DIPSHETU Experience of Integrated Socio-Economic and Health Program for the Destitutes in Bangladesh:

AN IMPACT STUDY

Abul Barkat, *Ph.D.* [1>]
Muzammel Huque, *MBA* [2>]
Murtaza Majid, *MBBS, Dip in MCH-FP* [3>]

HDRC **Human Development Research Centre**

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1> Professor, Department of Economics, University of Dhaka
2> Consultant, Human Development Research Centre
3> Consultant, Human Development Research Centre

EXECUTIVE SUMMARY

- Bangladesh scores extremely low with regard to its human development status measured against three specific indicators, such as life expectancy, education, and income. As against this definition of development, Bangladesh ranked 146th among 173 countries in the world during 1994. Life expectancy in Bangladesh was 51.8 years compared to the South Asian average of 58.4 years, and adult literacy rate was 32.2 percent against a South Asian average of 42 percent. While the age at initial schooling in Bangladesh was 2 years, the average age at this stage in South Asia was 2.2 years. Combined primary and secondary enrolment rate was 41 percent compared to South Asian average of 60 percent. Under-five mortality rate (per 1000) was 184 compared to 151 for South Asia, and per capita GNP was US$ 220 compared to US$ 320 for South Asia (Barkat 1994; UNDP 1994). As compared with other countries of the world, this scenario invariably portrays Bangladesh as one of the most disadvantaged countries.

  The emergence and development of NGOs in Bangladesh since the early 1970s is an inevitable process resulting from the conventional development paradigm followed by the Government. Analysis of GOB's response to human deprivation presented above show that the process of development planning and the top-down implementation of the programs through the rigid, non-responsive bureaucratic apparatus failed to accommodate the needs and priorities of the deprived population.

  Human deprivation profile of Sirajganj district was much worse than the country's average situation described above, and it was less advantageous than that of the most other districts. Regular floods and river-erosions are the additional factors exacerbating human distress in Sirajganj more directly than in many other districts. In addition, due to smuggling-in of Indian handloom products, and technological backwardness coupled with the lack of proactive policy of the Government, the relative poverty situation among the weavers has worsened during the last thirty years. It is reported that many weavers had also taken on internal migration in search of occupational advantages as well as in order to shift to other occupations.

  A consideration of relative disadvantageous situation of Sirajganj district shows that the choice of Dipshetu project location may be considered as being appropriate. It is rightly stressed in the project document of "integrated socio-economic and health program of Dipshetu" that "if a comprehensive socio-economic program is implemented, the landless destitute families, poor, weavers, cobblers and other nearly extinct occupational classes of this district can be effectively for their socio-economic upliftment. This project is a modest approach dedicated to the aforesaid theme" (Dipshetu 1990b). Considering the existing differences in the levels of human deprivation between Sirajganj and all-Bangladesh areas, the Dipshetu intervention may be thought of as a way toward enhancement of the quality of life among the distressed people of Sirajganj, and also narrowing the gap between Sirajganj and Bangladesh.

- Dipshetu (The Bridge of Light/Die Lichtbrücke) has been operating in the district of Sirajganj as a voluntary organization since the year 1990. This voluntary organization is aimed at enhancement of the quality of life of the distressed people. As of date, Dipshetu has implemented a total of three projects. In addition, the other three projects are still in their implementation phase in Dipshetu. One of the projects titled "linking handicrafts and small

enterprises and business with the credit program for the poor", aimed at development of entrepreneurship among the poor has already been implemented and phased out. At present, there are three projects running on their full scales. These are: *Sustainable and Integrated Development for Women* (aiming at empowerment of destitute women), *Academy for Education, Training, Self-Employment, Health and Social Services*, and *Mothers' Club* (for making good mothers for a good nation). The date of completion of the on-going projects spreads up to 2002. Based on the past experience of working among the distressed people, the Dipshetu management has gained comprehensive capabilities to implement these projects. The "integrated socio-economic and health program for the destitute" (ISEHPD) is one of the three on-going projects of Dipshetu, aiming at enhancement of the quality of life of the destitute inhabiting 17 catchment unions of five thanas, that is, Sirajganj, Shahjadpur, Kamarkhand, Raiganj and Kazipur- in the district of Sirajganj. This project, having started in 1991, had operated for a total of 11 years as at the end of December 2001. Beside the above project-type interventions, Dipshetu has, since long, been involved in operation of numerous hospitals and clinics aimed at accessing primary healthcare for the rural poor.

