EVALUATION REPORT ANNEXES

INDEPENDENT COUNTRY PROGRAMME EVALUATION ANNEXES

BANGLADESH

[2012-2016]

Evaluation Office

New York
April
2016

EVALUATION TEAM

EVALUATION TEAM

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Design and Printing: [Company Name]

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Abbreviations and Acronyms

ANC	Antenatal Care
APRO	Asia and the Pacific Regional Office (UNFPA)
ASRH	Adolescent Sexual Reproductive Health
AWP	Annual Work Plans
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
BGMEA	Bangladesh Women Chamber of Commerce and Industry
BIMSTEC	Bay of Bengal Initiative for Multi-Sectoral Technical and Economic Cooperation
BMMS	Bangladesh Maternal Mortality Survey
BNMC	Bangladesh Nursing and Midwifery Council
BPS	Bangladesh Parliamentary Secretariat
BSEHR	Bangladesh Society for the Enhancement of Human Rights
BSMMU	Bangabandhu Sheikh Mujib Medical University
BWCCI	Bangladesh Women Chamber of Commerce and Industry
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
COAR	Country Office Annual Report
CP	Country Programme
CPD	Country Programme Document
CPR	Contraceptive Prevalence Rate
CRHCC	Comprehensive Reproductive Health Care Centers
CSBA	Community Skilled Birth Attendant
CWFD	Concerned Women for Family Development
DH	District Hospital
DNS	Department of Nursing Services
DPS	Department of Population Sciences, Dhaka University
DWA	Department of Women Affairs
EMOC	Emergency Maternal Obstetric Care
EMNOC	Emergency Maternal and Neonatal Obstetric Care
ERD	Economic Relations Division (of the Ministry of Finance)
ERG	Evaluation Reference Group
EU	European Union
EVA	Especially Vulnerable Population
FGD	Focus Group Discussion
FIGO	International Federation of Gynecology and Obstetrics
FP	Family Planning
FPAB	Family Planning Association Bangladesh
FWA	Family Welfare Assistant
FWV	Family Welfare Volunteer
FY	Fiscal Year
GE	Gender equality
GED	General Economics Division
GEMS	Gender Equity Movement for Schools
GBV	Gender Based Violence
GDP	Gross Domestic Product
GOB	Government of Bangladesh
GRB	Gender Responsive Budget
HA	Health Assistant
HDI	Human Development Index
HPNSDP	Health Population and Nutrition Sector Development Plan
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
IDU	Injecting Drug User
IPPF	International Planned Parenthood Federation
LAPM	Long Acting and Permanent Methods
MARA	Most At-Risk Adolescents
MARP	Most At Risk population
MARYP	Most At Risk Young Population
MCWC	Maternal and Child Welfare Centre

MDG	Millennium Development Goal
MH	Maternal Health
MICS	Multiple Indicator Cluster Survey
MIS	Management Information System
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Rate
MPDR	Maternal and Perinatal Death Review
MNH	Maternal Newborn Health
MOHFW	Ministry of Health and Family Welfare
MOWCA	Ministry of Women and Children's Affairs
MR	Menstrual Regulation
MSM	Male Having Sex with Male
MTBF	Medium Term Budgetary Framework
NAPWA	National Action Plan for Women Advancement
NSV	Non-Scalpel Vasectomy
OCC	One-stop Crisis Centre
OECD-DAC	Organization for Economic Cooperation and Development – Development Assistance Committee
P&D	Population and Development
PEP	Post Exposure Prophylaxis for HIV
PNC	Post Natal Care
PPH	Post-Partum Haemorrhaging
PPR	Population, Planning and Research
PPP	Public Private Partnership
PRSP	Poverty Reduction Strategy Paper
QA	Quality Assurance
RHR	Reproductive Health and Rights
RMG	Ready Made Garment
RTMI	Research Training and Management International
SAARC	South Asian Association for Regional Cooperation
SBA	Skilled Birth Attendant
SEID	Socio Economic Infrastructure Division
SME	Small and Medium Entrepreneurs
SOP	Standard Operating Procedure
SPCPD	Strengthening Parliament's Capacity in Integrating Population Issues into Development
SPR	Standard Progress Report
SRHR	Sexual Reproductive Health and Rights
STIs	Sexually Transmitted Infections
SVRS	Sample Vital Registration Survey
SWAP	Sector Wide Approach
TA	Technical Assistance
TFR	Total Fertility Rate
TOT	Training of Trainers
TPP	Technical Project Proposal
UH&FWC	Upazila Health and Family Welfare Center
UNDAF	United Nations Development Assistance Framework
UPHCP	Urban Primary Health Care Project
UPHCSDP	Urban Health Care Services Delivery Project
VAW	Violence Against Women
VGD	Vulnerable Group Development
WFHD	Woman Friendly Hospital Initiative
WSC	Women Support Centre

Annex 1 Bangladesh 8th Country Programme Evaluation Terms of Reference

Evaluation Office

TERMS OF REFERENCE FOR THE EVALUATION OF THE UNFPA 8TH COUNTRY PROGRAMME OF ASSISTANCE TO THE GOVERNMENT OF BANGLADESH (2012-2016)

1. INTRODUCTION

The Evaluation Office is planning to conduct the independent evaluation of the UNFPA 8th Country Programme of Assistance to the Government of Bangladesh (2012-2016) as part of its 2015 annual work plan, and in accordance with the UNFPA evaluation policy (DP/FPA/2013/5).

As per the evaluation policy, evaluation at UNFPA serves three main purposes: (i) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (ii) support evidence-based decision-making; (iii) contribute important lessons learned to the existing knowledge base on how to accelerate implementation of the Programme of Action of the International Conference on Population and Development (ICPD).

The main audience and primary users of the evaluation are the UNFPA Bangladesh Country Office (CO), the UNFPA Asia and the Pacific Regional Office (APRO) and UNFPA Headquarter divisions, which may all use the evaluation as an objective basis for decision-making. The evaluation will also benefit government partners, the civil society, as well as other development partners (such as other UN agencies) in Bangladesh, through the dissemination of its results.

The evaluation will be managed by the Evaluation Office and conducted by a team of independent evaluators, in close cooperation with the UNFPA Bangladesh CO and the APRO Regional M&E Adviser.

2. NATIONAL CONTEXT

Bangladesh is a Least Developed Country, with an estimated population of 158 million inhabitants and the highest population density in the world (1015/sq. kilometre)[1] in 2011, except for some city states/countries such as Singapore.

Between 2004 and 2014, Bangladesh averaged a GDP growth rate of 6%. The per capita income is US$ 1,314. The economy is increasingly led by export-oriented industrialisation. The Bangladesh garment/textile industries are the second-largest in the world. Other key sectors include pharmaceuticals, shipbuilding, ceramics, leather goods and electronics etc. Bangladesh has also recently nearly achieved self-sufficiency on food production.

[1] UNFPA Bangladesh, Demographic Impact Study, BBS, 2014

Bangladesh has made significant progress in achieving many of the goals of the ICPD Programme of Action and the Millennium Development Goals (MDGs). The national development plans, i.e. the Sixth Five Year Plan, also focused on the general improvements in the quality of life of the Bangladeshi people. According to the World Bank, the percentage of the poor people in the country living on just less than $1.25 a day (PPP) declined from 58.6% in 2000 to 43.3% in 2010. However, progress has been uneven, and socio-economic, geographical and gender inequalities have been widened. Especially, inequalities in access to quality reproductive health services and disparities in health outcomes and gender inequalities in many areas persist in the country.

Following a very successful Family Planning programme, the total fertility rate (TFR) fell from 3.3 in 1999-2000 to 2.3 in 2011 (BDHS 2011). However since then, there has been no further decline in the TFR, and it stays at 2.3 until 2014 (BDHS 2014). According to the UNFPA-commissioned *Demographic Impact Study 2015*, the country is adding 2 million people to its population every year, and it will reach 200 million by 2041 based on the medium projection (TFP=1.9), and by 2031 based on the high projection if TFR stayed at 2.3. The country is now going through a 'demographic window of opportunity' with more than 30% of its population being young (10-24 years of age). Contraceptive Prevalence Rate (CPR) has only slightly increased to 62.4% in 2014 from 61.2% in 2011(BDHS 2014). The use of modern family planning methods constitutes 54%; pill is by far the most widely used method (27%), followed by injectables (12.4%), female sterilization (4.6%) and condom (6.4%). Uses of long-acting and permanent methods (LAPM) such as sterilization, IUD or Norplant have declined to 8.1% only. Unmet need for family planning has declined to 12% in 2014, from 13.5% in 2011. There are marked regional variations in the total fertility rate and contraceptive usage. Some key factors contributing to this phenomenon are low educational levels, continued son preference, high infant mortality, gender inequality, and poor status of women.

