

**Whose Public Action?
Analysing Inter-sectoral Collaboration for Service Delivery**

Identification of Programmes for Study in Bangladesh

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Table of Contents

Acronyms

Section -1 Objective of the Paper

Section- 2 The Sanitation Sector-Community Led Total Sanitation

- The Context
- The Current State of Sanitation
- National Sanitation Strategy: Roles of NSPs and Other Stakeholders
- Institutional Framework: State and Other Actors
 - Government Actors
 - NSPs/NGOs
 - Development Partners
- NSPs in Sanitation

Section- 3 Health Sector Overview-Primary Health Care (PHC)

- Primary Health Care
- The Context of PHC
- Types of Health Provider
- The State's Role in the Health Sector
- Emergence of NSPs in Health Care
- NSP in the Health Sector

Section- 4 Education Sector: Non-Formal Primary Education

- The Context
- State Provision of Primary Education
- NSPs in Primary Education
- The Campaign for Popular Education
- Non-formal Primary Education
- Government Contracting of NFPE
- Partnership between NGOs for NFPE
- Donor Involvement

References:

Sanitation
Reports
Persons Interviewed

References:

Health
Reports
Persons Interviewed

References:

Education
Reports
Persons Interviewed

Acronyms

ADB	Asian Development Bank
ADP	Annual Development Plan
BCC	Behavioural Change Communication
BCS	Bangladesh Civil Service
BNE	Bureau of non-formal Education
BEHRUWC	Basic Education for Hard to Reach Urban Working Children
BPHC	Bangladesh Population and Health Consortium
BWHC	Bangladesh Women's Health Coalition
CAMPE	Campaign for Popular Education
CBA	Centre Based Approach
CBO	Community Based Organization
CC	City Corporation
CHO	Chief Health Officer
CIDA	Canadian International Development Agency
CLTS	Community Led Total Sanitation
CTC	Close to Client
DAM	Dhaka Ahasania Mission
DANIDA	Danish International Development Agency
DFID	Department of International Development
DP	Development Partner
DPHE	Department of Public Health Engineering
DCC	Dhaka City Corporation
DG	Director General
DGHS	Director General of Health Services
DGFF	Director General of Family planning
DNFE	Directorate of Non-formal
DP	Development partner (aid agency)
DWSA	Dhaka Water and Sewerage Authority
DSK	Dustha Shasthya Kendra
ESP	Essential Service Package
ERD	External Resource Division
FIVDB	Friends in Village Development Bangladesh
ESP	Education Support Programme
FWA	Family Welfare Assistants
FHI	Family Health International
GO	Government Organization
GOB	Government of Bangladesh
GUP	Gono Unnyan Procheta
HIV/AIDS	Human Immune Virus /Acquired Immune Deficiency Syndrome
HPSS	Health and Population Service Sector
HPSP	Health and Population Sector Programme
HNPBP	Health, Nutrition and Population Sector Programme
INGO	International NGO
LGD	Local Government Division
LGED	Local Government Engineering Department
LGRD	Local Government Rural Development and Co-operative
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MLGRD	Ministry of Local Government Rural Development and Co-operative
MOHFW	Ministry of Health and Family Welfare

MOPME	Ministry of Primary and Mass Education
NCTB	National Curriculum and Text Board
NFPE	Non formal Primary Education
NFE	Non formal Education
NSP	Non State Providers
NSS	National Sanitation Strategy
NSTF	National Sanitation Task Force
NSDP	NGO Service Delivery Programme
ODA	Overseas Development Administration
PRSP	Poverty Reduction Strategy Paper
PNGO	Partner NGO
PHE	Primary Health Clinic
PIU	Project Implementation Unit
PD	Project Director
PIP	Project Implementation Plan
PSTC	Population Service and Training Centre
SAE	Sub Assistant Engineer
SDC	Swiss Development Cooperation
SDP	Sector Development Programme
SACOSAN	South Asian Conference on Sanitation
TW	Tube Well
UEO	Upazilla Education Officer
UP	Union Parishad
UN	United Nations
UNICEF	United Nations Children Emergency Fund
UNO	Upazilla Nirbahi Officer
UHFWS	Union Health Family Welfare Centre
UHC	Upazilla Health Complex
UPHCP	Urban Primary Health Care Project
UNFPA	United Nations Population Fund
UST	Unnyan Shohojogi Team
VERC	Village Education Resource Centre
VSC	Village Sanitation Centre
WAB	Water Aid Bangladesh
WHO	World Health Organization
WSS	Water Supply and Sanitation
WSP-WB	Water and Sanitation Programme World Bank

Identification of Programmes for Study in Bangladesh

Section 1: Objective of the paper

The ultimate objective of this research is to understand the dynamics of government relations with non-state providers (NSPs) of basic services in basic education, health and sanitation. In each service sector, three 'programme areas' are to be selected for detailed study through case studies. Therefore, the purposes of this programme analysis is to provide a basis for selection of programmes and case studies, to locate the case studies in a wider framework, to identify the main features of programmes, and to undertake a first analysis of factors that condition state and non-state relations¹.

The information for this programme paper has been derived from several sources. These include reviews of literature including in annual reports of NGOs, evaluation reports, process documents, progress reports, policy papers that were collected from different NGOs, government and individuals. The information was also collected from interviews of key informants including NGO staff, researchers, donors and government officials. What follows is a synthesis of the information collected from several sources. It is expected that this programme paper will help to identify the specific case studies in which to pursue the major research issues and questions of this study.

Section 2: The Sanitation Sector - Community Led Total Sanitation

The Context

Although safe water provision received significant attention from government and NGOs from the early 1970s, the importance of sanitation as a crucial factor to public health and fundamental to the prevention of a whole range of faecal-oral diseases including helminth (worm) was not realised by policy planners and other concerned authorities in Bangladesh. The provisioning of hygienic sanitation was cursorily linked with safe water which was an equally important public health concern. It is estimated that excreta of about 60% of the families and faeces of almost all children aged less than five years are disposed in an unsanitary way (Hoque 1998). The government policy was basically "safe water first and sanitation later". The situation is succinctly described as follows:

"In Bangladesh, it has been observed that in spite of tremendous progress in terms of providing microbiologically safe drinking water, the health impact has been limited. This is thought to be related to limited access to adequate sanitation, which until recently has lagged far behind the progress made in safe water provision". (Rahman and Ghosh 2006: 305)

¹ Derived from Whose Public Action? Research Approach. p. 9

So, hygienic sanitation did not get due attention as a public health concern by government or development practitioners. What follows is a brief description of the sanitation situation in Bangladesh.

Current State of Sanitation²

Although providing pathogen-free safe drinking water was a major priority, sanitation was not taken seriously by the government. The programme with regard to sanitation was scattered, disorganized, lacked policy direction and also a proper strategy for implementation in rural and urban areas. There had been some attempts to create a sanitation programme since the 1970s, but success in improving sanitation coverage has been far less than in the case of the water sector (SDP 2005). Government sanitation programmes were largely limited to on-site options, ignoring intermediate technology approaches that might be both cost effective and more suited to user preferences as well as to willingness and ability to pay. There was not even an attempt to develop and encourage appropriate technology or campaign to help people realise the importance of sanitation from the individual and public health perspectives.