- **This study** was aimed at evaluating the "Integrated Socio-Economic and Health Program for the Destitute" (ISEHPD) of the Dipshetu project, at Sirajganj in Bangladesh. This is the final evaluation of ISEHPD. It follows the mid-term evaluation carried out in the first quarter of the year 1995 reflecting therein the overall impact of the project as at the end of the first five-year implementation.

- The data necessary for this evaluation were collected in a survey fielded in the months of January-February 2002, preceded by completion of the 11-year implementation of the project over 1991-2001. Since the *Dipshetu* Training Centre was established during Phase 2 of the project, associated changes rendered as a result of the Training Centre were also ascertained in this evaluation.

  ISEHPD started its implementation in 1991, and a mid-term evaluation was conducted in 1995 (after Phase 1). The outcome of the mid-term evaluation came out as a book in 1997 showing the intermediary level outcomes of the project benefits. All relevant data and information in the mid-term evaluation were generated for two points (reference year)- 1991 and 1995. This study attempted to generate data and information for 2001, and thus indicator-wise data for three data points, 1991, 1995 and 2001 were designed.

- As in the 1995 study, a total of 250 sample beneficiaries (distributed by loanees and production program beneficiaries) were drawn and interviewed using the same questionnaire, which was used in 1995. Only the terminal period in the questionnaire was changed to year 2001 from the previous year mark of 1994. The sample population comprised of the longest-term beneficiaries of ISEHPD. As in the 1995 study, the longest-term beneficiaries were defined as those who had received, in addition to other services provided by *Dipshetu,* loans in 1991, the year of commencement of *Dipshetu*. This cohort was selected due to the reason that one of the major objectives of this study was to measure the impact on various aspects of lives of the beneficiaries. The sample size will be distributed by sub-centres using PPS (probability proportionate to size) technique. In addition to the beneficiaries, in-depth discussions with the ISEHPD employees were conducted. A checklist was used for this purpose. The same checklist, as used in the 1995 study, was used. However, new discussion areas were also incorporated in line with experiences regarding strengths, weaknesses and sustainability dimensions of Dipshetu

and ISEHPD as definitive institutions.

- Dipshetu is administered by a two-tier implementation mechanism, where the first tier is its Board of Trustee, and the second one is its operational organization comprising of the paid staff. There have been some changes in the overall organization structure since the year 1995. The total number of paid staff has increased from 56 to 59. The position of the Executive Director does not show up in this structure, rather the Executive Director has been shown as leading the implementation of the programs being entrusted with this responsibility by the Board of Trustee (that replaced the older so-called Executive Committee). Among the three older wings, the Maternal-and-Child Healthcare Wing is now non-existent. Overall activities of the organization are being carried out and overseen by two particular wings, namely, *General Section,* and *Socio-Economic Development Section*.

  A number of high-priority modifications in the Dipshetu organogram were suggested in the 1995-study, in order to enable Dipshetu to overcome the above structural deficiencies. As of the end of 2001, Dipshetu has been observed to still have some of those weaknesses, such as:

- Over-centralization in the overall organization structure still exists, especially in absence of the Maternal-and-Child Healthcare Wing and lack of initiatives to introduce project-specific heads
- Some of the specific designations are still mixed up with the generic ones
- Position of Production Controller-cum-Counselor has not been filled in
- Position of Administrative Officer has not been created

  Though the anomalies detected earlier (in 1995) in assigning specific responsibilities to the right persons still lurk, the difficulties evolving from such irregularities in implementation of the programs have decreased as a result of (a) the long-standing exposure of the staff in general to the activities of Dipshetu, and (b) due to a decrease in the rate of staff dropouts from this organization.

- The cost analysis of the “integrated socio-economic and health program” (ISEHP) of Dipshetu has shown that the total budget for ISEHPD and SEPDF during 1996-2001 was Tk. 23.29 million. Out of this total amount, the year-specific percentile distribution was as follows: 26.74percent in 1996 (ISEHPD and SEPDF together), followed by 19.82 percent in 1997 (ISEHPD and SEPDF together), 11.66 percent in 1998, 16.09 percent in 1999, 11.66 percent in 2000, and 14.03 percent in 2001.

