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INTRODUCTION

1. Problem perception
2. Core development concept
3. Profile of DSK
   a. Genesis
   b. Present objectives
   c. Target group
   d. Programme components
   e. Programme area
   f. Sources of fund
   g. Administration
   h. International relation
4. Social impact
5. Conclusion

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Problem Perception:

Grinding poverty, environmental degradation, and population problem facing the world. In Bangladesh the scene is chronic and increasingly acute.

The problem of poverty in Bangladesh remains no less significant today than it was at the time of its independence. Its percapita income, $ 170 in 1990 is one of the lowest in the world. Bangladesh is the eight most populated country of the world, where about half of its population live below the recognised poverty line. Deprivation of poor is primarily related to absence of command over resources. Landless and functionally landless houselolds constitute 59 percent, marginal and small land owners account for an additional 31 percent of the total peasantry. Lack of land emerges as a major initial disadvantage for the rural poor. On the other hand, limited access to institutional credit mechanisms makes rural poor vulnerable and dependent on usurious money lenders. Vulnerability of the land-poor households eventually leads to disinvestment of assets. This underscores the need for timely supply of credit to marginal farmers and landless poor groups to increase employment options.

However, lack of income earning opportunities in the rural areas is accelerating the stream of people coming to the urban centres in search of work. Dhaka was made capital of the then East Pakistan, (now Bangladesh) in 1947, its population was then only 0.25 mln. After liberation war of 1971 when it became the capital of the sovereign state of Bangladesh, its population had risen to 1.68 million (1974). Currently the total recorded population of Dhaka city is about 4.5 milion which spread over an area of 160 square miles (416 square kilometres). With this population, the metropolitan city of Dhaka has absorbed 30 percent of the total urban population of the country. By the year 2000, the population of Dhaka is expected to be more than double the present figure, growing to over nine million. Thus Dhaka has experienced a rapid population growth at a pace of 11 percent year during 1974-81 period and it will continue to grow more in the future. This may be compared to the national population growth rate of 2.4 percent over the same period.

This rapid growth of the urban population is largely attributed to continuing migration from rural areas (the outmigration rate from rural to urban areas is estimated to be 1 percent per year). Population pressure, lack of work, diminishing land men ratio, lack of agriculture and rural development and frequent occurence of natural calamities, are pushing the landless poor into the cities. Their perception of employment opportunities is one of the major factors which is pushing the poor to the cities.

Slum Problem

As a result of the heavy influx of migrants, severe service deficiencies in the metropoliton city has already assumed alarming proportions. The expansion of infrastucture and services can not cope with the growth of the city, which is making about 40 percent of the city population to live in slums. These slums are characterized by very high population densities, inadedquate circulation systems, absence or scarcity of water supply or drainage systems, lack of sanitary toilets, high incidence of communicable diseases, high rate of infant mortalities and malnutrition. Absence of adequate sanitation and drainage cause health hazards (e.g. diarrhoeal diseases). Access to suffcient drinking water is

a dream to most of the slum inhabitants. Finding no allternatives, the dwellers struggle for survival in these slums. Slums are spread out all over the Dhaka city. Dhaka Municipality, the largest of five municipalities, contains 1135 slums of different sizes. The total population living in these slums has been estimated to be 2 mln. The rapid growth of slums population has become a major concern for the city dwellers. Not with standing the deplorable situation, there is a lack of realization and sincere political commitment on the part of the Government, of the urgency for slum improvement. Government officials and ruling political leaders have neither any ideas nor the curiosity to get to know the magnitude of the problem.

Gender Issue

Women are one of the most disadvantaged groups in terms of finding productive employment, partly as a result of the prevailing economic conditions in the rural areas and partly because of socio cultural factors. A typical Bangladeshi girl receives 2% fewer calories than her brother and is likely to be malnourished and attend school for one or two years only. Half the girls are married by 17 even though the minimum legal age for marraige is 18. Tradition keeps her mainly confined within the household. There are still a wide spread incidences of gender violence, wife abuse, divorce, abandonment, polygamy and dowry these exist as means of exploitation. This situation has not improved perceptibly overtime; A number of studies have documented the poverty and deprivations of women showing that women are poor not only because their household income is low, but also because of the diasdvantages arising from traditional gender biases, attitudes leading to unequal inter-family distribution of consumption. Women are found working for longer hours than men for equivalent work and bear much of the load of household work.

Whatever employment opporunities the poor rural and urban women may have are constrained by inadequacy of required capital. Women's income, supplement family income which they usually spend on food, improving nutritional status of both women and children. This positive input is quite enough to compensate for loss of calorie and protein intake by children of working mothers. Recent experiences by the women's programme under BRDB, Grameen Bank (GB) however show that rural poor women are able to substantially improve there income, through credit-based self employment programmes. Recently GB has started giving loans to groups of poor landless peasant women on a number of activities including rice husking which is very popular among these women.

Education

Over one third of the children of primary school going age are not enrolled. This has placed Bangladesh among those countries where access to basic education is limited. Largely as a consequence of low enrollment over two thirds of all adults are illiterate. Only one in three school going age girl is in school. Lack of basic education is a major cause to poor health practices and limited social and economic prospects. Female life expectancy is only 49 years.

