Health Sector Strategy
[2009 – 15]

Strategic Vision:

Envisioned an enabling society with appropriate health care by acknowledging entitlement and increase access to the private and public health services in need.

Strategic Benchmark:

By 2015, 50% disadvantaged people in the target areas would have reduced health risk through increase access to quality services as per entitlement.

Increased public and private sector human and financial resources and enhanced institutional capacity.

Key organizational units of health management in DAM are equipped with professional capacity, decentralized planning and adequate quality assurance measures.

Dhaka Ahsania Mission
2009

Contents

1.0 Introduction

Dhaka Ahsania Mission has adopted perspective plan (2006-2015) as a strategic guide for program development in different sectors directly targeting poor distressed and disadvantaged people spread over the country. DAM's vision of the desired future of the disadvantaged communities of Bangladesh is reflected by their improved living conditions in social, economic and spiritual sense. DAM would reach its vision through increased access of the target communities to public and private services in the four interconnected areas of Lifelong Learning, Livelihood Development, Health and Human Rights & Social Justice with Environment being a crosscutting area. These four intervention areas will be considered as four core sectors during this Perspective Plan period.

This strategic document on health sector for next six years from 2010 to 2015 will be used for increasing access to health services. During the preparation of the strategy paper the working team has considered the context of health in Bangladesh including MDGs and PRSP's objectives. The main objective of the health strategy is to reduced health risk for improved quality of life and livelihood. In the strategy development process, the government initiatives of Bangladesh, concern of DAM's founders regarding health and thoughts of Perspective Plan of DAM (2006-2015) the Sectoral Strategy Paper on Health was also considered. On the other hand different aspects were also considered to develop the Sectoral Strategy Paper of Health which includes- health context of Bangladesh, excellence and track record of DAM in relation with health issues, programmatic approach of DAM, target population etc. It also includes- program coordination among the inter division or inter sectoral program of DAM and monitoring mechanism.

2.0 Health Context in Bangladesh

The ***constitutional commitment of the Government of Bangladesh*** is to provide basic health and medical requirements to all people in the society. The Constitution of the People's Republic of Bangladesh ensured that "Health is the basic right of every citizen of the Republic," as health is fundamental to human development. According to Articles 15 and 18 of the Constitution of Bangladesh access to healthcare is ensured for every citizen of the country. Bangladesh has a fair complement of well-designed public health strategies and policies, such as

- National Policy for Safe Water Supply & Sanitation (NWSS Policy), 1998
- Sector Development Framework (SDF), 2004 and Sector Development Plan 2005
- HIV/AIDS Strategy,2004
- Population Policy 2004
- National Sanitation Strategy 2005
- Maternal Health Strategy-2001 and Adolescent Reproductive Health Strategy-2005
- The Pro-poor Strategy for Water and Sanitation 2005
- National Health Policy (of which a revision has been drafted) 2006,

In the last 37 years of our Independence there has been significant progress in basic health. The health plans of the country emphasize Primary Health Care (PHC) as the key approach for improving health status of the people. The roles of the individual, family and community are emphasized in the intensified action programme for PHC implementation, which involves decentralized planning at Upazilla and union level.

The World Health Organization ***defines health*** as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Many factors influence health status and a country's ability to provide quality health services for its people. It is well recognized that health is an issue of socio-economical as well as biomedical, where

education, social rights, livelihood options play supplementary and complementary role in the fight against poverty. Health including population planning, nutrition and sanitation has been emerged as a special thematic sector in *PRSP* of Bangladesh, which address 5 MDG goals (out of 8 goals). The eight Millennium Development Goals (MDGs) build on agreements made at United Nations conferences in the 1990s and represent commitments to reduce poverty and hunger, and to tackle ill-health, gender inequality, lack of education, lack of access to clean water and environmental degradation. The issues have been translated into Health Nutrition Population Sector Program (HNPSP) for action in reaching the MDG targets.

Bangladesh has made significant progress in health outcomes. Infant and Child mortality rates have been markedly reduced. Control and prevention of diseases, such as measles, poliomyelitis, and diphtheria along with widespread use of ORS for diarrheal diseases have greatly reduced childhood mortality and morbidity. Life expectancy has risen steadily. Reversing past trends, women now live longer than men. The total fertility rate (TFR) declined significantly. Maternal mortality and under-nutrition rates, though still very high, are registering decline. Leprosy has been eliminated nationally. Case detection and treatment cure rate for tuberculosis has progressed significantly. HIV prevalence is still very low. Development of countrywide network of healthcare infrastructure in public sector is remarkable. Following description is presented on some major areas as health context in Bangladesh.

2.1 Situation on Water and Environmental Sanitation

Water: Bangladesh has made commendable strides in improving access to safe water. About 96% of the people drink tube well water. However, the majority of these do not have a proper platform and drainage, jeopardizing the current claimed level of access to safe water further. Surface water is the traditional source of water in Bangladesh but high pathogen, agro-chemical and industrial loads render most surface water sources unsuitable for consumption without treatment.

Contamination of shallow aquifer has recently been identified as a major problem with about 25% of the population exposed to arsenic level exceeding Bangladesh standards (0.05mg/l) (NWMP, 2001). Excessive levels have also been found in the South West and part of the North West, North East and North Central regions. Government has certified several household filters that use a variety of technologies for arsenic removal. GoB and NGOs have achieved some success in creating general awareness on the negative health impact of protracted ingestion of arsenic. Arsenic mitigation program and technical mitigation options are still limited in Bangladesh. Generally, water scarcity is a dry season phenomenon when the availability becomes less than the demand, or the quality of the water restricts its use. Shortage of safe drinking water will impose hardship to women and children those who are responsible for collecting the water for the family. Increasing saline water also will make health hazard for the pregnant women.

Issues to be addressed in Water

- Reduce contamination of surface water and technologies for consumption of surface water.
- Appropriate technological options considering geo-hydro geological context and mitigation options considering climate change.
- Integrated Water resource management at local level for managing demand and supply in the dry season.
- Operation and Maintenance (O&M) of installed options.

- Incorporating adequate environmental considerations in project planning, designing and implementation in line with various government policies and research findings.

Environment Sanitation including waste management: The striking 2003 Baseline Survey findings led the government to launch the National Sanitation Campaign to achieve a rapid progress in sanitation as a whole (from 33% in 2003, increased up to 88 % by 2008). In 2004 the government earmarked 20% of Upazila ADP grant for Sanitation and kept it at the disposal of Upazila and Union Parishads. It further earmarked 25% of this allocation for the 'software' and the 75% for the 'hardware' subsidy for the hardcore poor. As a result of these moves along with the political commitment the country has now been able to achieve 85% coverage at the end of June 2009. During the attempts of sanitation Government supported NGOs and privet sectors as well to work with common goal. This initiative create environment to work of Local Entrepreneurs (LEs) for playing vital role to make sanitation services available to the public doorstep and creating sanitation demand among the community people.

Total sanitation requires a profitable solution of rural waste management which can be done by promoting biogas, composting and vermin-composting. The options that have two way benefits for sanitation development and fertilizing the agricultural lands, need to be promoted. But there is no reliable data on environmental sanitation. Nonetheless it is generally recognized that only a small fraction of the solid waste generated in urban areas gets collected. Most urban centres have only a few drains that are seldom maintained; wastewater flows untreated into ditches, low lying areas or open water bodies. Except of these efforts there is no public system to manage latrine sludge. Sweepers empty and dispose latrine sludge according to convenience.