  In Phase I of this project (1991-1995), a significant portion of the first 5-year budget was allocated for capital expenditure, especially to establish the project infrastructure (in 1991). The subsequent annual budgets were significantly lower. In Phase II (1996-2001), starting with the acquisition of land and some construction work for establishment of a training academy and fresh injection of funds as revolving loan fund, the annual budgets for 1995 (SEPDF) and 1996 (ISEHPD and SEPDF) stood at the two highest levels.

  The total local financing accomplished in ISEHPD by 1995 was only 5 percent, in the form of subscriptions from the local elite and volunteers. In the following years (1996-2001), local financing was geared up with Tk. 700,000 having been contributed by Dipshetu itself in 1996-1997 (for ISEHPD). This contribution increased further (for SEPDF) to Tk. 1,075,000 in 1996-1997, to Tk. 2,669,700 in 1998-2000, and Tk. 5,132,739 for 2001-2003 (cumulative proposed).

Despite Dipshetu's conscious efforts toward making the project self-sustaining through such provisions in its budget, one should also look at the level of self-financing as reflected in Dipshetu's Receipts and Payments Accounts. During 1996-2001, Dipshetu itself generated and re-invested a total fund of Tk. 5,248,563 by way of such means as: service charge on revolving loans, income from sale of products (e.g., Tk. 120,000 in the year 2000), and bank interest. This self-financing stands at 18.68 percent of the total expenditures.

The net present values (NPVs) of various fixed assets owned by Dipshetu in ISEHPD and SEPDF were also calculated. The NPVs of the capital items possessed by Dipshetu as at the end of December 31, 2001, Dipshetu owned a total asset worth Tk. 25.37 million, which is equivalent to 72.92 percent of the total 11-year budget (Tk. 34.79 million) of ISEHP of Dipshetu. This amount is available in the form of physical stock (building, equipment, and vehicles), human capital (trained manpower), and financial capital (revolving loan fund).

The Integrated Socio-Economic and Health Program for the Destitute (ISEHPD) of Dipshetu has left significant impact on the economic, educational, demographic and health status of the target beneficiary families.

- Monthly average family income at the end of the tear 2001 stood at Tk. 3553, as against Tk. 2,368 at the end of 1995 (an increase of over 50 percentage point during 1995-2001). The average family income at the inception of the project was Tk. 1,742 in 1990, which had increased by 36 percentage point within the earlier four years- 1991 to 1995. The relative increase in the consumption expenditure during the last 10 years was 45 percent, from Tk. 1,680 in 1990 to Tk. 2,437 in 2001. The consumption pattern among the beneficiaries of ISEHPD changed positively as a result of the operations of this project. The expenses for consumption of food as percentage of the total value of consumption decreased from 69.30 percent in 1995 to 55.93 percent at the end of the year 2001. While the total absolute amounts of consumption on account of various items increased significantly, even an increase in the mean amount of food consumption (by Tk. 139.70, i.e., 11.42 percentage points over the 1995-benchmark) was offset largely by the concurrent increases in other related items of consumption. The relative situation in the ownership of agricultural land, has not improved much as a consequence of Dipshetu interventions. It has improved in terms of the mean amount of land ownership, and more so for the ownership of plough. In 2001, around 98 percent of the households owned land in any form, while in 1994, it was about 97 percent.

  The changes in the construction materials of the dwelling units of the respondent families indicate increased proportion of semi-pucca and decreased proportion of *kutcha* dwelling in the 1995-2001 period than in the pre-loan and 1991-1994 periods (Table 32). The relative changes that took place in between 1995 and 2000 were quite significant. The percentage of households having semi-pucca dwelling units increased from 3.7 percent in 1995 to 18.0 percent in 2001.

  Involvement of the beneficiaries in the business of livestock and poultry has improved during the reporting period, as in the 1991-1994 period. The pace of growth in this trade is almost uniformly significant. The mean number of cow/buffalo per family has been 1.23, that of cock/hen per family 11.30, and goat/sheep 1.46. Ducks/drakes per family have also increased

from 1.28 to 2.50 per family.

Mean numbers of both fruit trees and furniture/fuel trees have grown significantly all throughout the period of 1991-2001 as a consequence of Dipshetu's interventions. Compared to the pre-loan period, the mean number of furniture/fuel trees as of the end of the year 2001 has increased by about nineteen times, and that of fruit trees has increased five folds in the post-loan period.