Sanitary latrines are relatively new additions to most households and did not get momentum until the 1990s, before when the rate of increase of sanitation coverage was only 1% per annum. Currently the growth rate is estimated to be about 17%. For example, in 1991, while a majority of households (61%) possess latrines only 26% can be categorized as sanitary latrines. The remainder generally drains into water bodies or ditches. The most common sanitary latrines in the rural areas are pit, water sealed, and septic tanks. The situation is better in urban areas where 83% of all households possess latrines though only 48% of these have sanitary latrines. The favoured types of sanitary latrines, in order, are water sealed (single and double pit), septic tank, and pit (LGI, UNDP, UNICEF 1994: 20-21).

The situation has improved in recent years. A government conducted baseline survey of 2003 found that 33% of the families in the country were using hygienic latrines. Realising the importance of sanitation as an important public health issue, in January 2004 the government launched a special drive through local government institutions and also made increasing budgetary allocations for the very poor. **At the Upazila (meaning sub-district) level, 20% of the Annual Development Plan (ADP) grant was set aside for sanitation, out of which 25% was earmarked for “software” and 75% for the “hardware” subsidy for the hardcore poor.** Along with this multimedia awareness campaign, several sensitizing and motivational workshops of key stakeholders were organized as a part of the National Sanitation Awareness Campaign. Stakeholders in the sanitation awareness campaign included DPHE, LGED, UP, government officials from the Upazila and district levels, the NGOs and the local community. These activities led to an increase of sanitation coverage to 59.53% at the end of June 2005 which is an increase of about 26.32% from the base line of 2003 (SACOSAN 2006: 4-5).

The sanitation situation in the urban areas is relatively better. In 2003 the sanitation coverage was 53% in the Pourashavas and in the City Corporations it was 70%. This coverage had apparently increased to 74% by 2005. Furthermore, 8 Upazilas and about 180 UPs had achieved 100% sanitation coverage. Although Urban Sanitation coverage looks impressive in percentage terms, expansion of sanitation coverage is problematic and challenging due to institutional, technical and environmental issues in the urban areas. These can be summarized as follows:

² The following discussion is based on Bangladesh Country Papers (Bangladesh SACOSAN 2005 and 2006); National Sanitation Strategy (Local Government Division 2005); Sector Development Programme (GOB 2005) and also Bangladesh Situation Analysis: Water Supply and Sanitation (LGI, UNDP, UNICEF 1994).

- Due to high density of population in the urban and peri-urban areas on-site sanitation (i.e. pit latrines and septic tanks) will not be appropriate.
- De-sludging and safe disposal of pit latrines and septic tanks constitute environmental problem and pose a serious health hazard.
- In the densely populated metropolitan areas (like Dhaka and Chittagong), 100% provision of hygienic sanitation is impossible. There are about 4 million slum inhabitants in Dhaka city who are mobile and do not have any permanent settlement.
- Lack of land tenure and other issues in informal squatter settlements create formidable problems for sustainable service provision (Situation Analysis 1994: xv) Therefore, finding suitable land for building sanitary latrines for the slum population is perennial problem and stand as an obstacle in achieving 100% sanitation in the urban metropolitan areas.

We can sum up the current state of sanitary coverage in Bangladesh as follows:

- In recent years there has been a growing realisation that sanitation is an important public health concern leading to a set of initiatives by the government.
- Government has recognized the role of NSPs along with the other stakeholders. There is increasing GO-NGO collaboration in sanitation activities.
- Good progress has been made in sanitation coverage both in the rural and urban areas.

National Sanitation Strategy: Roles of NSPs and Other Stakeholders

In the past, Bangladesh did not have a sound water or sanitation policy which reflects the lack of state appreciation of the importance of such policy. However, in 1998 the government announced a “National Policy for Safe Water Supply and Sanitation 1998”. It was made clear in the objectives of the Policy that “steps will be taken for facilitating access of all citizens to basic level services in water supply and sanitation and also in bringing about behavioural changes regarding use of water and sanitation”. Furthermore, in achieving these objectives, several policy measures and strategies were suggested. One such strategy is the “development of water supply and sanitation sector through local bodies, public-private sector, and NGOs, CBOs and women’s groups involving local women particularly elected members”. However, implementation of the Policy has been weak with very limited coordination between sector actors, especially between government and the NGOs involved in water, sanitation and hygiene promotion (WaterAid undated a: 6). The policy also lacked strategic direction and delineation of the roles and relations which is normally expected in such a document.

The first National Sanitation Strategy (NSS) was launched by the Local Government Division (LGD) of the Ministry of Local Government Rural Development and Cooperatives in 2005. Sanitation which was so long an overlooked public policy issue was brought to the centre stage of both public health and development arenas through the enunciation of the Strategy. The Secretary of the LGD explained the background for launching the NSS in a note that reflects the change in the mind-set of the government:

“ In response to the global call, the water target 10 of the MDGs, subsequently expanded in WSSD in Johannesburg in 2002 to include sanitation target, the government of Bangladesh set its national target of achieving 100% sanitation by 2010. This challenging target is much ahead of the MDG target. *But government has realized the importance of sanitation for sustainable development and put emphasis on achieving the target that will have immense impact on poverty reduction.*” (Emphasis added).

NSS 2005 provides not only a strategy but also a framework, conceptual clarity on certain issues, policy guidelines, and definition of the roles of different stakeholders in achieving the 100% sanitation target. The process of preparing and finalising the National Sanitation Strategy 2005 was a long and arduous one. It was the outcome of advocacy, lobbying, persuasion, policy dialogue and many consultations by NGOs, donors, government officials, academicians and members of civil society. WaterAid Bangladesh (WAB) played a leading role in this process by organizing different activities, financial support, and also the publication of the strategy³.

In early 2000, when the PRSP document was under preparation, NSPs played an important role in lobbying the concerned authorities to incorporate safe water, environmental sanitation and hygiene issues as priority areas in the PRSP. However, when the second version of the PRSP was published in December 2002, there was cursory mention of water and sanitation in it. Foreseeing the negative consequences if WatSan were left out of the PRSP, WAB along with its civil society partners undertook advocacy to incorporate this in PRSP from January 2003. Indeed WAB facilitated a participatory process to analyse sector issues in the PRSP. This involved all key sector actors including government (DPHE, DWSA, LGD), international NGOs (CARE, Asia Arsenic Network, HEED), donors (World Bank, DANIDA, DFID, CIDA), UN agencies (UNICEF, WHO), partners and grass root communities (WaterAid undated a: 2).

In course of this process WAB organized and funded a number of workshops and a national level PRSP consultation, lobbied the ministries of finance, planning, health and family planning and LGD. The lobbying and the dialogue continued up to November 2004 when the draft PRSP was presented for public comments. The outcome of the consultation and dialogue was positive. From a situation where water and sanitation were barely mentioned in the PRSP, the final draft document contained some strong statements which were reflected recognition by the PRSP formulators (at least on paper) of the importance of water and sanitation issue. For example, the PRSP stated that “water supply and sanitation are considered among the priority areas to be emphasized in order to achieve accelerated growth and bring a pro-poor orientation in the growth process” (quoted in WaterAid undated a: 5)

After the successful incorporation of water and sanitation in the PRSP document, WAB pursued the inclusion of sanitation as a key environmental and developmental issue within the policy of government and development partners. WAB's activities have four main components: building a national platform on sanitation and hygiene issues; persuading government to host a regional meeting on sanitation; promoting a national sanitation campaign and developing a National Sanitation Strategy. WAB was quite successful in pursuing the relevant stakeholders to initiate and complete these activities.