A gender-inequitable culture of impunity and silence perpetuates the prevalence of gender-based violence (GBV) in the country. About 65% women have experienced physical violence from their husband.[2] Bangladesh is also the 2nd worst in the world regarding child marriage. In spite of the law allowing the girls to marry at 18, 65% of women of 20-24 years old were married before 18 (2011). Child marriage is followed by early first delivery. Adolescent fertility in Bangladesh is still one of the highest in the world, with 113 births per 1,000 women below 20 (BDHS: 2014), the worst in South Asia. Access to appropriate SRH information and services for young people, especially unmarried girls and boys, is inadequate. Young people are also vulnerable to STI/HIV/AIDS and drug abuse.

Bangladesh is one of very few developing countries in the world that are on track in achieving MDG 5. The maternal mortality ratio (MMR) declined to an estimated 170 in 2013, from 574 in 1990. 62% of the deliveries take place at home. 58% of all deliveries are conducted without any skilled health personnel (BDHS 2014). Still an estimated 5,200 women die in pregnancy or childbirth every year. Tackling maternal mortality and morbidity including obstetric fistula, will continue to be a serious challenge. Majority (51%) of the maternal deaths are due to two preventable causes, i.e. haemorrhage and eclampsia. One fifth of all maternal deaths are due to obstetric causes related to abortion and its complications, 14% of pregnant women's deaths are associated with violence and injuries. Morbidity is estimated to be 30 times higher than that of maternal mortality. Ensuing safe delivery with referral linkages, and addressing "three delays" and management of complications and Emergency Obstetric Care (EmOC) services, are critically important for saving women's life as well as the newborns. About half of the pregnant women are malnourished (BMI <18) and most of them suffer from anaemia and other ailments related to nutritional deficiency. Therefore, despite some progress in Human Development Index (HDI) (142nd in 2014), the status of women still remains low (0.529 GDI).

A recently published *Fragile State Index 2015* marked Bangladesh as one of the countries in the "Alert" category. With a Fragile State Index of 91.8, Bangladesh ranked 32 out of 178 countries.[3]

[2] Report on Violence against women (VAW) survey, BBS, 2011

[3] The Fund for Peace, 2015

Frequent calamitous cyclones and floods makes Bangladesh one of the most disaster prone countries in the world. According to the World Risk Index, the country is the fifth highest disaster risk country in the world and second in Asia, out of 172 countries.[4] Man-made disasters are also prevalent such as collapses of multi-story building, frequent fire in industries and drowning of water vessels in the river or sea have very high case fatalities. Dhaka, the capital city of Bangladesh, has been ranked as the second least livable city in the world, only after Damascus in Syria.[5] Recently, the country has also hit the international media scene with the situation in the Bay of Bengal and Andaman Sea involving migrants and refugees – Rohingya and others – from Bangladesh and Myanmar.

Bangladesh's economic growth and achievements have often been hindered by political turmoil that impacts democratic governance. Ever since the main opposition, 20 party alliances, boycotted the 2014 national election, the country has seen frequent Hartal (general strike) and road blockade that continued for the first three months in 2015. Hartal and blockade also disrupted the pace of development assistance including the work of UNFPA.

3. BACKGROUND OF THE 8TH COUNTRY PROGRAMME

The United Nations Population Fund (UNFPA) has been working in partnership with the Government of the People's Republic of Bangladesh since 1974 through technical advisory services and financial support. So far, UNFPA has completed seven country programme cycles, while it is currently carrying out its eighth country programme, 2012- 2016 (8th CP).

The 8th CP of UNFPA is built on the experiences of earlier country programmes and reflects the ICPD agenda and the Beijing Plan of Action, the MDG situation analysis (instead of CCA) and United Nations Development Assistance Framework (UNDAF), in response to the Government's national development goals including the Millennium Development Goals. The programme has also taken into account the findings and recommendations of the 7th country programme (CPE 2011) and guided by UNFPA's Strategic Plan (SP: 2008-2013 and 2014-2017). The programme emphasizes capacity development, service delivery, with particular focus on the poor and vulnerable populations, and gender equality and the empowerment of women, with special emphasis on gender-based violence (GBV). This programme also supports the health-sector SWAp (Health, Population and Nutrition Sector Development Programme – HPNSDP) through parallel funding as well as pool funding with a small proportion of funds placed in the pool. The programme is nationally executed with Government, in close partnership with other United Nations agencies, NGOs and the private sector.

The results and resource framework (RRF) of the 8th CP clearly identified the outcomes and outputs with relevant indicators and resource requirements. The 8CP set the target of a total of US$ 70 million (US$ 40 million from the Regular Resources and US$ 30 million to be mobilized from Other Resources) over the 5 years of 2012-2016.

The programme is organised around three mutually re-enforcing programme components: i) Reproductive Health (RH), ii) Gender, and iii) Population and Development (P&D). After the alignment with current strategic plan (2014-2017), a new component has been added to the country programme and the country office, i.e. adolescent and youth.

The **Reproductive Health component** mainly aims at increasing access to health services and improving their quality, particularly in underserved districts and urban areas with particular focuses on capacity development in the RH sector with special attention to safe motherhood (particularly emergency obstetric care (EmOC), midwifery and safe home delivery by community-based skilled birth attendants (C-SBAs), and maternal morbidity (fistula, cervical and breast cancer), family planning, Reproductive Health Commodity Security (RHCS).

[4] The 2014 World Risk Report, the United Nations University Institute for Environment and Human Security (UNU-EHS) and the Alliance Development Works/Bündnis Entwicklung Hilft, 2014

[5] Global Liveability Ranking and Report, Economist Intelligence Unit, August 2014

The **Adolescents and Youth component** was recently introduced in late 2014, focusing on the development of the adolescent and youth reproductive health, STI and HIV/AIDS prevention and gender responsive behavior among the adolescents. This component is also piloting adaptation of GEMS (Gender equity Movements in Schools) curriculum with Ministry of Education, Ministry of Women and Children Affairs and NGOs.

The **Gender Equality component** two objectives are pursued: (a) integrating gender equality and the human rights of women and adolescent girls in pertinent national and sectorial laws, policies, strategies, and plans; including women's empowerment, and raising awareness on gender issues and (b) prevention and protection from, and response to, gender-based violence improved at the national level and in programme districts.

The **Population and Development component** is intended to improve analysis and use of population data in national and sectoral planning and policies and strategies. It is emphasising the utilization of gender and poverty disaggregated data for development planning and poverty reduction. Also supported the whole range of census 2011 activities i.e. data collection, logistics and data analysis, and preparing technical paper and monographs.

UN agencies jointly decided to implement the UN programme in underserved focused districts and identified 20 districts for UNDAF 2012-2016 interventions. As per the UNDAF, UNFPA is programming on 13 underserved districts, of which nine are UNDAF Districts (out 20 UNDAF districts) and four additional priority districts chosen based on SRH and gender. Gender component is programming in four districts. There have been many interventions which are national in scope, e.g., advocacy, contraceptive security and the SWAp, campaign on GBV etc. The district level programme interventions are being coordinated through the seven district offices; UNFPA has introduced local level planning as well to promote national ownership and capacity development for planning and budgeting and monitoring at the local level.

The programme is nationally executed with the Government, in close partnership with other United Nations agencies, NGOs and the private sector. 17 implementing partners with 19 projects from eight ministries, five NGOs and two autonomous bodies (Bangladesh Garments Manufacturers and Exporters Association – BGMEA and Dhaka University), are carrying out the activities to achieve the above outputs and contributing to the outcomes. The Economic Relations Division (ERD) of the Ministry of Finance is the overall coordinating agency for the UN agencies, including UNFPA's 8th County programme.

In addition to the country programmes, UNFPA Bangladesh has had two joint programme during the period under evaluation, such as Accelerating the reduction of maternal and neo-natal mortality (Phase II, 2011-2016, funded by DFATD/CIDA), and Reduction of violence against women (MDG Spain fund- concluded in 2013). In addition, CO has one multi-bilateral project on "Generation Breakthrough" (funded by EKN). All these projects have contributed to the country programme.

4. CURRENT STATUS OF THE PROGRAMME

The 8th Country Programme is currently on its fourth year of its 5-year cycle. The programme implementation suffered from a slow start in the first two years, mainly due to the lack of readiness of the government departments, lengthy preparation and approval process of TPP (technical project proposal – internal legal document of the Government required for development partners to start activities), frequent political turmoil resulting in violent Hartals (general strike) and road blockade, etc. The Country Programme thus needed to wait till 2014 for a smoother implementation to kick in, after all the necessary agreements were signed with the implementing partners.