Therefore, it may be commented that ISEHPD has left significant impact for changes in consumption pattern, average propensity to save, ownership of plough, livestock and poultry raising, and ownership of fruit and timber trees.

- Literacy rate has shown a pronounced progression during the reporting period. It had earlier jumped from 23.7 percent in 1990 to 49.4 percent in 1994. Estimates based on census information on annual growth rates in the literacy in Sirajganj show that, had there been no Dipshetu interventions, the literacy rate in 1994 would have been 34.5 percent instead of the 49.4 percent found in the survey. Besides, in the reporting period (1995-2001), there had been significant improvements in the literacy situation of ISEHP's target beneficiary households in terms of a number of sub-variables under literacy. As for instance, while 74.7 percent of the children aged 5-12 years attended schools in the pre-loan period, their number in 2001 was 95.2 percent. On the other hand, the level of dropouts from schools had also decreased, from 5.3 percent in 1994 to 4.5 percent in 2001 (a decrease by 15 percent from the mid-term year of 1994). The proportion of eligible families (with school-age children) sending at least one child to the school was 95 percent in 1995-2001 compared to 75 percent in 1991-1994, i.e., an increase of 20 percent of total eligible families has been registered.

  Thus, Dipshetu has been successful in gearing up literacy and the motivation of the target communities to work comprehensively toward education for all over there, as a result of the efforts made by ISEHPD.

- Contraceptive prevalence rate (CPR), that is, use of family planning methods by eligible couples among the target families of ISEHPD, was high. Dipshetu started with a low CPR of 30.8 percent in 1990 when the national rural CPR was 38.5 percent, but the same increased to 55.4 percent in 1994 when it was 43.3 percent for the national rural. In 2001, this rate reached a point as high as 64.0 percent when the national CPR was 53.2 percent. The fertility reduction is clearly evident from the declining proportion of under-five children in the total population. As a consequence of high CPR, the TFR declined from 5.1 in 1990 to 3.07 in 2001, that is, a decline by around 40 percent.

  It may be mentioned that Dipshetu's ISEHPD has been a great milestone in the area of family planning operations. The significantly higher level of achievements above the country average is especially notable.

- The ISEHP achieved a significant improvement in the use of safe water (hand tubewell water) for purposes of drinking, cooking and bathing among the Dipshetu beneficiaries. The use of tubewell water, as evident from information in Table 41, for drinking purpose is now universal, and it rose from 67 percent in 1990 to 98 percent in 1994 and to 100 percent in 2001. The use of safe water for cooking purposes is also universal at this moment. Such usage of safe water has been reported by 100 percent of respondents in 2001, as against 88 percent of the respondent families in 1995. Remarkable success had been achieved in the use of hygienic

latrines (sanitary or water-sealed pit type), and use of soap after defecation in 1990-2001. As shown in Table 42, currently 84 percent of the respondent families use such hygienic latrines against a 31 percent of families in 1995. The present rate of usage of soap after defecation is 51 percent, while this rate was only 46 percent back in the year 1995. At the inception of ISEHP (in 1990), only 6.6 percent of the families were using soap after defecation.

Dipshetu achievement in the line of ensuring appropriate preparation of ORS (Oral Rehydration Saline) has been remarkable. The survey estimates at the end of 2001 show that among the beneficiary household members aged 10 years and above (i.e., not only the mothers) 98 percent now know how to prepare ORS. It was 97 percent in the year 1995 and 51 percent in 1990 (Table 44). Thus, the knowledge about method of preparation of ORS is almost universal among the project families.

Irrespective of age group of the beneficiary household members and irrespective of seriousness of sickness, the proportion seeking treatment from a medically competent person reported to have increased during the Dipshetu period. As for household members above 5 years, it rose up from 70 percent in 1994 to 78 percent in 2001 (In the year 1990, it was only 23 percent). As for those below 5 years, the corresponding proportions were 58 percent and 34 percent in 1995 and 1990 respectively, which increased up to 90 percent at the end of the year 2001.

Incidences of sickness among the members of the Dipshetu have been treated as one of the proximate indicators of health. In 2001, around 90 percent of the respondent families reported lower incidences of diseases than in 1990. In 1995, this rate was about 86 percent of the respondents. The reasons for lower post-loan sickness as mentioned by the respondents include mainly cleanliness, higher awareness about personal hygiene (cleanliness 78 percent and health awareness 75 percent), availability of Dipshetu health facilities (45 percent), and intake of nutritious diets (32 percent).