³ The following discussion is taken from WaterAid Advocacy Process documentation. ABM Zaiul Kabir, Programme Officer, Advocacy, WAB provided useful documentation.

There were two important outcomes of this process: (i) the formation of a National Sanitation Task Force (NSTF) headed by the LGD Secretary. Other members of the task force were: representatives from the relevant government agencies, NGOs, development partners, civil society actors, WAB and three of its partners; (ii) an annual National Sanitation Campaign Month was launched and has been maintained since 2003.

WAB, along with its partners, argued forcefully in different forums that the country needed a National Sanitation Strategy. Indeed it was in June 2004, at a meeting of the NSTF attended by the Minister of Ministry of Local Government Rural Development and Cooperatives and the Secretary LGD, that the idea of developing a National Strategy on Sanitation was agreed. The task was delegated to DPHE, LGED, the National Sanitation Secretariat and ITN-BUET. Several organizations and stakeholders actively participated in the preparation of NSS. They included UPI, DPHE, LGED, Sanitation Secretariat, WAB, WSP-WB, Unicef, WSSCC-B, VERC, Danida, NGO Forum, WHO and Plan Bangladesh. The process of formulation and finalization of the strategy was participatory. The LGD secretary described the process as follows:

“A participatory approach was adopted in developing this strategy. Consultative meetings were organized with stakeholders from the central to the grassroot level. Experience gathered from interaction with community people and LGI representative assisted in formulating this pragmatic strategy paper. Comments from different stakeholders reinforced the strategy paper further”. (Local Government Division 2005)

As the National Sanitation Strategy 2005 became a reality, simultaneously the government launched a related “Pro Poor Strategy for Water and Sanitation Sector in Bangladesh” in February 2005.

The government, non-state providers, development partners, local government and community representatives played an active role in the formulation of the sanitation strategy. WAB played a leading role in mobilizing various stakeholders and providing both financial and logistical assistance towards making the National Sanitation Policy a reality. The government was quite quick to respond to the recommendations of NSTF and NSS would become a successful example of Government-NGO collaboration.

Institutional Framework: State and Other Actors

A brief discussion of the institutional framework of the water and sanitation sector in policy and programme formulation, implementation and monitoring will be made in the following few paragraphs (based on Bangladesh SACOSAN 2005). An understanding of the activities of these institutions will help us to understand relations between them, and specifically between the NSPs that are implementing CLTS. By and large institutions involved in the WatSan sector can be categorized as government, semi-autonomous government bodies, local government institutions, NSPs and development partners. These are all formal institutions, but there are also informal institutions including *gram samaj*, (village society) *gram shalish* (village court), school and mosque committees and local civil society organizations. Informal organizations have a significant role in the rural socio-economic development of Bangladesh.

There are several tiers of administration in the Water and Sanitation sector of Bangladesh. The Ministry of Local Government Rural Development and Cooperatives (MLGRD & C) holds statutory responsibility for the sector. It maintains liaison with the other ministries and departments in taking policy decisions, in making sectoral allocations, and in project appraisals, approval, evaluation and monitoring. Functional responsibility is delegated to

the Department of Public Health Engineering (DPHE), the Local Government Engineering Department (LGED), the City Corporations (CCs), the Pourashabas and the Water and Sewerage Authorities (WASAs) of Dhaka and Chittagong⁴.

Government Actors

- DPHE is responsible for planning, designing and implementing water supply and sanitation services in the rural areas, Upazila towns and Pourashabas. DPHE has staff at the district and Upazila levels and is represented at UP by TW mechanics and masons. An executive engineer posted at the district level looks after the activities in the Upazilas under his jurisdiction.
- At the Upazila level, DPHE has a small office led by one sub-assistant engineer and he is responsible for looking after all types of Watsan activities in the Upazila. When NGOs plan to undertake any programme they have to coordinate with the engineer in order to avoid any duplication and overlapping of activities. The engineer also provides technical support whenever it is needed by NGOs. At upazila level, there is a WatSan Committee headed by a sub-assistant engineer of DPHE, and attended by UN bodies, the UP chairman, NGO representatives and relevant government departments. This performs the following functions⁵:
 - To avoid overlapping and to create an integrated approach to sanitation coverage through both joint and separate ventures.
 - To share, assess and review Watsan activities and plans of UPs, NGOs and related government departments.
- Although LGED has no mandate, it implements some water and sanitation activities where these are components of larger projects.
- WASAs are semi-autonomous government bodies with management entrusted to boards, reporting directly to MLGRD&C. WASA offices are located in the Dhaka and Chittagong metropolitan areas. However, in the absence of a sewerage system Chittagong WASA deals only with the supply of drinking water.
- Municipalities, known as Pourashabas, are under the administrative control of the Ministry of LGRD&C, and their committees of ward commissioners is locally elected. The Pourashabas are responsible for development and maintenance of social services and physical infrastructure in the municipal areas. The Pourashabas collect and dispose of solid wastes and are mandated to maintain a sanitary environment. They are also expected to operate and maintain piped water systems which the DPHE may install.
- District Councils known as Zila Parishad consist of elected and appointed members and are directly involved in planning, implementing and monitoring development activities within the district.
- Upazila Development Coordination Committees (known as Upazila Unnayan Samannaya Committees), chaired by UP chairmen, shoulder responsibility for planning, implementation, and evaluation at Upazila level. They include both elected and appointed members. Water and sanitation provision in the Upazila falls within the purview of the Upazila committee.

⁴ See SACOSAN (2005) for detailed discussion.

⁵ This information was derived from an NGO located at Madripur district.

NSPs/NGOs

- NGOs are involved in sanitation programmes both in rural and urban areas, but they are particularly active in the rural areas where they promote grassroots community involvement. They also finance and implement sanitation programmes.
- Private sector bodies provide various latrine components, including ring and slabs which are widely available through private outlets as well as DPHE sanitation centres. (The rings are made of concrete and cement which are pushed into the ground to make a septic tank and slabs are flat pans)

Development Partners (DPs)

- Many DPs support sanitation programmes, including both INGOs and multilateral and bilateral donors: World Bank, ADB, Unicef, Danida, JICA and many others. INGOs include WaterAid, Plan and Action Aid are very much involved in the water and sanitation programmes of Bangladesh.

It is possible to conclude from the above discussion that Bangladesh has a very elaborate institutional system for the implementation of sanitation programmes. In order to achieve the target of total sanitation, the government has brought together the different agencies in a National Advisory Committee comprising several ministers, the mayor of Dhaka, Secretary LGD and eight different task forces from the national to the ward level. Participation in the task forces was sought through a notification by the Secretary, LGD of Ministry of LGRD&C that was circulated nationally on 12 June 2006. A look at the composition of task forces shows that all the relevant stakeholders have been included as members. From the point of view of government, various ministries and departments are involved and they work according to set rules and regulations determined by the state. NGOs work according to their own strategy, model and programme perspectives, but within the framework set by the relevant departments of the government. The task before us is to understand the relations between NGOs and government actors and also to capture the processes and dynamics of these relations.

