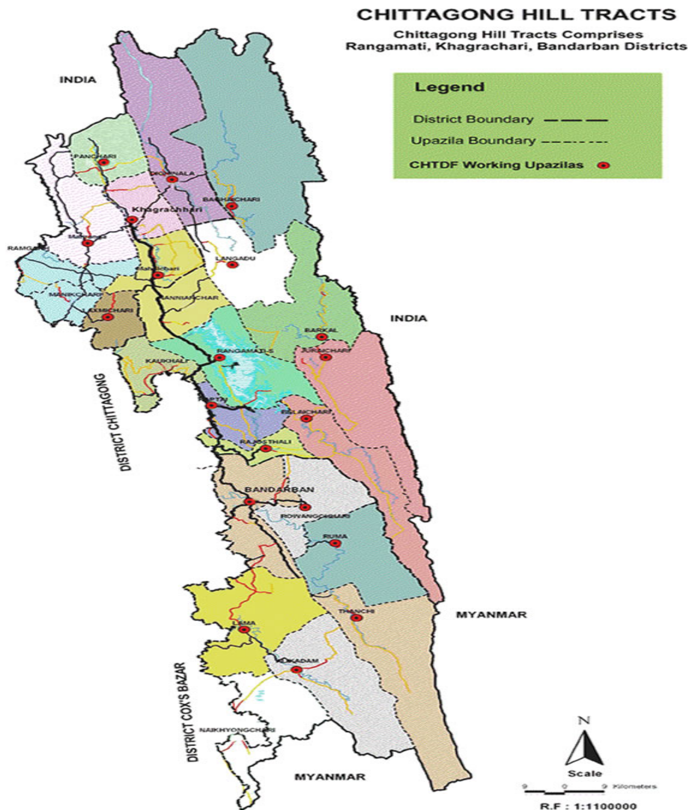
REGIONAL STRATEGY PAPER: RANGAMATI

DHAKA AHASNIA MISSION

Background

Rangamati region of Dhaka Ahsania Mission is a culturally diverse and physically challenging development arena. The region is recovering from decades of civil conflict and social segregation. CHT communities face major developmental, social, and cultural challenges. The region has suffered from development neglect over centuries, and access of rural communities to basic education, healthcare and other social services – especially in the frontier and outlying areas - remains among the lowest in the country. The socio-economic status of these communities is lower than that of other comparable communities in Bangladesh. The disparity is sharp even within the region, sometimes running along, and sometimes running through, ethnicity and gender.



CHT communities are traditionally self-reliant, due to the prevalence of subsistence-oriented jum cultivation and dependence on forests and other natural resources. They have many community safety net and mutual help practices. It is important that development interventions not disrupt these traditions of self-reliance and mutual help.

This region consist of three districts Rangamati, Khagrachari and Bandarban. These districts are located in the south-east of the country, near the Myanmar and Indian border and make up 10 per cent of the total land area of the country but only 1 per cent of the country's population. Home to at least 11 different indigenous ethnic groups, this is a unique part of the country, both in terms of landscape and its people. These districts were ravaged by over 25 years of civil unrest, which officially ended in 1997 with the signing of the Peace Accord.

The tribal peoples, collectively known as the Jumma, include the Chakma, Marma, Tripura, Tanchangya, Chak, Pankho, Mru, Murung, Bawm, Lushai, Khyang, Gurkha, Assamese, Santal, and Khumi and a large number of Parbatya Bangali .The population of the three districts (*zilas*) totalled 1,587,000 in the provisional returns of the census of 2011. There is a strong presence of diversities in terms of demography, ethnicity, culture, food habit, agriculture pattern, livelihood and language in this region.

Objectives of the plan:

- To align regional strategic directions with DAM priorities.
- To guide and outlining strategic direction for designing and implementing regional development plan.
- To facilitate a cohesive well coordinated programmatic framework incorporating all stakeholders.

Strategic targets (to be achieved by 2015):

- Almost 50 % of intervention areas will have local level planning for own development.
- In almost 50% intervention areas there will be a strong evidence of implementing the interventions of which DAM has excellence.

