**A TECHNICAL STRATEGY FOR HEALTH**

**CARE BANGLADESH**

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# Why Health strategy?

## Background and Purpose

CARE considers health a fundamental human right, and a critical factor in reducing poverty, gender inequality and marginalization. The centrality of health to development has been well established; it is known that poverty and health are linked as a causal cycle where poor health is both a cause and consequence of poverty and low human development. CARE Bangladesh strongly believes that poverty is a manifestation of unequal power relationship within the household and society. To bring positive changes in the life of the three CARE Bangladesh impact groups**,** i) Extremely poor people in rural areas and ii) Most marginalized groups in urban areas; iii) the socially, economically and politically marginalized women; CARE intends to alter this power structure, change social norms in terms of gender roles, ensure voices of the most marginalized and reduce vulnerability and exploitation.

The health and nutrition technical strategy aims to outline the relevance of health interventions to impact visions and explicitly identify the approaches that have been known (through evidence from our work and the work of others) to contribute to our focus on the most marginalized groups as defined in the impact statements. This will foster greater awareness and use of tested strategies as well as identification of gaps that need to be addressed for more meaningful change. This understanding is envisaged to contribute to a better alignment of the health and nutrition technical interventions with the three impact visions and theories of change. The strategy is specifically **aimed at (a) promoting an organization wide shared understanding of the inter-relatedness between health and nutrition interventions and the three impact statements; (b) establishing conceptual and operational clarity on which strategies contribute to enabling positive shifts in the lives of each of the target groups and progress within specific domains of change, the manner in which they do so, and what additional strategies are required; (c) promoting future project design in a manner that it contributes clearly and optimally to the impact programs; (d) developing a clearer organizational identity around our health and nutrition work and social justice that enables us to join others in advocating for the fulfillment of rights of the most marginalized.**

The health strategy will also contribute to the accomplishment of the MDGs and SDGs in Bangladesh by developing innovative, sustainable and replicable health, hygiene and nutrition programming that strengthen existing health system to deliver quality services and encompasses community participation to improve health situation of extreme poor and socially marginalized population.

## Process of development

The Health strategy developed in 2007 was revised and updated through a consultative process ensuring alignment with the **CARE 2010 program strategy**, **CARE’s Approach to Sexual, Reproductive, and Maternal Health Right (SRMHR), CARE- Bangladesh Program Strategy** and **GoB national health and nutrition priorities** to guide through the transition from Millennium Development Goals (MDGs) to Sustainable Development Goals (SDGs).

The key purpose of this thorough consultative exercise includes reviewing the external environment, the CARE global environment, and CARE Bangladesh’s strengths and potential for unique contributions.

Specifically, the process included the following activities:

* Initial and informational meetings with program and senior staff in CARE- Bangladesh
* External informant meetings to offer contextual perspective for the strategy
* Core strategy development team meetings to synthesize information and make recommendations
* Debriefing meetings with Country Director and with program staff

# How health is relevant to CARE Impact groups and aligned with programming principles?

In order to better explain the relationships with health and other program/sectors, it is important to describe with examples of some of ways to link broader programs and more explicit targeting of the poorest groups with health outcomes. The following examples would provide a context for exploring linkages and relationship between health and three impact population groups.

* Address Sexual Reproductive and Maternal Health (SRMH) needs clear understanding of SRMH rights and the right for women to control their own bodies. This becomes related to access to health services, changes in definitions of masculinity and men’s involvement in reproductive health, and participation in household decisions (such as allocation of resources and care-seeking) that may affect women’s health.
* Development of local governance and advocacy strategies to facilitate grass roots engagement in social change, management of gender-based violence, decreasing social exclusion, facilitate inclusive governance through promoting voice & accountability and the involvement of both government and private sector health services in insuring access to care.
* Facilitate access to quality health and nutrition services for our impact populations require holistic understanding of barriers and mitigation strategies using right based approaches (hours, cost, respect, proximity, addressing a range reproductive health needs )
* Advocate for health service accountability to under-represented groups

CARE Bangladesh focuses on three impact groups: marginalized women, extreme rural poor and bottom urban poor, for whom an impact statement was developed. The impact statement is based on the identification of a set of underlying causes of poverty and marginalization and a theory of change that addresses these causes to achieve the impact vision of that group.

The health strategy considers the theories of change for the three impact groups and analyses the health and nutrition situation through the **agency, structure and relationship model** **(attached as annex-1)**. The marginalization and vulnerability as well as their manifestation among the impact groups were considered to identify the role of health and nutrition. In order to address the health issues that affect each of these groups, a set of approaches were designed to holistically and sustainably tackle the underlying causes of the issues rather than simply the effects or manifestations.

### The socially, economically and politically marginalized women

CARE’s Theory of Change (ToC) for socially, economically and politically marginalized women considers women empowered if they exercise greater choice in decisions affecting their lives, violence against them decreases, and the combined effect is multiplied through men’s engagement and women’s solidarity. CARE believes that women’s and girls’ empowerment needs to be integrated into all programs to maximize, internalize and sustain impacts and should include the strengthening of agency i.e. women’s capacity and skills; stimulating supportive relationships in the household and community; and fostering an enabling environment through a strong structure that can support women to leverage their improved skills and enhanced relationships to access entitlements, opportunities and services.