NSPs in Sanitation

Most NSPs involved in providing safe water are also involved in environmental sanitation and hygiene. It is recognized in the National Policies that the provision only of safe water will not improve public health unless people have knowledge of basic hygiene and get access to sanitation facilities. In fact, NGOs working on providing safe water are also involved in providing sanitary latrines that ensure proper hygiene.

The provision of sanitation services by NGOs is critical to achieving health outcomes. The experience of different NGOs (i.e. VERC, UST, NGO Forum, Dhaka Ahsania Mission to name few) in the last one decade or so suggest that, compared to government, in many ways NGOs are in an advantageous position with their grassroots base and involvement with the local community to mobilize, raise awareness of the benefits of sanitary latrines, and work with the local community as well as with the government departments. The importance of NGOs' role in the WatSan sector is recognized by the donors:

“The provision of water and sanitation services by NGOs is also critical to achieving health outcomes. Around 700 NGOs are active in the water and sanitation sector, with international, national, and small local NGOs commonly working in partnership. The policy context is strongly supportive of NGOs' involvement, in recognition of the scale of need and the shortfall in present

provision, as well as of NGOs' capacities to stimulate behavioural change". (World Bank 2006: 26)

The Community Led Total Sanitation (CLTS) model that has been developed in Bangladesh is emerging as an example in South Asia. CLTS was developed by a few NGOs (especially VERC) and established methods that are participatory, community-friendly, cost effective and adapted to the needs of local communities. Many NGOs in Bangladesh are implementing CLTS and the NGO forum which is the apex organisation of water and sanitation in Bangladesh is promoting CLTS through its partner NGOs (PNGOs). It has also become the object of study by researchers and international organizations (Kar 2003; Allan 2003; WSP; World Bank 2005). The success of NGOs in CLTS has raised confidence that the achievement of the target of 100% sanitation by 2010 is possible. The following quote from NSS 2005 demonstrates that government has quite enthusiastically recognised the importance and role of NGOs in the sanitation programme:

"Many NGOs implemented successful sanitation initiatives by building community demand for improved sanitation. Starting in early 2000, a number of NGOs started a completely new approach. Instead of appealing to individual households, they addressed a whole village as one unit. The focus shifted from the individual action to collective action. There was no subsidy on hardware, not even for the poor people. Instead many types of latrine models were developed to suit all sections of the population. A vigorous motivational campaign was mounted to raise awareness and demand for sanitation. Villagers and local government were full partners in these campaigns". (Local Government Division 2005: 20)

Apart from this the private sector in Bangladesh is involved in water and sanitation sector in a number of ways (WaterAid undated b: 1)

- As manufacturers of pumps, pipes and fittings for water supply, and slabs and other materials for sanitation.
- As contractors for installation and maintenance of water supply and sanitation facilities.
- As consultants for planning and design of water, waste water and sanitation facilities.

Specifically the emergence of private entrepreneurs in the sanitation sector as producers of private latrines began around 1990s. These are actually small scale private entrepreneurs and are based locally catering to the needs of local people. It is also important to mention here that the NGO Forum has been supporting its partner NGOs and private sector actors in running Village Sanitation Centres (VSC). Different sanitation technologies such as water seal, home made latrines (san plat, off-set, twin pit, etc.) are being produced through the VSCs. In 2005, 577 VCSs were operated by the partner NGOs and 460 operated by private producers.

To understand the dynamics of State-NSP relations, this research will focus on CLTS, which provides ample scope to explore these relationships for the following reasons:

- CLTS is a community based approach where it brings together all the local stakeholders such as union parishads, community based organizations and local civil society.

- At the Upazilat level, NGOs are likely to work with the Department of Public Health and Engineering (DPHE) which is the statutory body for all Watsan activities in Bangladesh from Upazila to the National Level.
- At the upazila level, while implementing the CLTS programme, NGOs work with the Upazila Nirbahi Officer and other government officials at the upazila level.
- In the national sanitation strategy the role of NGOs in achieving total sanitation by 2010 has been recognized by the government. CLTS is one of the major innovations of NGOs in the sanitation sector.

Section 3: Health Sector Overview - Primary Health Care (PHC)

Primary Health Care

In recent years primary health care (PHC) has emerged as the core strategy for providing health care to the public. PHC includes both preventive and service delivery aspects. The basic premise of PHC is that it must address all causes of poor health, not just specific diseases and injuries. The eight core elements of PHC are⁶:

- Education about health problems and solutions
- Adequate food supply and nutrition
- Safe water and basic sanitation
- Maternal and child care; reproductive health
- Immunization against major diseases
- Prevention and control of endemic diseases
- Treatment of common diseases and injuries
- Provision of essential drugs.

So PHC is an important component of the health sector programme. In Bangladesh providing PHC facilities at a cheap and accessible rate is a challenge to both state and NSPs. Indeed PHC facilities in rural and urban areas are provided by both by the state and NSPs in Bangladesh. The focus of our research will be the Urban Primary Health Care Project (UPHCP) implemented by NSPs as a “contractor” of the government.

The Context of PHC

The early years of independence of Bangladesh witnessed disarray in the public health care system due to the accumulated backlog in the aftermath of the independence war. There was a lack of a well developed policy to serve rural and urban people alike. In this period, state policy was mainly geared to providing low cost and even some free health care services. During the late 1970s, attempts were made to reorganize health care services from a curative into a curative-preventative approach and also to redirect these services from the urban to the rural populations, from the privileged to the under-privileged, from vertical mass campaigns to a system of integrated health services and from the village level to the national level (Fakir 1987: 27).

⁶ Derived from programme guidance note on PHC by Natasha on 23/11/06

There is now growing recognition among politicians, government officials, health policy planners and members of civil society that health care services need to address ground level needs. The following are some issues which are summarized from different literature by the researcher⁷:

- Development of institutional mechanisms linking community level to the national levels.
- Understanding people's expectations of the health care delivery system.
- Recognition of the existence of parallel "traditional" and "modern" systems of healthcare, raising the question how they can be made complementary.
- Along with state provision there is a large number of non state providers, again raising the question how these can be made complementary.
- Discovering a mechanism to make existing systems accessible and affordable to the poor.

Types of Health Provider

Currently both state and non state providers are providers of health service both in the urban and rural areas. State provision includes services provided by hospitals, clinics, and other organizations managed and established by the state. These establishments are structured and managed through rules and regulations formulated by government. Health services are also delivered by a wide range of non state providers in Bangladesh, including: traditional healers, *palli daktar* (village doctors), private general practitioners, private hospitals both in the urban and semi urban areas, and NGOs providing both clinic based and outreach services. In this research we focus on the NSPs (i.e. NGO, CBO, Philanthropic) providing different PHC services.

The State's Role in the Health Sector

The state has always been the major provider of health services to the rural and urban areas before the emergence of NGOs in mid 1980s. These services are provided through a network from community to the national levels (see Fakir 1987 and Bangladesh Health Watch 2006).