Major issues to be addressed in Environmental sanitation

- Awareness of the benefits of sanitation on health and economic productivity. This is reflected to large percentage of people resorting to open defecation or using unhygienic latrines.
- Appropriate latrine options particularly critical in haor, char, coastal or flood prone, low lying areas and hill including urban slums. Various sanitation options for emergency situation at the shelters, mobile toilets, pot defecation for children, pregnant women and aged people need to be available.
- Financial resources for having latrines in the households of extreme poor. (landless/ homeless, day laborer, households headed by disabled or non-earning persons). Amount of subsidy remains constant despite varying need at different places.
- Emergency preparedness program and emergency response plan on sanitation. Designate flood shelters e.g. schools, colleges, cyclone shelters and other public private institutions with adequate sanitation facilities.
- Adequate public toilet facilities in public places and city corporation areas. Improve solid waste management system and Fecal Sludge Management (FSM) for septic tanks or pit latrines need to be addressed.

Hygiene Practice:. Hygiene promotion deserves equal attention besides of latrinization. It is very much known that healthy practices prevents diseases, this because effective protection measure can be built up against the microbial contamination by breaking the cycle faecal –oral route. Behaviour change through hygiene promotion received less attention. Hygiene promotion is not simply a matter of providing information. It is more a participation of the community itself about hygiene and related health problems, to encourage improved hygiene practices.

There are many approaches for public awareness made by the different GO and NGO as well as individual initiatives to promote better health practices beside of installing sanitary latrines. Of which most common are community group discussions, where small groups are appearing with discussion meeting. Integrated program to improve hygiene practice is required which can contribute to establish social norms for behavioural change.

Issues to be addressed in Hygiene Practice

- Integrated hygiene program to address total community at household, school, hat-bazar and offices.
- Key hygienic messages package during emergencies.
- Key hygienic messages for specific group like HIV high risk group, ANC provider, family members of disable/differently able people etc.

2.2. Situation on Mother and Child Health Care

Maternal health (MH): Bangladesh has made progress in achieving maternal health goals, including MDG 5, with the MR of 332 maternal death per 1,00,000 life births in 1998-2001 (NIPORT et al, 2003). Antenatal Care (ANC) coverage is 51% (target is 55%). Skilled attendance at birth has increased slightly since 2004, largely due to increased use of private sector by the wealthier quintiles. The gap between the highest and lowest quintiles has increased. About 82% of women deliver at home. As per BDHSs finding it is found that one third of maternal deaths due to hemorrhage or Eclampsia or infections or obstructed labor or abortion.

Child Health (CH): Neonatal health and survival is closely related to care received by the mother before, during and after delivery and care of the new born. A large proportion of women each year deliver with no skilled birth attendants, and many more mothers and newborns go without any post-natal care during the most vulnerable days and weeks after birth. A key indicator is skilled attendance at delivery, which increased 18 percent from 13 percent in 2004. Interestingly, almost all of this increase was due to increase institutional delivery (from 9 percent to 15 percent). The children who received all vaccines increased percentage from 82% in 2007 from 73% in 2004. It is found from the survey BDHSs that the urban- rural difference was narrower, with coverage being 86% in urban and 81% in rural areas.

Postnatal care for women and neonatal care is low at 19%. Several reports both quantitative and anecdotal, testify to the poor quality of care in institutional facilities. Only 22% of children receive appropriate care within 24 hours of birth. Neonatal mortality is 37 (per 1000), according to the Bangladesh National Health Survey.

Reproductive health (RH): RH implies that people are able to have a satisfying and safe sex life and that they have the capability and freedom to decide their reproductive choices.

RH problems such as early and unwanted childbearing, HIV and other sexually transmitted infections, and pregnancy-related illness and death account for a significant part of the burden of disease among adolescents and adults in developing countries. The 1993 World Development Report showed that at least 13% of all DALYs were caused by RH problems. For women the proportion was 33%. RH problems are particularly concentrated among the poor who often lack access to minimal RH care.

The adverse consequences of poor RH and the benefits of good RH, extend well beyond health, and have an impact at the societal level. For example, early childbearing can have

negative health and social consequences for young mothers and lasting effects on their children. Good RH increases productivity and well-being.

Nutrition: Children born to unhealthy mothers are also more likely to be under weight and to have difficulty combating illness. They face an environment that is less able to provide safe and nurturing conditions that are necessary for their healthy growth and development. Poor nutrition leads to ill health and ill health causes further deterioration of nutritional status.. Sixty percent of all child deaths in 2000 were associated with malnutrition. But the children who die represent only a small part of the total disease burden due to nutritional deficiencies. Maternal malnutrition and inadequate breastfeeding and complementary feeding represent huge risks to the health of those children who survive. Vitamin A, iodine, iron, and zinc deficiencies are still widespread and are a common cause of excess morbidity and mortality, particularly among young children. In the region about half the under-five children are underweight; 15% are wasted; and, in low-income countries one in every three children at age five is stunted. The effects of poor nutrition and stunting continue over the child's life, contributing to poor school performance, reduced productivity, and other measures of impaired intellectual and social development.

Following matrix is presented as maternal health, child health and nutrition context with some major indicators: (*Source: BDHSs-2007)*

Indicators	92-1996	95-1999	99-2003	2002-06
Neonatal mortality rate/ 1000 LB	48	42	41	37
Infant mortality rate/1000 LB	82	66	65	52
Under-5 mortality rate/1000 LB	116	94	88	65
Indicators	92-1996	95-1999	99-2003	2002-06
Children's vaccination (%)	54	60	73	82
ANC by trained provider (%)	28	33	48	52
Delivery by trained person (%)	9	12	13	18
Children underweight for height (%)			17	13
Children underweight for age (%)			48	41
Total fertility rate (TFR)	3.3	3.3	3	2.7

Health Professionals: It is true that some of the progress is uneven and there still exists inequalities between different groups and geographical regions. A major constraint identified towards reaching health goals is the issue of shortages in the health workforce and the uneven skill mix. Moreover the number should have 60,000 doctors in addition to the 40,000 presently working (BHW,2008) in Bangladesh. Though there are Upazila Health Complex (UHC) at sub-district level with "comprehensive emergency obstetric care services" (EOC) service, with an expert gynecologist and Union Health and Family Welfare Centre (UHFWC) at all Union level, but unfortunately there is low utilization of most facilities at the primary level (Upazila and below) and over utilization of facilities at the secondary and tertiary levels.

Severe inadequacy of midwifery trained persons is a major constraint to increasing skilled attendance for births both at home and in facilities. A strategy for increasing midwifery skills in the country has been outlined and accepted. This is an important milestone. It now needs to move rapidly into implementation phases. The upward trend in use of emergency obstetric care is encouraging, but the gap between poor and rich is very great. Since the expected rate for caesareans is 10-15%, it demonstrates that the poor are not receiving care they need while the wealthier are being subjected to 'over-medicalisation' during childbirth.