The Lancet 2014 series that reviewed the evidence on violence against women (VAW) also identified that successful programs engaged multiple stakeholders with multiple approaches, aimed to address underlying risk factors for violence including social norms that condone violence and gender inequality, and supported the development of non-violent behaviors. Health systems play a crucial role in the multi-sector response to violence against women.

Gender equality and the empowerment of girls and women will not be possible without the realization of sexual and reproductive health and rights. For women and girls to lead healthy lives, and to be free to participate in social, economic and political life, they need universal access to quality services, information and education, and conditions that allow them to realize their sexual and reproductive rights. Women’s participation and leadership in public and political life is essential for tackling poverty, gender inequality and realizing their health rights especially sexual and reproductive rights. If women’s participation is to be transformative, their voices need to be heard across public spheres, from households and community meetings to national parliaments.

CARE Bangladesh approaches to ***change the relationships*** between people in families and communities by addressing ***social norms relating to gender roles*;** and change the relationships between people and communities, service providers, governments, and other power‐holders by ***strengthening health systems of equitable governance and mutual accountability***.

The approaches, tools and processes that have been used to contribute to Women Empowerment includes **Social Analysis & Action (SAA), Birth Planning (BP), Community Support System (CmSS),** integration with EKATA group, adolescent group/fun centers etc.

### Extremely poor people in rural areas

While Bangladesh made considerable progress in terms of reduction of poverty, maternal and child mortality and stunting; the Bangladesh Maternal Mortality Survey (BMMS), 2010 and Bangladesh Demographic and Health Survey (BDHS), 2014 shows huge geographical and wealth inequality. Maternal Mortality Ratio and Infant Mortality Rate in Sylhet division stand at 425 and 59, much higher than the national, 194 and 38 respectively. According to the Bangladesh Integrated Household Survey (BIHS) 2011-2012, 14% household reported health shocks in the prior two years, while only 4% household reported flood shocks; in contrast to the common perception that natural hazards are the most common form of livelihood disruptions. Poor Health and Nutrition; and poor HH preparedness to cope with these shocks make the households vulnerable to drop further in the wealth indices leading to further poor health, nutrition and development. The health care cost is also considerably high and out of pocket expenditure on health stands at 64%( Bangladesh National Health Accounts, 2007).

The Theory of Change (ToC) for extremely poor people in rural areas considers reduction of exploitation and dependence on others as a result of increased access to and use of resources and services as well as active engagement of the poorest in local governance and development processes as the key pathways to change. CARE’s experience has helped to identify and analyze a number of underlying causes that perpetuate the vicious cycle of poverty resulting in the intergenerational transfer of extreme poverty. The analysis identifies **social inequalities, limited and fragile livelihoods and weak and unaccountable support structures** as the underlying causes of poverty.

Health interventions enables the poorest and marginalized to participate in decisions that impacts their health and nutrition, they reduce their vulnerability to drop further in the poverty ranking by increased access to health and nutrition services and improved environmental conditions. Risk management tools such as **microfinance, social protection and preventative health** can both mitigate poverty and serve as a springboard to enable pursuit of productive opportunities.

The health interventions enable the poor and marginalized to realize their health rights through improving their access to **equitable, affordable and quality health services,** ensuring their voice in the health governance by **strengthening the community platforms, such as Community Support Systems (CmSS) and** increasing their resilience to mitigate health shock through **access to the resources along with other risk management tools.**

### Most marginalized groups in urban areas

CARE’s ToC for most marginalized groups in urban areas defines that if increased social acceptance and reduced exploitation, equitable access and entitlements to services, resources and livelihood opportunities and enhanced quality and resilience of living conditions are multiplied by active engagement in urban governance processes backed by pro-poor urban policy; poverty and vulnerabilities of the extreme poor in urban areas can be reduced. To materialize this poor governance, economic inequalities, social exclusion and environmental degradation needs to be addressed.

With urban population increasing at a rate four times that of the rural population, urban policy and services have not kept pace with this increase. Migration, illegality of residence, absence of identity and a governance system that does not honor the right to basic services for citizens who it views as illegal, limit the formation of an adequate and effective health service infrastructure for the **most** **marginalized urban populations**. These populations include slum dwellers, migrant workers, sex workers, drug users, people with disability and other individuals on the social periphery. These individuals are caught in a cycle of ill health and poverty, fuelled by poor hygiene, contaminated water, inadequate or low quality services, stigma, discrimination and an unrecognized right to basic services. Food insecurity, poor nutrition, maternal and child mortality and morbidity, HIV and other sexual and reproductive disorders become rampant. Consequently, **food and nutrition security, clean water and environmental sanitation, risk reduction to HIV and other sexually transmitted diseases, and reproductive maternal and child health** constitute the desired health outcomes for the urban marginalized populations