Dipshetu has also made a visible impact on maternal health, which has been measured using three indicators of maternal care. As for each last birth before and after 1995, women were asked whether they had received a tetanus toxoid (TT) injection while pregnant, whether they had obtained antenatal consultation during the pregnancy from a medically competent person, and whether a medically competent person assisted them at the time of last delivery. Around 92 percent of the recent mothers in Dipshetu reported that they received TT injection during their last pregnancies (Table 49). The success is evident from the fact that this rate is still higher than that in 1995 (86 percent). In addition, in the year 1995, this rate had just doubled since 1991. A total of 93 percent of births in 2001, the mothers had reported that they had received some antenatal care from a medically competent person (doctor or trained nurse or midwife).

In order to analyze the 2001-situation of ISEHP in a more comprehensive manner, a new indicator (*percentage of families who could provide 3 meals for all 7 days in a week by age group*) has been applied. Inter-temporal estimates on this indicator have revealed that, in 2001, 98 percent of family members aged above 5 years and 99 percent of family members aged 5 years or below were given 3 meals a day for all 7 days of the week. In 1994, only 85 percent of the household members aged 5 years or below and 90 percent of the household members aged more than 5 years were given 3 meals for all 7 days in a week. The corresponding figures for 1990 were 83 percent and 49 percent. Young children $\leq$5 years of age were always taken care of in terms of provisioning of 3 meals in all 7 days in a week;

however, it was not so in the case of those above 5 years of age before Dipshetu intervention. This improvement in the provisioning of 3 meals for all 7 days in a week among those over 5 years of age constitutes a major success of Dipshetu.
As apparent in the above paragraphs, in a similar pattern as the one that prevailed at the end of 1995, the health benefits drawn by the target beneficiaries in ISEHPD were relatively more pronounced than the impact on their other aspects of life. Interestingly, they were found at the end of 2001 to be aware of both preventive and curative initiatives that are necessary for sound healthcare management in their respective communities. The increase in disposable income, coupled by a higher level of health-awareness and access to medical supplies or improvisations, finally led to an overall improved health status among ISEHPD's target community.

- Dipshetu is administered by a two-tier implementation mechanism, where the first tier is its Board of Trustee, and the second one is its operational organization comprising of the paid staff.

  There have been some changes in the overall organization structure since the year 1995. The total number of paid staff has increased from 56 to 59. The position of the Executive Director does not show up in this structure, rather the Executive Director has been shown as leading the implementation of the programs being entrusted with this responsibility by the Board of Trustee (that replaced the older so-called Executive Committee). Among the three older wings, the Maternal-and-Child Healthcare Wing is now non-existent. Overall activities of the organization are being carried out and overseen by two particular wings, namely, *General Section,* and *Socio-Economic Development Section*.

  The Board of Trustee is the policy making body. The existing members on the Board of Trustee include people from all walks of life. They usually play an important and significantly influential role in matters relating to decision-making processes in their respective communities. One of the major strengths of Dipshetu lies in the fact that popularly accepted and recognized members of the civil society represent their respective segments of the civil society on the Dipshetu Board of Trustee.

  Dipshetu has been observed to still have some of those weaknesses that were identified in the 1995-study, such as:

  - Over-centralization in the overall organization structure still exists, especially in absence of the Maternal-and-Child Healthcare Wing and lack of initiatives to introduce project-specific heads
  - Some of the specific designations are still mixed up with the generic ones
  - Position of Production Controller-cum-Counselor has not been filled in
  - Position of Administrative Officer has not been created

  Though the anomalies detected earlier (in 1995) in assigning specific responsibilities to the right persons still lurk, the difficulties evolving from such irregularities in implementation of the programs have decreased as a result of (a) the long-standing exposure of the staff in general to the activities of Dipshetu, and (b) due to a decrease in the rate of staff dropouts from this organization. Dipshetu has made conscious efforts for streamlining its organizational set-up in tune with its overall objectives and has come forward with pragmatic plans for preparation of a number of manuals in this direction. Moreover, transparency has been ensured in position-

wise recruitments, division of functional compartments and delegation of authority.