Quality Health care services: The HNPSP recognizes the poor participation in local level planning and therefore focuses to pro-poor health planning with quality target services to poor and community people specially the underserved and underserved geographical areas. HNPSP has allocated 65% of Health Nutrition Program (HNP) resources for a package intervention delivered from "close-to-client" facilities or household level instead of previously arranged health services, which were used to go to better off people of the society. Unfortunately, still the gaps remain in health service delivery mechanism in accessing services by all.

On the other hand the PRSP says on "access to information that leads to opportunities that generate resources and hence information is linked to resource building. In this context, making information available to the poor people and people in remote areas and dissemination of information is essential. But lack of information deprives people from accessing government services that are causes of week transparency, accountability, and efficiency and equity in allocation of public resources.

– The major gaps identified are as follows: Service delivery points (SDP) are not available equally in everywhere (under served and unserved areas);

- Poor service quality of the health institutions and other service providers;
- Lack of right based/ demand driven services and information about health resources;
- Due to inadequate knowledge and awareness about Union Health service system, Union Parishads are not fully capable to monitor and support quality services to the population under its constituency.
- Lack of integration between WATSAN & Health program;
- Disorganized and inaccessible safety net for hardcore poor;
- Inadequate resource mobilization & coordination among SDPs;
- Uneven/ inadequate institutional capacity in delivering quality services to the community people and partnership for referral.

Issues to be addressed in Mother and Child health care

- *Health-sector governance* to improve effective and quality service delivery (especially in maternal and child health services).
- Effective *service delivery facilities* with approach to ensure extreme poor, so that they can take the service smoothly.
- Reduce unwanted pregnancies and the risk of contracting HIV and other sexually transmitted infections. Providing life coping skills including *RH education* for boys and girls.
- *Trained birth attendants* including health-related disaster management capacity.
- 24 hours *women friendly service facilities* where high quality antenatal and postnatal care will be available with skilled health professional.
- *Health safety net* for the extreme poor
- *Access to information* regarding effective health services.

Situation on Limited Communicable Disease Control

Infectious diseases--cholera, dysentery, diarrhea, measles, diphtheria, tetanus and poliomyelitis--and parasitic diseases such as malaria, filariasis, and helminthiasis-- were responsible for widespread illness and numerous deaths. Dengue fever, Malaria, Tuberculosis, Leprosy are also major communicable diseases needs to be addressed.

The increasing trend of drug use/abuse is alarming to the global society. Uses of drugs are increasing and Drug related crimes are aggravating over years, which range from the family

and society to the national and international levels. On the other hand, injecting drug use and addicted behavior are the causes of widespread infection of HIV. According to the last HIV sero-surveillance report (7th round-2006) in Dhaka, the HIV prevalence of IDUs is 7% and for the first time, the rate of HIV infection among IDUs was found to be 10.5%. It is estimated that there may be as many as 4.6 million Bangladeshis who use illicit drugs. While the vast majority of drug users are heroin smokers. FHI estimated in 2004 that there were at least 25-40,000 IDUs in Bangladesh.

Issues to be addressed

Threats of HIV/AIDS, particularly from Injectable Drug Users, pockets of malaria, kalazar and filaria and multi-drug resistant TB are also emerging as prior issues.

Situation on Limited Non-Communicable Disease

As per HNPSP the limited communicable disease control includes drug prevention, cancer prevention & control and mental health incorporation. Major issues are described in relation with the context of mentioned area:

Use of drug: Uses of drugs are increasing and drug related crimes are aggravating over years, which range from the family and society to the national and international levels. The geographical location of Bangladesh, bordering India and Myanmar makes it particularly vulnerable as a transit country for the trafficking of drugs. Currently, many narcotic drugs are diverted from the illicit drug market in India and smuggled into the country where they are abused. It is believed that the main exit points of narcotics are at provincial airports such as Sylhet and Chittagong and the main seaport in Chittagong (International Narcotics Control Board 2007 Report).

Cancer: Research has shown that up to two-thirds of cancer deaths are caused by smoking, physical inactivity and poor diet choices. So it can significantly reduce risk for cancer by improving diet, increasing physical activity, quiting smoking and getting screened. Tobacco use is one of the worst things for health. It is deadly and causes cancers of the lung, throat, mouth and esophagus, in addition to causing heart disease, emphysema and many other smoking-related health problems.

Mental health and disability:

For too long, mental disorders have been largely overlooked as part of strengthening primary care. This is despite the fact that mental disorders are found in all countries, in women and men, at all stages of life, among the rich and poor, and in both rural and urban settings. It is also despite the fact that integrating mental health into primary care facilitates person-centred and holistic services, and as such, is central to the values and principles of the Alma Ata Declaration.

Mental health is linked to physical health economic productivity, and employment and to other development issues. Too many people with mental disability are exposed to a wide range of human rights violations both within psychiatric institutions and in the community. Violence against women, alcoholism and HIV/AIDS are some of the areas where social pathologies interact with health problems.

Mental disorders affect hundreds of millions of people and, if left untreated, create an enormous toll of suffering, disability and economic loss. Yet despite the potential to successfully treat mental disorders, only a small minority of those in need receive even the most basic treatment. Integrating mental health services into primary care is the most viable

way of closing the treatment gap and ensuring that people get the mental health care they need. Primary care for mental health is affordable, and investments can bring important benefits.

Issues to be addressed

- Health education and a mechanism for early detection of cancer prevention.
- Integrated primary and mental health care services to care treated in a holistic manner.
- Awareness among the target groups about consequence of drug abuse.
- (still too long context)

3.0 DAM's Experience and Capacity

3.1 Issue based experience

- ***DAM Experience on Water & environmental sanitation***

DAM has been started work on the Water and Environmental Sanitation sector of the country since long. Safe water, sanitation and hygiene promotion were the three major agenda of DAM's intervention. The implementation of various projects of DAM has build up experience towards making sustainable and focused intervention in WatSan sector as follows:

√ The Water and Sanitation program of DAM has a diversified range of activities and approaches to serve the disadvantaged poor community including Hard-to-Reach in different areas of the country like coastal, hill, char and barind. From 2000 to 2009, DAM implemented large-scale water and sanitation programme for the people living in ***coastal areas*** covering 303 unions spread over 8 districts to increase the access to safe water, facilitated screening of arsenic and wider coverage of use of sanitary latrine and hygiene practices directly or indirectly benefiting 7.5 million people.

√ DAM has experienced during 2004 to 2009 to develop a sustainable Upazilla Total Sanitation model through strengthening ***Institutional capacity of the local government***, √ From 2006 DAM started work with the community in 8 sub-district of ***Chittagong hill*** who have different culture and socially behind in terms of water and sanitation practice.

√ DAM had a major thrust during last three years for introducing ***technology focused entrepreneurship development*** in WatSan service delivery. This included piloting of disaster friendly WatSan concept, improved sanitation technologies and arsenic free watsan options. √ DAM has also played a strong supporting role to Local Government Division through as a ***member of National Sanitation Taskforce*** in developing sanitation strategy, designing national campaign program, publication of rural sanitation catalogue and monitoring mechanism for assessing national sanitation coverage.

√ DAM WatSan Program is now spread over 48 upazillas of 19 districts ***covering 8.32 million people***. Through these existing WatSan program DAM has developed ***integrated hygiene promotion approach and participatory monitoring system*** at community, school and public places with the participation of LGD, government department of health, education and various level of sanitation taskforces.