CARE’s approach to urban marginalized population is to reduce social exclusion, meet basic needs and build assets as well as improve governance. Therefore, strategies aimed at the provision of basic services for the urban poor, such as **expanding and strengthening health systems**, in combination with strategies that reduce this exclusion through enabling the realization of the rights of the urban poor through community mobilization and empowerment in a rights framework will contribute to desired impact goals. These strategies rely on the **Community Lead Approaches (CLA)** to the voice of the urban poor and enable them to **demand better services, linking with services and advocacy to enable the realization of their rights by addressing their exclusion** in a manner that enables them to meet basic needs and presents the potential to strengthen governance by seeking greater accountability to the rights and entitlements of the most marginalized.

# What are OUR priorities in health and nutrition?

CARE-Bangladesh has developed a unique combination of cross-cutting approaches for health system strengthening with a social and gender lens which can be applied to technical health interventions areas. **This combination, of technical health interventions from a systems perspective and incorporating social and gender barriers to health, will be the foundation for CARE Bangladesh health programming**.

This health strategy prioritizes potential focus areas in two categories:

1. **High priority areas** - These are areas where CARE already brings significant strengths and contributions or intends to demonstrate significant contributions. These will be what CARE-Bangladesh wants to be known for, and are areas where CARE-Bangladesh can be a leader.
2. **Priority areas where CARE-Bangladesh will be strategic user** - using state of the art knowledge and experience as part of CARE-Bangladesh programming. This also includes health areas that are high priority, but need further consideration as programming and strategy development move forward over the coming years.

**High Priority Areas**

**Health System Strengthening (HSS):**

This is an area where CARE- Bangladesh has strategically developed capacity and influence over recent years, and this will continue to provide a focus for its work in health and reproductive health. The six building blocks of the World Health Organization (WHO) Health System Framework; **service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance (stewardship)** were considered while formulating this. Considering the gaps in existing health system and CARE’s comparative advantages, we focus following three specific building blocks to complement, bringing lasting changes and multiplying impact:

* **Governance:** Promoting voice and accountability – Through its work with Community Support Groups, and beginning work on Community Scorecards, CARE- Bangladesh brings its unique community foundation, as well as experience in governance and empowerment, to assuring equitable access to quality services.
* **Health Workforce:** Development of front line community level services and personnel where there are gaps through development of public – private partnerships CARE- Bangladesh can continue to develop innovative models/approaches to reach underserved populations with quality health services in both urban and remote rural settings. The social entrepreneurship components can be incorporated through collaboration with Private Sector Engagement (PSE) unit. Already involved in training and capacity building for health service providers, CARE- Bangladesh’s value-added is a focus on the equity, gender and social aspects of service delivery.
* **Information:** Monitoring and Data for Decision Making – CARE- Bangladesh has implemented several projects where community surveillance for pregnant women and newborns offer community groups a tool for tracking and assuring access to services. CARE-B can bring this practical experience in community level monitoring and using data for community discussion and action to health service strengthening and accountability.

**Urban health:**

Through its experience with NGO partners to develop models for urban health, as well as its work with HIV, CARE- Bangladesh is already a leader in developing new models (eg. OST service for intravenous drug users) to improve access for poor and marginalized people in urban setting. While continuing to work with the intravenous drug users and HIV, CARE Bangladesh intends to expand its work to other urban marginalized groups such as RMG workers and their family members, street based female drug users’ etc.. CARE will closely work with public health system, and also engage and collaborate with private facilities, institutions and providers to tailor health services to the marginalized group by increasing responsiveness & accountability reducing exploitation and expanding choices, and increasing resilience to address health shock. In collaboration with other CARE programs (WE, Urban) and sector (PSE), we will innovate and develop urban health models/approaches to strengthen urban health system in Bangladesh for addressing rapidly increased needs. CARE Bangladesh will test different innovative approaches, generate evidence and conduct evidence based advocacy to influence policies and practices.

**High Priority Technical Areas**

These are also priority areas where CARE- Bangladesh brings comparative strengths and contributions, including the potential for applying many of the cross-cutting approaches mentioned in the previous section. Within these priorities, CARE- Bangladesh can identify strategic and funding opportunities as they arise, being careful to follow the foundational package approach which applies the cross-cutting health systems interventions with the social and gender lens to whatever health interventions the team undertakes.

Technical areas where CARE- Bangladesh will provide focus in next five years may include:

* **Maternal and Reproductive health** including married adolescents. CARE- Bangladesh has got proven experiences to improve maternal health through enhance the women decision making ability using MNH services, promoting men/husband engagement, develop social capital and increase linkages & accountability of service facilities.
* **Nutrition**, particularly as it has been developed in the context of wider economic and food security programming. CARE- Bangladesh demonstrated reduction of 23% stunting through implementing integrated approaches of nutrition specific interventions with livelihood, women empowerment, multi-sectoral approaches and inclusive governance interventions.
* **HIV / Opioid Substitution Therapy (OST)** – CARE- Bangladesh has found itself leading work in OST, leaving it in a position of strength for further funding and leadership. While this may not be a long term priority for CARE-Bangladesh, it offers an entry point for reaching the urban poor and marginalized populations, which clearly is a long-term priority.