Prevailing problems and challenges:

Poverty and Food Security

The majority of CHT people live in chronic poverty; under-employment and illiteracy and an overall lack of economic opportunity is endemic; and the proper functioning of social services is inhibited, with serious consequences for all inhabitants, as highlighted in the Social Economic Baseline Survey commissioned by UNDP in 2008. Despite having approximately 3 million acres of land, the region is one of the most land scarce regions in Bangladesh in terms of availability of land for cultivation. Traditionally, the indigenous communities practice Jum cultivation, a local form of 'shifting' or 'rotational' slash and burn cultivation. Besides, forest and natural resource extraction continues.

Nearly two thirds of rural households rely on farming as their primary income. Of these, 55% are involved exclusively in field cropping, 30% are involved in Jum, and 15% are involved in both field and Jum agriculture. More than 35 different crops are cultivated in the CHT. However the major crops in the region are limited to 7 types which include rice, turmeric, ginger, chilli, yam, upland rice and banana. Of the major crops, over 60% of rural households produce rice, 19% of households produce turmeric and 11% produce ginger. The economy of the CHT is heavily dependant on agriculture. CHT agriculture, in the broader sense, comprises crop, livestock, poultry, fisheries and horticulture. About 75% of CHT households are living below the lower poverty line (<USD 12 per person per month) and 86% below the upper poverty line (<USD 15 per person per month). The poverty status of women in the CHT is of even greater concern. Almost all women in CHT (94%) are living below the absolute poverty line and about 85% below the hardcore poverty line.

Most indigenous people in the CHT are not secured throughout the year in relation to food availability; Ashar (June-July) and Sravan (July-August) being the worst months. Harvests are often damaged by extreme weather conditions and pests (rats, boars etc).

Health: Children, especially infants, still suffer from vaccine preventable diseases. Women and children in the CHT are anaemic. Women experiencing complications during pregnancy and childbirth die due to the lack of transportation to reach the appropriate health facility or the lack of available health care staff/services at the health facility. Access to safe drinking water in the

CHT has been difficult due to the topography of the area. Often the safe water options available are costly and require specific technical support not easily found in the CHT. Many of the "paras" (villages) continue to use open hanging latrines or open defecation. Malaria is the number one deadly disease in the area. Infant mortality in the CHT is also higher than the national figures, for example, 61/1000 births compared with 45/1000 births nationally (BBS, 2006). Another reason for high maternal and infant mortality in the CHT could be the lack of knowledge within communities on the importance of Ante and Post Natal Care (ANC and PNC). While significant investment has been made in providing safe water supply throughout Bangladesh, waterborne disease, basic sanitation and hygiene remain major public health challenges in the CHT

Education:

Access to primary schools remains difficult for many paras in the CHT and not all children have enrolled at school. The challenging terrain, the lack of qualified teachers and the lack of adequate learning spaces for children are issues to be addressed in the future education support in the CHT. In addition, multilingual education has yet to be realized as schools offer lessons only in Bengali and not in local languages. CHT communities could also be vulnerable to HIV. One of the elements of the Peace Accord was to recognize the rights of indigenous communities to land and other sovereign issues, which have yet to be fully realized and remain a source of tension in the CHT. The region is geographically distinct from the plains and in many places, dense bamboo forests. The rough terrain, remoteness of villages and various political issues associated with a protracted conflict have seriously impeded the economic development of the region.

Villages in the CHT have lower access to education as compared to the rest of the country. An appropriate maximum distance to schools (2 km as defined by the government) in the plains areas can take significantly longer to walk in the hills. The difficult terrain makes the journey much longer and potentially unsafe, especially for younger children. Literacy rate among adult women and men is lower than that of the plain land.

More than half of the children enrolled in primary school drop out of school in their first years. In the Baseline Survey 65% of respondents reported discontinuation of their children's education before completion of the primary cycle, and 19% at transition to secdondary. The average

number of children in the survey sample who had discontinued education was calculated at 1.1 per household

The reasons for early drop-out vary but include lack of finance (over 85% of respondents), distance to school, feeling unsafe, not being welcome at school, not understanding the medium of instruction, having to stay at home to help parents, and not wanting to study (Baseline Survey, 2009). Schools often lack sufficient classrooms and are designed without a designated head teacher or teacher's room. Basic facilities like suitable furniture, black boards and other teaching materials are frequently absent, and there are still a large number of schools in the CHT without a safe water supply and adequate sanitary latrines. However, Education is one of the 'subjects' transferred to the three Hill District Councils.