- First at the home and community level there are Family Welfare Assistants who primarily provide family planning and maternal health services to households. Male Health Assistants working in every ward of the union (three wards per union) also provide domiciliary services including distribution of vitamin A capsules, immunization, detection of malaria and treatment of diarrhoeal diseases etc.
- Second, at the union level, health and family planning services are provided through union sub-centres and Union Health Family Welfare Centres (UHFWS).
- Next at the third level there is the Upazila Health Complex (UHC) which is the primary referral level and the centre of all health care services at the Upazila level. It operates a 31-50 bed hospital, which provides both in-patient and out-patient services. Nine medical doctors who belong to the BCS medical cadre are posted in every Upazila.
- The district level represents the secondary referral level. There are district hospitals in every district, and sometimes a medical college hospital. The hospital and civil surgeon is the chief medical officer of the district.

⁷ See BRAC 2006.; World Bank. 2005a. World Bank. 2005b and also Fakir 1987; Barkat, Abul et al. (2000).

- The national level is the tertiary referral level and is the centre of policy formulation and implementation.

There are three tiers in the health administration of Bangladesh. The statutory responsibility for the health sector is vested in the Ministry of Health and Family Welfare (MOHFW) headed by a Minister. The Ministry is responsible for policy formulation, decision-making, maintaining liaison with donors and other line ministries, and also looking after the activities of the directorates and departments under its jurisdiction. The ministry has a Health Division and a Family Welfare Division, each headed by a director general (DG). DGs are responsible for health programmes and projects under their directorates. Below the DG, the civil surgeon is the team leader and chief of health services at the district level. The upazila health and family planning officer is responsible for technical and administrative supervision of health and family planning activities at the upazila level and constitutes the last tier in health administration.

The rural areas of Bangladesh have an extensive and elaborate institutional mechanism to provide health services to the people compared to the urban areas. Both in the district town and also in the metropolitan city facilities to provide health care services are limited. There are district hospitals and medical college hospital attached to medical colleges in many towns of Bangladesh. The access to these hospitals is very limited. In recent years there is a mushroom growth of private hospitals and clinics some of which have inadequate facilities while others with modern facilities beyond the reach of the common people.

Emergence of NSPs in Health Care

Since the 1970s when NGOs were expanding their activities beyond relief and rehabilitation, the provision of basic health care services by NGOs had growing importance in their programmes. During this period and also in later years, the emphasis was on family planning, immunization, and maternal and child health (MCH). There were instances of government-NGO collaboration in immunization and family planning (Fakir 1987, Huda 1987, Barkat et al 2000). Gradually NSPs' activities became more institutionalized as their activities became linked to government programmes. Non state providers became active in major health programmes like HPSP, HNRP, and UPHCP through competitive bidding and contracting out to.

Quite a large number of NGOs have been involved in providing basic health services, including the components of PHC, as a part of their normal activity. Recently they have also taken on new roles such as raising awareness of arsenic contamination of water, and providing medical services to arsenosis patients. NGOs have provided PHC services either with their own funding or with donor support, but not necessarily entering a partnership or any kind of relationship with government. Public contracting by government of NGOs for health care delivery is a new phenomenon which illustrates government's trust in NGOs effectiveness.

During the implementation of HPSP the concept of the Essential Service Package (ESP) was introduced with the goal of increasing responsiveness to the needs of clients and especially children, women and the poor (Alam et al 2002: 2). The ESP provides reproductive and child healthcare services, communicable disease control, limited curative care, and behavioural change programmes (Alam et al 2000, Mercer et al 2004). The ESP seeks to provide PHC services in an integrated way at the Upazila level and below for **close to client** (CTC) facilities. Currently, the ESP constitutes around 48% of the Ministry of Health and Family Welfare's (MOHFW) total expenditure (World Bank 2005b: 5).

Along with the ESP, another programme known as Urban Primary Health Care Project (UPHCP) supported by ADB as principal donor has gained momentum since 2000⁸. The UPHCP is based on the rationale (revealed by several studies) that health indicators of the urban poor were worse than those of the rural poor because of poor urban living conditions, and limited urban PHC. The project is expected to improve the health status of the urban population in all the six city corporations and five municipalities. The first phase of the project ended in 2005 when the second phase begun. The project comprises four main elements: i) provision of PHC through partnership agreements; ii) strengthening the urban PHC infrastructure; iii) building capacity of the city corporations to manage such programmes, and iv) supporting project implementation and operations research (Chowdhury et al 2004: 38).

The UPHCP project is implemented by an elaborate administrative structure (Project Implementation Unit 2005 (Figure 1)⁹. A project implementation unit (PIU) headed by a Project Director (PD) was established at Dhaka City Corporation. The Local Government Division (LGD) of the Ministry of Local Government Rural Development and Cooperatives is the executing agency of the project. LGD provides overall guidance and coordination. Several other committees have been formed to supervise and monitor the activities of the project. The National Urban Health Care Committee, the highest administrative committee of UPHCP, is chaired by the Minister. The other committees at national levels are:

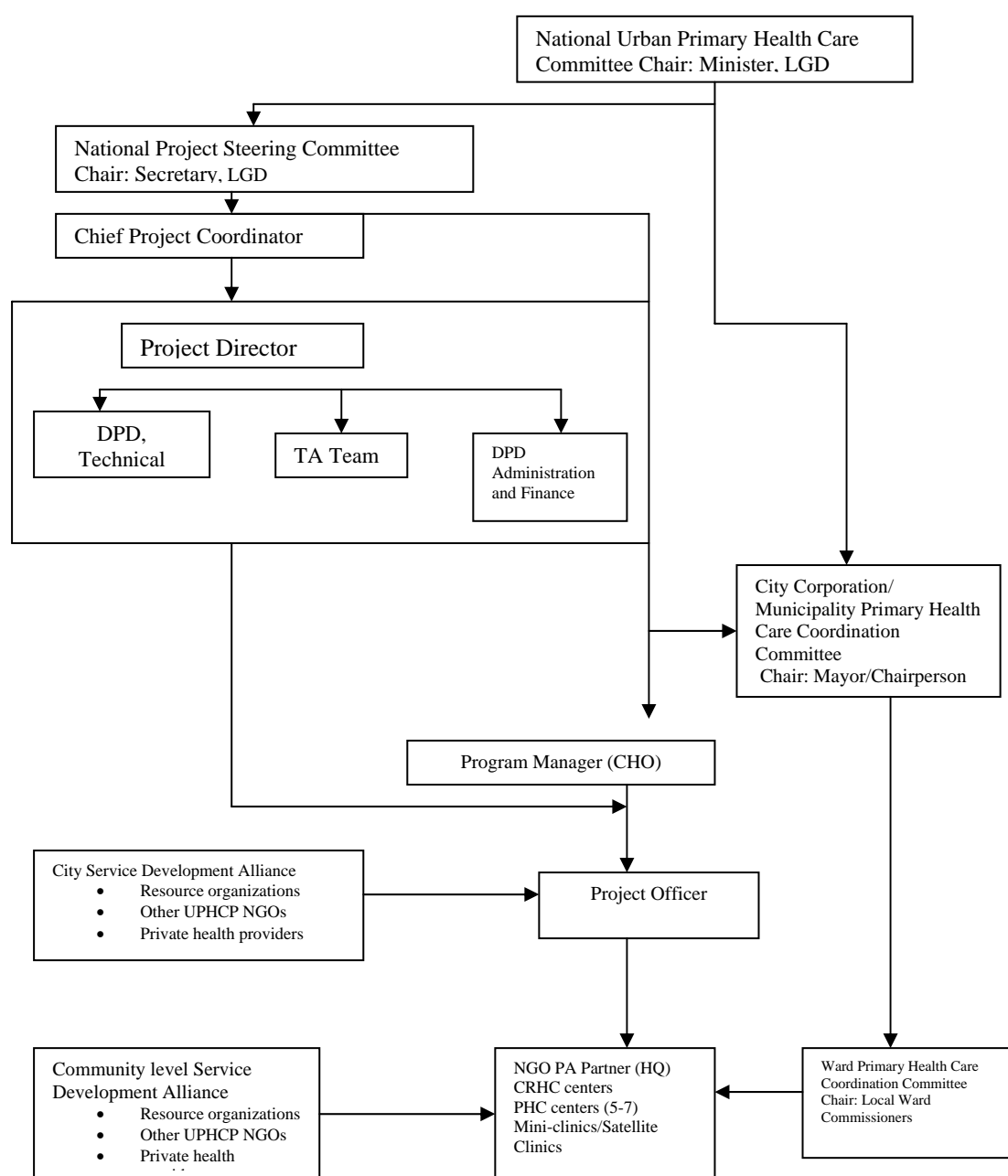
- *National Project Steering Committee* headed by Secretary LGD is the next most important committee. It has members from MOHFW, ERD, IMED, Planning Commission, NGOAB, concerned NGOs, monitoring officer of Women Affairs, city corporations and other related organizations.
- *Project Coordination Committee* is headed by the chief coordinator of UPHCP, the chief Health officer (CHO) of each of the city corporations, members of DGHS, DGFF and LGD. *Project Director* of the project acts as the secretary of the committee.
- There is a *Ward Committee* in every ward where the project is implemented, with a committee headed by the concerned ward commissioner.

