyone sick in the field.

I work 6 days a week except Friday. Sometimes we work on Friday also. Usually I want to be free from work for 1 or 2 days. I take weight of children and give growth-monitoring training once a week. I provide health education in the satellite clinic. I am assigned to visit 140 households at field. If I find any children or parents sick, I refer them to Coalition. If the patient is beyond BWHC's capacity we usually refer them to Shishu hospital or Sohrawardy hospital, or DMCH. I visit 10/15 houses every day.

There are more than 800 houses in this slum. We are 6 CHVs working here and each of us has to oversee 140 houses. We take care of each of the houses of Karam Ali slum.

I come to SC every Tuesday by 9:30 AM. My responsibilities are to arrange everything to open it. It includes - set up sitting arrangement, clean the room, help Paramedics apa in carrying instruments and medicines for clinical services, provide health education, motivate mothers and see off Paramedics apa after *Zohr* (prayer at noon). I provide health education to mothers who come to Satellite clinic and take classes for health education as long as the clients are present. I got assistance from another CHV who is responsible for record keeping.

CE: Rabeya Khanam

"We select CHV. The candidate must be slum based and must have education up to class V. She must have willingness to volunteer the service. We also have CHVs who are SSC passed. They must live within our working area. They must be encouraged to do job. We do not provide them any salary. We just give them an honorarium of Tk. 300 per month."

"Sometimes we face difficulties while performing duties. Woman with education up to class X could perform better as a CHV, but we can not hire them, as the honorarium is very minimal. That's why we do our assigned work with the woman having education to class V."

Jharna*: a beneficiary of community-based health promotion activity

Jharna (35) hails from Pabna and resides in Nur Mohammad slum. She can only sign her name. Her husband Abul Kalam (45) is a Car Driver. Alike Jharna, he also does not have any formal education, only can sign own name. She has two daughters (11 years and 4 years old) and a son (8 years). First two children are school-going. She has been living in this slum for last 18 years. Her father died but mother along with other family members lives in her home district.

I came to Dhaka with some neighbouring fellow from my village and worked as maidservant. Actually I fled away from my village and stayed at Dhaka for seven years. Then I went back to my village. Again I came here. My guardian Mr. Nur Mohammad, the owner of this slum, arranged for my marriage. I got married for my security.

I aborted one child recently. The baby that I aborted was of 12 weeks. I went to Coalition office as I was facing some problems in my body. Apas exercised some check up but could not identify my problem. They advised me to have an ultrasonogram from a pathological centre. I could not do that for want of fund. My husband is completely a non-cooperating person. So I could not manage fund for the test. Then one lady residing in this slum gave me some medicine. After having that medicine I had miscarriage causing great suffering to me. Since then my physical condition started deteriorating. I could be dead due to excess bleeding.

At this stage, Jahanara Apa and others from Coalition came forward to help me. They help me with cash money, medicine free of cost, treatment without any fees. Now having medicines from them I am well by the mercy of Allah.

Apas gave me 400/- for my further treatment. Jahanara Apa took me to Sohrawardy Hospital first. They referred me to Dhaka Medical College Hospital. My husband did not give permission to go there. He thought that as I was almost a dead person, if I go to DMCH I could not come back alive. He arranged salines with the help of a local doctor. I recovered quickly after having saline and medicines in my body.

I decided to go for the abortion of my baby as my husband did not would the child. He accused me saying that I was bearing an illegal child in my womb. He stopped giving money for bearing my daily expenses. My husband scolded me and said, 'I forbid you not to conceive any baby but you are now carrying a baby.' He tortured me a lot. Finding no other alternative, I took decision of my own for abortion.

I worked in a house as a maid servant. Now I am not working.

I earned Tk. 600 per month while I was working. Now I am completely dependent on my husband. Rawshan Apa from Coalition suggested me not to continue my job for the sake of my health. So I am without job for last two months.

I learnt about BWHC, A from neighbours at Motaher slum. I went there to get rid of the unwanted problem. But alas! Then my life was numbered. I went to that lady hiding my husband. My husband came to know when I faced excess bleeding. My husband was indifferent when I was totally sick. He did not want to spend any money for my treatment. Other people scolded at him at the same time advised him to get me under treatment as I was facing life risk.

Coalition is very popular here. Apas used to come here to provide assistance to sick people. They used to feed polio to all babies.

I used to go to Coalition for my health problem. Other than that event, I went to the Coalition for immunizing my babies and also for my problem with legs.

At present I do not have any good relation with my husband. There is a gulf of difference between my husband and me. We just live under the same shade. That's all. Hardly he talks with me. He lives of his own. He does not want any help from me. He has been sick for last two days but did not seek my help. You know I have three kids. That's all for my life. They are the inspiration of my life. I pass my days with these three kids with great miseries and sorrows.

*[It was not possible to take Jharna's interview at her house as her husband was staying there right at that moment. So we have to had her to another lady's house and made the interview there]

Awareness Raising Program

Concept

BWHC,A runs Awareness Raising program (ARP) in its six pockets under Agargaon slums. In order to make all women aware of all vital issues, BWHC,A organized this program.

The topics that are covered in ARP include health, social, environmental and legal issues. These are personal health and hygiene, safe water and sanitation, diarrhoeal diseases, food and nutrition, maternal and child healthcare, family planning and contraceptive methods, MR, STD/AIDS, Child Immunization and six diseases, common disease management, acute respiratory tract infections (ARI), first aid in emergency cases, prevention and control of gynecological diseases, legal aid, social awareness, and human and family law.

Process

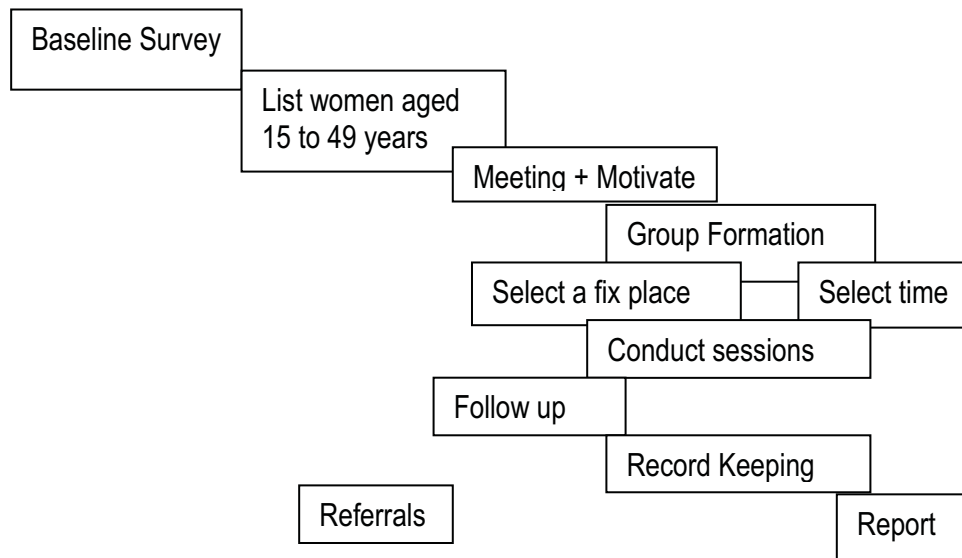
In order to form a group for ARP, initially a base line survey is done. CEs with the help from CHVs prepare a list of all women aging 15 to 49 years under each BWHC,A pocket. CEs and CHVs perform motivational work with these listed women. They form 16 groups in each slum containing 10 women for each group. It brings 160 women under this program from each slum per year. After groups are formed, place and convenient time is fixed consulting with them.

Based on group-wise participatory non-formal approach, CS and CEs conduct all sessions. BWHC-developed health education materials and GoB-developed IEC materials are used during sessions.

Follow up, record keeping, referrals and report writing are the other steps of this program.

The whole program is supervised by CS, MOs and Paramedics.

Description	
WORKING HOURS	9:30 - 11:30 AM
WORKING DAYS	6 days (Saturday - Thursday)
STAFF	Community Supervisor Community Educator -5
LEARNERS	Women (15-49 years of age)
APPROACH	Group-wise participatory non-formal approach
GROUP FORMATION	Groups are formed by the CEs
GROUP SIZE	10 learners
NO. OF GROUPS	16
MATERIAL USED	Health Education material developed by BWHC and IEC materials developed by GOB
ISSUES COVERED	Health Social Legal Environmental
COURSE PERIOD	12 months



Group size: 10
16 groups per slum per year
IEC materials are used in the sessions
Supervisors: CS, MO and Paramedics