During the last years, the Country Programme has focused mainly on strengthening technical and institutional capacities of government counterparts. Capacity development activities have been promoted, including development of protocols and guidelines and training materials, conducting

training and orientations in relevant reproductive health and population and development and gender issues, and supporting knowledge-sharing activities.

After the approval of the UNFPA's new global Strategic Plan 2014-2017, UNFPA Bangladesh Country Office in 2014 went through an alignment exercise with support from APRO. This has helped to identify line of contribution to global outcomes, readjustment/revision of Results framework (RRF) including indicators, Human resources alignment and also drafted a partnership plan.

Country Programme is linked to UNDAF Action Plan and contributing to six UNDAF Pillars out of seven. Major contributions are on the Pillar 3 (social services and human development) and Pillar 7 (Gender equity). An UNDAF wide baseline survey was supposed to be done; which however was not undertaken based on a change in a UNCT decision. That placed UNDAF as well as UNFPA is a little bit difficult situation as many information on indicators supposed to be covered through baseline. However, those indicators were later covered with data from secondary sources and project based information/surveys. Monitoring of implementation status of planned activities was done quarterly; seven district offices have been established to support 11 districts and to coordinate and monitor the targeted interventions in the respective districts and a number of relevant research studies were conducted during the 8CP.

OBJECTIVES AND SCOPE OF THE EVALUATION :

The objectives of the independent evaluation of the UNFPA 8th country programme for Bangladesh are:

- to provide the UNFPA country office in Bangladesh, national programme stakeholders, the UNFPA Asia and Pacific regional office , UNFPA headquarters as well as the wider audience with an independent assessment of the relevance and performance of the UNFPA 8th country programme for Bangladesh;
- to provide a specific analysis of how the UNFPA CO took into account and addressed the drivers to fragility in Bangladesh
- to provide an analysis of how UNFPA has positioned itself within the development community and national partners with a view to adding value to the country development results;
- to draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programming cycle.

The evaluation will cover all activities planned and/or implemented during the period 2012-2016 within each programme component (reproductive health and rights, gender equality, population and development and adolescent and youth). Besides the assessment of the intended effects of the programme, the evaluation also aims at identifying potential unintended effects.

5. EVALUATION CRITERIA AND EVALUATION QUESTIONS

In accordance with the methodology for CPEs as set out in the Evaluation Branch Handbook on How to Design and Conduct Country Programme Evaluations (2012)[6], the evaluation will be based on a number of questions (limited to a maximum of ten) covering the following evaluation criteria.

Relevance

- To what extent are the objectives of the programme (i) adapted to the needs of the population (in particular the needs of vulnerable groups), (ii) aligned with government priorities (iii) as well as with policies and strategies of UNFPA?
- To what extent is the UNFPA country programme aligned with the United Nations Development Assistance Framework (UNDAF) for 2012-2016?
- To what extent was the country office able to respond to changes in the national development context?

Effectiveness

- To what extent have the expected results of the programme been achieved?

Efficiency

- To what extent were programme resources (funds, expertise, time, etc.) converted into results?

Sustainability

- To what extent are the results of UNFPA supported activities likely to last after their termination?

Coordination

- To what extent did UNFPA contribute to coordination mechanisms in the UN system in Bangladesh?

Complementarity

- To what extent did UNFPA contribute to complementarity (i.e. avoiding overlap and duplication of activities / seeking synergies) among UN agencies in Bangladesh?

The generic questions listed above are only indicative; the final set of evaluation questions will be determined during the design phase, after a discussion with the evaluation reference group. **The final list of questions will include two questions pertaining specifically to "fragility" issues**.

[6] http://www.unfpa.org/public/home/about/Evaluation/Methodology

6. EVALUATION METHODOLOGICAL APPROACH

Data Collection

The evaluation will use a multiple-method approach including documentary review, group and individual interviews, focus groups and field visits as appropriate.

Validation mechanisms

The Evaluation Team will use a variety of methods to ensure the validity of the data collected. Besides a systematic triangulation of data sources and data collection methods and tools, the validation of data will be sought through regular exchanges with the CO programme managers.

Stakeholder participation

An inclusive approach, involving a broad range of partners and stakeholders, will be taken. The evaluation team will perform a stakeholder mapping in order to identify both UNFPA direct and indirect partners (i.e. partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic area in the national context). These stakeholders may include representatives from the Government, civil-society organizations, the private-sector, UN organizations, other multilateral organizations, bilateral donors, and most importantly, the beneficiaries of the programme.

7. EVALUATION PROCESS

The evaluation will unfold in five phases, each of them including several steps.

1) Preparatory phase

This phase will include:

- the drafting of the evaluation *terms of reference*;
- the selection and recruitment of a *team of evaluators*;
- a *scoping mission* in Dhaka;
- the constitution of an *evaluation reference group*.

2) Design phase

This phase will include:

- a *documentary review* of all relevant documents available at UNFPA headquarters, regional office and country office levels regarding the country programme for the period under assessment: 2011-2014;
- a *stakeholder mapping* – The evaluation team will prepare a mapping of stakeholders relevant to the evaluation. The mapping exercise will include state and civil-society stakeholders and will indicate the relationships between different sets of stakeholders;
- a reconstruction of the *intervention logic* of the programme, i.e. the theory of change meant to lead from planned activities to the intended results of the programme;
- the finalization of the list of evaluation questions;
- the development of a data collection and analysis strategy as well as a concrete workplan for the field phase.

At the end of the design phase, the evaluation team will produce a **design report**, displaying the results of the above-listed steps and tasks.

3) Field phase

After the design phase, the evaluation team will undertake a three-week in-country mission to collect and analyze the data required in order to answer the evaluation questions as agreed upon at the design phase.

At the end of the field phase, the evaluation team will provide the CO with a debriefing presentation on the preliminary results of the evaluation, with a view to validating preliminary findings and testing tentative conclusions and recommendations.

4) Reporting phase

During this phase, the evaluation team will continue the analytical work initiated during the field phase and prepare a first draft of the final evaluation report, taking into account comments made by the CO at the field phase debriefing meeting. This **first draft final report** will be submitted to the evaluation reference group for comments (in writing). Comments made by the reference group will then allow the evaluation team to prepare a **second draft of the final evaluation report**.

This second draft final report will form the basis for an **in-country dissemination seminar**, which should be attended by the CO as well as all the key programme stakeholders (including key national counterparts). The **final report** will be drafted shortly after the seminar, taking into account comments made by the participants.

5) Dissemination and follow-up phase

This phase will include:

- the publishing and dissemination of the evaluation final report;
- the preparation of a management response to the recommendations of the evaluation;
- a quality assessment of the final report;
- a follow-up of the recommendations of the evaluation (one year later).

8. INDICATIVE TIMEFRAME

Phases/deliverables	Dates
1. **Preparatory phase**	**Jun.-Sep. 2015**
- Drafting of Terms of Reference	*Jun. 2015*
- Recruitment of evaluation team	*Jun.-Aug. 2015*
- Scoping mission	*end Aug./early Sep. 2015*
-Constitution of reference group	*early Sep. 2015*
2. Design phase	**Sep.-early Oct. 2015**
- Draft design report	*end Sep. 2015*
- Final design report	*early Oct. 2015*
3. Field phase	**Oct. 2015**
4. Synthesis phase	**Oct. 2015-Mar. 2015**
- 1st draft final report	*early Nov. 2015*
- 2nd draft final report	*early Dec. 2015*
- Stakeholder workshop (in Dhaka)	*early Dec. 2015*
- Final report	*end Feb. 2016*
5. Dissemination and follow-up phase	**Mar. 2016-Apr. 2017**
-Evaluation quality assessment	*Mar. 2016*
-Management response	*Apr. 2016*
- Follow-up to the recommendations (by Programme Division)	*Apr. 2017*

9. COMPOSITION OF THE EVALUATION TEAM

The evaluation team will consist of:

- a **team leader** (Evaluation Adviser at the Evaluation Office, UNFPA), with overall responsibility for the evaluation process, from the preparation of the ToR to the production of the final report. He will lead and coordinate the work of the evaluation team and will also be responsible for the quality assurance of all evaluation deliverables.
- a **co-team leader** (consultant), who will support the team leader and provide expertise in one of the three programmatic areas of the evaluation (reproductive health and rights, gender or population and development). She/he will take part in the data collection and analysis work during the design and field phases. She/he will be responsible for drafting key parts of the design report and of the draft final and final evaluation reports, including (but not limited to) sections relating to her/his area of expertise. She/he will be responsible for putting together the design report, the draft final and the final evaluation reports based on inputs from other evaluation team members.
- two **evaluators** (consultants), who will each provide expertise in one programmatic area of the evaluation. Each evaluator will take part in the data collection and analysis work during the design and field phases. Each evaluator will be responsible for drafting key parts of the design report and of the draft final and final evaluation reports, including (but not limited to) sections relating to her/his area of expertise.