**Priority Areas where CARE-B will be strategy-users**

These are areas where CARE- Bangladesh recognizes their importance, but where CARE- Bangladesh is not in a position to take the lead in innovations development. CARE- Bangladesh welcomes the opportunity to learn from the work of others, and to integrate others’ innovations into the health program.

* **Mobile Health** or Information and Communications Technologies (ICT) which are currently being developed by others in Bangladesh.
* **Adolescent health** – This is consistent with some of the CARE’s broader program pathways, such as the empowerment of women and girls, and it is likely a priority given the potential for linking with other sectors and programs. CARE- Bangladesh does not have a lot of adolescent reproductive health experience to build upon at this time, but may be able to develop adolescent health as a “complement” to programming originating from another sector/program ( such as Education, WE). Options might include:
  + Integrating reproductive health with current education programming
  + Reaching young married adolescents for reproductive health through the early marriage work
* **Quality assurance functions** – While CARE- Bangladesh won’t focus on the technical aspects of quality assurance, some of the governance / Community Scorecard work may offer an opportunity to leverage other quality assurance efforts by bringing in client expectations and priorities. However, CARE-Bangladesh needs to facilitate win-win collaboration with the agencies ( e.g. UNICEF, UNFPA, WHO, JICA, MSI etc.) having skills and expertise on technical aspect of quality of care.
* **Health in Emergencies** – This is a priority for CARE globally and the Bangladesh program needs to think about how to broker partnerships to assure health service delivery, including assuring access to reproductive health services.
* **Other Health Technical areas** not mentioned above where others may already be positioned for leading the effort:
  + Broad behavior change (BCC) or health communications campaigns
  + Non-communicable disease screening and management
  + Child health
  + Health financing to ensure universal health coverage

# What are our approaches?

Health interventions have the potential to bring shifts in the underlying causes of women’s marginalization to contribute to improved health. Health viewed as an inalienable right has enabled the most marginalized women to fight the discrimination and stigma that keeps them in poor health.

Health interventions have enabled the poorest and marginalized to participate in decisions that affect their lives, they have reduced their vulnerability by increased access to health and nutrition services and improved environmental conditions.

CARE health program considers women empowerment as the key to in any analysis of all its programming goals and principles.

**Approaches**

* **Application/use of** **Social Action & Analysis (SAA)** tools and processes at household level with the participation of all HH members (including decision maker) to identify and challenge the deeply rooted social norms, socially defined gender roles and relationships to improve recognition of health rights, decision making ability, mobility and control over own health. (SAA tools, Birth planning Card)***–(Agency****)*
* **Establish community platform** like Community Support System (CmSS), EKATA, WG, adolescent group to share and identify common issues and raise voices expand relationship with relevant agencies/groups for influence/mobilize supports. ( CmSS, CSG, WG) *–(****Relationship****)*
* **Capacity building of impact population** (women and adolescents) on SRMHR and Nutrition as well as entitlement. *–(****Agency****)*
* **Engage men, local government and community gate keepers** to support women and adolescent SRMH and nutrition***(relationship)***
* **Strengthen “community health system”** to promote inclusive governance, strengthen referral linkages and mutual accountability. (reform, capacitated and use existing governance structure; Community Score Card-CSC) ***(Structure)***

**Priority Models for Expansion, Development, and Learning**

As mentioned in the section on priority focus areas, CARE- Bangladesh has developed several key approaches for health systems strengthening that integrate the social and gender perspective with technical health interventions. Regardless of the specific health project or funding opportunity, these will be considered as foundations for the ways CARE- Bangladesh does its work in health more broadly, recognizing that different combinations will be appropriate in different contexts and programs.