Formation of TBAs

Concept

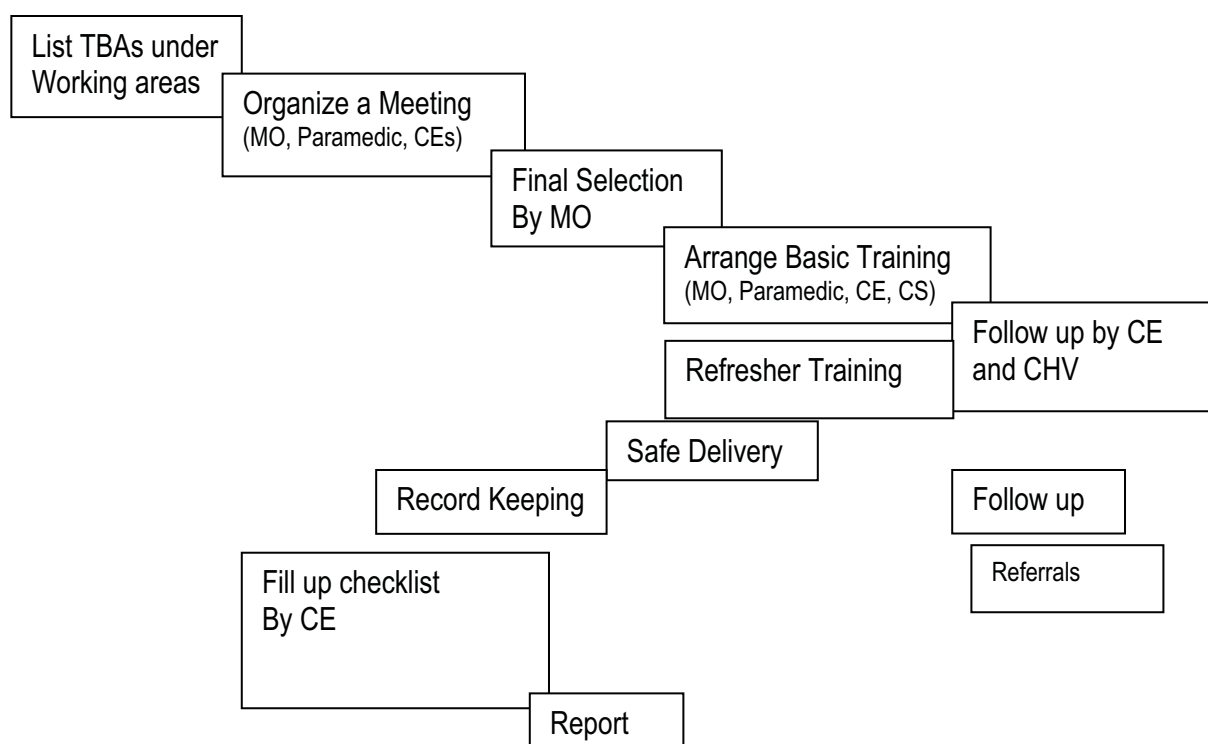
Slum-dwellers are reluctant of having their babies at Hospitals or other maternity clinics. In reality, many children are born at slums, so to ensure safe delivery BWHC,A introduced TBA training at slum set-up.

BWHC,A believes the traditional birth attendants (TBAs) act as volunteers and promote safe delivery in the community working areas. This activity has two aspects:

- i. in order to promote safe pregnancy, efforts are undertaken to enhance the skill of the existing TBAs
- ii. TBAs are utilized productively for referral, follow up and promotion of EPI purposes.

Process

First of all, TBAs under Agargaon slum is listed out. BWHC,A organize a meeting with TBAs. MOs, Paramedics and CEs facilitate the meeting. MOs select TBAs for formal training. A five day basic training is organized by BWHC,A. Both CEs and CHVs get involved in post-training follow up activities with all trained TBAs. Finally a refresher training is organized after a month. TBAs remain responsible for safe delivery in the slum area. They also keep records of all pregnant cases and refer to proper places if the case is out of their reach. CEs are assigned to fill up a checklist prepared for TBA activities. Based on those format, CEs prepare a report of TBA activities.



Sufia, a trained TBA Speaks

I have been helping pregnant mothers during their deliveries since long ago. But before having training from BWHC, I hardly knew anything about safe delivery. At that time I used to work with non-boiled blades as well as threads during any delivery. Now, I am aware that for safe delivery, I have to use both blade and thread boiled. Coalition apa also taught us how to understand that the boiling is over: they suggested us to pour some rice (hardly two or three) within the water being boiled for blade and threads; if the rice get cooked, it implies blade and threads are now germ free. I used to tie up cords of newly born babies with single binds. But now I know from the training the correct procedure to tie up the cord of a baby. Agey amara jantam jodi ful na porey tobey bachcharey to eibhabey rakha jaibona. Tokhon bachchar naavi na ketey tara tari doodh diley taratari ful porey jai. I used to get scared of cutting cords if fuls are not cleared up. But now I have every confidence to cut cords. Just after cutting cord, a baby is given colostrum.

I got the training 10 months ago. I went there twice. Duration of the first training was of 4 days and the second training 2 days. I know a lady is to be treated as a risky mother if she is pregnant before 20 years or after 30 years. In that case, we have to deal with a risky mother very carefully.

I remember one incident of a risky mother. The lady got pregnant when she was 19 years. During her pregnancy, she was completely kabu/kator of (sick) severe pain and vomiting. I was called to her house. I understand the time for her delivery is still far. I suspected with my knowledge I earned from the training that the lady was suffering from malnutrition and only possible way to be recovered is that if she could have treated under a physician. Ami taderkey bujhalam jey eti kono jhar phoker kaj na. I suggested her to visit a doctor immediately but she informed me that she only could visit a physician if her husband allows. So I waited there till her husband returned home from his work. I made him understand the importance of visiting a doctor at that moment. He allowed her wife to go with me. The doctor also suggested taking enough food, as she is malnourished and prescribed some short course medicines. The lady followed all suggestions that the doctor made for her. The most interestingly the lady recovered within a very short time. I was very happy to hear that she delivered a healthy child without any complication at her due date.

I have been providing assistance during delivery for last 8 years. A neighbor of mine was pregnant. During her delivery, there was nobody present in the house. She did seek my help as she felt the time has come to deliver a baby. Because of human ground I just appeared before her. Actually even I did not have that wisdom or experience to suggest her calling a doctor. Eventually she delivered without any problem. I became confident in doing this as I got involved with many other cases time to time. I already rendered my assistance to seven pregnant mothers after getting this training. Till date, at least 80 babies have been delivered through my hands.

Two months ago, a lady experienced with severe labor pain called me to her house. After my arriving there, I suggested her to go to a doctor as I guessed it was not within my reach. She disagreed. I returned to my house but following morning her sister, Rahima, came to my hut. Rahima informed me that her sister got a baby last night but she is *osthiir* (nervous) because of her *ful* (umbilical level) related complications. I rushed to her house and found the baby wrapped with heavy cloths. I saw no bind in baby's cord and severe bleeding was taking place from there when I took the kid on my lap. The mother was also in a very bad condition. I suggested her to take her to Medical College Hospital. Cut baby's cord with a boiled blade and stitched over there with a clean thread. The lady was taken to Medical College Hospital and remained there for two days.

I learnt a lot from this training: How to bind and cut the umbilical cord, Colostrum to be given just after a baby is born, need to put a thin wet cloth on face and nose of a baby if s/he does not cry after birth, need to give our breath to the child if it does not breathe.

I don't charge anything as my fees. I consider this as a sacred task. I feel it is one of my obligations. People used to give me some gifts like sarees, soap or oil out of gratitude. There are 4 other TBAs in this area. Most of them are very commercial. They visit any pregnant mother, if a wholesome amount is ensured, otherwise they remain reluctant.

BWHC,A Cultural Team

Concept

BWHC,A believes in case of rendering health as well as development messages, cultural performances are more effective than anything. People pay more attention to music or a drama rather than a speech. At the same time, BWHC,A experiences that adolescent girls are very much enthusiastic in performing cultural activities. Exploring this opportunity, BWHC,A developed a very strong cultural team. The team performs in various programs attended by BWHC,A. It becomes the mouth piece of BWHC,A. In order to develop this team, post of a Male Social Worker has been re-designated to Social and Cultural Educator (SCE). SCE is responsible in organizing everything for this team.

Criteria

Adolescent girl under BWHC,A
Interested in performing cultural activities

Activities

Songs
Drama
Recitation

Messages used to cover through these performances are: breast-feeding, importance food, safe motherhood, prevention of AIDS, contraception, cleanliness, against dowry, risk of early marriage and early child bearing etc (see sample messages).

Impacts

BWHC,A witnesses some direct impacts for activities performed by the Cultural team.

SCE remembers, "Being the audience of a drama titled *Moyejuddin Sangshar* (The story of Moyejuddin), an aged man came closer to the stage and finally embraced me. He was so impressed that he lost his words. Only he commented 'really people could learn many things from such a drama.' It was staged near the radio station and the area was full of audiences from Agargaon slums. The drama held in a pin drop silence."

He continues, "The next day, a truck driver came to the Evening clinic. He was suffering from some sexual diseases. His sex organ abnormally *phulley gaechhey*. All along he experienced with multiple sex partners. Now he realizes he is in a very risky zone. He reported that he came to know about this clinic from the drama held on previous evening. He just said, 'Please save my life. I can not bear all pains I am facing with.' Our MO treated him and eventually he recovered. One day I saw him in our clinic with floral wreaths in his hand. Out of gratitude he offered us floral greetings."

The PM says, "After the program, young males became vocal. It is reported that if anyone saw any commercial sex worker, he cautioned others saying, 'Beware of this girls – they are the root cause of AIDS.' Or in case of shaving to a barber house, people were heard requesting the friseur, 'Brother, please use a new blade for me.' So this type of impacts we experienced with."

Nishu: the Heart of BWHC, A Cultural Team

Nishu is only 7 years old. But because of her tremendous talents she could easily sing songs full of messages. Her age limits her from realizing the very meaning of each message. But she could perform without any hesitation. She pronounces all hard words like AIDS, Diarrhea, Family Planning etc. so smoothly that everyone cannot but pay attention to her. She also can dance.

The mother of Nishu is one of the CHVs of this project. Her name is Mira. Nishu is fatherless. They live at Tarer bera bastee. One day Mira told the SCE that her two daughters remain at home during working hours. She was worried, as they do not have anything to do. Mira requested the SCE whether he could include them in the cultural team. The SCE assured her. He arranged a program on the occasion of AIDS day and included them in the team. Everybody praised Nishu. She does not find difficulty to mix with girls senior to her. With her continuous effort, Nishu became the heart of BWHC, A cultural team.