The team might be assisted by a translator/interpreter, according to its needs.

The work of the evaluation team will be guided by the Norms and Standards established by the United Nations Evaluation Group (UNEG). Team members will adhere to the Ethical Guidelines for Evaluators in the UN system and the Code of Conduct, also established by UNEG. The evaluators will be requested to sign the Code of Conduct prior to engaging in the evaluation exercise.

10. DELIVERABLES

The evaluation team will produce the following deliverables:

- a design report including (as a minimum): a) a stakeholder map ; b) the evaluation matrix (including the final list of evaluation questions and the corresponding judgement criteria and indicators) ; c) the overall evaluation design and methodology, with a detailed description of the data collection plan for the field phase;

- a debriefing presentation document (*Power Point*) synthesizing the main preliminary findings, conclusions and recommendations of the evaluation, to be presented and discussed with the CO during the debriefing meeting foreseen at the end of the field phase;

- a draft final evaluation report (potentially followed by a second draft, taking into account potential comments from the evaluation reference group);

- a powerpoint presentation of the results of the evaluation for the in-country stakeholder workshop;

- a final report, based on comments expressed during the in-country stakeholder workshop.

All deliverables will be drafted in *English*.

11. MANAGEMENT OF THE EVALUATION

The team leader will also be the manager of the evaluation.
He will be assisted by a **reference group** composed of the UNFPA Bangladesh country office M&E focal point, the UNFPA APRO regional M&E adviser as well as representatives from the national government partners and the civil society.
The role of the reference group will be of a *technical nature*. Its main tasks will be:

- to discuss the terms of reference drawn up by the Evaluation Office;
- to provide the evaluation team with relevant information and documentation on the programme under assessment;
- to facilitate the access of the evaluation team to key informants during the field phase;
- to discuss the reports produced by the evaluation team;
- to advise on the quality of the work done by the evaluation team;
- to assist in feedback of the findings, conclusions and recommendations from the evaluation into future programme design and implementation.

The team leader and the reference group will communicate mostly via e-mail, although “virtual” meetings (via tele or videoconference) may also be convened.

12. QUALIFICATIONS OF EXPERTS

1. Co-team leader

- An advanced degree in social sciences, political science, economics or related fields;
- Extensive previous experience in leading complex evaluations, especially in the field of development aid for UN agencies and/or other international organizations evaluations;
- Specialization and significant experience in one of the programmatic areas covered by the evaluation (reproductive health and rights, gender or population and development);
- Significant experience in and/or knowledge of humanitarian settings and fragile contexts;
- Familiarity with UN and/or UNFPA mandate and activities;
- Excellent management skills and ability to work with multi-disciplinary and multi-cultural teams;
- Excellent analytical, communication and writing skills;
- Fluency in English is required.

2. Evaluators

- An advanced degree in social sciences, political science, economics or related fields;
- Specialization and/or significant experience in one of the programmatic areas covered by the evaluation (reproductive health and rights, gender or population and development);
- Significant knowledge and experience of complex evaluations in the field of development aid for UN agencies and/or other international organizations;
- Significant experience in and/or knowledge of humanitarian settings and fragile contexts;
- Familiarity with UN and/or UNFPA mandate and activities;
- Strong interpersonal skills and ability to work in a multi-cultural team;
- Familiarity with UNFPA or UN operations;
- Excellent analytical, communication and writing skills;
- Fluency in English is required.

13. DURATION OF CONTRACT AND NUMBER OF WORKDAYS

Repartition of workdays among the evaluation team will be the following:

- 65 (sixty-five) workdays for co-team leader;
- 40 (forty) workdays for each evaluator;

The repartition of workdays per expert and per evaluation phase is the following:

	Co-team leader	Evaluator 1	Evaluator 2
Preparatory phase (scoping mission)	5		
Design phase	5	5	5
Field phase	15	15	15
Reporting phase			
contribution to final report	*20*	*18*	*18*
coordination + consolidation of evaluation report	*15*		
Preparation and facilitation of stakeholder workshop	*5*	*2*	*2*
Subtotal	40	20	20
TOTAL	**65**	**40**	**40**

Workdays will be distributed between the date of contract signature (no later than 1 September 2015) and 31 March 2016.
Payment of fees will be based on the delivery of outputs, as follows:

- Upon satisfactory contribution to the design report: 20%
- Upon satisfactory contribution to the draft final evaluation report: 50%
- Upon satisfactory contribution to the final evaluation report: 30%

Daily Subsistence Allowance (DSA) will be paid per nights spent at the place of the mission following UNFPA DSA standard rates. Travel costs will be settled separately from the consultant fees.

ANNEX I : Ethical Code of Conduct for UNEG/UNFPA Evaluations

Evaluations of UNFPA-supported activities need to be independent, impartial and rigorous. Each evaluation should clearly contribute to learning and accountability. Hence evaluators must have personal and professional integrity and be guided by propriety in the conduct of their business

Evaluation Team /Evaluators:

1. To avoid **conflict of interest** and undue pressure, evaluators need to be **independent,** implying that members of an evaluation team must not have been directly responsible for the policy/programming-setting, design, or overall management of the subject of evaluation, nor expect to be in the near future.

Evaluators must have no vested interest and have the full freedom to conduct impartially their evaluative work, without potential negative effects on their career development. They must be able to express their opinion in a free manner.

2. Should protect the anonymity and **confidentiality of individual informants**. They should provide maximum notice, minimize demands on time, and: respect people's right not to engage. Evaluators must respect people's right to provide information in confidence, and must ensure that sensitive information cannot be traced to its source. Evaluators are **not expected to evaluate individuals**, and must balance an evaluation of management functions with this general principle.

3. Evaluations sometimes uncover evidence of wrongdoing. Such cases must be reported discreetly to the appropriate investigative body.

4. Should be **sensitive to beliefs, manners and customs** and act with integrity and honesty in their relations with all stakeholders. In line with the UN Universal Declaration of Human Rights, evaluators must be sensitive to and **address issues of discrimination and gender equality**. They should avoid offending the dignity and self-respect of those persons with whom they come in contact in the course of the evaluation. Knowing that evaluation might negatively affect the interests of some stakeholders, evaluators should conduct the evaluation and communicate its purpose and results in a way that clearly respects the stakeholders' dignity and self-worth.

5. They are responsible for the clear, accurate and fair written and/or oral presentation of study limitations, evidence based findings, conclusions and recommendations.

For details on the ethics and independence in evaluation, please see UNEG Ethical Guidelines and Norms for Evaluation in the UN System

http://www.unevaluation.org/search/index.jsp?q=UNEG+Ethical+Guidelines

http://www.unevaluation.org/papersandpubs/documentdetail.jsp?doc_id=21

[Please date, sign and write "Read and approved"]

ANNEXE II : Management response

UNFPA Management response	Country Programme Evaluations *(from-to): ……(name of the country)*

Note: The following management response lists the recommendations as they appear in the evaluation report. Please refer to the report for more details on each recommendation. Recommendations may be organized by clusters, e.g.: strategic recommendations, recommendations associated with the country programme, recommendations associated with cross-cutting issues. Within each cluster, recommendations should be ranked by priority levels (from 1 to 3).

Instructions for completing the management response:
1. Boxes in white to be completed upon receiving the present request
2. Boxes in grey to be completed one year later.

Cluster 1: Strategic recommendations		
Recommendation #	**To ……. *(e.g Executive Director's Office*)**	**Priority Level ….*(from 1 to 3)***
Management response - *Please provide your response to the above recommendation. Where recommendations (or parts of) are not accepted, please provide detailed justification. Where accepted, please indicate key actions for implementation*:……		

Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	**Comments**

Recommendation #	**To …….(*e.g. Country office*)**	**Priority level …..**
Management response - *Please provide your response to the above recommendation. Where recommendations (or parts of) are not accepted, please provide detailed justification. Where accepted, please indicate key actions for implementation*:……		

Key action(s)	Deadline	Responsible unit(s)	Annual implementation status updates	
			Status (ongoing or completed)	Comments

Cluster 2: Recommendations associated with the programme		
Recommendation #	**To ……..**	**Priority level …..**

Management response - *Please provide your response to the above recommendation. Where recommendations (or parts of) are not accepted, please provide detailed justification. Where accepted, please indicate key actions for implementation*:……
……..……
……..…….....
.....