2. Core development concept

The DSK is to put employment generetion at the core of development strategies. This country has been flooded by donor aids since 1971, but role of aid is still open to question. In view of this, DSK is propagating to make Bangladesh self-relient with core initiative from private sector. This is noted that growing private sector has got some unique potentials in comparison with others. Corporate sectors are professionally equiped with skills in the field of finance, management and marketing. In this connection our idea is to involve private indigeneous corporate sector in development issues, especially in employment generation. This idea in the field of development allternatives is relatively new. But if a economically workable relation between this two i.e. corporate sector and urban, rural poor can be established, and it may broadly ensure the following major things:

a. Employment for large section of people through local level small scale enterpreunership development.
b. This will increase buying capacity of a large section of our countrymen and thus skewed internal market can be expanded.
c. This approach shall earn a social prestige for local private sector.
d. Ultimately this approach can lead our country to a self-reliant status, where people will be able to taste the quality of life, which is a long dream of our fellow countrymen.

3. Profile of DSK

a. Genesis:

In response to the aforementioned circumstances in early 1986 a group of enthusiastic committed medical practitioners and social workers, launched a non-profit venture to deliver health services to Dhaka city slum dwellers, Prompted by their sense of responsibility towards the disadvantaged section of their fellow countrymen. This initiative ultimately led to the establishment of Dushtha Shasthya Kendra (DSK)

b. Present Objectives

1. To render primary health care and family planning sevices to the rural and urban poor, in general and women and children in particular.
2. To exploit all potential options prevailing at local level to generate gainful employment for the rural and urban poor, with special emphasis on expanding women participation in these income-earning ventures.
3. To channelise efforts in supplying various production inputs, Particularly disbursement of credit, to the rural and urban poor for realising the available employment generation opportunities.
4. To undertake illitracy eradication initiatives, including adult education.
5. To attempt improving the living condition of the urban slum dwellers, campaign about their right to live and providing shelter to those in need.
6. To launch relief and rehabilition to the affect in time of natural calamities.
7. To sensitise the corporate sector and local level community about their social role in the development process and encourage collaborative arrangements.

c. Target group

The target group of DSK remains to be landless and functionally landless as well as marginal farmers in rural areas. On the other hand, slum dwellers especially slum women and children constitute DSK target group in urban areas. Female headed households are given priorities while selecting strategy programme participants.

d. Programme Components

Present activities of DSK is divided into two major components, viz. The urban and rural components.

A. The urban component:

(a) Health programme

The core programme of DSK in urban slum areas of Dhaka city constituting of primary Health care and family planning (PHC-FP) DSK is presently operating its health programme through two primary centres located in slum areas of Tejgaon under Dhaka Municipal Corporation.

Location: a) Slums near Nakhalpara.
b) Begun-Bari slum areas.

1. Working hands: Two primary centres, operates one day a week, according to their own time schedule (e.g. on Thursday and Tuesday's).
2. Personnel: Six doctors (with MBBS and higher postgraduate qualifications) and eight health workers by rotation on volountary basis, run the primary centres regularly.
3. Number of patients: 45-50 on average are treated on every clinic day.
4. Drugs and other facilities: (a) DSK provide some medicines which they have collected, centrally, to the patients.

b) If need arises primary centres solicits help of specialists, who also render their services free of charge.
c) DSK supplies health cards to the patients.
d) Immunization.
e) Sanitation.
f) Installation of Tap Water or Tube Wells.
g) Assistance for surgical contraception.

(b) Non-formal Primary Education Programme: Three nonformal primary education centres in slum areas are run with the help of DSK.

(c) Skill Devolpment : So far, about 20 women were trained in income generation skills. Now they are involved in income earning activities.

(d) Shelter Programme : 1. Organization of campaign against evictions of the slum-dwellers.

2. To launch a pilot scheme for developing a new type of house structures using jute as a part of building materials.

3. To provide legal aid for protecting slum dwellers right to live, as basic humam rights.

B. Rural Component

Presently DSK is implementing a small project in Durgapur Upazilla of Netrokona district covering fifty poor peasant and landless women. The project has undertaken following activities:

a) Integration of local tribal women, especially from Hajong community in development process.
b) Awareness raising campaign about role of women in development process.
c) Motivation and group formation.
d) Organisation of self employment schemmes of above mentioned groups, through rice husking operation (difference between the price of paddy and rice shall make earning for them.)
e) Provision of PHC-FP, nonformal education for children and fuctional education for above-mentioned group.

Disaster management:

Following the unprecedented cyclone and tidal bore in southern part of Bangladesh, DSK has undertaken a relief and rehabilitation project in April '91, Which covered about five hundred families in two upazillas of the affected area.

Training:

DSK has introduced an one-day training programme for its volounteers; Mainly focusing on motivation, employment generation, PHC, nonformal primary education, family planning, community spirit solidarity feeling and organisation.