To what extent the existing programmes address the hill people's needs

Dam has been working in this region for last five years to bring change in, Education in grass root level, Awareness raising, Water & Sanitation facilities, Community capacity building and child development through pre-primary and primary education, remedial support to local primary school students, capacity of local teachers, people's organization development, community awareness on quality education and water and sanitation, improving local governance in watsan, hygiene promotion and improving water supply system covering almost 5 million inhabitants of this region.

Regional excellence: Watsan & Hygiene promotion and awarenesss on mother tongue based education

Rangamati region lacks civic amenities support for long period of time. Of them, safe water support and sanitation services are important. DAM has provided watsan support through hardware and software in different para of this region since 2007. It has capacitated the para committee members watsan management in their respective para. Local school children and

and tutors were given hygiene orientation, the knowledge and skils of which orientation have been disseminated to their family members and neighbours. Since this regions belong to different ethnic communities, ICC and BCC materials have been developed in major ethnic language for watsan and hygiene promotion for its better understanding and practice. DAM provides pre-primary and primary education in this egion through mother language of these ethnic communities. A strong social awareness has meanwhile been created in this region for ensuring education through mother language alongside giving equal importance in Bangla and English. However, in all DAM run children learning centers, respective ethnic language is followed as medium of instruction.

What can be done to make existing programmes contextually appropriate

- Since climate change, livelihood and rights issues are a major focus in this region, all existing and new programs to be taken in this region integrating these issues.
- During any planning for the Hill people, their traditional culture, beliefs and taboos needs to be given highest consideration.

Missing Opportunities

Apart from watsan and education activities, DAM has huge potentials to immediately plan and implement health programs to promote improve local health service and facilities for hill people particularly in malaria prevention, pneumonia control and MCH support. Also some direct poverty reduction activities through IGA, micro financing, agriculture and food security of jumia families. Marketing of the agro-products and hand made textiles of the ethnic communities can be a focus of DAM's future planning for this region for improved access to market information, improved coordination between producer groups and associations and improved dissemination of information,

Stakeholders:

Ethnic people, Community leaders: Headman, karbari, Religious leaders, Local Government/para committee, Government departments (DPHE, DPE, DSE, ICDP), CHT Regional and District council, UNICEF, UNDP and local NGOS

Integration and Coordination:

DAM and its respective projects/programs may take initiative through the on-going mechanism of Coordination among different projects in DAM working areas. All DAM offices from head office to branch offices at remote areas may undertake initiatives using this mechanism of coordination to identify the needs of local community and tap the resources for implanting the development agenda. Respective Central focal person from DAM may coordinate with all Central Focal Persons and Regional Focal Persons to lead, coordinate and carry out this movement at local level once the issue/regional action plan is decided.

Resources to implement the plan:

Although it is the respective community who will be responsible for materializing regional plan, there are other sources through which resources can be explored: These are: (a) From DAM's existing project/program, (b) from community/stakeholders DAM works and (c) From the core fund of the organization (DAM/partner organizations/forums).

Review process:

This document can be changed, revised, re-strategized from time to time according to changed situation and needs.

PREPARED BY Rangamti REGION

Annex-01

DHAKA AHSANIA MISSION

Theme paper on Sanitation and Hygiene for Rangamati Region

1. The theme:

Sanitation is human and animal waste management. World Health Organization (WHO) defines sanitation as group of methods to collect human excreta and urine as well as community waste waters in a hygienic way, where human and community health is not altered. Sanitation methods aim to decrease spreading of diseases by adequate wastewater, excreta and other waste treatment, proper handling of water and food and by restricting the occurrence of causes of diseases.

Sanitation is a system to increase and maintain a healthy life and environment. Its purpose is also to assure people clean water for washing and drinking purposes. Typically health and hygiene education is connected to sanitation in order to make people recognize where health problems originate and how to better sanitation by their own actions. Essential part of sanitation is building and maintenance of education on sewerage systems, wash up and toilet facilities. In defining United Nation's Millennium Development Goals (MDG) two terms are used in sanitation: improved sanitation or broader concept basic sanitation.