Sample Messages (Song)

Messages on Breast-feeding

gv Rbbx
I gvgwb †kvb bv
gv Rbbx, I gvgwb †kvb bv
Avgvi †QvU fvBwU†K Zzwg
†Zvjv `ya LvlqvBI bv

gv Rbbx, I gvgwb †kvb bv
fvBwU†K †Zvjv `ya w`†j
†c†Ui cxovq fzM†e †m
Acywó†Z fzM†e †m gv, my`
mej n†e bv

gv Rbbx, I gvgwb †kvb bv
†Zvgvi ey†Ki `ya †L†j
cywónxbZv ` i n†j
†jLv cov wkL†e †m gv, †evKv
n†q _vK†e bv

gv Rbbx, I gvgwb †kvb bv
Avgvi †QvU fvBwU†K Zzwg
†Zvjv `ya LvlqvBI bv
gv Rbbx, I gvgwb †kvb bv

Oh dear mother
mother, please listen
mother, oh dear mother, please listen
please do not feed my younger brother
the tinned milk
mother, oh dear mother, please listen

If you feed him tinned milk
he will suffer from diarrhoea
he will have malnutrition, and never
will be a health boy

mother, oh dear mother, please listen
due to having your breast milk
he will be free from mal-nutrition

He will be able to continue his
education, he will not be fool
mother, oh dear mother, please listen
please do not feed my younger brother
the tinned milk
mother, oh dear mother, please listen

Messages on AIDS Prevention

GBWm tivM cÖwZtiva KiþZ
wk¶v MÖnY Kþiv bv
wbþRiv fzj Kþi AKvþj þKD
þgvþiv bv

Please take lesson to prevent AIDS
Do not die due to your own fault

GBWm tivM cÖwZtiva KiþZ
wk¶v MÖnY Kþiv bv
wbþRiv fzj Kþi AKvþj þKD
þgvþiv bv

Please take lesson to prevent AIDS
Do not die due to your own fault

mvgvb" fzþji Rb" kixþj GB tivM
nq
tivM cÖwZtiva ¶gZv
axþi axþi Kþi ¶q

Little mistake causes this disease
Power to prevent disease starts
reducing gradually

mvgvb" fzþji Rb" kixþj GB tivM
nq
tivM cÖwZtiva ¶gZv
axþi axþi Kþi ¶q

Little mistake causes this disease
Power to prevent disease starts
reducing gradually

wewfbœ tivþM _vþK wNþi
Jlþa Avi KvR nq bv

Different diseases attack
No medicine works on

wbþRiv fzj Kþi AKvþj þKD
þgvþiv bv

Do not die due to your own fault

GBWm tivM cÖwZtiva KiþZ
wk¶v MÖnY Kþiv bv
wbþRiv fzj Kþi AKvþj þKD
þgvþiv bv

Please take lesson to prevent AIDS
Do not die due to your own fault

GB tivþMi wPwKrmv bvB-
cÖw_exi þKvb `vþb
cÖwZtivþai AvþQ Dcvq
Pwiþ MVþb, Pwiþ MVþb

This diseases has no treatment in any
place of the world
the only prevention is to build up a good
moral character
by building a good moral character

GB tivþMi wPwKrmv bvB|

This disease has no treatment

GBWm tivM nþj cþi
KZ tivM þ`Lv þ`q
Kvwk mw`© Rjimn `az tivMx
cvZjv nq
`az tivMx cvZjv nq

Various types of diseases affect
as a consequence of AIDS
Patient becomes thinner having cold,
cough and temperature
Patient sooner becomes thinner

þVvþU gyþL Nv _vþK me mgq
Kþi cvqLvbv
wbþRiv fzj Kþi AKvþj þKD
þgvþiv bv

Various types of diseases affect
as a consequence of AIDS
Patient becomes thinner having cold,
cough and temperature
Patient sooner becomes thinner

GBWm tivM cÖwZtiva KiþZ
wk¶v MÖnY Kþiv bv
wbþRiv fzj Kþi AKvþj þKD
þgvþiv bv

There is infection at lips and mouth and
also having problem
related to motion (stool)
Do not die due to your own fault

Please take lesson to prevent AIDS
Do not die due to your own fault

Messages Building a Healthy Nation

my^ৱ RvwZ MV**ভ**, my^ৱ RvwZ MV**ভ**
 nvq**ি** my^ৱZvi `iKvi
 gv**ি**th †L**ি** n**ি** cywóKi Lvevi
 my^ৱ RvwZ MV**ভ**, my^ৱ RvwZ MV**ভ**

To build up a healthy nation, to build up a healthy nation

Sound health is required

Nutritious food is required for mother

To build up a healthy nation, to build up a healthy nation

my^ৱ gvB w`**ি** cv**ি** my^ৱ wkii Rb**ি**
 nvq**ি** cywóKi Lvlqv gv**ি**cÖavb
 Kg©
 nvq**ি** cywóKi Lvlqv gv**ি**cÖavb
 Kg©

Only a healthy mother can give birth to a healthy child

It is essential for a mother to take nutritious food

Remember, it is essential for a mother to take nutritious food

my^ৱ RvwZ MV**ভ**, my^ৱ RvwZ MV**ভ**
 nvq**ি** my^ৱZvi `iKvi
 gv**ি**th †L**ি** n**ি** cywóKi Lvevi
 my^ৱ RvwZ MV**ভ**, my^ৱ RvwZ MV**ভ**

To build up a healthy nation, to build up a healthy nation

It is necessary to be free from diseases

Nutritious food is required for mother

To build up a healthy nation, to build up a healthy nation

†Kvb Lvev**ি** †Kgb ,bv,b, †Kgb †L**ি**
 n**ি**
 nvq**ি** †Kvb Lvev**ি** †Kgb ,bv,b, †Kgb
 †L**ি** n**ি**

wbqg Kvbyb mKj gv**ি** †R**ি** wb**ি**
 n**ি**
 nvq**ি** wbqg Kvbyb mKj gv**ি** †R**ি**
 wb**ি** n**ি**

Every mother should know the food value of each item and

types of food she should take

my^ৱ RvwZ MV**ভ**, my^ৱ RvwZ MV**ভ**
 nvq**ি** my^ৱZvi `iKvi
 gv**ি**th †L**ি** n**ি** cywóKi Lvevi
 my^ৱ RvwZ MV**ভ**, my^ৱ RvwZ MV**ভ**

To build up a healthy nation, to build up a healthy nation

It is necessary to be free from diseases

Nutritious food is required for mother

To build up a healthy nation, to build up a healthy nation

Aí eq**ি** Kiv Avi Nb Nb mš vb
 nvq**ি** Aí eq**ি** Kiv Avi Nb Nb
 mš vb

Every mother should abstain from getting married at their early age and

to give birth babies frequently

Every mother should abstain from getting married at their early age and

to give birth babies frequently

Gme †**ি** me gv**ি** weiZ _vKzb
 nvq**ি** Aí eq**ি** Kiv Avi Nb Nb
 mš vb

my^ৱ RvwZ MV**ভ**, my^ৱ RvwZ MV**ভ**
 nvq**ি** my^ৱZvi `iKvi
 gv**ি**th †L**ি** n**ি** cywóKi Lvevi
 my^ৱ RvwZ MV**ভ**, my^ৱ RvwZ MV**ভ**

To build up a healthy nation, to build up a healthy nation

It is necessary to be free from diseases

Nutritious food is required for mother

To build up a healthy nation, to build up a healthy nation

Comment by a member of the Mobile Cultural team

We never knew before what we have learnt through this song. First we used to move around here and there and did not find any place even to play. After coming here we have learnt music, dance and other activities of this adolescent club by utilizing time. We are all given education and we are learning more and more gradually. We have tried to give messages to the mass population through our songs that we learnt from here. For example, we did not know about AIDS, now we are aware of this and have made people conscious about this through our song.

Unless we came here we could not know many things and consequently it would not be possible for us to let the other people inform about this. Our life could be miserable, if we did not come here.

Earlier we were not aware of the bad sides of moving here and there. Now we do not walk here and there. We did not have opportunity to study but now we have. Now we attend a class in which we have 30 girls. I have been promoted to class eight this year. I remember my parents did not want me to get admitted in class seven due to lack of fund. I came here and informed *apa* and they helped me to continue our (me and my sister) studies. I feel proud to be here because I myself learnt a lot from here and which I am able to teach other people.

Dealing with Most Sensitive Segments**RTIs/STDs and the PREVENTION OF HIV/AIDS:**

This is a new area in Bangladesh for both data collection and services. However, what is known thus far is worrisome. There have been both rural clinic-based (SAVE/US) and urban clinic-based (BWHC) studies conducted on the prevalence of RTIs. The findings are consistent regarding the prevalence of RTIs with 56 percent in the rural area and 60 percent in the urban area. The most commonly found STDs in the studies which have been conducted thus far are gonorrhea and chlamydia in the rural SAVE/US sample and gonorrhea (3.8 percent) and syphilis (0.5 percent) in the urban BWHC study. Other significant outcomes of these studies is that women, possibly because of their considerable suffering with these infections, are willing to come for treatment and care. Prior to the opportunities for care that the clinical studies provided, they had not been passive about the infections. They have sought care from traditional healers...usually with little relief.

The BWHC study was based on an initial informal survey of self-reported reproductive morbidity where approximately 22 percent of women complained of symptoms suggestive of RTIs.

Floating Prost

As soon as I entered into Sharifa's room I found some girls sitting over there. No later I arrived there, they started laughing at me and showed me some signs with body language. With my work experiences in the Tan bazaar, the largest brothel, it was not that difficult for me to understand who they are. I confirmed after asking Sharifa. After their departure she told that they are all floating prostitutes. I wanted to discuss with them. She told that it is not possible. Finally Sharifa called the *Sarderni* before me. I introduced myself and also shared some of my experiences in the Tan bazaar. After that she agreed to talk with me along with the group.

I have worked with many prostitutes at Tan bazaar. We developed peer educator. One of them is Mira. During our sharing the group could recognize Mira. So it made the situation smoother. I made them clear that I do not want to suggest them to give up the job they used to perform. I asked them whether they know any other job except prostitution. They identified garment work provided time is given to develop their skills. One of them suddenly said in a harsh voice, "Garments? They do not provide salary on time, workers are under paid, employer scolds every now and then and we have to be abused there also by the owner. So what's the difference?" Others agreed to that.

That day I packed up my discussion here.

After two days again I wanted to sit with them. This time I wanted to know where do they work? Some one told, "I was a housewife. Being cheated by my husband I came at Agargaon baste. My husband divorced me. I took a job as maidservant where the owner of the house raped me. Then I went to police who also abused me. Now I selected this occupation. There is no shelter in this society. Tell me where shall I go?"

Another said, "We earn taka 500 per day. But no one will give me even 2 taka. Tell me, will you give me 2 taka.? So we prefer this job for the sake of our existence. We earn a lot from this. We don't want to be a beggar".