- ***DAM Experience on Mother and Child Health Care***

√ Dhaka Ahsania Mission is working on mother ***child health and nutrition (MCHN)*** under SHOUHARDO Program. The main aim of MCHN is to prevent widespread malnutrition and related mortality in nutritionally vulnerable groups by providing supplementary ration for all pregnant and lactating women with children up to 2 years old of hardcore poor and poor households.

√ Illiterate women are deprived of access to basic health services. It has been widely recognized that if the female literacy rate is low, infant and maternal mortality rate tends to be high due to lack of knowledge about basic health care and insufficient health services for mothers and children. To overcome this situation, Dhaka Ahsania Mission implementing a project titled "supporting ***maternal and child health improvement*** and building Literate Environment (SMILE), with financial support from ACCU, Japan.

- **DAM Experience on limited communicable diseases control**

√ Recognizing the economical, familial and societal consequences of drug and keeping in mind the spirit of UN Convention against illicit trafficking in Narcotic Drugs and Psychotropic Substances in 1988, DAM launched a program for ***preventing the abuse of drugs*** in 1990 which is known as AMIC (Addiction Management Integrated Care).

√ Furthermore DAM is ***a member of the Framework Convention Alliance*** (FCA) and International Council on Alcohol and Addiction (ICAA). DAM has playing an important advocacy role in tightening policies in tobacco control by the government. In addition, various programmes are organized on the occasion of World No Tobacco Day and International Day against Drug Abuse and Illicit Trafficking and World AIDS Day to raise awareness among the common people.

- ***DAM Experience on limited non-communicable diseases control***

√ DAM has experience to work with prison inmates for ***HIV/AIDS prevention***. DAM has experience in some specific mentionable areas which includes; Long team treatment and rehabilitation including vocational training and job placement, Inpatient, Community and Home based detoxification, Managing STIs, VCT services, Abscess management, TB service, Providing emergency health care support, Formation of self help group, Outreach activities for preventing the spread of HIV/AIDS, Organize capacity building training and Materials development, Establish Smoke Free Zone, Awareness raising program on tobacco, drugs and HIV/AIDS , Advocacy with the policy makers.

√ Considering the importance of creating awareness and life skills to prevent HIV and AIDS, DAM consider incorporating the issues with Non Formal Education as one of the potential ways to reach the illiterate adult population. Considering NFE as the delivery channel, DAM has been implementing project titled "***Mainstreaming HIV and AIDS prevention in Non-formal Education in Bangladesh***" with financial support from UNESCO Dhaka. Under the project materials package for the NFE Facilitators, TOT to the Master trainers and project stakeholders have been developed. Through this initiative DAM will disseminate the messages to 1.6 million adult learners.

√ To reduce the traumatic situation of the rescued, repatriated victims, DAM implemented an integrated project called "***Quality Assurance in Mental health Care System for Survivors of trafficking and Violence***" in 2006. It was an

integrated intervention not only incorporated the development of the situation of the recipients' mental situation but also incorporated the techniques and methods to improve the delivery system of the services by the concern institutions. During the project period four training manuals were developed for the counselors and the care giver. There are eight organization from Bangladesh and four organizations from West Bengal took part in the project.

3.2. Approach based experience

- ***DAM Experience on Community Platform***

DAM is promoting community based organization through its Ganokendra (GK) approach. GK as people's organization would create an enabling democratic environment for its members and other community people to become aware to claim rights and increase their accessibility to private and public services for improved position and condition as human being. Community Resource (CRC) is a forum of Ganokendras and an institutionalized platform for root level advocacy.

DAM Experience on work with LGI

DAM has potentials to work with local government institutions which represent the local people and intends to promote them as functioning institutions through ensuring people's participation and local resource mobilization in the development actives. DAM has capacity to strengthen the institutional capacity of the local government bodies particularly the Union Parishads to play a steering role in ensuring community participation and coordinated efforts by the local stakeholders. In the health sector LGI can play a vital role to enhance accountability of service provider.

3.3 DAM's Capacity

- ***Material and Training Division of DAM***

The material and Training Division of DAM is working for building institutional capacity of DAM and its partner organizations. The division provides training on skills development of disadvantaged people for improving their livelihood. DAM's Training and Materials Development Division, manned with sufficient number of experienced and capable persons is taking care of the vast need of imparting training and developing of appropriate materials. On an average the training unit of it provides training to about 60 thousand persons in a year. The materials development unit has so far developed 384 materials, which is the highest number on part of a single organization. DAM materials are widely used in various GO and NGO programmes.

- ***Research Division of DAM***

This division works as a professional support and services unit to fulfill the growing demand for generation and systematic analysis of information in connection with the diversified development projects of DAM. The Research unit conducts various studies to provide support to various programmes of DAM as also to others. It also carries out advocacy activities primarily by disseminating research findings.

- ***Monitoring Unit of DAM***

Central Monitoring & MIS Unit (CMU) runs by a group of experienced professionals under direct supervision of Executive Director. CMU is comprised of two basic Parts such as monitoring and MIS. CMU has a prescribed guideline to monitor diverse Projects/Institute. CMU has been playing significant role in the area of monitoring of project as well as institute. In present DAM is going to introduce participatory monitoring system for across the organization. MIS facilitates vertical and horizontal flow of information across the organization through a series of activities assisted by MIS software. Knowledge management is in the process to be introduced in DAM by MIS in short future.

4.0 Sectoral Priority

The program package under health sector will be emphasized on need based and integrated quality health services. Priority will be given for ensuring accessibility and equity in healthcare, with particular attention to the disadvantage people. Following issues will be addressed as program priority under DAM Health sector considering health context in Bangladesh and experiences of DAM. **New issues under six categories may be included or excluded or integrated based on local situation of specific program areas.** The prior issues of health sector of DAM are as follows:

Prior Issues for health program
a. **Environmental Sanitation and Public Health :** o Water o Environmental Sanitation including waste management o Hygiene practice o Occupational health at work places
b. **Mother and Child health care:** • Maternal health • Child health • Reproductive health for Women, Adolescent group and high risk group • Nutrition • Health Professionals including Skilled Birth Attendants (SBA) • Quality Health care services
c. **Limited Communicable Disease Control:** • RTI/STI prevention • HIV/AIDS prevention
d. **Limited Non-Communicable disease control:** • Drug Prevention • Cancer prevention • Mental Health and disability

5.0 Strategic Framework of DAM Health Sector

5.1 Strategic Vision and Benchmark

Strategic Vision

Envisioned an enabling society with appropriate health care by acknowledging entitlement and increase access to the private and public health services in need.

Strategic benchmark

- By 2015, 50% disadvantaged people in the target areas would have reduced health risk through increase access to quality services as per entitlement.
- Increased public and private sector human and financial resources and enhanced institutional capacity.
- Key organizational units of health management in DAM are equipped with professional capacity, decentralized planning and adequate quality assurance measures.

5.2 Geographical priority

At present DAM has been working with selected community people to address the issues related with environmental sanitation and limited communicable disease.