Hygiene is commonly understood as preventing infection through cleanliness. In a broader scientific term, hygiene is the maintenance of health and healthy living. It ranges from personal hygiene, through domestic up to occupational hygiene and public health; and involves healthy diet, cleanliness and mental health. The term hygiene means *"the practice of keeping oneself and one's surroundings clean to prevent illness or the spread of diseases"*.

Hygiene also means some attitude or conduct which can help people to be healthy. Hygiene is closely associated with the idea of hygiene promotion. Hygiene promotion includes strategies that encourage or facilitate a process whereby people assess, make considered choices, demand, effect, and sustain hygienic and healthy behaviors. The goal of hygiene promotion is to assist people to understand and adopt practices designed to reduce their exposure to disease. Hygiene promotion covers a range of facilitating and enabling approaches as well to prevent water and sanitation related diseases and optimizes the effects of water and sanitation interventions. It is the part of a broader health promotion framework which attempts to address the structural determinants of health while supporting people's capacity and confidence to control the factors that determine their own health and the health of others.

2. Relevance and implications of the theme with the Regional Context:

The impact of water supply and sanitation programs on hygiene promotion in Bangladesh still remains very low in spite of the improvements in the physical provisions. As the second leading cause of child and infant mortality, pneumonia and diarrhea still remain a matter of concern in the country. Hygiene promotion remains as the weak link of the WSS sector[1], which needs concerted efforts to have desired health impacts. In the absence of that, health impacts derived from the sector interventions (of water supply and sanitation) may remain elusive. The challenge suggests the need for new emphasis to match the availability of safe water supply and sanitation facilities with sustained use of facilities and improved hygiene practices to reduce transmission of water and sanitation related diseases.

Improving water quality, hygiene practices and excreta disposal are all important in reducing disease transmission. Furthermore, evidence also suggests that improvements to all activities have a greater impact on disease transmission than the sum of their individual parts. As such, improving hygiene practice often involves greater water usage and it is therefore important that hygiene promotion strategy should be integrated with the overall sector policies and strategies to improve access to safe drinking water supply and sanitation.

'Hygiene practice in Chittagong Hill Tracts is very poor. People are mostly poor and their livelihood is primarily based on agriculture and forest resources. In many ethnic communities, especially some in Bandarban district, it is the usual practice that human and animals live very closely and animal excreta remains scattered in the immediate neighborhood. Use of latrines for defecation differs greatly. Young children are not expected to use the latrines and their excreta is not thought to be polluting. The Multi-indicator cluster survey (MICS), 2009 on CHT indicates that around 60 percent of adults use some form of constructing a latrine for defecation, around 97 percent of children under the age of five defecate in open places. The percentage of people practicing safe hygiene practices, especially hand washing with water and soap after defecation, is about 64 percent in Rangamati district, 55 percent in Khagrachari and 57 percent in Bandarban. The most common type of latrines in CHT is made of packed earthen floor or concrete slab (without water seal) with a superstructure of bamboo and reeds. The language is sometimes a barrier in communication as some tribal people who do not know Bangla are excluded from the national hygiene promotional campaign through radio or television[2].

Moreover, latrine maintenance and management in CHT are not sufficient. Women's problem is more acute. The problems are very acute, according to MICS 2009. In rainy season human waste flows to cannel/chara. The overall sanitation situation is very bad. At present,the RFL plastic slabb is very popular. People put a plastic slab on a dug hole. Of all three districts, the

[1] National Sector Development Plan (FY 2011-25) for the Water Supply and Sanitation Sector in Bangladesh, March 14, 2011

[2] *ibid*

situation is worst in Bandarban. Due to poor communication, sanitary materials carrying is also a problem. Sangu river is already heavily polluted. People usually drink water from river and lake (Rangamati). Even people take shower after 4-7 days in areas like Thanchi. In Kaptai, there is no water supply. There are just ring-wells. Rainfall is costly (10 times of Shallow TW). Ethnic group 'murong' living on high hills hardly have access to water and sanitation services. Food habit sometimes non- hygienic due to lack of water. Menstruation hygiene management by women is traditional and hardly hygienic.