- During 1991-2001, Dipshetu operated ISEHPD under this title for 7 years (1991-1997) and under a different title (i.e., SEPDF- Socio-Economic Project for Development of the Poorest Families) during a total of another 7 years, that is, 1995-2001. It is, therefore, clear that both these projects operated together during 1995-1997. As the reports on financial operations submitted by Dipshetu reveal, the total budget for ISEHPD and SEPDF during 1996-2001 was Tk. 23.29 million. Out of this total amount, the year-specific percentile distribution was as follows: 26.74percent in 1996 (ISEHPD and SEPDF together), followed by 19.82 percent in 1997 (ISEHPD and SEPDF together), 11.66 percent in 1998, 16.09 percent in 1999, 11.66 percent in 2000, and 14.03 percent in 2001.

  In Phase I of this project (1991-1995), a significant portion of the first 5-year budget was allocated for capital expenditure, especially to establish the project infrastructure (in 1991). The subsequent annual budgets were significantly lower. In Phase II (1996-2001), starting with the acquisition of land and some construction work for establishment of a training academy and fresh injection of funds as revolving loan fund, the annual budgets for 1995 (SEPDF) and 1996 (ISEHPD and SEPDF) stood at the two highest levels. At another stage in 1999, further funds exclusively as revolving loan fund were injected. Without considering these two exceptions, it may be commented that the annual budgets of ISEHPD and SEPDF showed a generally decreasing trend.

  With regard to self-financing by Dipshetu, during 1996-2001, Dipshetu itself generated and re-invested a total fund of Tk. 5,248,563 by way of such means as: service charge on revolving loans, income from sale of products (e.g., Tk. 120,000 in the year 2000), and bank interest. This self-financing stands at 18.68 percent of the total expenditures. Since 1995, Dipshetu had stopped raising subscriptions from local elite and volunteers because of its higher capacity to generate funds by itself. Therefore, the rise in self-financing by 13.68 percent over 5 percent since 1995 in a highly constrained situation is really plausible.

  As for the period of 1996-2001, out of a total budget of Tk. 28.10 million, around 30.57 percent comprised capital expenditure, and the remaining 69.43 percent recurrent expenses (salaries, traveling, contingencies, and other expenses). As compared with the corresponding figures for the 1991-1995 period, a downward trend in the capital expenditure (from 30.69 percent to 30.57 percent) and an upward trend in the recurrent expenses (from 63.10 percent to 69.43 percent) is visible. This change carries the implication that though certain fresh injections of funds have taken place in the form of investments in the revolving loan fund and the training centre, the overall trend in ISEHPD's financial management since 1996 has been to make incremental usage of the already established infrastructure through acquisition of reasonable amounts of funds for recurrent expenses.

  As at the end of December 31, 2001, Dipshetu owned a total asset of Tk. 25.37 million growing out of a total actual capital expenditure of Tk. 17,419,441, which is equivalent to 72.92 percent of the total 11-year budget (Tk. 34.79 million) of ISEHP of Dipshetu. *This amount would be available in the form of physical stock (building, equipment, and vehicles), human capital (trained manpower), and financial capital (revolving loan fund). What is commendable is that Dipshetu, beside serving the cause of the really distressed rural poor, has gained and proved its capability to move toward a sustainable future as a result of its entrepreneurial handling of funds, mostly in case of RLF management, generating additional funds.*

- As Dipshetu moves towards greater sustainability, its top management will have to concern itself regularly with the key aspects of institutional, managerial and financial strategies. A key role for the Dipshetu strategists should be to convert the Dipshetu mission into operational specifies which are simple and clear to the general members, the executive committee, the staff, and the community people.
  As for the utility of ISEHP, 96 percent of the beneficiaries perceive it as very useful and 4 percent as useful. Beneficiaries were observed to be least ambiguous in replying to this question. Regarding the individual components of Dipshetu, the beneficiaries were found to assign more values to the loan and health programs than to the production program. While comparing three programs, 78 percent of the beneficiaries picked up the loan program as the most useful, and a 12 percent of them ranked health program as the second most useful program of Dipshetu.

  There are various reasons as to why the beneficiaries reported loan or health or production component of Dipshetu as the `most useful'. Loan program was reported as the most useful due to the following reasons: helps income generation, financially more beneficial, helps establish small business, terms and conditions are easy to comply with, low rate of interest and low *kisti* amount, helps agricultural and environmental development, helps survival/ subsistence, helpful for children's education, accelerate financial solvency through poultry raising, helpful for self-employment, etc.