Thus conversation passed by. In one moment I raised the point on condom use. I rendered all messages in this context. But they looked worried whether their customers will be satisfied. Finally they realized and agreed to use condom in order to protect themselves from HIV/AIDS.

** Reported by Social and Cultural Educator*

Afterwards when I met them they told, "We are now using condoms. We keep those with us and sell each condom at Taka 5. You know we give condition to our clients during contract that we will not meet if condom is not used.

The prostitutes are getting treatment under this project as RTI/STD patients. But other projects of BWHC do not allow them, as it is a sensitive as well as controversial issue. Irrespective of occupation and socio-economic status, we provide services. Whoever s/he is, we will treat her/him as a patient and provide her/him proper treatment if s/he develops RTI/STDs.

ROZINA

A girl named Rozina lost her mother at her infancy. Alike fairy tales, Rozina became the subject to torture as her father performed his second marriage. One day she could not but fled away from house to save herself from her stepmother and arrived at Sadarghat Launch Terminal. She was introduced with a woman who took her to a house. The landlord appointed her as maidservant. Within few days the landlord's son sexually abused her. After that she left the house with anger and went to the Police for help. But the Police was very sincere to catch hold of her and rape her. Then another woman took her to another building, which was actually a brothel. She found there many women like her. She then asked that woman about them. She replied that Rozina would understand everything at night. She also suggested her to eat, to take rest and to get herself fit for the upcoming night. Rozina could guess her fate but stayed there, as she had no other place to go.

At night a man entered in her room. Prostitution became her last resort for existence. The new episode of her life began in this way. Astonishingly at that time she was merely a girl of 9 years' old. Now she moves around Sangshad Bhaban (National Parliament House) where she is the leader of other girls. Though she still resides in Agargaon slum but used to go to Hotel Sheraton and RAOWA club (The Club of Retired Army Officers' Welfare Association) for the call from elite society.

CHAPTER TWELVE

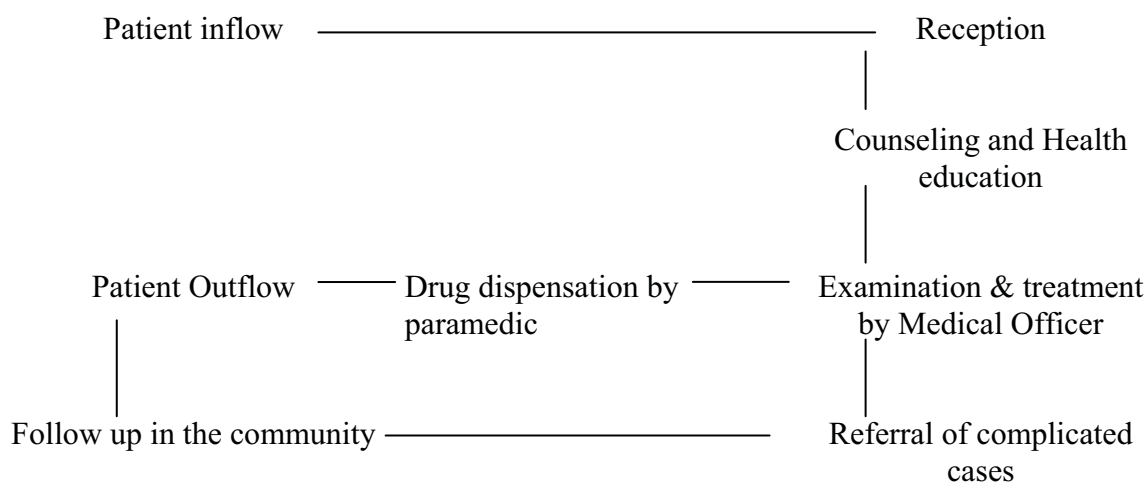
EVENING CLINIC

Concept

The last one and half year's data shows that the number of clients is increasing and the number of couples visiting the clinic are also increasing. This means there has been an increase in the awareness on STD/RTI in the target population. However, the rate of increase is slow. Other organizations who runs male clinics are also experiencing similar phenomenon. MSCS (Marie Stopes Clinic Society), FPAB (Family Planning Association of Bangladesh) and a few other organizations have undertaken operations research pilot programs to increase utilization of male clinic. BWHC,A is trying to glean positive lessons learned by similar projects of different NGOs to improve upon the performances of its male clinic.

Descriptions	
WORKING HOURS 4:30 - 8:30 PM	ACTIVITIES Clinic based Treatment and drug dispensation Counseling Health education Community based Follow up Rapport building Motivation Special day observance
WORKING DAY 5 days (Sunday - Thursday)	SOURCES OF CLIENT MSW Client to client Day clinic CE CHV
STAFF Medical Officer -1 Paramedic -1 MSW - 1	
SERVICES PROVIDED RTI/STD Syndromic management Counseling on - HIV/AIDS prevention Practicing safer sex Condom promotion Sex education	

Service flow chart : Evening Clinic



CHAPTER THIRTEEN

EFFECTS AND IMPACTS

Effects and impacts are the most crucial components for an organization that works for community health and development. BWHC,A is heading towards its fifth year - so it is quite natural to look behind seeing all aftermaths that is achieved through continuous journey since its inception. In order to assess effects and impacts of BWHC,A - the study prefers to listen voices of dwellers in Agargaon slum as a whole.

Figure 1 (see over leaf) shows available health service points where slum-dwellers of Agargaon used to go for their health problems. Other than BWHC,A – they used to visit three doctors (Mostafa doctor, Rashid doctor and Zakir doctor) within the slum area. They also visit dispensary located almost within the slum. They used to go there for treatment or purchasing medicines.

In case of emergency, they go to hospitals and clinics outside slum area. This includes governmental hospitals like Dhaka Medical College Hospital, Sohrawardi Hospital, *Pangu* (orthopaedic) Hospital, *Shishu* (children) Hospital and Bangladesh Medical College Hospital. Though very rare, but some times they also get admitted in clinics out of doctor's suggestion. They also visit privately run Bangladesh Medical College Hospital as well. Figure shows that they move around one fourth kilometer to 5 kilometers outside the slum area for receiving health services.

Figure 2 is the visual presentation of available health facilities in Agargaon slum in terms of importance and accessibility. Participants from Karam Ali slum prepared this Venn diagram. Table 2 is constructed from Figure 2.

Table 2: Available Health Facilities in Agargaon Slum according to Importance and Accessibility

Health Service Provider	Importance (Size)*		Accessibility (Distance)**	
BWHC, Agargaon	#####	9	#####	9
Shishu Hospital	#####	8	#####	6
Pangu Hospital	####	4	#	1
Sohrawardi Hospital	#####	6	##	2
Dhaka Medical College Hospital	#####	7	###	3
Clinic	#####	5	####	4
Bangladesh Medical College Hospital	###	3	#####	5
Adjacent Dispensary	##	2	#####	8
Rashid Doctor	####	4	#####	8
Mostafa Doctor	##	2	#####	7
Zakir Doctor	#	1	#####	7

***size** : largeness of each chapati; numbers are assigned according to the size: the smallest chapati is denoted by 1 and the largest chapati is denoted by 9; all other chapatis are in between 1 and 9. The largest chapati implies the highest importance.

****distance** : length of each *chapati* from the centre (the slum); the farthest chapati is denoted by 1 and the closest chapati is denoted by 9; all other chapatis are in between 1 and 9. The farthest distance implies the least accessibility.

Above table shows slum-dwellers' views about available service delivery facilities in terms of importance and accessibility. Importance implies the significance of available healthcare

facilities in their life and accessibility implies convenience of receiving different services from each service delivery point.

It is clear from the table that slum-dwellers identified BWHC,A as the most important service delivery point. BWHC,A is also considered as the most accessible, followed by local doctors. *Shishu* Hospital is also very important for them after BWHC,A. It implies children are the important section for their health care services.

While slum-dwellers were asked to identify reasons for preferring BWHC,A, they mentioned points as follows:

We like Coalition (BWHC,A) the most as we

- get proper suggestions from here
- pay half price of all medicines
- can avail opportunities for family planning
- can avail menstrual regulation facilities
- receive formal check up during pregnancy
- receive TT injection
- get door to door services of *Rabeya Apa* and some other *Apas* for the betterment of our health
- have to carry our children to distant health centers for immunization earlier but now we get them immunized in close by (nearby) satellite clinic
- get further treatment of our children in other places referred by Coalition in case of serious diseases
- receive foods and medicines free of cost for our malnourished children

Above shows the reasons why dwellers of Karam Ali slum prefer BWHC,A. During the session, they highly appreciated BWHC,A.

During the session they also commented that they feel the fees for treatment in Coalition is expensive compared to governmental health centers. Even the treatment cost in Radda Barnen is lesser than that of in Coalition. But still they prefer Coalition the most. Finally they suggested it will be better for everyone, specially for the destitute, if coalition does not charge any price for medicines.

Some comments made by them are as follows:

'We prefer Coalition the most. We have faith on Coalition as it gives us proper treatment. If the treatment for the patient is beyond their capacity, they used to refer the patient to other appropriate places. We used to go there not only because it is located close to us, but also due to its quality services. They used to render advice appropriate for the patient. We get proper treatment in cheaper price as it waives half of the price for medicines'.

'We are getting positive results for our health consulting with Coalition. It is great as *Apas* from Coalition used to visit our slums. We can share with them time to time respecting our health problems almost sitting on the yards'.

'Few days' ago, we were threatened to be evicted by the concerned authority. We rushed to our favored *apas* to share all fears that came to our minds. They gave us courage saying not to be worried. They also confidently said that we would not be evicted without any alternative arrangement'.

Thus Spoke Noorjahan

I am Noorjahan. Now I'm running 30 years. Got married when I was 17. I have only one son. My husband Sujon carries on small business. My home district is Manikganj – a two-hour drive from Dhaka. As my husband stays in Dhaka for his trading, so I came to this Karam Ali slum 10 years ago. My son is now 13 years' old. He stays with my mother in village.