Publications:

Dushtha Shasthya Kendra (DSK) publishes a yearly journal in Bengali which expresses views on different development issues. First two issuse are already at hand. There is a constant drive to make the journal more regular and to have wider circulation.

e. Programme area

At present DSK operate in Dhaka city slums, Carries out income generating activities in Durgapur upzilla of Netrokona district and implements relief and rehabilitation project at Banshkhali and Anowara upazillas of Chittagong district. DSK plans to expand its activities in other areas in near future.

f. Sources of fund:

Apart from the own contributions of the office beares, DSK has received, small funds from a number of sources, viz local philanthropists, Rotary club of Dhaka Buriganga, Royal Netherlands Embassy Dhaka, SKN.

g. Administration:

The organisation is governed by an Executive Committee (E. C.) consisting

(which includes eminent physician, scientists, lawers, social workers etc) of 11 members. Day to day work of the organisation is run by motivated central staffs. They are closely supervised and guided by secretary general of the organisation.

According to organisational needs local units of DSK may be formed in project area. With the participation of people from near-by community. Local units function according to guidelines given by E.C.

h. International relation :

DSK has became an associate member of an International forum, named as CITY NET. A forum of NGO's organised by ESCAP which is engaged in solving human settlement issues.

4. Social Impact of DSK Activities

(a) Employment

Employment generation is the core develoment strategy of the organisation. Most of this employment shall involve women. In rural areas DSK stresses on nonfarm employment generation. On the other hand in urban slums it encourages small scale enterpreneurial activities and trading.

(b) PHC.-FP :

Primary health care operation has opened up some oppurtunities for urban slum women and children. Ultimately this shall run as a self-sustaining system through community participation.

(c) Women :

In the long term the involvement of women in the productive labour force and the equitable access of women to resources and opportunities will be the most important impact of DSK. To the extent that the pattern of house hold spending would be strongly influenced by women income earners, the household will spend more on nutrition, health, sanitation and education.

(d) Private sector involvement :

This is a relatively new development approach in this country. This strategy should increase purchasing power of the poor people, expand local merket. Since this strategy is essentially based on philanthropic initiatives of private sector, a successful implementation of the programme would also contribute to the social prestige of the indigenous business groups. This strategy may lay a path, to lead our country to a economically self-relient status.

(e) Human Settlement :

This is a vital issue for urban and rural poor. The problem is especially acute in urban areas. This organisation is interested in the rights of the poor to live in peace and dignity. Through actions it will be possible to lead our people to a new developed stage.

5. Conclusion:

Human settlement, primary health care, non-formal primary education, family planning and employment generation of rural and urban poor, wider participation of women in development process, are the prime concern of DSK.

To achieve above mentioned objectives sincere political committment from the part of Government is essential. We believe that a self-reliant strategy should be sought by the GOB for sustaining development process in Bangladesh, within the prevailing parameters of the economy and polity. There is a great deal more which can be done to utilise existng factors of production more fully and productively. The enhancement of the rate of savings, both programmed through policy and administrative intervention would be an issue of prime concern. The move towards self reliance would thus involve a major expansion in the role of the state in the economy in terms of policy and resource use and a considerable enhancement in the efficiency with investments for both public and privately managed sectors.

On the other hand, we believe it is impossible for government to take all necessary steps to pull out our motherland from the decades of underdevelopment. There should be sincere efforts from all quarters to salvage our motherland. In our proposition it should be named "as salvage operation." In line with this, private sector initiative in employment generation should be placed at the core of development allternatives.

In this connection we also propagate that concerned quarters especially GOB, NGOs, private sector and political forces, should reach to a minimum concensus, regarding the targets of, employment generation, education, health care and family planning objectives facing the country. Despite their differences of opinion and views, they should work together in above mentioned fields to pull out our motherland from underdevelopment and long time sufferings.

In absence of proper political committement and democratisation of our political institution, our organisation will continue its programme to achieve a minimum level of employment generation, primary health care, nonformal education and population control for urban and rural poor.

Bangladesh : Social and Demographic Indicators

Area:	143, 998 square kilometers
Population (1989) :	111 milion
Rate of growth	2.4 percent per annum
Density :	757 per square kilometer
Population characteristics :	
Life expectancy	51 years
Share of population under 15 years	45 percent
Infant mortality	111 per thousand
Crude birth rate	36 per thousand
Crude death rate	14 per thousand
Urban population	13 percent
Labor force :	
Total labor force	32 million
Females in labour force	7 million
Overall participation rate	29 percent
Health:	
Population per physician	5,210
Population per hospital bed	1,204
Income distribution (1982):	
Highest quintile	42 percent
Lowest quintile	12 percent
Poverty incidence (1985/86) : 2	
Rural population	51 percent below poverty line
Urban population	56 percent below poverty line
Land ownership (1978) :	
Owned by top 10 percent	
Access to piped safe water (1985):	
Rural population	49 percent
Urban population	24 percent
Nutrition (1983) :	
Average calorie intake	84 percent of requirement
Per capita protein intake	42 grams per day
Education :	
Adult literacy	33 percent
Primary School enrollment	52 percent

Sources: World Bank, Social Indicators of Development, 1990

1. Unless otherwise indicated, data presentence refer to 1987/88.
2. The poverty line is defined as income required to meet the cost of a daily food purchase of 2.122 calories.