Key action(s)	Deadline	Responsible unit(s)	Annual implementation status updates	
			Status (ongoing or completed)	Comments

Clusters 3: Recommendations associated with cross-cutting issues		
Recommendation #	**To ……**	**Priority level …..**

Management response - *Please provide your response to the above recommendation. Where recommendations (or parts of) are not accepted, please provide detailed justification. Where accepted, please indicate key actions for implementation*:……
……..
……..…….....
.....

Key action(s)	Deadline	Responsible unit(s)	Annual implementation status updates	
			Status (ongoing or completed)	Comments

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Annex 3 Bibliography

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Focus Groups of the Reproductive Health and Rights and Gender Equality programmatic areas

Locations	Participants/Background	Themes
Kutupalong Refugee Camp, Cox's Bazaar District	Approximately 12 women, each with 1-3 children receiving family planning and contraceptive information from a Community Skilled Birth Attendant (CSBA), with pictorial instruction book. The women have been instructed in all traditional and modern methods, they understand the pros and cons of each.	1. Most women are using injectables or implants which are reversible, and only one using an IUD (the nurse said that some cannot take the IUD because their uterus is unhealthy). Only one older woman has had a tubectomy. 2. In general their husbands do not want them to use the non-reversible, they want fertility to return in 3-5 years. 3. The women agree to space their births by 3- 5 years, the Imam promotes this. (Note: many men have 2-3 wives, thus each family may have 5-8 children.) 4. They all attend the (required numbers of) ANC and PNC. 5. They explain how to save their lives in emergencies, including not to wear the burka and hijab when they evacuate. 6. They know where to go to report GBV.
Barisal Nursing College, Barisal District	Approximately 10 nursing instructors who have participated in Training of Trainers supported by UNFPA, from 2013-2014, for 28 days of training and have conducted subsequent training for nurse midwives through the Barisal Nursing College. They extended the training to other districts who came to the college and were mixed in the classes. This training has been running for 2 years. The outputs of the training included: identification of pre-eclampsia and referral to appropriate assistance.	1. Overall the TOT was excellent but there was not enough time for enough exposure to more practical training. The materials (unspecific) were not enough. 2. They think they evaluated the course at the very end of the course but it has not been evaluated since they returned to their work. 3. The course was interpreted from English which was a liability but they received new information and techniques which were very positive outcomes. These have now been included in the syllabus for the college and include ante natal care using head to toe and post-natal assessment 4. They understood the need to have more normal births and fewer C-sections. 5. The teachers were not able to fully answer our questions regarding the training skills they developed, but they said that they observed new training methods and they used and/or developed lesson plans. The technical support from UNFPA included the training module, a resource folder, lesson plans and honorarium and DSA. 6. The post six month training they conducted for nurse midwives at the Barisal Nursing College was also not followed up, however, they believe that eclampsia cases have decreased. 7. Overall for the purposes of qualifying the nurse midwives to higher levels of decision e.g. with medical doctors, regarding emergency cases and referrals, the training has been very effective. In terms of the roles of the nurse midwives, they have been strengthened through the expertise they gained and they are getting the authority to respond. They confer closely with chief ob/gyn surgeon Dr. Selina Begun. 8. They lack a life sized mannequin and a pelvic model (tour of facilities confirmed this).
Barisal Nursing College, Barisal District	Approximately 25 midwifery students (3 years) from the first and second batches. There are two programs plus a 6 month training. The four year BSC in	1. The understanding of the students is that they will be placed in positions already established. However, they do not know whether the posting is automatic and where and when they will be placed, but they accept that they can be posted anywhere at district, upazila or union. They need to complete an exam through the DNS before placement.

Locations	Participants/Background	Themes
	Nursing/Midwifery and three years for midwifery, and the 6 month midwifery post basic EmONC qualification for nurse/midwives. There are 18 out of 25 original students in the first batch of Midwifery and 24 in the second batch. They are selected competitively from high school students. The first batch graduate in December 2015 and the second December 2016.	2. The quality of teaching at the college is very good but the practical at the medical college hospital is not adequate, they are not spending enough time in the delivery room and they get used to help with the nursing to service the overcrowding. They want more exposure to duties in the labor ward, and among the newborns, and with the ob/gyns, and less in the classroom. 3. They would also like a digital classroom to access more information. They think that due to insufficient exposure to the "real" world, they need a six month internship after the 3 years. There is too much in the syllabus, they suggest a BS in midwifery. 4. They will be doing largely normal births and will refer the complicated cases to the nurse midwives. They said there is no scope at all for them to address the emergency referrals and complicated births. 5. The living conditions are very unsuitable for them, there are 7 girls in a room meant for 2, it is not sanitary and also a security risk as they have to go outside their rooms to study.
Barisal Medical College Hospital, Barisal District	6-8 Nurse midwives who received 6 month midwifery training through the Barisal Nursing College supported by UNFPA	1. They received training from UNFPA and are extremely satisfied after they returned to work, their status was increased in that they can effectively refer complicated cases either to surgery for C-section generally and newborns to pediatric department, in case of the premature or newborn distress. There is 24/7 EmONC. 2. They are largely used for midwifery and not for Epi – injuries, infections and contagious diseases. 3. Despite the crowding, they manage to deliver 15+ babies a day, without problems in the normal births. They are more revered by doctors now and take part more in the decisions, there are still too many C-sections. 4. The worst problems in the hospital is the overcrowding by family members and infections.
Nayatola satellite clinic, Dhaka slum	Approximately 12 women pregnant and post-partum, some obviously child marriages, and MCH staff (3) The health staff brings condoms, pills and injectablesto each clinic, there were no patches. They have no supply outages, and they use stock registers; the request for modern contraceptives is getting higher every day. Services the women are receiving include antenatal care 4 to 5x during the pregnancy, tetanus immunization, pathology, medicine, malaria drugs, etc. free of cost, nutritional advice and family planning advice.	1. The young newly married girls may know about family planning before their weddings if they are from Dhaka, some information is available to them in the slums, the migrants to Dhaka probably do not have this information. 2. Randomly selected pregnant and post-partum women described their treatment, pregnant described where they will give birth, hospital, and how they will get there, rickshaw or by foot, they are all in the same neighbourhood 3. Randomly selected pregnant said they will bring their babies for postnatal care 4. Random women said they told their friends about the services and some use them now. 5. Randomly selected women discussed their FP, in general they will have only 2 children, no one had more than 2 children, one will wait five years after her first child to have the second child and use birth control, this is endorsed by her husband, others will have 2 and then use birth control, unspecified. 6. Walk into the slum area, randomly selected one room family dwelling, woman with 2 children, she has stopped having children but has not selected LAPM, uses a patch.
Nari Maitree Health Center, Dhaka, Adolescent corner	Approximately 12 adolescent girls, 10-15 year olds. They receive information in the center on HIV and AIDS and STDs, menstruation, reproductive systems, changes during puberty, problems with early	1. A show of hands indicates that all want 1-2 children; randomly selected were able to explain about the population issues in Bangladesh and the personal financial burdens for raising children 2. Random girls explained that they were very happy to have access to the information provided in the center as they are not given this in school, they receive no advice there. 3. They do not have specific RH books at school but they