I don't have enough education. My husband is an illiterate. Fortunately I have gained little education from adult literacy classes conducted by Rabeya *apa* (the CE). Adult literacy classes were taken place at my house.

After my child was born, I started taking pills. My husband used to purchase pills (Ovastat) for me but it did not suit me. Always I had a vomiting tendency.

I came to learn about this clinic from Rabeya *apa*. She told me that family planning and other medical facilities are available here. I shared my aforesaid problem with Rabeya *apa*. She suggested me to visit BWHC, A base clinic. Doctor *apa* advised me to take injectables instead of pills. I agreed. My husband also liked the method. I rarely face any physical problem now a day. Since then I used to go to BWHC, A clinic.

In general, if you visit a doctor, you have to pay at least tk. 100, but in case of BWHC, A you will get the same service at a cheaper price. BWHC, A charge half price of any medicine. I have every trust on them. Due to their quality service number of clients are increasing day by day. Whenever I face any problems I just rush to them and narrate everything to them.

It is interesting that several times I became the subject of Videos. I also attended different programs being invited by them. We get many things from them. I like them very much.

a. Significant Changes due to BWHC,A

Women at Tulatola slum acknowledged that a number of things have been introduced with the initiation of BWHC,A at their locality (see table below).

Table suggests that they knew messages like causes behind diarrhea, how to prepare oral saline, how to clean vegetables, and provide weaning food to a baby up to 5 months beforehand but they have been more conscious about these all after BWHC,A started working in that area. Participants also enjoyed some immunization facilities for children and check up facilities for pregnant mothers before BWHC,A comes here.

Participants identified eleven components which they did not know at all before BWHC,A intervention in Agargaon slum. Five of them are child health related including provide children polio at house, measure weight of children in every week, provide vegetables to children in preventing them from night blindness, provide colostrum to newly born baby and provide breast milk to a baby until 2 years.

They became also aware of getting TT injections during their reproductive period. There was no practice of pushing TT injections before BWHC,A intervention.

Before BWHC,A women in Agargaon slum did not have any clear idea about STD/RTIs as well as AIDS. Now they know causes behind these fatal diseases.

Participants of the session informed that they were ignorant of iodine salt earlier. BWHC,A made them aware of taking iodized salt in every meal to be free from Goiter. Personnel from BWHC,A also get them educated the process of testing iodine in the salt.

Topic	Before BWHC,A	After BWHC,A
Checkup facility during pregnancy	***	*****
Provide children polio coming at our house	-	*****
Immunization facility	**	*****
Provide TT injections to women between 15-49 years	-	*****
Measure weight for children in every week	-	*****
Make aware of nutritious food	*	*****
Inspire cultivating vegetables	**	*****
Educate how to prepare oral saline	****	*****
Educate how to clean vegetables	**	*****
Make aware of causes behind Diarrhea	**	*****
Make aware of hidden diseases (RTI/STD)	-	*****
Make aware of causes behind AIDS	-	*****
Educate how to test iodized salt	-	*****
Suggest to have iodine salt in every meal	-	*****
Suggest to give vegetables to children for preventing them from night blindness	-	*****
Suggest to feed colostrum to newly born baby	-	*****
Suggest to provide breast milk to a baby until 2 years	-	*****
Suggest to give other foods to a baby after 5 months	****	*****
Provide Menstrual Regulation (MR) services	-	*****

Participants: Rahima, Sufia, Safura, Majeda, Parveen and Nurjahan of Tulatola slum; **Facilitator:** TR Noor

They also pointed out that services for MR they received only from BWHC,A at slum-setting. They also identified that BWHC,A suggested them providing weaning food to a baby after 5 months but some of them practiced it earlier. According to them, the extent of mothers in Agargaon slum providing weaning foods to their babies is increased after BWHC,A intervention.

An interesting discussion took place in Tulatola slum on MR and some other issues. All the participants were women and clients of Coalition. They were seven in number. Participants' age was ranging from 20 to 55 years but it did not hamper the flow of discussion. Three of them work in other's house as maidservant and the others are housewives.

During discussion, one of them took stand against MR and others in favor of it. Finally they came to a conclusion that MR is sometimes necessary in a woman's life. The discussion keeps going shifting one issue to another. Followings are quoted from that discussion:

'In addition to general health support, Coalition also helps in menstrual regulation services. In this context, *apa* used to give medicine after check up. Several types of check-up are done here, for example, general health check up, pregnancy test, check up for irregular menstruation etc'.

'If any patient comes to this centre for MR, Doctor *apa* finally asks the pregnant woman whether she want to give birth the child or not. If the patient agrees to go for an MR, only then *apa* takes necessary steps accordingly'.

While asked whether they support MR, one of the participants opposed saying that she does not support MR. Another one contradicts. She says, "Suppose, one of us has three children but she got pregnant accidentally. She or her husband does not want any more babies. In that case I will say MR is the best remedial measure. Many organizations as in Mohammadpur do not take money at all for MR, but some other like Coalition takes taka 200. Yet I will say MR is a blessing for those who are facing unwanted pregnancies".

Finally all agreed with this point.

Participants informed that till date none of them went for any MR. During discussion they accepted MR as a remedy in case of unwanted situation but suggested a female must be cautious/careful before conceives.

'Coalition advises us to adopt different methods like needle (infectable), birth control pills, and condoms. Maximum women of this slum take mainly pills and uses needles. There are two types of injectables: one is for 3 months and the other continues up to 5 years (meaning Norplant implant). Some women also go for setting copper Ts'.

They complained saying that males are very reluctant taking any method, even condoms for birth control. 'So a woman accidentally conceives if she forgets to take pill'.

'I select birth-controlling method after counseling with my husband. He buys pills for me from the local shop'.

'Since I am married, my husband brings pills for me. Recently I started my motherhood. God has gifted me a child after 5 years'.

'I am very pleased with the Coalition as it helps me in different ways during any health problems in my household'.

'Earlier we do not know what causes goiter. We used to purchase salt of taka 1 or 2 from groceries nearby, but now we purchase the packet of iodine salt that costs taka 10. Apas from Coalition suggested us to test the salt whether it contains any iodine. They also taught us how to test this. So before using, first we test the salt with a lemon'.

'Coalition has taken our class to make us understand that how important it to take salt with iodine'.

'At first we do not know the usefulness of colostrum milk. They made us understand about usefulness of colostrum for a newborn baby in case of its physical as well as mental growth. Since then, all of us do not ignore feed colostrum to a newborn baby'.

'They can be free from different diseases due to having colostrum. That is why we give them colostrum'.

'We didn't know the importance of colostrum before Coalition arrives here. The richer section of the society did not feed colostrum to their baby earlier. But now they also feed their baby the colostrum'.

'The newborn baby was not served breast milk until 3 or 4 days passed after its birth. In this period, we used to serve the baby only sugar water or honey. Recently we are informed that it is actually harmful for a newborn. Rather we are suggested to give baby breast milk just after its birth after cleaning the busts'.

'Credit goes to Coalition. We came to know all these things mainly from Coalition even not from TV or Radio'.

'Now mothers follow the lessons of Coalition. I will say that gradually positive changes have been taking place in this area'.

'We want to stay well than before'.

'We give *khichuri* (balanced mixed food) to our child when they are of 5 months. Apa from Coalition always advises that we have to serve our baby *khichuri* after their 5 months'.

'Really it (*khichuri*) is good for baby's health'.

'We used to go to *Shishu* hospital earlier and they just prescribe medicine while seeing the baby. Now after the formation of the Coalition, we take our children there for any kind of treatment'.

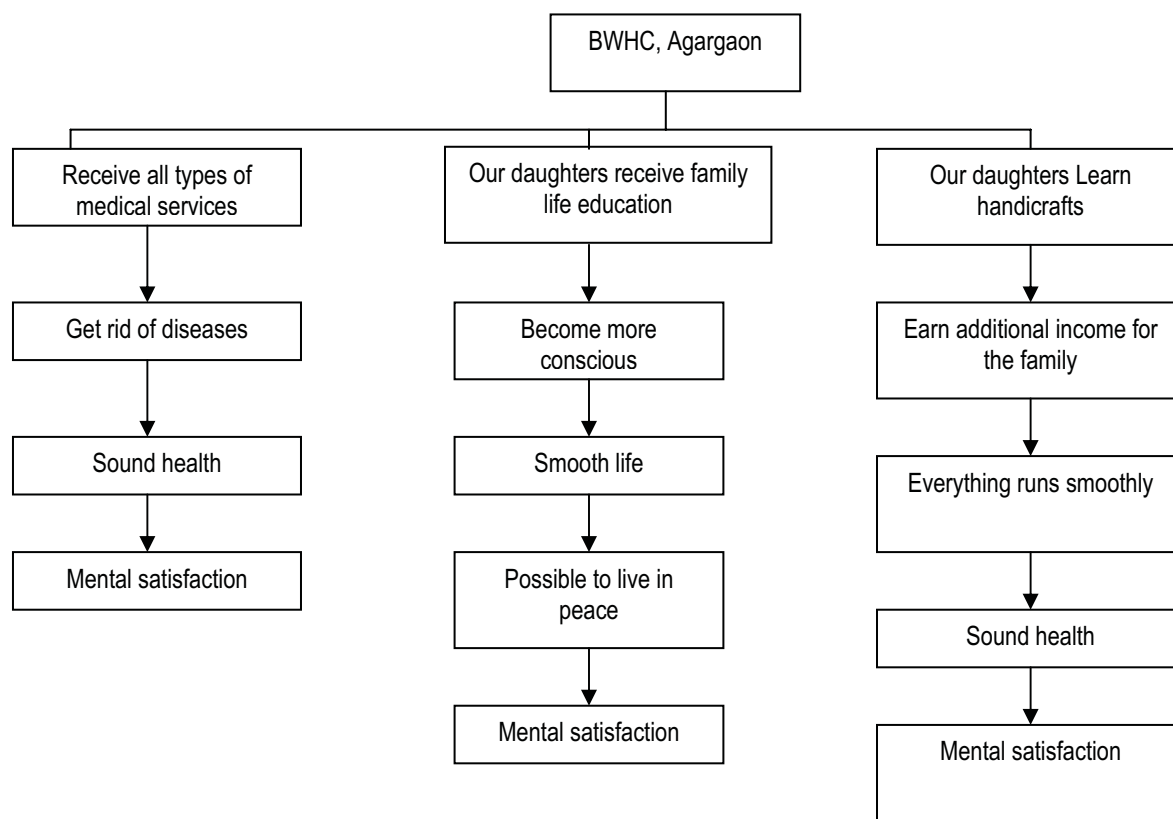
The places where we used to go earlier for treatment were *Shishu* hospital, Rashid Doctor, Shamsu Doctor, *paaka* Market and Azimpur maternity. Now we mainly go to Coalition for our treatment. If *apas* refer us anywhere only then we go there'.