* Establishment of working links between **community groups, local government, and service providers to address health service access and accountability**:   
  By focusing on strengthening community participation and community groups, CARE- Bangladesh facilitates a collaborative approach to problem solving and action involving those who have power along with those who benefit from services.
  + In the case of the **Community Support Systems (CmSS),** CARE- Bangladesh has a strong model which is ready to expand within the rural health context.
  + While CARE- Bangladesh sees the three-way involvement of community, service-providers, and government structures as essential, the model of involving different these different community structures working together for problem solving and action needs to be adapted for the urban health context, and for use in other sectors (e.g. school committee, food security for vulnerable families). The key players and structures for interaction will likely be different than those in rural areas.
  + The introduction of **Community Scorecard work** building on these structures offers an opportunity to combine governance with service quality improvement.
* Use of participatory community monitoring as a **Data for Decision –Making (DDM**):   
  DDM offers communities and providers a way to actively participate as partners and allies, using data to draw conclusions and make decisions for improvement. Several CARE- Bangladesh surveillance programs have begun developing this as a strategy for action. However, further development is needed to more effectively disaggregate data for the poorest and most marginalized populations, as these otherwise have a tendency to become invisible.
* **Gender reflective activities:** Through work with social analysis and action (SAA) and its women’s empowerment programming, CARE- Bangladesh has begun establishing tools to facilitate community reflection for social action. CARE- Bangladesh recognizes that this kind of process is fundamental to addressing many of the social and gender barriers that limit health and development yet application of this approach in health programming has been relatively slow. In order to strengthen this approach in health, further development is needed:
  + Continue developing internal staff capacity for personal reflection as well as for facilitating reflection with others
  + Consistently apply a gender and social norms lens in planning, developing interventions, and monitoring
  + Strengthen male participation in the change process
* **Integration and collaboration with other programs and sectors** 
  + Through its development of a Program Approach focused on impact group outcomes, CARE- Bangladesh emphasizes integrated programming to increase impact. This is an area where health needs to challenge itself – both bringing health to work in other program/sectors and applying innovations from other sectors to the health program through win-win collaborations. Among others, work with youth, RMG workers; Workforce Development, Women Empowerment, Private Sector Engagement, urban development, and emergency preparedness are areas for development within CARE- Bangladesh where this integration can be developed from the beginning.
  + As this strategy rolls out, CARE- Bangladesh’s health program can also strengthen partnerships and alliances outside of CARE itself. This is an important shift in the way CARE- Bangladesh works, and the health program needs to further develop this capacity, particularly as it develops new initiatives that may be more broadly focused than just health. Outside partnership may include research & academic institutes for knowledge management, WHO and other relevant UN organizations, training and technical institutions, professional bodies like BMA, BGMEA, OGSB etc.

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| --- |
| **Some ideas for integration of health and other sectors**   * Private Sector Engagement (PSE) and Private Health Worker initiatives in remote communities * Women Empowerment and Garment Worker Health initiative * Inclusive Governance and Health both in urban and rural areas * Education and ARSH * Early marriage, nutrition, maternal health, violence prevention * Nutrition, income generation, WASH, maternal newborn health   For all of these opportunities, the CARE- Bangladesh health program will challenge itself to address the social determinants of inequality through a reflective approach to change in addition to recognizing that there are a range of both technical and social barriers across sectors and programs which need to be addressed to achieve health. |

# HOW WE CAN MULTIPLY IMPACT – Advocacy and partnerships

Diffusion of innovation depends on strategies for advocacy, as well as strategies for partnership. The CARE-Bangladesh health program will continue to develop both of these. Like with the models for intervention, CARE-Bangladesh has a range of experience to bring to the task of multiplying the impact of its health programming and different combinations of scale-up strategies will be appropriate for different contexts.

**Advocacy**

In order to multiply impact, a program needs to do advocacy with policy-maker levels and with the community or partner (including government and NGO partners) implementation levels. Experience with the following models for advocacy will be built into health programming, adapting and combining them as appropriate.

* Use of implementation science for innovation and scale – The CmSS process is an excellent example of this, beginning with a simple community-based intervention more than ten years ago, and gradually strengthening, expanding, and documenting its impact for wider acceptance.
* Programmatic policy advocacy – In the case of the Family Violence Act, CARE- Bangladesh advocated at the national and policy-maker levels for a policy that has a significant impact on its priority target populations.
* Influence national priorities and strategies through representation by a strong technical / program team – While CARE- Bangladesh has not managed advocacy in this way up to now, it can learn from Save the Children’s example with Saving Newborn Lives.
* Advocacy for under-served populations and/or the poor – With its clarity around prioritizing the poorest and most marginalized sub-populations, CARE- Bangladesh is able to combine programming with an advocacy strategy on behalf of these groups, promoting both policies and the need for additional resources / programming. The HIV / Opiate Substitute Therapy program offered an opening for reaching a very marginalized population, and CARE- Bangladesh’s success with this group offered a platform for advocacy on their behalf.

**Partnerships**

There are multiple models and combinations for establishing partnerships, depending on the partners and the needs. Partnerships fall on a continuum including alliances and thinking partners for complementarities on one side, ranging to sub-contracted partners who implement as they are directed on the other. While CARE- Bangladesh has traditionally sub-contracted local NGOs for implementation, it has less experience developing alliances for enhanced programming. While partners for implementation will continue to be important, the health program will want to further explore and develop longer-term partnerships that function as alliances for learning and advocacy. This will require more sharing in decision-making, as well as partner involvement from the earliest phases of program design and funding development.