Locations	Participants/Background	Themes
	marriage. The older youth receive information about contraceptives. They spend one month at the center 4 x a month; the center offers other services such as musical instruments, singing, games and computers. The corner is open every day, there are about 25% boys, they meet in separate groups. There are about 90/week.	have some information from religious books. Most share information with their mothers. 4. Random girls said their most appreciated information was on rights of women, menstruation issues, STDs, questions about RH matters that concern them. 5. Some girls wished to know more about women's rights, women's rights to achieve their potential, some were unsure whether men and women are considered equal in Bangladesh.
Adolescent Club in Mirajagonje, Patuakhali District	8 youth, 11 to 17, (4 boys and 4 girls) they were not dropouts (the clubs are largely supposed to serve dropouts).There are problems with attracting dropouts, according to the managers of the club, they may need to work or are already married but the reasons are unclear.	1. They come to the club to learn about the negative impact of child marriage and SRH; but for the boys mainly to use the computer. 2. They could answer correctly about the need for population control, the legal age of marriage, the health risks of early pregnancy, and they knew about the GBV help line. 3. They have professional aspirations as per them telling us what they wanted to do, like teachers, nurses, working for NGOs, etc. 4. They said they came to the club for 2 hours, 2 days a week. 5. They suggested that there should be more creative ways to involve the parents and also to give the messages like through folk singing, theatre. 6. The boys would like sports to be included.
Social Protection Group, Dewanganj Union Parishad:	There are 16 members in the SPG including 3 women of which 1 woman is member of UP. The group mentioned that reduction of GBV including prevention of child marriage their regular activity since the group has been formed in June, 2014. Since their involvement in the project they feel empowered as once it was difficult to call a police officer or constable but after the formation of SPG thry are able to even directly to call SP.	1. The SPG members mentioned that In this union 98 percent women are unemployed. Girls' dropout rate from SSC level is around 80 percent. 2. Sixty percent of population falls below poverty line due to becoming frequent victims of riverbank erosion. Seven villages are prone to river erosion. Houses, schools, clinic needed to be shifted from one place to another. 3. Schools often run on temporary basis. Adolescents and pregnant women face acute problems. Families become scattered, some even face the shifting more than 10 times. Girls in these disaster affected poor families are married off at early age as families think them as liabilities. Whereas boys are given value as they can earn to maintain livelihoods. 4. They opined that perception about women and girls will be changed when girls in poor families will receive skill training; raising domestic animals to support themselves. The major issue related to GBV is child marriage. 5. Self dependence of girls will help them in continuing education as well as delaying marriages. Initiative related to disaster risk reduction should be taken along with preventing child marriage. 6. They recommended that capacity building of SPGs in regular interval should be emphasized. Minimum support or award should be given. Constitution of SPG does not indicate gender composition. 7. Documentary should be made by the community people, which will be presented by SPG.
Women group in Kanil village, Jamalpur Sadar Upazila	A total of 14 women participated in the FGD. All of them are married with men who are mostly involved in day laboring or rickshaw/van pulling (often remain unemployed in the lean season). Most of the women have no or little	1. Women reported that poverty is the main reason that men become violent on women and parents arrange child marriage. 2. Women reported that violence against women was a common phenomenon so as the child marriage. Prior becoming member of Women group they did not have knowledge on what should be done after being beaten or abused 3. They are aware about negative consequences of child

Locations	Participants/Background	Themes
	education and have limited access to income generating activities. Out of 14 women 09 attended primary school and 05 completed grade VI or VI in the high school. Recently a cooperative has been formed for women on stitching quilt and they are earning about 3000 to 4000 taka per month. Some women are also engaged in day laboring. Daily wage of a woman is 100 taka as oppose to 300 taka daily wage of a man. A village Ambassador has been selected by SP in collaboration with UNFPA to form the Women group	marriage and prevented 17 child marriages in the village as a group. 4. Now they know from the meeting arranged by Village Ambassador on how to inform an adolescent girl not to be trapped even by a man she knows. 5. They know a rape survivor should go for filing a case or medical test without taking shower or washing the body. 6. Although measures have been taken for reducing child marriage they suggested to take more steps on preventing the practices of dowry, which is very common in the locality. 7. Women suggested for arranging health care services for them as they do not get proper health support. The only health care facility is available in hospital is 3 km away from the village. There a satellite clinic closes to the village, which only provides health support to children.
BGMEA project management unit	The seven participants (including Deputy Project Director) of the Project Management Unit in different districts of BGMEA mentioned that UNFPA is working with 40 factories in Dhaka, Ashulia, Gazipur, Naraynaganj and Chittagong under the CHNAGE project. VAW unit exists in some factories. Training has been planned to for high officials (e,g General Manager), mid level management, compliance officer, field level officers. However, training has not been fully started as funding for the present quarter is yet to be received. Awareness raising training has been given to workers. By 2016 a total of 35000 workers will be trained on prevention of GBV and early marriage.	1. UNFPA is working to achieve the High court order and national priority which give emphasis on minimizing sexual harassment of garment workers, who are mostly aged 19-25 years. 2. They suggested that as in the garment industries 85-95% workers are girls and belong to the reproductive age group, reproductive health support is required 3. Training should be continued to orient new comers as drop out and recruitment of new staff are regular phenomenon in RMG sector 4. The particiants enquire that In Bangladesh there are about 3500 active factories (although 5000 are registered). UNFPA is covering only 1 percent what about the rest? 5. They suggested that gender sensitivity needs to be taken as a compliance factor and UNFPA can play role to make it work. 6. The awareness raising on GVB is fine but UNFPA need to focus beyond as it has a good branding, especially in the field of reproductive health support. For example BGMEA during the 7th CP BGMEA, with other partners such as MOLE, implemented a UNFPA supported project on promotion of reproductive rights including HIV/AIDS prevention for 2/3 years. Four health centres were supported by UNFPA at that time. This was a good initiative and would have been continued. 7. Following UNFPA initiative BGMEA has established 12 Health Centres `in garment factories with their own resources employing 2/3 doctors, paramedics and other staff. Four schools have also been established in the 12 centres. Support of UNFPA would have been continued in hospital. Any programme would be effective if it is connected with service delivery.
Garment workers at Envoy Group, Manta Apparels Ltd	The FGD was held with 13 workers (7 women and 6 men) in Manta Apparels Ltd. All the young women are working as machine operators and young men are engaged as swing operator (03), telephone operator (01) and office bearer (01). All of them received one day training on gender together. A	1. While asked about the type of training they have received, they mentioned the following: Gender equality means boys, girls, women and men should be treated equally. However, it seems that they are not familiar with the term 'gender' but understand the meaning. 2. The training does not include issues related to SRHR. 3. No discussion in menstrual management or family planning has been done. 4. They suggested for more in-depth training. 5. Girls reported that a company called Lien Fung (American Eagle) is working in their garment on RH issues (in addition to UNFPA intervention).

Locations	Participants/Background	Themes
	total of 300 workers in the factory have already received this orientation training.	6. For every 20 girls there is a 'health friend' to provide all kind of advice and support related to reproductive health (in addition to UNFPA intervention).
Staff of One Stop Crisis Center (OCC), Cox's Bazar	A total of four staff (female) participated at the FGD and serving as Medical officer, Programme Assistant and Nurse (2). At present four of them serving as permanent staff and another part time staff (the Project Manager of WSC) is working as psychosocial counsellor. All of the participants/staff are new to the OCC, appointed between May 2014 and March 2015. The part time staff providing Psychosocial Counseling is involved with OCC since the inception of UNFPA intervention.	1. The new interventions in OCC started in 2014 and the staff have not received any kind of training on GBV from UNFPA. Awareness raising activities have been done at Upazila level. 2. It has been reported that the UNFPA interventions discontinued in 2012 due funding constraints (they do not know the detail about it). All the staff and women survivors of GBV supported by UNFPA had to leave the OCC. 3. GBV survivors take admission to emergency and later sent to OCC. In each month around 10-15 women and girls seek admission to OCC, which can only accommodate 6 of them in the available beds. 4. After providing treatment police is called to file a case. OCC does not have the right to file a case. 5. It has been found that OCC only have records on how many women are coming to them in different months, however, systematic records are not available. It is not possible to know how many of these women returning to their in-laws or to their parents or elsewhere as there is no follow up mechanism. 6. No clear referral system existed between OCC and WSC (implanted by DWA) or WHD (implemented by Police) whereas all of them are working in the same district aiming to prevent gender based violence. However, since July, 2015 data on number of women taking shelter to WSC have been recorded (3 women were referred to WSC by the counselling expert, who is also the head of WSC, over the last 3 months). Counselling is given only once or more if required. However, there is a need for regular counselling, especially for adolescent girls. No evident of referral system with WHD has been found. 7. The group recommended the following: • Capacity building of OCC staff • Scope to filing a case at OCC • More visible awareness raising activities to be taken at Upazila level • OCCs need to be established at Upazila Health Complex so that local women get immediate treatment and support • Frequent and regular counseling is required