- Special efforts will be made to scale up health program in geographically inaccessible areas and areas having difficult geo-hydrological conditions. On the other hand unserved poor and disadvantage community people, who are not getting quality health services, will be concentrated in the areas, through other programs of DAM such as education, livelihood and human rights are being implemented through integrated approach.
- The health service will focus primarily on community level either through direct service provision or capacity building of institutions and advocacy to increased access quality services.
- The emerging health needs will be targeted the existing working areas. DAM has been taking the initiatives of regional and area level program since 2006.
- DAM Program Regions in terms of geographical coverage will be preferred to launch new health program considering better Regional coordination. DAM's Regions, which is particular geographic cluster of Projects, Districts, Upazillas and Unions. There are six working region in DAM as follows:

Region	Covering District/Upazilla
Dhaka	Dhaka, Gazipur, Narsingdi, Manikgonj, Narayangonj, Munshigonj, Faridpur, Shariatpur, Gopalgonj,Sylhet, Hobigonj
Jamalpur	Jamalpur, Mymensingh, Netrakona, Sherpur, Kishoregonj, Sunamgonj,
Barguna	Barguna, Pirojpur, Jhalokathi, Barisal, Patuakhali, Bhola
Jessore	Jessore, Jhenaidah, Satkhira, Bagherhat
Rangpur	Rangpur, Nilphamari, Gaibandha, Kurigram, Lalmonirhat, Dinajpur, Chapai Nwabgonj
Chittagong	Chittagong, Noakhali, Laxmipur, Feni, Rangamati, Khagrachari, Bandarban

5.3 Core Strategies

The sectoral prior issues as mentioned in section#4, will be implemented/addressed in four program through 4-sub-sector as mentioned below:

i. Sub-Sector on Environmental Sanitation and Public Health Program (ESPHP)
ii. Sub-Sector on Mother and Child Health Care Program (MCHCP)
iii. Sub-Sector on Limited Communicable Diseases Control Program (LCDCP)
iv. Sub-Sector on Limited Non-Communicable Diseases Control Program (LNDCP)

Considering the people's participation, DAM has been developed a general approach with four strategic choices for across the organization to implement all development program. Health program implementation will follow the four-stroke strategy, which includes Community Capacity Building, Institutional Capacity Building, Advocacy and Service Delivery.

5.2.1 Community Capacity Building:

a. Creating Demand

Effective demand creation will be an integral part of DAM's implementation of Health strategy to increase access of health services for poor people. In the context of service provision, DAM will give importance to create demand by the community themselves rather generated by the outsider for the communities which will contribute to decentralized system at local level to make decision-making and management of resources meaningfully and accountable to the ordinary people who depend upon government services. Increase entitlement and access to the basic services could be increased by organizing people's voice under a people's organization platform and link them with other appropriate network. DAM will utilized its people's organization known as Ganokendra and Community Resource Center to create an effective demand of the services and to bargain and negotiate with public and private service providers for increase accessibility.

b. Community Participation

The core implementation process of DAM will through a highly participatory process which creates an opportunity for all men and women to raise voice in decision-making, either directly or through legitimate intermediate institutions that represent their interests. Such broad participation will built on freedom of association and speech, as well as capacities to participate constructively. Enabling environment will be created for all, especially poor community to access to knowledge, information and decision-making processes of the local level sector actors or service providers. This mutually accountable and transparent process of organizing people will help to protect the interest of the poor and disadvantaged and enable to create a social safety net to protect from all forms of violence and oppressions.

c. Institutionalizing capacity building

CBOs/Ganokendra/Community Resource Centers and other issue based action group/task force will be activated or formed where necessary within the community. Interested and potential people will be identified to develop capacity to act as catalyst under the CBOs. All community mobilization related activities would be implemented through community-based organizations popularly known as Ganokendra. DAM would facilitate to these GKs for

developing capacity to increase their consumer power over the govt. and other service providers at the local level.

d*. Collective claim and bargaining with LGIs & service providers*

DAM will facilitate both the LGIs and CBOs for networking and collaborating, so that they undertake joint initiatives with the poor communities to extrapolate optimum level of local resources. LGIs will engage for effective utilization of resources, in a consultative process with the existing service providers, CBOs and poor communities so that they collectively can judge, considering the socio-economic context and decide on the individual families that should be targeted for getting respective facilities. Creating and strengthening internal governance system as well facilitate the governance system of the service providers is an essential try out so that the collective bargaining power can be increased.

5.2.2. Institutional Capacity Building

a. Strengthening Institutional Governance (Accountability & transparency- RTI, citizen charter)

Capacity building would be the core strategy of DAM for developing knowledge and skill of local government institutions through training, workshop, exposure visit and on-the–job support to explore internal potentials of the LGIs and build their confidence level to lead implementation. Strengthening the transparent and accountable system within the local government institutions and other institutions working as duty bearer to provide services are core elements of the strengthening institutional capacity building efforts. These initiatives will enable the skilled persons to be more focused on LG structures, activities and role, good governance, people's participation and disseminate their attained knowledge among institutions and the community people. DAM will ensure, that the local government institutions are adequately involved, so as to ensure that the participatory planning and implementation at local level takes place with an enabling environment for all stakeholders' participation, which can be sustained, mainstreamed and scaled up.

b. Human Resource Development of the duty bearers

The strategy for integration of various human resources could help to contribute for greater implication in the community. Local level Teacher, religious leader, youth, children group, artists, cultural organizations and field staffs of local NGOs are regarded as good human resource for community mobilization and awareness creation. As said earlier that ensuring and establishing Human Rights and Social Justice is a complex dynamics, adequately sharing of information on relevant issues and clarity of roles are very important to develop the human resources within the duty bearers so that they can function with more accountability.

c. Develop Partnership & Collaboration

Partnership and collaboration among the stakeholders i.e. GO, NGO, Private sectors, among LGIs, private and public service providers etc. and community will be an important strategy of DAM to develop social partnership, work together for creating united movement directed to common goal, recognize comparative advantages and contribution of each stakeholder and to integrate efforts and resources owned by each stakeholders. In fact, the role of DAM would be to act as Facilitator to strengthen coordination and collaboration among GO-NGO, private sector and community people through sharing and consultation for ensuring the coordinated services and resource mobilization.

d. Joint Planning

Joint planning would be an important strategy for institutional capacity building and partnership development as well as collaboration among GO-NGO, civil society leaders, Youth, Children, private sector and community people at Union, Upazilla and District level. The main objective of this planning is to formulate strategies for achieving the desired objectives, to solve the problem, or to improve the present status in the Union/Upazilla by the participation of mentioned stakeholders. The output of the local level planning could be important input to national planning process especially national budget formulation, allocation of resources and safeguarding the interest of the poor and disadvantaged. As denial of rights of the poor and disadvantaged citizens from their right to live and livelihood are often been a reference point, the joint planning process may facilitate to listen the voices and opinions of the unheard and hard to reach people.

5.2.3. Advocacy:

a. Category based Advocacy

Advocacy is a pleading technique and support services that is used around the world by non-governmental organizations (NGOs), activists and even policy makers themselves, to influence policies. It is also about creation or reform of policies, but also about effective implementation and enforcement of policies. Advocacy is a means to an end, another way to address the problems that we aim to solve through other programming strategies. It is a combination effect of multi stakeholder's participation for persuasion towards the target considering the present context/problem.