The implementation authority of the project is the Dhaka City Corporation (DCC) which is under the Local Government Division (LGD) of the Ministry of Local Government, Rural Development and Cooperatives. The first phase of the project was funded by ADB and several donors (i.e. ADB, SIDA, DFID and UNFPA) supported the second phase of the project which started on July 2005. In the second phase the project is being implemented in 24 partnership areas, 10 in Dhaka, 3 in Chittagong, 2 in Khulna, 2 in Rajshahi and seven in Sylhet and Barisal. In Dhaka there are 10 partnership areas and 8 NGOs are involved in implementing project activities. The NGOs were chosen through process of competitive bidding. So in the implementation process of UPHCP there are four types of stakeholder: government ministry, Dhaka City Corporation and other municipalities, NGOs and the donors.

⁸ The discussion in this section is based on the project brief D:/LOAN BAN 36296-01 Second Urban Primary Health Care Project. HTM retrieved on 5/12/2006

⁹ Ministry of Local Government Rural Development & Cooperatives. Local Government Division. 2005

Figure 1: Project Management Document



Source: Project Document, UPHC, June 2005

Another relevant programme is the USAID-funded NGO Service Delivery Programme (NSDP) which is a partnership of eight international and Bangladeshi organizations. NSDP delivers family health services in 62 districts of the country with 41 participating NGOs (World Bank 2005). The principal aim of NSDP is to expand the range and improve the quality of the ESP which is provided by NGOs at the clinic and community levels and also to influence GOB policy, in coordination with other donors.

NSP in the Health Sector

From the mid 1970s the activities of NGOs in the fields of health and family planning began to expand. Their activities were directed towards promotive, preventative, curative, and rehabilitative health care and also towards the promotion of family planning services. Some NGOs (e.g. GK) have implemented their own, independent programmes while many others are collaborating with government in strengthening as well as in implementing government programmes. Government-NGO collaboration increased in the 1970s and 1980s on national programmes relating to tuberculosis, leprosy, immunization, family planning and nutrition (Mercer et al. 2004:187). Indeed, the NSPs have significant roles in providing health care services to the poor. For example, in 2003, 88% of households seeking health care went to NSPs while another survey undertaken in 2001 found that 82% of the sampled households received treatment from NSPs (Chowdhury et al 2004:24).

The ratio of government to NGO spending on health is 3:1 but NGO health expenditure has expanded over the past decade from 2.9% in 1996-97 to 9.2% of the total expenditure on health (World Bank, 2006: 25). Another important feature of NGO spending is that the large NGOs spend 73% of the total NGO expenditure on health.

Although the health sector has made impressive progress toward most of the health related MDGs the sector is beset with weak governance and its services remain beyond the reach of the most people (World Bank 2005 a). This impressive progress in health related MDGs is mostly due to the proactive and participatory role of NGOs outside the public sector and delivers 60-70% of health care services in Bangladesh. The public sector has failed to serve the poor and public sector spending going to delivery of primary health care has actually declined over recent years. The World Bank report suggested several reasons why public health services are non-responsive to service users.

Reasons why Public Health Services Remain Non-Responsive to Service Users

- Service providers are not accountable to service users but rather to a distant and centralized bureaucracy.
- The normal supervision system within the bureaucracy which could have helped to enforce accountability has broken down.
- Facility managers have little training and independence in decision-making.
- Support services such as drug supply etc. are managed by a part of the ministry bureaucracy which is beset with corruption and lengthy procedures.
- The health bureaucracy suffers turf battles and other forms of infighting.
- There is little coordination between the two health service delivery organizations within the ministry i.e. the Directorates General of Health and of Family Welfare.

Source: World Bank 2005: 24-25

On the other hand, the literature claims that NSPs have proved to be more efficient in delivering basic services to the poor through well articulated policies and management. The comparative advantages of NSPs to government are said to be:

NSPs in Health Service Delivery

- NGOs have a base at grassroots level and have better knowledge of the community;
- NGOs has network all over the country to serve all segments of the population.
- NGOs have a large number of *karmis* with access to the fur flung areas of the country;
- NGOs have developed good expertise in the delivery of PHC and also in certain other areas which include TB, leprosy, immunization, family planning etc.
- NGOs are innovative in linking health services with credit and other services.
- NGOs are effective in training, developing BCC and IEC materials which have an impact on health service provision.
- NGOs are relatively efficient in the utilisation of funds.
- NGOs are more innovative in ensuring participation, gender equality and accountability.
- NGOs' health service provision is less bureaucratic and efficient.
- NGO services are affordable and within reach of the poor.

Source: Compiled from literature review

During the mid 1990s, development partners have become increasingly interested to involve NSPs in providing basic health services. There has been an increasing attempt to involve NSPs in policy dialogue, programme formulation and implementation. There have been instances where NSPs, and civil society more generally, have participated in policy discussion and formulation of HPSP, HIV/AIDs policy and UPHCP. NGOs have also played an important role in the formulation of the National Drug Policy in the early 1990s and also in the National Health Policy (Chowdhury et al 2004:25).

The involvement of NGOs in the implementation of large donor funded health projects has shown a significant increase in recent years. The HPSP, HNRP, UPHCP, HIV/AIDS prevention and Care and Tuberculosis Control are a few major examples of these projects, where special project mechanisms were created for the involvement of NGOs in the implementation process. NGOs have become crucial players in provision of basic health services to the poor. They have proved effective and efficient in reaching out to target groups, who are mostly poor and live both in the rural and urban areas. NGO programmes are mostly at grassroots level and community based. They tend use community health workers who have good access and rapport with the community and are able to provide door to door services.