While not an exhaustive list, possible models for partnerships that can be purposefully developed and expanded include:

* **Partnering with Government of Bangladesh** – This has been an effective strategy for improving quality and coverage of key health interventions and will continue to be important, particularly in underserved rural areas. This may be a less relevant model in urban areas where the private sector will have a greater role in assuring access to services. In urban areas, CARE- Bangladesh needs to learn facilitating partnership with private sectors (NGO and for profit private health service facilities) keeping Government in stewardship role to address the health needs of rapidly growing urban low income populations.
* **Public Private Partnership (PPP):** This is also an effective strategy and GoB has huge commitment to promote but always not capacity to facilitate it. The three-way partnership between government, service providers and community members (or other similar variations of public – private partnerships depending on the context) that can be facilitated to develop sustainable solutions. CARE- Bangladesh’s role becomes one of catalyzing and facilitating independent identification and action among these partners including public and private actors.
* **Sub-contracting implementation partners** to achieve wider reach – This will continue to be an important strategy for achieving wide program coverage while supporting interventions by local NGOs. In HIV project, CARE- Bangladesh provides both technical and financial supports to local NGOs and CBOs to increase program coverage.
* **Strategic and technical partner to large, flagship and innovative learning program**: CARE- Bangladesh can join different consortium with strategic and technical roles to build capacity and reach out large impact populations through sharing proven approaches and interventions. CARE- Bangladesh provides technical and capacity building supports to USAID/DFID funded around $US 80 million NHSDP (Smiling Sun service network) program working throughout the country and reaching 20 million service contact each year. The technical supports include Community Mobilization, reaching out poor, nutrition, integrating gender etc.
* **Learning partners / alliances for complementarities** – This is an important partnership model as CARE- Bangladesh moves forward with its health strategy, but it needs more development. CARE- Bangladesh needs to proactively join existing different alliances and forums both share learning and influences broader health agenda at the national and global level. CARE- Bangladesh currently members of Civil Society group of Scaling up Nutrition (SUN), civil society constituency of Bangladesh Country Coordination Mechanism (BCCM) etc.

# OPPORTUNITIES FOR LEARNING IN A BROADER PROGRAM CONTEXT

**Learning Opportunities in Current Programming**

CARE- Bangladesh’s health program has a strong track record for developing innovations and learning. This is reflected in the earlier discussion on “What are our approaches”, highlighting ways health programming can integrate interventions that address rights and social determinants. However, the potential for learning and impact could be enhanced if the health program could work more effectively with other programs across CARE- Bangladesh to develop similar approaches for the different “entry points” these programs represent. This then becomes an opportunity for a more coordinated learning strategy that can complement CARE- Bangladesh’s program strategy.

For the health program to move towards this kind of program-based learning, it will need to define a learning agenda. Learning priorities would be formulated within cross-cutting themes or strategies such as governance, engaging men and boys, gender equity, etc. and staff needs the capacity to use a critical reflection and learning approach for understanding and applying models to program design, implementation and documentation.

Thoughts for possible learning themes where health would contribute include:

1. Learning from differences between urban and rural programming by considering the commonalities and differences in the application of program strategies and principles.
2. Opportunities to adjust and adapt essential elements of Community Support Group model (access and accountability) to other contexts and sectors
3. Focusing the Data for Decision making approach on specific issues for priority impact groups, including careful disaggregation of data for analysis and advocacy
4. Mainstreaming nutrition into existing community and community health system, and how other food security programs of CARE- Bangladesh use and benefit from the learning through adjusting and adopting key approaches for increasing the impact
5. Situation-specific and adapted models for partnership such as the development of long term technical and learning alliances

# What to measure ourselves against?

The changes that we intend to bring in the life of our impact population through our health initiatives are related to improvement of their health and nutrition status as well as to bring shifts in the underlying causes of their marginalization and vulnerability to contribute to improved health. The broader areas that we will measure to identify the program impacts are following-

| **Sl** | **Areas/ change** | **Impacts** |
| --- | --- | --- |
| 1 | Improved health and nutrition: | Reduced mortality, morbidity and stunting |
| 5 | Reduction of child marriage and adolescent pregnancy | Increased age at first marriage and first pregnancy |
| 2 | Reduced exploitation of the impact population that impact on their health/nutrition outcomes | Reduced stigma, Reduced health care cost, increased resilience against health shock |
| 3 | Reduced wealth and geographical inequity and disparity in accessing health services | Increased service access by poor and extreme poor, Increased service access in rural areas, increased access to marginalized in urban areas. |
| 4 | Increased access and expand choice to health services | Reduction in health care cost, Increased resilience against health shock |
| 5 | Increased participation of women in health and health care decision making: | Reduction of all forms of discrimination against all women and girls everywhere;  Increase in universal access to sexual and reproductive health-care services, including for family planning, information and education |
| 6 | Increased mobility of women to seek health care; | Increase access to and timely utilization of quality health services |
| 7 | Increased access to and control over resources to seek health care: | Increased resilience against health shock |
| 8 | Reduced VAW | Reduced tolerance towards violence against women (BDHS), increased participation of men in preventing VAW; |
| 9 | Increased ability to seek social, legal and health assistance in case of violence, harassment and exploitation: | Increased percentage of impact population seek and receive assistance when faced violence, exploited or harassed. |

# Conclusion and way forward

As we mentioned in the background section that the purposes of health strategy include bringing clarity of our health work both relevance and approaches, how to work with three programs to contribute our theory of changes, proactive design of new health initiatives that align with CO program approaches and ability of articulating & representing CARE health work with outside audiences. By implementing Health strategy, CARE B needs to demonstrate some changes of way of working at different level and ultimately contributing to achieving the impact across three programs.