'One of my children got hurt in his chest after falling. Then we take him to Coalition. They gave medicine, but the medicine did not work. They referred him to PLAN office for further action. PLAN sent him to a clinic. My child was operated there. I don't have that much money for the operation. So I am grateful to Coalition as they tagged me with PLAN on time. If I could not get help from them, my child could die'.

b. Impacts of the Project

In order to capture impacts through the eyes of beneficiaries, a participatory session was conducted at Tulatola slum. Impact Flow Chart was developed with their warm participation. The output of the session is given below (Figure 3):

Figure 3: Impacts of BWHC,A over the slum-dwellers in Agargaon



Participants : Rahima, Sufia, Safura, Majeda, Parveen and Nurjahan of Tulatola slum
Facilitator : Tawheed Reza Noor
Co-facilitators : Nargis and Nurjahan
Date : December 7, 1999

Participants of the session were mainly mothers. They identified two-fold impacts of the project. One direct impact is for all household members including themselves and the other for their adolescent children.

Medical services that BWHC,A used to offer has been identified as a common impact for all. For their adolescent children, they think they (the children) get aware of family life education as well as learn handicrafts through this project.

Family Life Education directs them to lead a secured healthy life. Skills for handicrafts make them confident in saving money for their tit-bits and also opportunities to earn pocket money.

All these brought mental bliss to them.

c. Anatomy of the Project under Innovation Context

Couple Counseling

BWHC, A used to counsel for FP, ANC, PNC and STD/RTIs. These services are basically rendered to couples. Usually organizations in reproductive health sector counsel to women only but here in BWHC, A couple counseling is done. According to the staff of BWHC, A this couple counseling is an innovation for this project.

TBA training

BWHC, A trained 20 birth attendants to serve pregnant women in Agargaon slums. According to Paramedics, in case of slum-dwellers - most of the deliveries are done in their huts/squatters. In order to minimize/reduce maternal deaths, BWHC, A developed 20 TBAs for Agargaon slums. Participants claimed no NGO other than BWHC, A developed TBAs at slum-level. So they considered this component as an innovation.

Nutritional Rehabilitation Unit (NRU)

Other centres of BWHC lack this unit. BWHC, A is directly involved in nutritional status improvement process through this component. It used to refer severely malnourished children, to concerned clinics or other health centres. For moderately malnourished children BWHC, A includes them in this unit and serves food for admitted children and their attendants for subsequent 10 working days. At the same time, the NRU supervisor performs cooking demonstration. This is for ensuring continuity of nutritious food for children at their household level.

Formation of CHV at slum level

To get all efforts of this project sustained in the slum areas, community health volunteers (CHV) play a vital role. Socio-cultural environment of a slum is not very conducive for smooth operation of a project. Here, the CHV drawn from the Slum-Community, acts as a bridge between the clients and the service providers. According to the participants, formation of CHV is also an innovative component of the project.

Evening Clinic

Women in slums usually work outside their dwelling area. Most of them work in garments. Others work in houses as maidservants. So from the project perspective, it is difficult to serve them and ensure full coverage either through day clinic or satellite clinic. To get them under this project, BWHC, A introduced a clinic during non-working hours. The clinic starts at 3:30 pm and closes at 9 pm. Hence, the clinic is called Evening Clinic. So the clinic serves for all working women dwelling in Agargaon slums. In addition to that counterparts of all women who themselves or their husbands suffer from STD/RTIs are welcome to receive all facilities through this clinic. This type of clinic is absent in other projects of BWHC. Non-manager staff of BWHC, A claimed, "We did not copy any other NGO for developing an evening clinic, rather it is the outcome of our community demand."

BWHC, A Cultural Team

BWHC, A considers cultural team as a part of social mobilization. Cultural team is formed with 20 adolescents who are seemingly vocal. This team broadcasts messages to people through songs, drama, dance or recitation in day observance activities of BWHC, A. There is

hardly any cultural team like this in NGO providing health care services in the urban slums in Bangladesh. BWHC,A formed this team selecting performers directly from slums.

Male Social Worker

Male Social Workers can directly mix up with adult males in Agargaon slum. So other than routine work in the field, if there occurs any problem due to non-cooperation from husband of any client for adopting FP methods or any other services - MSW just rushed to that person, make him aware and get him motivated for that. Thus the client is ensured to get required services. In a slum context, it is very hard to work with women, so MSWs reduce all difficulties that are expected to be originated from male domain. Besides, MSWs handle all unwanted, unexpected tasks for BWHC,A.

Record Keeping

BWHC,A maintains systematic record of their activities. It preserves a separate file for each client containing all necessary data as well as medical history. From the view point of ensuring of quality service including follow-up, this systematic record keeping is obviously an innovation. 'Based on this, we can decide the nature of future treatment or we can consult with the client ins and outs of her/his disease.'

Autoclave

'After use, we pour all syringes to a container and we boil them under a particular pressure and temperature. It is called autoclave. This is for ensuring quality service. So this is also an innovation.'

Incineration

'We burn all used cottons and gauges to reduce the probability of spreading diseases.'

Adolescent Club

The idea behind formation of Adolescent club is to effectively communicate and work with adolescent girls under a club-setting in a slum area. The main goal of the club is to help adolescents in becoming responsible citizens of the country. There are programs for adolescents in many NGOs but activities for adolescent girls centering a club are an exception. BWHC,A incorporated this component almost from its inception and has been doing a lot through this for adolescents.

Poor Fund for the poor by the poor

Though not in-built, the poor fund concept is a promising innovation of the team working in BWHC,A. This concept can bridge both providers and clients, if beneficiaries are agreed upon to contribute in generating funds. This may develop sense of responsibilities of slum-dwellers in health context. They may get rid of the 'passive receiver' domain through this effort.

CHAPTER FOURTEEN

EXPANDING BWHC, A IDEAS FURTHER

a. Scope for Expansion

The model that BWHC,A follows is based on community participation. However, sometimes process seems to be verily top-down. BWHC,A believes that the program can only be sustainable if community participates at all the stages – needs assessment, planning, implementation, monitoring and evaluation.

Based on the experiences, BWHC,A is planning to introduce the system of Community Managed Health (CMH). The concept of CMH assumes that if a community is capacitated through this system, then they will be able to identify problems of their own and also can locate expected solutions for that. If BWHC,A plays role in building capacity of the community people, then the community will be equipped enough to deal with all of its problems. To establish and adapt certain systems of CMH, BWHC,A will be following Child Focus Community Development Approach (CFCDA).

Basically capacity building is a long process. Both political and social unrest prevails in the slum areas. Simultaneously in and out migration is a reality. As BWHC,A deals with an unstable settlement in Agargaon, so it is difficult to follow the model in to to. BWHC,A is trying to overcome these challenging situations by incorporating a compatible part of the model.

BWHC,A has a clear idea about its target people as it has been dealing with people in Agargaon slums since last four years. At the same time BWHC,A has a very strong rapport with its target population. First step of CMH model, Immersion, is already done. The whole process is expected to be participatory. Community people will play roles both in designing and planning different activities of BWHC,A. It will introduce CFCDA only for three programs on nutrition, behavior change communication (BCC) and adolescent groups.

BWHC,A also did General Situations Assessment (GSA) for the project using PRA tools. GSA helps identifying problems for a community. In that case, top five problems that BWHC,A identified for people in Agargaon slums are malnutrition, severely contaminated and degenerating sanitary environment, infant and child morbidity, maternal morbidity and STD/RTI.

In the upcoming program strategy, BWHC,A will put emphasis on nutritional component. BWHC,A has a nutritional rehabilitation unit at its centre but it introduced growth monitoring program to bring all children up to 3 years under growth monitoring.

As GSA phase is over, BWHC,A is interested to deal with community people for redesigning and re-planning the whole project.

Base clinic and satellite clinics will remain as it is. The project is going to witness some major changes pertaining to the program area. BWHC,A will redesign its program area to make programs more successful. Instead of six specific pockets, BWHC,A will select new pockets and deal with more people residing in various slums in Agargaon. BWHC,A has been working in six pockets which are scatteredly located (either side of the BNP Bazar road).

But this time to make the CFCDA approach meaningful, it will select all slums from eastern side of the road.

In future, BWHC,A will expand its intervention area for preventive services to 15 slums of Agargaon. Curative service will be open for all dwellers of 28 slums as before.

GROUP WORK WITH NON-MANAGER STAFFS*

EXPECTATIONS ON BWHC, Agargaon

- ▶▶ A spacious set up
- ▶▶ The center to be a complete and permanent hospital
- ▶▶ Each satellite center to be turned to a mini clinic
- ▶▶ Render health services to all poor free of cost
- ▶▶ Transportation facility
- ▶▶ Provide services irrespective of socio-economic status
- ▶▶ Develop a modern residential training center including auditorium inside
- ▶▶ Develop a Pathology center
- ▶▶ Develop facility for pregnancy test internally
- ▶▶ Enjoy pension facilities
- ▶▶ Provide health services in collaboration with the government
- ▶▶ Purchase ambulances for serious patient

* (Participants: Maya Rebeka Gomez, Zinia Seheli, Promila Roy, Nasima Shaheen, Shahin Ara Dil Afroz, Basanti, Momtaz, Selina; facilitated by TR Noor, November 28, 1999)

b. Organizational Challenges

Now the big challenge for BWHC,A is to implement community health management concept through CFCDA. In order to make it a success, BWHC,A has to develop some more efficient volunteers at the community level. Currently each volunteer has to look after at least 140 households but if the number of volunteers is increased then workload for each volunteer will be reduced.