Annex 5 Stakeholder Matrix

Donors	Implementing Agencies	Other partners /stakeholders	Beneficiaries
UNFPA Global Strategic Plan Goal - To achieve universal access to SRH (including family planning), to promote reproductive rights, to reduce maternal mortality, and to accelerate progress on the ICPD agenda and MDG 5 (A and B)			
REPRODUCTIVE HEALTH AND RIGHTS			
Strategic Plan Outcome 2: Increased access to and utilization of quality maternal and newborn health services. **UNDAF Outcome 1:** Increased and more equitable utilization of quality health, population, education, water, sanitation, and HIV services for the deprived population in selected areas, with particular attention to women, children and youth;			
CP Output 1.1: *Improved quality and accessibility of sexual and reproductive health information and services, with a focus on family planning and skilled care*			
ATLAS – R201: Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction in Bangladesh (Joint Programme) incorporated into U201 and U202 in 2013)			
Government of Canada, Department of Foreign Affairs, Trade and Development (former CIDA, DFATD) (DFID/EU funding for 2012)	Government of Bangladesh Directorate General of Health Services (Reproductive Health Program); Directorate General of Family Planning; (DGHS & DGFP), UNFPA, UNICEF and WHO	District level DGHS and DGFP in eleven, four phase-one districts, Jamalpur, Moulvibazar, Narail and Thakurgaon and seven phase-two districts of Panchghar, Patuakhali, Sirajganj, Sunamganj, Rangamati, Bagerhat and Barguna.	In targeted districts: Medical workers, staff of hospitals and clinics, pregnant and lactating women, providers and beneficiaries of the Women Friendly Hospital Initiative (4 districts and 2 UHCs)
Strategic Plan Outcome 3: Increased access to and utilization of quality family planning services for individuals and couples according to reproductive intentions.			
Strategic Plan Outcome 6: Improved access to SRH services and sexuality education for young people (including adolescents).			
CP Output 1: Improved quality and accessibility of sexual and reproductive health information and services, with a focus on family planning and skilled care, in selected districts, urban areas and refugee camps			
ATLAS – U201: SRH Information and Services through DGHS/Ensuring RH service delivery in Nayapura and Kutupalong refugee areas/ Joint GOB-UN_MNH Initiative/ICT4RH			
UNFPA, Canadian DFATD, Maternal Health Trust Fund; ADB, SIDA	UNFPA, DGHS and DGFP, ICDDRB (The International Center for Diarrheal Research)	Local Government Divisions, Ministry of Local Government, Rural Development and Cooperatives; District Medical Centers, Research Training and Management International, CARE Bangladesh; Concept Foundation, Rangamati Hill District Council, Medical College Hospital	In targeted districts: Medical workers, staff of hospitals and clinics, nurse- midwives, FWVs, CFA, CSBAs. pregnant and lactating women, Adolescents and Youth, providers and beneficiaries of the Women Friendly Hospital Initiative (4 districts and 2 UHCs)
CP Output 2: Improved knowledge and awareness of and attitudes towards sexual and reproductive health and rights and HIV, among service providers and community members. including young people, in selected districts, urban areas and refugee camps			
ATLAS – U202: (DGFP/Midwifery/Fistula)			
UNFPA, Canadian DFATD, Maternal Health Trust Fund; USAID	UNFPA, DGHS and DGFP, ICDDRB (The International Center for Diarrheal Research)	Local Government Divisions, Ministry of Local Government, Rural Development and Cooperatives; District Medical Centers, Research Training and Management International, CARE Bangladesh; Concept Foundation, Rangamati Hill District Council	In targeted districts: Medical workers, staff of hospitals and clinics, nurse- midwives, FWVs, CFA, CSBAs, pregnant and lactating women, Adolescents and Youth, providers and beneficiaries of the Women Friendly Hospital Initiative (4 districts and 2 UHCs)
ADOLESCENTS AND YOUTH			
Strategic Plan Outcome 3: Increased access to and utilization of quality family planning services for individuals and couples according to reproductive intentions.			
Strategic Plan Outcome 6: Improved access to SRH services and sexuality			
RH CP Output 1: Improved quality and accessibility of sexual and reproductive health information and services, with a focus on family planning and skilled care, in selected districts, urban areas and refugee camps			
RH CP Output 2: Improved knowledge and awareness of and attitudes towards sexual and reproductive health and rights and HIV, among service providers and community members. including young people, in selected districts, urban areas and refugee camps			
GE CP Output 1: Increased awareness and knowledge of and positive attitudes towards reducing the vulnerability of women, including the incidence of violence against women and early marriage			
ATLAS - BGD8U602: Generation Breakthrough			

Kingdom of the Netherlands, UNFPA	Ministry of Education Directorate of Secondary and Higher Education, Ministry of Women and Children Affairs, Plan Bangladesh, BC Media Action	Staff of schools and youth clubs; school management committees; Concerned Women for Family Development (CWFD); District Women's Affairs Officers	Medical staff, and staff of schools and youth clubs receiving training in targeted areas; Youth and adolescents in schools and youth clubs in target areas
HUMANITARIAN			
Strategic Plan Outcome 2: Increased access to and utilization of quality maternal and newborn health services			
RH CP Outcome 2: Increased availability in emergencies and in early-recovery settings of gender-sensitive, high-quality reproductive health services and services to combat gender-based violence **RH CP Output 3:** Strengthened national capacity for emergency preparedness and response in order to address reproductive health and gender issues, including gender-based violence, during natural disasters			
ATLAS - BGD8U203: (MISP/RH/FP and disaster management)			
UNFPA	UNFPA, DGHS and DGFP, Ministry of Disaster Management and Relief?	Local Government Divisions, Ministry of Local Government, Rural Development and Cooperatives; District Medical Centers	In targeted districts and refugee camps: Medical workers, staff of hospitals and clinics
POPULATION AND DEVELOPMENT			
Strategic Plan Outcome 7: Improved data availability and analysis resulting in evidence-based decision-making and policy formulation around population dynamics, SRH (including family planning), and gender equality.			
CP Output			
ATLAS – BDG7P101: Population and Housing Census 2011			
UNFPA, EC	Bangladesh Bureau of Statistics (BBS), Planning Commission.	N/A	BBS technical staff
CP Output 1: Strengthened national capacity to collect and analyse data disaggregated by sex, age, economic status and location.			
ATLAS – BDG8U701: Strengthening capacity of BBS in P&D data collection using GIS maps.			
UNFPA, EC	Bangladesh Bureau of Statistics (BBS), Planning Commission.	N/A	BBS technical staff
CP Output 1: Strengthened national capacity to collect and analyse data disaggregated by sex, age, economic status and location. **CP Output 2:** Increased capacity to integrate population and gender concerns, including emerging issues, into national and sectoral plans and policies.			
ATLAS – BGDU702: Strengthening the capacity of teaching and research facilities at the Department of Population Sciences, University of Dhaka			
UNFPA	Department of Population Sciences (DPS) of University of Dhaka	N/A	Government agencies, national and international NGOs and organizations, individual academics.
CP Output 1: Strengthened national capacity to collect and analyse data disaggregated by sex, age, economic status and location. **CP Output 2:** Increased capacity to integrate population and gender concerns, including emerging issues, into national and sectoral plans and policies.			
ATLAS – U102: Enhancing the capacity of SEI Division to integrate population and gender issues into sectoral planning/Strengthening Capacity of the General Economics Division (GED) to Integrate Population Issues into Development Plan/Strengthening Parliament's Capacity in Integrating Population Issues into Development (SPCPD)/			
UNFPA,	SEI Division of Planning Commission, General Economics Division (GED), Planning Commission Bangladesh Parliament Secretariat	N/A	SEI Division staff, GED Division staff, Parliamentarians
GENDER EQUALITY			