A large number of NGOs have collaborated with government in a number of important health care projects. These include diarrhoeal disease control, distribution of vitamin A capsules for blindness prevention, tuberculosis and leprosy control, and nutrition. The success of immunization programmes is cited as an example of fruitful government-NGO collaboration. NGOs have also proved effective in disseminating health messages through grassroots level initiatives. There are examples of NGOs using their micro credit groups to disseminate health messages, which has been found quite effective.

The HPSS which was launched in 1998 marked a radical departure from the previous government health plans for two reasons: 1) it moved away from a projectized approach to supporting the health sector towards coordinated donor support of a sector wide plan (Chowdhury et al 2004: 27) it recognised that proper coordination and implementation of HPSS would require effective sector wide partnership between the government and NGOs. In the Project Implementation Plan (PIP), 10 broad principles for government-NGO collaboration were spelled out (World Bank 2006: 25). The PIP listed a total 14 different areas of activities where NGOs were to be utilized. Some of these areas are related to Behavioural Change Communication (BCC), service delivery, training and research.

Another key strategy of HPSP was the establishment of a new tier of health facility at the village level called the “Community Clinic”. Although community clinics were an important new tier of health facility at the village level, they remained ineffective for some time and in 2003, the MOHFW asked three intermediary NGOs to take over the management of the clinics on a pilot basis. Six community clinics were contracted out to NGOs by BPHC to develop an effective, sustainable and replicable model of community clinic that could be rolled out on a national basis (Chowdhury et al 2004: 34).

Government was involved in the contracting process in different ways. At the national level, MOHFW assigned areas where NGO services were required, government officials participated in the tendering process and also received quarterly progress reports from the BPHC. At the district level, partner NGOs reported to the civil surgeon and to the Upazila Health and Family Planning official. NGOs received important support from government both at the national and local levels (Chowdhury et al 2004: 10). BPHC as intermediary demonstrated that an NGO programme could provide ESP services effectively to a large, widely distributed rural population, achieving high coverage and relatively good health outcomes (Mercer et al 2004: 196).

A DFID funded research report (Chowdhury et al 2004: 43) describes the NSPs’ performance in the health sector as follows:

“The NGO sector has grown considerably over the last decade and is taking on an increasingly important role in health care provision. It has many advantages over the public sector, including the willingness to serve in remote areas, and ability to target and reach the poor, facilitate community participation in health care planning and management, and address health needs of special client groups, such as sex workers and men who have sex with men”.

Section 4: Education Sector: Non-Formal Primary Education¹⁰

The Context

While the government is the main provider of education in Bangladesh, NSPs play an important role, especially for those in remote areas or with particular needs. Currently there is a variety of providers of primary education in addition to government, including the private sector, communities (through Registered Non-Government Primary Schools), faith-based organizations, and NGOs (Chowdhury et al 2004: 46).

The provision of primary education by NGOs, CBO and philanthropic organisations began in a scattered and very small way in the aftermath of independence during the relief and rehabilitation phase of NGO development (Alam, 2007). NGOs became particularly visible in the education sector when they emerged as significant players in the socio-economic advancement of Bangladesh from the mid-1980s. Initially, NGOs’ programmes remain limited to adult education and eradication of illiteracy. However, they were given an impetus when the government declared a Compulsory Primary Education Policy in 1992. This policy led to an expansion of primary education and also to an awareness building campaign to increase enrolment.

¹⁰ Three documents were very useful in preparing this programme profile. These are: the research programme guidance note by Pauline Rose, Chowdhury et al 2004: 46-67, and World Bank 2006. .

State Provision of Primary Education

Government is the main player in the education sector. Government policies and programmes are formulated and implemented by two ministries. These are the Ministry of Education and the Ministry of Primary and Mass Education. The MPME operates under the direct control and supervision of the Prime Minister. One advisor who enjoys the rank of State Minister looked after this ministry during the immediate past regime. There are two directorates under the MPME: the Directorate of Primary Education and the Directorate of Non-formal Education. The latter ceased to exist in 2003, but a new institution known as the Bureau of Non-formal Education (BNFE) was created in 2006. At the district level, the main government officer of the education ministry is the District Education Officer, in addition to whom there is a District Primary Education Officer. The District Education Officer looks after secondary and madrasa education. At the Upazila all activities relating to education are under the supervision of the Upazila Education Officer (UEO). At the primary level, most children are enrolled in government primary schools. However, an estimated one-quarter of the total enrolment is with Registered Non Government Primary Schools, which receive most of their funds from government

NSPs in Primary Education

NGOs have become important actors in the education sector, particularly since the mid 1980s. Their activities are mainly associated with adult literacy, non-formal primary education (NFPE), in recent years the private sector has also become important especially secondary, college and university education provision. A particular characteristic of private schools and universities (there are currently 54 universities) is provision in the English medium. The private sector in Bangladesh is creating its own space and emerging as an important actor in the education sector.

It is estimated that around 8% of all currently enrolled primary students are in NGO schools. The total number of children enrolled in these schools is 1.5 million, of whom the vast majority (1.2 million) are enrolled in BRAC's network of around 35,000 non-formal primary schools (World Bank 2006: 29).

NGOs are best known for their 'non-formal primary education programme'. Even though the term continues to be used, many NGOs in Bangladesh now prefer not to use the word 'non-formal' to refer to their education programmes, preferring to see them as part of regular primary education¹¹. The present tendency of NGOs is to focus on primary-aged children in a 3 - 4 year cycle with the ultimate aim of making them eligible for admission into government secondary schools.

A large number of NGOs use materials produced by the National Curriculum and Text Board (NCTB) in their schools, following the government curriculum and materials through classes I, II and III, thus allowing their pupils to transfer to secondary schools. A major concern of these providers is whether their students will be able to continue their education at the secondary level.

Until 1997 NGOs used books and materials supplied by NCTB free of cost. But in 1997 the government suddenly stopped the free supply of books to NGOs. Since then some large NGOs (i.e. BRAC, DAM, FIVDB and Proshika) have been producing their own reading materials and many other NGOs began to use these in their NFPE programmes. The

¹¹ This was revealed during the interviews with VERC, CAPME, SEVA and BRAC.

government resumed supplying books to NGO schools free of cost due to the personal intervention of the Prime Minister, and the NGOs (for example, Ghasful in Chittagong) that follow the government curriculum are again receiving the NCTB materials free of charge. In order to be eligible for books NGOs are required to apply through CAMPE which forwards applications to the Ministry of Primary Education. The ministry then sends these applications to the Upazila Education Office and, after verification, the books are supplied to NGOs from the Upazila Education Office.

The Campaign for Popular Education

Approximately 700 NGOs are enlisted in the Campaign for Popular Education (CAMPE), set up in 1991 as the umbrella organization for NGOs involved in education. CAMPE is a networking organization and recently moved to adopt a role of policy advocacy to government and donors. Its member NGOs are involved in adult education, child education services, pre-primary education, and primary education. Some NGOs are also involved in providing support services such as teacher training, curriculum and materials development.

CAMPE realised that, if they were to campaign successfully with government, they would need evidence to support their advocacy. So from 1996 CAMPE took the initiative of undertaking research to assist policy advocacy engaging educational experts, civil society, ex-bureaucrats who worked in education and implementation agencies and ex-teachers. In 1999 the first issue of *Education Watch* was published and six reports were published in the following nine years. These include different language versions, emphasizing accessibility so as to capture the attention of policy makers and other involved in education.