The range of hygiene behaviors and social norms that may affect disease transmission can be broadly classified into five clusters called '***behavioral domains***'. Sanitation hygiene, water hygiene, personal (including menstrual) hygiene), food hygiene Domestic and environmental hygiene. Each domain involves a series of hygiene practices

In CHT there are more than 4 thousand *para kendro*. UNDP and ICDP (Integrated Community Development Program) working since 1982 through these para Kendra and implement various development programs. There is only one *para-kormi* working in each *para kendro* but development awareness is not spread up to the expected level. There is a lack of coordination among organizations and institutions working in CHT.

3. Synergic elements of other interventions with the theme

The UNIQUE II project, though an education project, has many elements of its own to promote sanitation and hygiene. In children learning centers, sanitation and hygiene message can be disseminated to children and their parents. The necessary message can be provided with the teachers during their refreshers so that they can transfer the information related with sanitation and hygiene. Low cost latrines with covered pit can be installed in each CLC with the support from the community. (sanplat) while during the routine home visits, tutors can disseminate, monitor and follow up sanitation and hygiene practice of the students and their family members. During the meetings of Community based committees (CAG/CMC) and other stakeholders, the issues regarding sanitation and hygiene to be discussed and actions can be taken accordingly.

4. Strategies to implement the issues

According to the National hygiene promotion strategy, 2011, three approaches have been focused to initiate any promotional activities: a) Behavioral and social change communication b) Community participation and social mobilization and c) Social marketing approach. In Chittagong Hill Tracts, all these three approaches can be followed and implemented

A behavior and social change strategy can encourage and support targeted behavior changes to improve sanitation and hygiene situation. The activities should ensure **community participation** at its various stages of management such as planning, implementation,

monitoring and evaluation. It should focus not only the needs of individual or groups, rather on the interests of the whole community to protect their health and well-being. This requires a holistic (i.e. Social mobilization) approach for creating sustainable impacts. **Social marketing** is a systematic approach to public health problems. It goes beyond marketing, and is not motivated by profit alone but is concerned with achieving a social objective. Social marketing shall therefore be concerned with how the product is used after the sale has been made. They will aim not simply to sell latrines, but also to encourage their correct use and maintenance[3].

However, keeping these approaches in consideration following strategies can be taken up:

1. Keep UNICEF, ICDP, DPHE and Zila Parishad in the communication loop of any intervention.
2. Make community/*para*-wise need assessment.
3. Incorporate the hygiene issue in ICDP planning and discussion agenda
4. Track and monitor Union Parishad Budget if there is any allocation for sanitation and hygiene promotion.
5. Reactivate District, Upazila, UP and Ward level WatSan committee.
6. Develop and disseminate IEC and BCC materials (indigenous languages) on sanitation and hygiene in the region.

[3] National Hygiene Promotion Strategy, December 2011

Annex-02

Short-term Implementation plan of the theme: **Sanitation and Hygiene for Rangamati Region**

Perspective	Activities	Location	2013										Support required	Responsibility	Monitoring/ follow up
			M	A	M	J	J	A	S	O	N	D			
Micro	**Awareness and capacity building:** Provide Training/orientatiton to CAG/CMC/PCMC/ReligiousLedears/SMC/ teachers/Students/LGI's members/Headman/Karbari	Para Center/CLC/ LRC/School/ Khyang/UP/ Districts												DPC WinS/ UNIQUE II	
	Workshop with DPHE/RC/HDC/UNO/DPEO/CS/ICDP	Govt offices												DPC WinS	
	Campaign-Film /Drama /Culture Show within Community	Community												DPC WinS	
	Courdyard Meetings at para level	House holde base													
	Community Base hardware Support and Social Markiting: Latrine and Tube Well installation	As per need base												DPC WinS/ UNIQUE II project	
	Hand Washing Device distribution among community	Growth cente/School												DPC WinS	
	Linkage support for local entrepreneurs														
	Awareness materials development(Poster/Bill board/Film Show/Drama (Indigenous Languages) Culture Show													DPC WinS, HYSAWA	

Perspective	Activities	Location	2013										Support required	Responsibility	Monitoring/ follow up
			M	A	M	J	J	A	S	O	N	D			
Macro	Advocacy for integrating hygiene session in schools													DPC WinS, HYSA WA	
	Policy Review														
	Networking with service providers														
	Researching on sanitation and hygiene status														

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