This health strategy is a living document that may needs to adjust & re-adjust during its implementation process in next five years. It has been developed as a working guideline rather than theoretical paper. Since, a participatory process has been followed to develop the health strategy, it captures wider perspectives and there were conscious efforts to challenge some of our traditional ways of thinking, working modalities, silo approach, therefore it would need consistent efforts to come out from the comfort zone, working collaborate with others, addressing underlying issues rather symptoms to be more impactful and relevance to CARE’s program principles. Each project head needs to demonstrate new leadership to build the capacity of project staff and change the ways of working that fit with CARE’s program approaches and principles. In order to change the ways of working, often it requires combination of both negotiation and assertiveness skills.

Followings some specific milestone to be achieved in next 5 years period:

|  |  |  |
| --- | --- | --- |
| **Mile stones** | **Means of verification** | **time** |
| Clarity on health strategy among health project staff and three program Directors | Orientation and reflection meetings  Reflect the health strategy appropriately both verbal and written communications. | By February 2016 |
| Integration and collaboration between health and three program developed and implemented | The action plan developed and followed up with three program Directors to facilitate integrations/collaborations | By June 2016 |
| Developed and scaled up two innovative models using both technical and social/governance/gender lens to increase resilience to health sock both rural and urban impact population | Public Private Partnership to address Human Resource for Health in remote and un-served community  Inclusive governance model for equitable health service provision in urban low income groups, especially RMG workers and their family members | By December 2018 |
| Nontraditional partnership developed with appropriate UN, Private, research and professional bodies to increase impact and influence | Three MOU signed with the strategic partners that include research, academic and technical/professional bodies/UN | By December 2016 |
| Proactive design of CARE-B Health project that are align with CO and CI program principles | Two concept note designed that describes how CARE want to facilitate health works | By December 2016 |
| CARE-B contribute to realize the SRMH right about 2 million women in Bangladesh | 2 million women participated in different health program interventions that enable them to realize SRMH rights (access and dignity, reduce exploitation, increase decision making ability, promote accountability) | By 2020 |

We also adjust and re-adjust some technical priorities to be consistent with Sustainable Development Goals that to be set by government of Bangladesh.

# Annexure

# Annex1: Analysis of Marginalization and Vulnerability of the three impact groups:

**(Related to their Health and Nutrition)-Agency, Structure and Relationship**

The marginalization and vulnerability of the impact groups, the rural poor, urban marginalized, marginalized women; related to their health and nutrition is described in terms of agency, structure and relationship model.

**Agency (The impact Population):** All three impact populations have poor capacity in terms of their knowledge on health and nutrition, availability of health institutions and services; which multiplied by their low self esteem and confidence leads to their poor negotiating capacity with the community and particularly with the health system and providers and compromise the ability to demand their health rights. All the above mentions factors and the existing gender norms and power structure within the household leads to poor participation of women in decision making related to their own health and health care as well as decisions regarding their children’s health care. The Women are also subjected to violence within the household by their husbands and in laws which are accepted as social norms and tolerated by the community.

**Structure:** The structure includes both health and non-health the formal support systems, especially which impact the health and nutrition status of the impact population either directly or indirectly. The health system includes both public and private health facilities and providers. The health care he providers with poor capacity and limited understanding of the specific problems and constraints of the impact populations are poorly connected, motivated, non responsive and often exploitative to the poor and marginalized, especially women. Policies to ensure equitable services for these groups are either poorly implemented and or not in place.

**Relationship (The Social capital)**: The position, connectivity and acceptability within the community as well as within the family are considered as social capital or relationship. The impact population is poorly connected with limited social support leading to poor social capital. Their poor recognition and acceptability by the community and structure compromise their ability to participate in community spaces and raise voices which results in poor accountability of the health and other systems towards them and their causes. The women hold a lower position and less valued as an equal member both within the family and in the community due to the existing gender roles, social norms and values, have poor access to resources and poor mobility to which compromises their ability to seek timely care. Women’s poor connectivity results in inability to seek legal, social and health assistance after violence which leading to further poor mental and physical health.

**Manifestation of marginalization and vulnerability:** All the above mentioned issues manifests as poor health and nutrition of the impact population with high maternal and child mortality, high anemia and stunting. They are often exploited by the health system and the providers, both public, private and NGO, which raises their health care expenditure with poor quality services in context of their limited financial capacity and access to resources and leads to poor resilience to health shock. Women’s participation and autonomy in decision making related to health and health care seeking compromise their rights to health. They are also subjected to gender based violence with poor access to assistance after violence and exploitation. The high rate of child marriage and adolescent pregnancy are both a consequence of existing social/gender norms and also a cause of further poor health and nutrition among women and children that feeding into the cycle of poverty and violence.