The first report (CAMPE, 1999) gave rise to a huge debate. Initially government rejected the facts presented. From the 2nd edition onwards, the government acknowledged that, though the report might not reflect the government's view, it raised issues that the government needed to respond to. The tension has reduced since the Ministry of Education itself took on the role of launching CAMPE's Education Watch reports. So, though there is disagreement in some areas, there is now a move towards joint commitment.

For the World Bank-funded Reaching Out of School Children (ROSC) programme the government and World Bank decided that CAMPE would play an independent monitoring role, but later due to the need to comply with service procurement rules they asked CAMPE to submit an expression of interest. Over a period of 18 months, they then identified NGOs to provide services through the ROSC programme without consulting CAMPE. CAMPE threatened to withdraw on the basis that it could not monitor NGOs without being involved in the selection process. World Bank requested CAMPE not to withdraw from the programme, and had a series of discussions with CAMPE, who has now become more involved.

Non-Formal Primary Education

According to interviews at CAMPE, BRAC and SETU, there are many reasons, summarized in the box below, why NGO NFPE programme are widely recognized and valued.

Reasons for Valuing NGO NFPE Programmes

- Wide coverage including of school drop-outs, poor and deprived households.
- Education that emphasizes literacy, numeracy and social studies.
- Inclusion of English at the grade II and III levels.
- Low cost of managing the schools.
- Provision of training for teachers both at entry and in-servicing.
- Non-salary expenditure of NGO primary schools is far larger than in government primary schools.
- High attendance and low drop-outs.
- Recruitment of teachers from the local community having knowledge of local culture and environment.
- Existence of co-curricular activities (such as singing, dancing, drawing) as part of curricular activities.
- Community participation in conducting the activities of NGO schools.
- Intensive supervision and continuous monitoring.

Source: Interviews at CAMPE, BRAC and SETU

NFPE programmes of NGOs are implemented in three main ways. 1) directly by individual NGOs (including both large NGOs such as BRAC, as well as small, independent NGOs); 2) as contractor of government and 3) as a partner of large NGOs and particularly BRAC. Under (1), some NGOs in Bangladesh implement their own small education programme from their own revenue. These NGOs mostly use curriculum and materials developed by big NGOs.

Government Contracting of NFPE

Government and NGO collaboration received a new impetus with the establishment of Directorate of Non-formal Education (DNFE) in 1995. One of the main implementing strategies of DNFE was outsourcing to or contracting of NGOs. The activities included in this group were based on two programmes – the Centre-based approach (CBA) and Hard to Reach Basic Education for Urban Working Children (BEHTROC). A large number of NGOs were contracted to implement the NFPE programme, although large NGOs such as BRAC remained independent of this. However, questions were raised whether the contracting out by DNFE was done in a correct and transparent way. Indeed later it was found that three quarters of NGOs fell short of the eligibility criteria, some did not even have any experience. There were also serious allegations of mismanagement of funds and monitoring problems. For these reasons, government discontinued the activities of DNFE and it ceased to exist from 2003 (Ahmad and Lohani 2004). The problem with DNFE has been summarized in the following way:

“Due to systematic deficiencies relating to operational aspects including NGO selection and financial management, DNFE failed to maximize the use of the available resource to the benefit of the programme. DNFE was established as a government directorate working directly under MOPME and hence did not have any organizational autonomy defined in terms of degree of freedom from the supervising Ministry. DNFE management was weak especially in policy formulation, planning, monitoring, and evaluation. There was no environment for learning, vision or leadership in the organization to take up these challenges. (Ahmad and Lohani 2004: v)

The government is now reviving DNFE's activities by creating a different management structure through the establishment of a Bureau of Non-formal Education. BNFE received legal recognition through a government gazette notification in February 2006. It is not clear how the new arrangements will avoid the problems identified with the DNFE.. For example, on the issue of outsourcing, it is stated in the government gazette that, "whenever needed, outsourcing of technical support, training, materials development, assessment and evaluation and other activities through cooperative partnership relationships with academic and research organizations, capable NGOs, various government agencies and the private sector will be done".

Partnerships between NGOs for NFPE

The Education Support Programme (ESP) of BRAC is the largest programme of collaboration of large NGOs with small NGOs in the NFPE programme¹². The ESP concept stems from the idea of reaching out to more children using the NFPE model by working with smaller partner NGOs operating in areas of Bangladesh which BRAC's education programme had not reached. According to a Government Notification of 8 February 2006, the goal of ESP is "to expand education opportunities for disadvantaged children through partnership with small NGOs and provide them with technical and financial support to implement BRAC's NFPE model with adaptation as needed".

The ESP programme started in 1991 and currently BRAC is supporting the activities of 624 small NGOs. These small NGOs are running 5,500 schools in 359 upazilas of 63 districts. The partner NGOs for ESP is selected following certain criteria, ranging from legal compliance to location and size. Four specific criteria that are worth mentioning are:

- NGOs must be motivated and accept the whole NFPE model of BRAC.
- The NGO should be small and working in a union, upazila or district.
- NGOs headed by women and persons with ethnic minority communities get preference.
- The NGOs must be secular and follow a secular approach to development.

In the ESP, BRAC provides different types of support to partner NGOs to enhance their capacity to run NFPE schools effectively and successfully. There is support on: school organisation, teacher training, staff training, classroom management and instruction, community participation, development of curriculum and materials, resource allocation and financial management, and progress monitoring.

One of the major challenges of NGOs working in the NFPE programme is mainstreaming children into government provision in both primary and secondary schools. A World Bank report states that "coordination between government and NGO education programmes in primary education remains weak. NGO schools are not formally recognized in official statistics on primary education. Since the closure of the Department of Non-Formal Education, there has been no mechanism to coordinate government-NGO activities". (World Bank 2006: 31)

The executive directors and directors of several NGOs mentioned that mainstreaming of NGO school children was a serious problem, but all of them mentioned that they had taken care of the problem locally through their own initiative and influence. We were told that ESP had been working to complement the GoB primary education programme. A BRAC report claims that 98% of the children belonging to ESP schools are later admitted to formal government primary schools. However, the number of students seeking admission

¹² The following discussion on ESP is based on BRAC 2005 which contains discussion on BRAC's ESP programme

to the government primary schools far exceeds the places available in those schools. This is a crucial issue and should be pursued in the case study phase of this research. Furthermore, NGO officials revealed that they faced problem in getting NCTB books for their. NGO officials suggested that since NGOs an important provider of basic education, government should formulate a policy regarding the relation between government and NGO education programmes.

Donor Involvement¹³

NGO education programmes largely depend on external financing. Donor financing of the education programmes of large NGOs has remained relatively stable over recent years. Annual disbursement to the eight largest NGOs was 1,479 million taka in 1998-99 increasing to 1,786 million taka in the year 2002-2003, and averaging 1,765 million taka annually over five years¹⁴ (World Bank 2006: 89). This dependence on external financing for a basic service like education raises a concern about sustainability. ADB, World Bank, DFID, UNICEF and SDC are the major external players in the education sector.

¹³ Based on World Bank 2006

¹⁴ US\$ 1 = Tk. 69.50

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