DAM's present advocacy interventions can be categorized into four levels which include: 1. Grassroots or Local level advocacy, 2. National level advocacy, 3. Regional level policy advocacy and 4. International -level advocacy. Hence, the following actions must be in place for harvesting end result towards change:

b. Issue based Action Research

Design different action research on different issues related to the health. DAM perspective plan can be set up issue based longitudinal and cross sectional studies in the different short term and long term sector project implementation. Under the sectoral approaches, periodic researches and studies with cross-cutting issues can be planned to explore the new interventions or new options or risks identification or coping mechanism etc. for better living of pro-poor factors and environmental issues factors affecting the human lives are aprioristically acknowledge in the strategic advocacy planning. The research results plan to present through advocacy campaign and lobbying among the concern authority for remedial actions and further improve planning.

c. Coalition building and Networking

In most cases, the success of advocacy depends on the number of people support the particular case for advocacy. For this reason, it is essential to build coalition and strong networking among the stakeholders i.e. GO, NGO, Private sectors and community will be an important strategy of DAM to develop social partnership. Working together for creating united movement directed to common goal, recognize comparative advantages and contribution of each stakeholder and integrate efforts and resources owned by each stakeholder. In fact, the role of DAM would be to act as a Facilitator to strengthen coordination and collaboration among GO-NGO, private sector and community people

through sharing and consultation for ensuring the coordinated services and resource mobilization. DAM should lead the process through building a network of friends considering:

- Shared Ownership
- Participation and openness
- Mutual Accountability and transparency
- Gender Sensitivity
- Organization's Vision and Core Values

d. Policy Lobbying

Policy lobbying is one of the strategic approaches for obtaining the result of advocacy. Under this endeavor, DAM will have the opportunity to be involved in national as well as other levels. Multi dimensional initiatives can be undertaken to reach the targets. It is very important to maintain regular lobbying and advocacy relation with policy makers, government officials, politicians, development organizations, journalist and other concerned organizations. For building strength and forceful campaign along with service holders, DAM should make a liaison with multi stake servicing agencies to ensure the lobbying channel, ensure the performances of the channel through accelerating mobility and campaign of need based intervention in the name of advocacy. To run the policy influencing activities it is essential to have policy analysis, identify the loopholes, prepare policy briefing documents and disseminate it to the relevant stakeholders.

Means of Advocacy/policy lobby

There are various means for advocacy, some are mentioned below:

i. Seminar/workshop.
ii. Lobbying with the influential persons and meeting with relevant stockholders.
iii. Publication of materials on the subject of advocacy.
iv. Media, audio, video.
v. Community meeting and community mobilization

5.2.4 Service delivery

a. Need based service

DAM will take initiative to identify gaps in existing system of providing most essential health services in consultation with community and local service providers. Participatory program will be designed to provide need-based services in the gap areas and increase community service delivery facilities in line with DAM health sectoral program.

b. *Partnership program*

DAM must not plan to shoulder the responsibilities for ever, so from the very beginning, efforts will be directed to make the DAM services mainstreamed with the government services, government institutions like Union Health Complex (UHC) and Mother and Child Welfare Center (MCWC) start to function effectively.

DAM will facilitate to develop partnership among local government, government departments, local NGOs; civil society and private sector for reinforce the comprehensive intervention. Join hands of the concerned stakeholders would support respective intervention at the community level and also at the national level. In case of large scale program

implementation through partnership with local NGOs, DAM will build capacity of the partner organization and provide necessary technical support to them. In hard to reach areas, where there is no local NGO or CBO, DAM will explore partnership directly with UP.

As per government health strategy DAM will implement health education support to contribute in national health program jointly with Bureau of Health Education (BHE). In line with this DAM will provide school health education, hospital health education and service center based education through partnership arrangement with BHE, LGIs, local level health service providers and DAM's education and livelihood sector.

c. *Collaborative service with DAM institutions:*

Joint collaboration with Ahsania Cancer Hospital, VTI, AMIC treatment Center will be taken to provide for prevention of drug use, HIV/AIDS, cancer and mental health along with grass-root stakeholders and community as well. Joint effort will made with Disaster Management Unit to ensure health preparedness and emergency health services.

5.4 Stakeholders' roles

DAM will encourage for analyzing and determining the role before planning of each intervention according to the following definition of stakeholders of Health Sector:

Primary Stakeholders are those ultimately affected, either positively (beneficiaries) or negatively	Secondary Stakeholders are the intermediaries in the service delivery process. These stakeholders are also involved in decision-making processes.	Tertiary Stakeholders are those who can significantly influence or are important to the success of the program
• Beneficiaries • Mother (Pregnant and Lactating) • New born and Child • Adolescent/youth • Pole from DRR prone areas • Indigenous people • Disadvantaged, Marginalized, Poor & Ultra poor community • Trafficked children & women • Disable people • Drug user • HIV/Positives people • Elderly people • Arsenicosis people • Families of drug user • Local Entrepreneur • CBOs	• CBOs • Local NGOs • LGIs • Civil Society • Partner/Donor • Upazila Health Complex • Union base/community health clinic • Health Ministry • Education Department • Environment Ministry • Information Ministry • Ministry of Women & Child welfare • National Institute of Mental Health • Ahsania Cancer Hospital • DAM rehabilitation services centers	• Civil Society • Mass people of the country

6.0 Program Framework

6.1 Environmental Sanitation & Public Health Program (ESPHP)

Target Group: All community people in the targeted area and worker at industry, production house and clinic

Expected Results	Interventions
Poor and disadvantaged communities in selected areas have access to, and control over safe and adequate water, environmental sanitation facilities and are empowered to raise their voice to demand water and sanitation services from Government and other institutions.	**Community mobilization on Environmental Sanitation and Safe Water Services** • Community mobilization for latrine coverage at urban and peri-urban areas and public place in rural • Capacity building of CBOs/Taskforce and create demand for ensuring the services by the respective organization. • Community based situation analysis and prepare participatory plan to develop a community based management system to improve the existing situation. • Participatory monitoring
Enhanced institutional capacity of LG to increased public and private partnership, financial resources mobilization and improvement in WASH service delivery.	**Strengthening Institutional Governance and Partnership** • Advocacy meeting, exposure visit, training and planning workshop for building their confidence level to lead planning, implementation and monitoring. • Coordination meeting among GO-NGO, private sector and community people for ensuring all level stakeholders participation. • Joint planning workshop and consultation for ensuring the coordinated services and resource mobilization.
Promoted community based resource mobilization mechanism that contributes to address extreme poor for household sanitation facilities, water resource management, protection of environment and O&M of installed technologies.	**Local Resource Mobilization** • Facilitate community to identify the extreme poor and claim demand for water/sanitation facilities as per government policy. • Resource mapping and advocacy for utilizing the ADP allocation/ GoB subsidies and other fund mobilization for addressing the local needs. • Introduce community based operation and maintenance of water and sanitation facilities. • Develop advocacy capacity of local resources for social mobilization, root level advocacy to increase the yearly WASH budget through issue based campaign, cultural program and use of BCC materials. • Formation of management committee to ensure the O&M system towards sustainability. • Build network/coalition to move at national level towards environmental sanitation.
Developed technological options on water, sanitation including	Action Research and Technology Improvement