BWHC,A plans to select one mother from every fifty mothers as a volunteer. It will also develop a comprehensive monitoring system for them. For convenience, each indicator of the monitoring format will be expressed by a symbol. The volunteer will use colors to give more attention. Monitoring process will be simplified so that no education is required, only commitment and dedication are needed to use such a monitoring system.

Next to that, BWHC,A is planning to promote current CHVs as community health workers each of whom will be responsible for every 250 households. To capture the whole expected program area BWHC,A has to develop some more health workers in addition to current CHVs at the community level. So it is a great challenge for BWHC,A to select efficient health workers from the field.

Ultimate intention of BWHC,A is that it will retain all community health workers as its community work force. Over time, all CEs will be phased out as they were recruited from outside. But roles of CEs will be re-defined. They will be responsible for conducting community based adolescent program and providing intensive training of CHVs and CHWs. BWHC,A believes the CHWs will carryout the whole program even in absence of this project as they are developed from the community.

Thus BWHC,A depicts to conquer the slum area by making them worthy in health context.

c. Implications of Replications

FOUR PROPOSITIONS OF REPLICATIONS

Proposition	Assumptions
1. Replicate BWHC,A Model as it is.	a. similar socio-economic and political conditions b. public servants have similar qualities like BWHC,A staff c. the host country’s institutions are not resistant to BWHC,A procedures.
2. Very little can be learned from BWHC,A	a. BWHC,A is unique b. Institutions can learn only their own lessons, not each others
3. Use it as an initial model for action research	a. similar socio-economic-political conditions b. learning organizations can be created c. personnel can be located to be trained in skills and attitudes
4. Transferring certain principles and policies of BWHC,A	a. the whole of the institutional structures and culture are not transferable. But some individual features/policies are transferable b. environmental differences are significant

Replication requires flexibility.

- Some times official aid agencies have too much bureaucratic procedures
- Relatively NGOs perform better
- Higher degree of motivation and loyalty of the grassroots level employees

- Training has to be proved very effective
- To ensure incentive structures: both material and motivational

LIMITATIONS OF BWHC,A MODEL

1. Initially the model needs heavy subsidization. This requires foreign assistance, which may mean conditionalities. Such conditionalities may constrain autonomy.
2. If higher management loses touch with the ground – tensions may build up

BWHC,A model is dynamic as:

It is not stagnating, rather innovating

It has not degenerated into a conventional health project

It is friendly to external evaluation

It has been able to establish very good rapport with its well wishers

STEPS OF REPLICATION

There may be four steps for replication as follows:

- Step I : Know BWHC,A model and its surrounding socio-economic condition well
- Step II : Experimentation as close as possible to BWHC,A model
- Step III: Improve techniques, if required, after initial experimentation
- Step IV : Remain open to changes and adaptations following internal and external evaluations

ROLE OF BWHC IN REPLICATION

1. Organize dialogues where potential replicators may join
2. organize exchange visits
3. provide technical assistance to others
4. disseminate all replicating experiences through in-house newsletter

ROLE OF INTERNATIONAL ORGANIZATIONS IN REPLICATION

1. Support the potential replicators to visit BWHC,A
2. Organize international, regional seminars, workshops, training programs for exchange of experiences of “best practice” models.
3. Provide initial funding for experimentation
4. Provide TA for evaluation of the replications by well known experts in the field

CHAPTER FIFTEEN

LESSONS LEARNT AND ISSUES FOR UP-SCALING

- 1. Unmet need based comprehensive reproductive health program having close ties with the community works well in the urban slums.** BWHC,A provides RH information and services using various platforms -- base clinic, satellite clinic, evening clinic, nutrition rehabilitation unit, adolescent club, non-formal primary education, and various forms of community development activities (using the TBAs, mobile cultural teams, etc). BWHC,A initially started with a single component-FP-MCH, other programme components were subsequently included into the circuit responding to the unmet-need posed by the slum people themselves. Thus emerged the programmes like family life education for the adolescent boys, programme activities to deal with the sex workers, establishment of evening clinic, converting the evening clinic from male only services to services for both male and female, and formation of the mobile cultural teams. BWHC experience in the Agargaon Slum reveals that incrementalism works if the demand is generated from the grassroots level and the community participates in the process.
- 2. Reproductive health components supported by other developmental efforts which contribute to the transformation of human deprivation into human development are important for the success of RH programme in the context of urban slum.** In this connection programmes like non-formal primary education and mobile cultural teams were found to generate much impact on the life of the slum people. These programmes, on the one hand, was instrumental in increasing awareness and self-esteem among the beneficiaries, and on the other hand, was instrumental in changing behavior at the level of family and community. The later, trickle down effect was reflected in resisting early marriage, dowry, improving hygienic practice in the family, using of ORS while diarrhoea, protest against possible violence against women (mothers/sisters) and children etc. Thus, the concept of life-cycle based comprehensive reproductive health programme accompanied by educational and cultural developmental efforts is not only acceptable, but also works very efficiently in the context of urban slum.
- 3. Partnership and collaboration with other NGOs and Government are necessary conditions for the success of a comprehensive reproductive health programme in the urban slum.** No NGO alone would be able to take care of all components of RH services needed in the urban slums. For example, it is not possible for BWHC,A to provide comprehensive emergency obstetric care services (requiring C-section, OT and Anaesthetist) or various higher level (microbiological) pathological services to its clients. Thus, service-based collaboration and partnership with those having facilities and comparative advantages are needed. Such partnership, based on mutual trust, is not only beneficial in provisioning of full-range of RH services to the slum population, but also produces trust of the community on the NGO and thereby enhances image, which in turn is essential for the institutional sustainability of the NGO itself. BWHC,A has been able to institutionalize such partnership with both the government and NGOs. To mention a few, partnership with government's Dhaka City Corporation to procure logistics and supplies related to EPI, collaboration with Bangladesh Television for telecasting the Agargaon project activities, with BRAC for support to the NFPE program, with SSC for training on programme designing, with FPAB to organize program for adolescents, with PLAN, UNFPA and UNICEF for funding support, etc. These partnerships work successfully due to various reasons including high visibility of BWHC program in the Agargaon slum, inter-partner trust,

managerial capability and commitment of BWHC staff (including community health volunteers), unflinching support from the community leaders, etc.

4. **Success in dealing with least explored and culturally sensitive RH issues needs experience, appropriate planning, acceptability, and 'humane' touch in service delivery.** BWHC seemed to have much success in dealing with some of the culturally sensitive RH issues, such as sexual and reproductive health needs of the adolescents (both girls and boys), violence against women and children, RTI and STD clients, commercial sex workers, drug abusers, etc. As one of the very few NGOs having long-standing experience in dealing with the commercial sex workers, BWHC has applied its outstanding experience in the Agargaon project. In terms of planning for services considered were the following: Linkages among the program components (i.e., integrated approach to service), involvement of community in service planning (e.g., rescheduling of awareness raising program based on clients inputs, application of COPE), etc. 'Humane' touch in service delivery is ensured through the dedicated efforts in counseling, educational activities, sensitization activities involving the community, and creation of an environment of informed clients who can demand quality services. Thus, BWHC has created a situation in the Agargaon slum whereby the passive recipient of services has been transformed into active seekers of services.
5. **Instituting strong referral and follow-up system is key to the success of RH program in the urban slums.** Appropriate referral and follow-up systems constitute one of the major missing links in the reproductive health programme in Bangladesh. BWHC,A has a relatively simple but effective referral and follow-up system involving appropriate protocols, record keeping system and living contact with the referral points. Agargaon project refer complicated pregnancy cases, without delay to various government hospitals (e.g., Azimpur Maternity Centre, MFSTC); severely sick and malnourished children to Dhaka Shishu Hospital or Al Markajul, etc. The system exists to follow three things (1) ensure that those referred to, have actually gone to the place of referral and received services, (2) follow-up after receipt of services from the point of referral, and (3) enquire about the service delivery situation in the referral centre (based on this provide feedback at the appropriate fora).
6. **Slum people are willing to pay for reproductive health care services, but services should be of high quality and pricing strategy needs careful designing.** Slum people are essentially economically poor and most have come from rural areas where health services in the government facilities are given free-of-cost. This historical 'relief mentality' prevails in the slum for obvious reason. This is why an 'initial resistance' to pricing for RH services is also natural, to a large extent. However, the BWHC,A experience have shown that people are willing to pay (to save time in urban setting where the opportunity cost of time is much higher than in the rural setting) providing services are easily accessible, available and of reasonably high quality. Here, slow but firm process of persuasion among the service recipients and the opinion leaders in the slum is important. Charging for RH services in the slum setting has three limits (i) price should be at the lower scale of the market, (2) there should be a provision for deferred payment, in case of emergencies (e.g., emergency obstetric care cases, severely malnourished) and in the event of clients' willingness to pay later, and (3) there should be safety net provision for those poor who are unable to pay.