**Figure: Analysis marginalization and vulnerability of with its manifestations in terms of health**

To improve the Health and Nutrition outcomes of the impact population CARE-Bangladesh intends to bring changes both at the agency, structure and relationship level and will observe the shift or changes of these manifestations among the impact populations to monitor the progress, in addition to the conventional health service access and knowledge level changes/indicators.

## Annex-2: Government of Bangladesh Priorities

This exercise was neither exhaustive, nor made any pretense of representing the priorities of the Government of Bangladesh (GOB). However, during the scan of the external environment and during meetings with different informants, possible GOB directions and priorities were discussed.

Following are some of the health priorities that people felt CARE-B should be considering in their strategy.

Health Services Strengthening

As Bangladesh wrestles with what universal coverage of health care will mean in the face of their ever-growing population and the increasing middle class, a range of service delivery issues come up which will need attention during the coming years. It was recognized that CARE-B has been a strong player in health service strengthening, and this probably doesn’t need to change.

* Quality Assurance – contributing to quality assurance approaches that include the voice and participation of health service users as well as providers.
* Health service accountability – to all people needing health care and not just those who can pay for it or who otherwise have access.
* Human resources management continues to be one of the biggest challenges, not only considering the total pool of qualified staff but the ability to map the locations of different provider skills to assure adequate distribution. Positive supervision and reinforcement also continue to be a significant challenge.

Increased Access to Health Care

Lack of access to health services for the poor, marginalized, and geographically isolated people continues to be a challenge for the GOB and is not likely to decrease in the near future. The ability to assure health care coverage for everyone will depend on mobilizing private providers, NGOs and government services to work together in a complementary way, with different service modalities serving different populations.

* Focus areas probably need to be nutrition and maternal health, while recognizing that urban health and adolescent reproductive health are also currently significant gaps.
* NGO / PVO support for Community Support Groups and Community Clinics has been instrumental and people recognize that the potential role for Community Support Groups has not yet been realized.
* There is a need for a lot more discussion around the definition of a minimum package of care, options for funding costs, and how to best address the non-communicable disease burden that is expanding rapidly.

## Annex-3: CARE Global Priorities

As CARE Bangladesh looks toward its internal program review, it is considering how to best link its current country office priorities with the direction CARE Global is moving. While this strategy does not address this in detail, some key principles influenced the team’s thinking:

* The CARE Global Program Strategy prioritizes the humanitarian response, promoting lasting change, and multiplying impact. These became a lens through which the Bangladesh strategy options and priorities were considered.
* The Program Strategy also emphasizes cross-cutting approaches to achieving CARE’s priorities. These include strengthening gender equality, promoting inclusive governance, and increasing resilience. Currently, these approaches are being developed through three work streams within the SRMHR platform:
  + Gender Sexuality and Rights, including development and reinforcement of the Social Analysis and Action approach to addressing gender and social barriers to reproductive health.
  + Governance and Accountability including development of the Community Scorecard as a strategy to develop participatory governance and voice at the community level and joint quality improvement efforts through partnership with service providers.
  + Reproductive Health in Emergencies, including the integration of reproductive health services such as family planning and emergency obstetric care with traditional emergency response packages.

## Annex-4: List of peoples consulted and engaged Health Strategy development process

**Contact People and Meetings**

**Core Strategy Development Team:**

1. Fatima Jahan Seema - Impact & Evaluation Coordinator
2. Murad Bin Aziz - Governance Coordinator
3. Khan Tawhid Parvez - Senior Technical Manager-HHN , SHOUHARDO II
4. Hafijul Islam- Technical Coordinator-KM, NAC
5. Sakina Sultana - Technical Coordinator-Program, GFIDU
6. Jahirul Alam Azad - Team Leader, MNH
7. Salahuddin Ahmed - National Nutrition Coordinator
8. Abu Taher-Community Mobilization Advisor, Women and Girls Empowerment Program
9. Azizur Rahman, Urban Health Specialist, NHSDP
10. Jeba Lovely, Gender specialist NHSDP
11. Rina Rani Paul- Project Manager
12. Jahangir Hossain - Program Director- Health
13. Marcie Rubardt-Senior Technical Advisor –SRMHR, CARE- Atlanta

**Key informants / people contacted:**

Internal CARE

* Jamie Terzi, CD
* Members of the Senior Leadership Team
* Health project coordinators
* Representatives of other programs: Reza Mahmoud Alhuda, Team Leader for Education, Nurul Amin Siddiquee, Coordinator-Agriculture & Value Chain, ERPP, and Sonia Afrin- Team Leader, Women 360 Initiative,

External to CARE

* Zakir Hussein, Ex-Director of Primary Health Care and Disease Control, Government of Bangladesh
* Yukie Yoshimura, Chief Advisor, SMPP Safe Motherhood Project, JICA
* Sharms El Arifeen, Director, Center for Adolescent and Child Health, ICDDRB
* Dr. Kaosar Afsana, Director Health, Nutrition and Population, BRAC
* Michael Foley, Director of Health and Nutrition, Save the Children