waste management and hand washing device considering geo hydrological context	• Promote rural based surface water treatment options, community based arsenic mitigation option and community based water safety plan. • Promotion of appropriate and improved sanitation options at household level along with Gender, disabled, disaster, child-friendly. • Promote ecological sanitation at rural community, public center, community clinic and industry by using improved waste management technologies. • Increase schools based water, sanitation and hand washing facilities, with separate facilities for girls along with menstrual hygiene. • Promote entrepreneur to available improved water and sanitation options in market places. Link with micro financing organization to support entrepreneurs for promoting improved technologies. • Awareness of the benefits of sanitation on health and economic productivity.
Provided support for emergency preparedness program to address WASH hazards during and post disasters and to increase the adverse impact on water and sanitation services.	**WASH preparedness and emergency support** • Awareness on WASH hazard due to disaster • Local level planning session for developing WASH preparedness. • Activate disaster management committee to raise fund emergency WASH support.
Improved hygiene practice maintained by all target communities through joint effort with the involvement of GO-NGO and private stakeholders to reduce health risks at community, school, hat-bazar and work places.	**Integrated hygiene education and behavioral change** • Hygiene education at community, school and public places. • Menstrual hygiene education for women and adolescent girls at school and community. • Campaign for food hygiene at household and public places. • Promote hand washing devices at household, school and public places • Awareness through education center • Promote basic levels of health protection at workplaces to decrease inequalities in workers. • Movement for access of all workers to preventive health services and link occupational health to primary health care. • Improve the knowledge base for action on protecting and promoting the health of workers.

6.2 Mother and Child Health Care Program (MCHCP)

Target group: New born and child under 6 years age, Mother (Pregnant & Lactating), Adolescent/youth, Indigenous people, disadvantaged, marginalized, poor & ultra poor community, Adolescent, Women, Drug user, Family members of drug user and Birth attendants.

Expected Results	Interventions
Community people are adopted in practicing improved behavior i) on quality MCHC ii) to reduce malnutrition among target people, especially children and mothers; and iii) empowered communities to increase their access to quality health services, claim quality health services and watch for quality services for MCHC.	a. **Community mobilization for MCHC and Nutrition** • Community baseline and situation analysis on MCHC and Nutrition • Community planning to get improve service for safe motherhood, child health care. • Identify the community practice and cause analysis regarding iron deficiency and anemia to make participatory preventive plan with adolescent girl. • Campaign for diverse food sources to rich in micronutrients and counseling on use of fortified food, and supplements including iodized salt, iron/folic acid and vitamin supplements, and promote micro-nutrient rich diets; • Consultation with local leaders to develop food security strategy, safety nets, including targeted income transfers, e.g., targeted food subsidies, food stamps, micro-credit, farm input packages. b. **Health Education** • Skills-based education on nutrition for adequate energy/protein consumption and access to/control over food for adolescent. • Education with adult and youth on reproductive health through learning centre. • Learning session on high-risk behaviors, particularly among youth and other high risk groups c. **Life skills and capacity building** • Life skills training on reproductive health and sexuality education to reduce risk behaviors associated with HIV/AIDS/STDs in schools or community learning center. • Develop health workers' skills *which include develop and adapt case management guideline, Train health providers at first level health facilities and referral level in standard case management* • Develop capacity of community people to organize and claim their rights and watch for quality services. • Local level task team development for taking integrated mechanism to improving nutrition status of all segments in targeted communities.
A social protection mechanism being evolved to support social assistance to the vulnerable people, risk protection against natural disasters and ensuring social equity in accessing health	**Support social assistance to the vulnerable people** • Mapping of social safety net services for the poor, vulnerable and marginalized people jointly with the service providing institutions, local Union and Upazila Parishad and community based organizations

and livelihood services	• Review workshop of ongoing social protection programmes, safety net measures by the public sector organizations • Promotion of legal protection services like offering para-legal support, legal counseling • Creation of community funds to mitigate sufferings during extreme vulnerability and disaster catastrophes.
Governance and service delivery capacity of the public and private health service providers strengthened and improved.	**Governance in service delivery** • Consultation workshop with service providing institutions. • Training for health standing committees of Union Parishad, CBOs and other committees to work with improved management. • Establish health budget monitoring for public and private service delivery of the service providers • Monitoring health facilities and services at Union and Upazilla centers and ensure accountability with peoples' participation • Mobilize local services provides for quality health service for taking Joint initiative by the existing government Union Health Centers. **Improving human resources in quality health services** • Consultation workshop for reviewing the existing health service delivery situation and create demand for improving quality of health care delivery services among the local service providers. • Capacity building program jointly with government institutions for the health staff and initiate performance based financing for encouraging quality services. • Strengthen the capacity of standing committees and Union Parishad and other committees of service providing institutions on community managed / community driven program planning and implementation. • Joint program with government or establishment of community managed static/satellite service delivery points to address the 24 hours women friendly services with the support of GK, CRC, Learning Center or IGA group. • Establish alternative health care services, such as ayurvedic, unani and Traditional Medicine.
Increased institutional capacity of LG to activate pro-poor and demand driven MCHC services with participation of local stakeholders	**Strengthening Institutional Governance and Partnership** • Advocacy meeting, exposure visit, training and planning workshop for building their confidence level to lead planning, implementation and monitoring. • Coordination meeting among GO-NGO, private sector

	and community people for ensuring all level stakeholders participation. • Joint planning workshop and consultation for ensuring the coordinated services and resource mobilization.

6.3 Limited Communicable Disease Control Program (LCDCP)

Target Group: Youth & adolescent, Drug user and HIV/Positives people, Family members of drug user and HIV/Positives people

Expected Results:	**Interventions**
Community people are adopted in practicing improved behavior on LCDC	**Comprehensive service** on **HIV/AIDS & DRUG Control (HADC)** Provide service to prevent the menace of drug and HIV/AIDS and HIV/AIDS risk behaviors which include: o Primary prevention o Risk reduction o Treatment and rehabilitation. Each of these also includes HIV testing and counseling **Peer based out reach activities** to reach out the drug users and the sex partners. **Drop-in centers (DIC)** will provide drug users and their sexual partners with sexual health education, health and counseling services, life skills training and distribute condoms. **Behavioral Change Communication** (BCC) through materials, using positive role models, demonstrate sensitivity to social and cultural norms and expectations and community outreach efforts to reinforce messages. **Need based rehabilitation services and Voluntary Counseling and Testing (VCT)** and STI treatment will be provided through treatment centers and referral services.
Skilled health worker are available to provide service on CDC	**Capacity Building Training**

6.4 Limited Non-Communicable Disease Control (LNCDC)

Target Group: Women an adolescent girl, Disaster affected community, Trafficked children & women, Disable people and Elderly people, Drug user and HIV/Positives people, Arsenicosis people