  Around 82 percent of the beneficiaries said that they would face problems if Dipshetu phased out. The total number of beneficiaries that said this in the year 1995 was as high as 9 percent. This reduction by 16 percent from 1995-mark up to the year 2001 implies the positive contribution made by ISEHP toward self-sustaining benefits and possibly permanent changes in the behaviour pattern of these beneficiaries. Despite this, the willingness to depend on the efforts made by ISEHP still lurks at a significant level. This upward trend in perception can be explained considering the widespread poverty context, short-span of Dipshetu interventions (so far only four years), and nature of positive changes that has already taken place but difficult to sustain.

  To sum up on the basis of the existing financial strength and community-level acceptance of Dipshetu and its ISEHPD, it appears obvious that Dipshetu has the need to operate ISEHPD in future with more self-generated funds from Dipshetu and providing for some amount of recurrent expenses from outside.

- Based on the findings of this study conducted with participation of a wide array of stakeholders, it is being suggested that Dipshetu, in order to further carry forward the interests of its distressed beneficiaries, should pave the way for introducing changes by following the recommendations noted below:

Organization and Management:

- The existing organogram should be immediately modified by bringing about changes suggested in the 1995-study.
- A well-designed and regularly updated salary structure based on rational principles from the viewpoint of both the organization and the employees should be put in place.
- To keep the morale of the employees high and to develop competitive attitude among them a moral incentive scheme in the form of `**DIPSHETU SPIRIT AWARD**' may be

introduced and institutionalized.

- Coverage may be expanded and cost per beneficiary may be reduced by adding one more beneficiary group to each community worker (CW) and/or six more members in each group.
- Dipshetu should develop staff skills at all its levels by providing necessary skill development training.

Phasing-out:

- Phasing-out should be contingent upon institutional and behavioral sustainability designed over a relatively longer timeframe.

Loan Program:

- ISEHPD should increase the unit size of loan further beyond the existing size of Tk.5,000 (per loanee per year) beside increasing the savings rate, number of beneficiaries, proportion of productive loan, and introduction of house building repair, or maintenance loan. At the same time, efforts should continue to include more eligible distressed beneficiaries within the available funds.
- Dipshetu should pre-consider transport and travelling problems during the monsoon, while planning to provide particular loans.
- Dipshetu management should immediately introduce the system of prior feasibility studies into specific loan proposals in order, among others, to determine the appropriate size of loan to be sanctioned and disbursed. (Such a system, once introduced and followed properly, will enable Dipshetu to overcome the debate over the optimum size of loans to be provided).

Creation of skill development opportunities:

- In order to ensure women's participation, to prepare them for leadership and to create job opportunities for them, arrangements should be made for imparting more streamlined training to women on (a) general small business skills, and (b) trade skills in emerging, viable and profitable businesses.

Income generation activities:

- A higher emphasis should be attached to investments in only the profitable cottage/handicraft industries having attractive market potentials.
- Self employment projects should be promoted with the supply of skill development training, various tools and equipments.
- Dairy projects with necessary back-up support services may be established.
- Promotional activities should be undertaken to expand the market of the products of Dipshetu financed projects or production units.
- Simplistic feasibility studies should be carried out in schemes producing goods having near-saturated markets, considering inter-alia, transport and travelling problems during the monsoon.

- Dipshetu should try to reach the very poor beneficiaries in other villages increasingly with further growth in its capability for management of viable small enterprises and other businesses and enterprise and for training beneficiaries involved in such businesses.

Health services:

- Dipshetu should soon go ahead with establishment of a subsidized health centre to provide more comprehensive health services in exchange of minimum service charges. Steps to ensure quality of care and services in that centre should also be taken on.

Participation of others:

- Dipshetu should optimize the use of public sector resources e.g., government officials, government donation, government premises etc. should be ensured.

- More and more local leaders should be involved and more local communities should be motivated to participate at higher frequencies with a stronger commitment at all stages of the planning, implementation and monitoring off the project activities.

Socio-environmental awareness:

- A regular adult literacy program should be undertaken.

- Steps toward reduction of the number of drop-out of schools should be taken up.

- Dipshetu should mobilize and efficiently use resources in developing an effective program for the enhancement of socio-environmental awareness.