7. **Recruitment of certain staff from within the slum is important for the success and sustainability of the RH programme in the urban slum.** The basic design of the Agargaon project is such that for work at the grassroots level it relies mostly on the grassroots people themselves. That is why in all available cases the people from the slum are deployed. This philosophy of recruitment from within slum rests on 3C paradigm: Concern, Commitment and Competence. It is natural that slum people are more concerned about their problem than the others, and if committed people from them are recruited and imparted with training to enhance their competence they will generate more outputs. Almost all the community health volunteers (literacy, health, social, cultural), community educators, Traditional birth attendants, male social workers (MSW), and Ayas of Nutrition Rehabilitation Unit are recruited from the slums, and then imparted with basic training and subsequent refresher training. These staff drawn from the slums have high acceptability in the community; they act as a bridge between the slum people and the service providers; they refer clients to the clinics (base, satellite and evening clinics), they organize group meetings; they are active in ameliorating misconception among slum people about various dimensions of reproductive health; they actively pursue the common goal of the project towards “better quality life” of the slum dwellers. Thus, in a way, the design has been to train some of the slum people to serve the slum people. This has distinct sustainability impact on, at least two counts: (1) even if, BWHC withdraws, these people will remain with the knowledge, skill and expertise earned in the process, (2) some of these people will continue to work and contribute to ensure good health of the slum dwellers (e.g. the trained TBAs, community literacy and health volunteers). The above design carries the philosophy of “community-managed health” (CMH) – an welcome departure from the so called ‘community-based health’ (CBH), which, in most cases, is not owned by the community people.
8. **Tackling the issue of adolescent reproductive health (ARH) requires holistic approach.** BWHC Agargaon experience shows that the issue of adolescent reproductive health can be addressed effectively through implementation of integrated approach involving components, such as preventive and curative health, family life education, functional literacy and numeracy, legal rights issues, skill development, and safe recreation. All these efforts directed towards enhancement of knowledge-base, confidence building and self-esteem are crucial in ensuring healthy adolescence in the slums. Among various channels to address the adolescents, the successful ones are AFLE (adolescent family life education) through clubs, AFLE (non-formal primary education) through schools, AFLE in the NFPE, and community-based AFLE. The conducive mind-set of the service providers to ensure adolescent-friendly services, and carefully designed behavioral change communication activities for the parents are the two most important spheres needing vigorous efforts in the future for the further success of ARH program.
9. **Mobile cultural team with the adolescents is a low cost but effective means to disseminate reproductive health messages and to ensure positive changes in the behavior of slum dwellers.** Perhaps, BWHC is the only NGO providing health services in the urban slums in Bangladesh which has experimented regular dissemination of high priority reproductive health messages through songs, drama, dance and recitation using the mobile cultural team comprising of adolescent (20 in each team) performers drawn from the slum. These cultural teams have been formed by BWHC and performed not only in their respective slums but also in the national television. The teams were found to be effective in disseminating messages through songs on promotion of breast-feeding, prevention of AIDS, need for nutrition

food for pregnant women, curse of early marriage, etc. The chain-effects of the mobile cultural team include, among others, it gives a neutral place for the adolescent to gather, getting to know each other, and discuss relevant issues; it enhances confidence among and self-esteem of the adolescents; it gives the avenue for others in the community to know important life and health issues from the performances of the teams; it reproduces demand for more information and better services relating to health and development in the urban slums.

10. **The comprehensive reproductive health approach pursued by the BWHC in the Agargaon slum is replicable in the other slums in Bangladesh.** Both the NGOs and the Government can replicate the BWHC,A model in the urban slums. NGOs having health sector interventions in the slums can gainfully learn from BWHC,A about the key dimensions of planning and implementation of comprehensive reproductive health programme, and adopt and adapt in their organizational context. NGOs pursuing non-health interventions in the urban slums but interested in RH also can learn from BWHC,A as to how to incorporate RH components in to their programme in a phased-in manner. BWHC believes in “learning organization” and the organization culture is conducive to openness, which will facilitate exchange visits by and open dialogues with NGOs interested in learning from BWHC Agargaon experiment. From the viewpoint of NGOs interested in implementing comprehensive RH program in the slum context, the BWHC’s Agargon project can at least be viewed as an experimental laboratory and a training ground. Because of the compartmentalize structure of the government (each ministry has its own domain not to be stepped by others) and slow in implementing programs at grassroots (low social mobilization capability), it is most likely that the RH programme of BWHC.A is implementable only piecemeal within the governmental framework. For example, although adolescent reproductive health has been accepted as one of the major RH care services under ESP of HPSP and at the same time government has declared ARH as one of the major challenges in the health and population sector (MOHFW 1998, 1999) but nothing significant has so far been achieved in the field of ARH in the government sector. Thus, government (Ministry of Health and Family Welfare) can learn from the BWHC Agargaon experience about how best to speed-up incorporation of ARH component into the Government’s programme. Incorporation of ARH component in the MOHFW’s programme can be done using the NGO services within the HPSP framework, and the same can be incorporated in the MLGRD’s programme using the NGO services within the framework of Urban Family Health Care Project (under implementation in the urban slums).

APPENDICES

Appendix A: BWHC,A-developed Household Monitoring Format for Slum-dwellers

REFERENCES

Miscellaneous

- 1: Motahar Slum
- 2: Nur Mohammad Slum

Why BWHC,A is different from other organization

Characteristics of BWHC,A:

There is no male social worker or ACE post in other organization
[With the help of us, BWHC.A has developed a lot. This may be used as model]

Since its inception, initiatives are taken to form a adolescent group
No other organizations except Tanbazar worked with the women who are prostitute and used to move around here and there.

No other project has cultural group like us, which I have introduced.
[This fact gets so much importance that the Central Office of BWHC,A has created a post namely 'Popular Cultural Organizer' who will be responsible to form a group like this in our each center]. I myself applied for the post. I am capable of giving message to 100 people at a time. It is time consuming to give message to people from door to door. Music influences people very much. People irrespective of age carefully listen to all messages that used to deliver to them through songs and try to abide by all lessons in their lives. Being inspired, some people used to come and request us to include them in our cultural group. Sometimes we include audiences in our group, if they are found worthy.

We have evening clinic. But other project does not have that.
We have more doctors (3) than other projects.

Our project is going on at 22 slums of Mirpur Baulia Bazar Center. Those slums are well organized. But we work here which are very unorganized slums. I do not know about this place but slum dwellers at Agargaon bastee take heroine, pathedrine, ganja, fencidil. All kind of crimes used to take place. But we are working there. So that this project can be considered as a model.

Mostafa:

Services that are given at Agargaon bastee are a bit different from that of other clinic due to its inherent characteristics. They are to be served for 6 slums. For example: attempts are taken at Agargaon project to prevent RTI/STD, HIV/AIDS. So this is a new component for the project.

Another program is NRU. Children suffering from malnutrition are kept here for at least 10 working days and given treatment.

But other centers just provide treatment only. But we not only give treatment, we observe their further development also. We teach mother how to cook nutritious food.

Adolescent Club
AFLE
Cultural Group

These are absent in other projects. If any adolescent boy/girl suffers from RTI, in that case the other clinic just provide him/her treatment. They do not advise to use sanitary pad or how to behave with in laws. But this is practised in Agargaon baste. BWHC,A performs stage program only.

Agargaon: Health Service Provider

1. CFCD
2. World Vision
3. Paka Market

BWHC,A is performing most efficiently among other organizations. It provides-

- better quality services
- medicine of high quality

There is a clinic of Mary Stopes in front of the Beltola baste. The service provider comes here but they are not available all the time. This is the same case for Paka Market. They do not care whether they take medicine in time or not. This is also like World Vision to some extent.

Regarding Health:

We first, counsel with the patient in regard to health which makes him curious to know more. There is no Educator like us in other clinics. While giving treatment, we keep their name and address to follow up them whether follow our instruction. If the treatment is out of our control, we then refer him to AI-Markajul if considered as PLAN patient,whatever amount is needed. If he is not PLAN, in that case we refer him to DMCH or Sorwardi hospital. The MO may give him slip indicating that the patient is needy, if required.

Nutrition Side:

NRU keeps the skinny child for 10 days under close observation as long as the child moves towards better condition., The mother is given demonstration lesson about how to cook nutritious food and to feed her children as well.

Weaknesses:

BWHC,A does not have any pathological lab which could play a vital role in detecting the diseases correctly. Doctors need the detailed history of the patient first. Health service is provided by any clinic but none of them keep detailed history of the patient that we do. We maintain individual records for each patient.

But no other project will be able to give treatment history like us.

Problems:

Patients may need to wait for long time. Due to this sometimes misunderstanding may happen among the patients. Actually, those who comes to take FP are counseled first, so the patient who comes earlier , may misunderstand the patient who needs FP.

Further Development:

We will be able to provide better quality services, if few male volunteers join us. We, two are not enough for this job. The female CHV get ashamed talking about male. Then we have to go there leaving our assigned work that creates more load on us. So we can share our load if we have two more male volunteers.

Besides, the place for Health Education Class is not convenient. There are several reasons for the patients to be inattentive in the class. The class room should be large one and away from reception. It would be convenient to work, if there remain definite place for patient to sit which will ultimately make them attentive.

- I used to work here as legal assistant earlier. Now it is closed due to fund constraints. The bastee dwellers have mental agonies along with physical diseases. They are the victim of dowry, female abuse etc. We organized many programs before. After performing a program, a woman in 1998 came to us and started crying. She told me that her husband wanted to divorce her. So she request us to help her. We told her not to be worried. We discussed with guardian/older people living besides the house of that woman. After giving my own identity, I asked her husband whether he wanted her to divorce. We explained to him the possible consequences of divorce he will face. We informed him about what punishment may be applicable for him. He told to discuss with us later. He came at that night and informed us that his wife filed a case in a court. And the problem is finally solved after his written document in a stamp paper that he will not divorce his wife.
- We found a man sitting around the radio station while conducting our program. After watching the drama "Moyezuddin er Songshar" came to the dias and embrace me and started telling that " We need this type of man-----
-----"
- The next day a man -----told us his life history very frankly. He is a truck driver. He had sexual intercourse with many women.-----
----He told me to save him. I can not stand any more. He was cured after having proper treatment. One day we found him coming to our office with bouquet.
- We came at our club at 11:00 before it caught fire. Usually my office starts from 1:00. Knowing that there is a life risk, I entered into the club after breaking the lock. I entered there to save the documents of the club. I found out all the papers collected them in torn curtain(?). I could not stand seeing that the club is transformed into ashes in front of my eyes. -----and then helped the bastee dwellers. Now I feel good.
- I enjoyed very much when I went to Sylhet to help the distress people during flood. I was there about 1 month 3 days.----- . All of them started crying during my departure. Mr. Massod of Head Office gifted me his own watch as a token of friendship and recognition of my work done.

I enjoy very much when I can do something for them