Expected Results:	Interventions
Community people are adopted in practicing improved behavior and enabled to demand for quality health services on LNCDC	**Mental Health Services (MHC)** • Awareness: About mental health and mental disorders, their causes and prevention, and the availability of effective interventions. • Counseling: Counseling for common mental health problems, adolescent group, disaster affected community, trafficked children & women, disadvantage-marginalized women, disable people, drug user, HIV/Positives people, elderly people and arsenicosis people. **Mass campaign and awareness for Cancer Prevention (SCP)** • Community mobilization on *"Learn easy steps and share messages with family and friends"*. • Campaign on key steps to leading a longer and healthier life (*call to action Eat well, Be active, Don't smoke and Get screened or "prevention story love to hear from you*" etc). **Referral service** • Establish community based counseling service center for improving mental health, adolescent crisis and other issues as required. • Community level service for breast screening for early detection, more options for diagnosis and treatment and improved therapies • Provide referral service to link the potential cancer patients with the Ahsania Mission Cancer Hospital. **Activate of Community Action Group** • Training
Skilled health worker are available to provide service on NCDC	**Training** • Increase the numbers of health workers and other relevant personnel (teachers, social workers, community based rehabilitation workers, psychologists) who can recognize and manage or refer patients with mental health problems.
Established service for prevention of drug user and cancer by the respective service providers	• Advocacy with service providers • Campaign for community awareness • Counseling service for preventive measures

7.0 Cross Cutting Theme

1. **Reaching the hardcore poor:** Holistic interventions in health, priority to be given to the poorest and most vulnerable groups for the provision of services. DAM will identify the targets communities from un-served and underserved difficult areas. The un-served and underserved areas are also areas where the poor live. The depressed districts in the North, South and North East and the chars, areas especially vulnerable to floods, are generally the home of the poor, and so are the settlers in the hoar/ baor areas. A large proportion of people in the hill districts are indigenous and poor. Although small in number there are also poor indigenous people in the North-East, North-West and South-West.

2. **Equity & Inclusion: As per the international proclamations, health & sanitation are** amongst the basic human rights for an individual, DAM is committed to ensure health service with equity and without discrimination. Gender consideration will be taken obligatory as crosscutting issue and in line with NSAP DAM will be given focused on (i) ensuring rights of women for a better physical and mental health at all stages of their life cycle, (ii) strengthening PHC for women with emphasis on reducing maternal and infant mortality, (iii) strengthening reproductive rights and reproductive health of women at all stages of population planning and implementation, (iv) preventing women from HIV/AIDS and Sexually Transmitted Diseases (STD) through awareness raising, and (v) creating women-friendly facilities at all pubic health complexes. Moreover, efforts will continue to (i) communicate the importance of ANC, delivery care and PNC to all household heads at the grassroots level, (ii) communicate importance of women status in family for her own and children's nutrition, (iii) give special training to service providers at the community and higher levels on gender equity, and (iv) include topics on the health needs of both males and females and their impact on gender disparities in school curricula.

3. **Environment and Climate change:** Climate change has already emerged as a serious challenge to development in general and poverty reduction in particular. Bangladesh has experienced unnecessary loss of lives and property due to climatic factors such as too frequent occurrence of cyclones, tidal bores, and a rise in sea level leading to salinity, floods and landslide due to torrential rains. Climate change poses serious health hazard and new disease due to temporal pattern, rainfall with more intensity in the southeast region and rainfall scarcity in the northwest region; frequent floods and prolonged and widespread drought, greater salinity on the surface, in the ground and soil in the coastal zone etc. DAM always would be conscious to adopt the activity in relation with about the new diseases.

4. **Disaster Risk Reduction:** Bangladesh is one of the world's most disaster-prone countries. The kinds of natural disasters that occur in Bangladesh are floods, river erosion, cyclones, tidal waves and drought. Bangladesh is also located in the earthquake zone though there has been no major earthquake in the recent past. Available statistics indicate that the frequency of natural disasters in Bangladesh has been increasing in recent years. Many people suffer disabilities and distress and experience extreme misery due to the disaster. DAM would be given priority to emergency health service during disaster and ensure the facilities which are disaster resilience.

8.0 Management, Coordination and Monitoring

8.1 Program Management

DAM will take initiatives to develop health sectoral unit with equipped both professional and institutional for achieving expected results. DAM will uphold a team to develop sectoral program and project based professionals will be recruited when as required.

Phase wise planning need to be prepared for exploring the program directly by DAM or small scale action research. In this regard DAM will introduce implementation of innovative scheme initially in small scale or by piloting and gradually scaling up program upon successful results of the pilot. In this type of specialized intervention, DAM will look for collaboration with specialized, technical or research organization for incorporating technical expertise of that organization in the program implementation process. On the other hand DAM will take initiative for scaling up of the best practice or learning at field.

8.2 Roles of DAM Divisions and Institutions

Following table is shown the intersectoral or inter divisional support as required to address the issues of health sector

Division/ Institute	Roles
Training & Material development	Capacity Building and BCC material development
Research	Action Research
Monitoring	Monitoring system development
Ahsania Mission Cancer Hospital	Joint Program for cancer prevention
AMIIC Treatment centre	Treatment of drug user and other high risk group

8.3 Quality Assurance and Monitoring

The need for monitoring is important to ensure quality and sustainability of the initiatives in order to fulfill the objects of any heath programs of DAM. The monitoring system will be developed based on the health strategy paper of DAM. The methodology of the monitoring system should be participatory. Monitoring Unit would help to develop Result Based Monitoring System (RBM) to monitor the sectoral results. Monitoring objective(s) will be sat and monitoring plan will be prepared to undertake the monitoring tasks (identifying indicators, frequency of data collection, methods of data collection, tools/ instruments to be used, budget allocation for monitoring) in a participatory manner. Both monitoring process as above would provide information on the progress of activities along with implementation process and it's contribution towards achieving quality outputs and objectives.

Progress/performance monitoring and reporting

For tracking the progress/performance against the plan, a quarterly performance monitoring and reporting system will be developed in consultation with the development partners and DAM central monitoring unit. For data processing, reporting and preservation a user-friendly software will be developed by the health sector.

Process /Programme Audit

For ensuring the quality, efficiency and effectiveness of the activities and assessing the quality of services and performance of different level stakeholders, a participatory process/ programme audit will be conducted during and after completion of the activities.

Output to purpose review, mid –term review and final evaluation

Based on the health strategy and programme or project duration the health sector will define its review and evaluation system. Health sector will responsible for developing ToR for review and evaluation specialists.

9.0 Knowledge management and documentation of lessons

Interactive process (sharing, small group discussion, sensitization meetings) will be adopted for dissemination of health messages and promoting demand among the target groups.

- Activity based common implementation guides and manuals and IEC/BCC materials will be developed for target group as well as use for other stakeholders. The geographic variations in terms of Geo-physical condition, environment, climate, culture, livelihood and socio-economic condition in major geographic areas will be considered in developing IEC/BCC materials.
- Popular theatre and folk cultural will be promoted at different level of the community for educating the rural communities.
- Web based archive on Health information will be developed for strengthening technical competence of DAM towards contributing at national and international level.

10. 0 Way forward

The health strategy paper will be used as a guide for development issues related with health program, simultaneously it will create scope of work jointly with institutional collaboration under DAM health sector.

The implementation of this strategy will be in two phases. The initial phase will be for three years from 2010 to 2012. After the initial phase and review of the strategy the next phase up to 2015 will be developed. This strategic paper will be a living document and will be monitored and reviewed in every year by the program division and suggest for necessary adjustment annually. All new sector programs will be reviewed according to the new strategy.