Strategic Plan Outcome 5: Gender equality and reproductive rights advanced particularly through advocacy and implementation of laws and policy **SP Outcome 3:** Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth. **UNDAF Outcome 2:** Social and institutional vulnerabilities of women including the marginalized and disadvantaged are reduced			
CP Output 1: Increased awareness and knowledge of and positive attitudes towards reducing the vulnerability of women, including the incidence of violence against women and early marriage			
ATLAS – **BGD8U501 and 502: 'Advancement and Promoting Women's Rights' implemented by Directorate of Women Affairs (DWA), MoWCA**			
UNFPA	Government of Bangladesh Directorate of Women affairs Ministry of Women and Children Affairs	HQ, districts and Upazila offices of MoWCA (DWA)	Women and girls in targeted districts: Sylhet, Cox's Bazar, Jamalpur, Pathuakhali, Dhaka
CP Output 1: Increased awareness and knowledge of and positive attitudes towards reducing the vulnerability of women, including the incidence of violence against women and early marriage **Project Outputs** Output 1: Increased access to comprehensive A-SRHR and GBV prevention information Output 2: Increased access to comprehensive adolescent's friendly SRHR/GBV services among the adolescents and young people aged 10-19 in project areas Output 3: Adolescents and young people aged 10-19 equipped with gender equitable attitudes, respect for diversity, and skills to promote A-SRHR and to prevent violence. Output 4: Effective model developed for GBV prevention, A-SRHR and gender equity for advocacy and upscaling			
ATLAS – **BGD8U501: 'Generation Breakthrough Project'**			
UNFPA EKN	Government of Bangladesh Directorate of Women affairs Ministry of Women and Children Affairs Ministry of Education	Schools, clubs of districts and Upazila level	Adolescent and youths in targeted districts: Barguna and Pathuakhali
CP Output 1: Increased awareness and knowledge of and positive attitudes towards reducing the vulnerability of women, including the incidence of violence against women and early marriage **Project Outcome:** Women, particularly the marginalized, are empowered with increased access to income and SRHR. **Project Outputs:** Improved entrepreneurial and technical knowledge and skills of women, which will allow them to start their own business enterprises in selected areas of Bangladesh.			
ATLAS – **BGD8U501 a project 'Economic opportunities and sexual & reproductive health and rights – a pathway to empowering girls and women in Bangladesh'**			
UNFPA	Government of Bangladesh Bangladesh Women Chamber of Commerce and Industry (BWCCI)	Sylhet, Sunamganj and Maoulavibazar districts	Potential and existing women entrepreneurs
CP Output 1: Increased awareness and knowledge of and positive attitudes towards reducing the vulnerability of women, including the incidence of violence against women and early marriage **CP Output 2:** Increased availability of and access to shelters, medical, psychological and legal support and vocational training for survivors of gender-based violence in selected districts **Corresponding output:** Strengthen existing facilities/shelters (WSC, OCC, DH, UHC), medical, psychological and legal support; and training for IGA for survivors of GBV in programme areas			
ATLAS – **BGD8U 502 the Project 'Protection and Enforcement of Women Rights'**			
UNFPA	Government of Bangladesh Ministry of Home Affairs (MOHA) DWA, MoWCA	Four districts	Police stations, women and girls, WSC, OCC, DH, UHC
CP Output 1: Increased awareness and knowledge of and positive attitudes towards reducing the vulnerability of women, including the incidence of violence against women and early marriage .			
ATLAS – **BGD8U 502 the Project 'Protection and Enforcement of Women Rights'**			
UNFPA	Government of Bangladesh Bangladesh Garments Manufacturers and Exporter's Association (BGMEA)	40 selected garments factories	women, particularly the women in landless households with below poverty line

Annex 6 Overview of Budget versus Expenditure 2012-2015

Annual budget and expenditure by IPs from 2012 to 2015

IPs	2012		2013		2014		2015				Total Budget (2012-2015)	Total Expenditure (2012-2015)
	Budget	Expenditure	Budget	Expenditure	Budget	Expenditure	Budget	Revised Budget	Total Expenditure (Upto Q3)	Implementation rate		
RH Comoponent												
DGHS	6,875,118	1,701,429	2,890,767	2,266,902	2,390,068	2,147,221	2,480,007	1,897,707	1,237,072	65%	14,053,660	7,352,623
DGFP	5,222,708	1,713,733	2,361,937	1,961,518	2,286,966	2,192,648	2,029,767	2,071,267	1,666,778	80%	11,942,878	7,534,677
LGD	-	-	602,200	555,807	470,000	430,608	600,000	600,000	548,752	91%	1,672,200	1,535,167
RTM	258,499	244,624	183,963	184,027	180,000	172,751	180,527	172,527	128,889	75%	794,989	730,291
CARE	-	-	54,196	3,277	224,538	188,138	265,066	220,066	145,983	66%	498,800	337,398
ICDDRB	2,645,309	1,500,718	360,504	252,522	118,575	118,576					3,124,388	1,871,816
RHDC (UZJ09)							158,400	158,400	92,556	58%	158,400	92,556
Concept Foundation							180,000	180,000	78,210	43%	180,000	78,210
Contribution to pool funds	3,000,000	3,000,000									3,000,000	3,000,000
UNFPA implemented WP for Prog Management	203,750	182,805	920,353	1,014,122	1,451,891	1,111,128	1,503,173	1,503,173	777,574	52%	4,079,167	3,085,629
Sub-Total RH	**18,205,384**	**8,343,309**	**7,373,920**	**6,238,175**	**7,122,038**	**6,361,069**	**7,396,940**	**6,803,140**	**4,675,814**	**69%**	**39,504,482**	**25,618,367**
Gender												
MOWCA (RR)			358,971	174,600	690,000	591,943	500,000	418,500	350,266	84%	1,467,471	1,116,808
MOWCA - JPVAW	541,212	490,960	266,211	266,257							807,423	757,217
MOHA	-	-	463,401	241,276	467,500	378,915	399,999	325,612	184,748	57%	1,256,513	804,939
MORA-JPVAW	82,639	59,554	47,034	37,542							129,673	97,096
MoSW-JPVAW	423,934	393,480	256,290	154,934							680,224	548,414
MOI-JPVAW	205,211	207,202									205,211	207,202
MoYS-JPVAW	19,431	17,117									19,431	17,117
JPMO-JPVAW	1,244,704	570,136	747,407	572,356							1,992,111	1,142,492
GB-MOWCA	-	-	-	-	301,170	208,570	437,940	457,265	194,709	43%	758,435	403,278
BWCCI	-	-	71,758	48,955	50,859	43,061	115,000	52,976	40,666	77%	175,593	132,682
BGMEA	-	-	-	-	26,295	17,797	290,000	288,291	172,184	60%	314,586	189,981
UNFPA implemented WP for Prog Management	101,875	91,403	259,261	207,344	549,860	463,428	648,625	648,625	403,831	62%	1,559,621	1,166,006
Sub-total Gender	**2,517,131**	**1,829,852**	**2,470,333**	**1,703,263**	**2,085,684**	**1,703,714**	**2,391,564**	**2,191,269**	**1,346,404**	**61%**	**9,366,292**	**6,583,233**
PPR Component												-
SEID	-	-	95,758	59,812	132,740	92,248	100,000	60,000	51,473	86%	288,498	203,533
GED	-	-	125,269	117,071	154,718	130,181	150,000	130,000	58,467	45%	409,987	305,719
Parliament	234,614	126,291	157,778	130,798	157,704	149,378	199,977	149,977	118,827	79%	700,073	525,294
Dhaka University	-	-	-	-	111,700	66,274	199,900	270,000	172,588	64%	381,700	238,862
GIS, BBS	-	-	295,277	271,360	703,785	547,345	886,632	887,137	762,431	86%	1,886,199	1,581,136
Census, BBS (EC)	1,528,242	414,111	2,157,790	255,486	1,400,500	1,072,395	2,632,337	2,718,169	1,638,438	60%	7,804,701	3,380,430
Pop Council							199,663	199,663	20,272	10%	199,663	20,272
UNFPA implemented WP for Prog Management	101,875	91,402	194,086	170,971	348,000	259,242	303,647	303,647	196,526	65%	947,608	718,141
Sub-total-PPR	1,864,731	631,803	3,025,958	1,005,498	3,009,147	2,317,065	4,672,156	4,718,593	3,019,022	**64%**	**12,618,429**	**6,973,388**
Adolescent and Youth												-
GB- Plan	-	-	548,329	134,386	782,755	644,321	1,404,148	1,396,873	779,960	56%	2,727,957	1,558,667
GB-MOE	-	-	-	-	-	-	1,155,294	1,155,293	54,421	5%	1,155,293	54,421
A&Y Mgt.							456,500	456,500	211,364	46%	456,500	211,364
Sub-total Adolescent & Youth (A&Y)	**-**	**-**	**548,329**	**134,386**	**782,755**	**644,321**	**3,015,942**	**3,008,666**	**1,045,746**	**35%**	**4,339,750**	**1,824,452**
PCA	**325,000**	**290,503**	**200,000**	**125,178**	**237,000**	**106,446**	**300,000**	**300,000**	**137,592**	**46%**	**1,062,000**	**659,719**
CP Total	**22,912,246**	**11,095,466**	**13,618,540**	**9,206,500**	**13,236,624**	**11,132,615**	**17,776,602**	**17,021,668**	**10,224,576**	**60%**	**66,890,953**	**41,659,158**

Annex 7 Evaluation Matrix

Evaluation of the UNFPA 8th Country Programme for Bangladesh (2012-2016) – DRAFT Evaluation Matrix

EQ1 To what extent is the Bangladesh 8th Country Programme (2012-2016): 1) adapted to the needs of the population, in particular the needs of the vulnerable groups; 2) aligned with government's priorities; and, 3) aligned with UNFPA's policies and strategies?			
Assumptions to be assessed	**Indicators**	**Sources of information**	**Methods and tools for the data collection**
A 1.1 : The evolving needs of the Bangladesh population, in particular those of vulnerable and special groups, such as women, adolescents and youth, and those from less developed geographic areas, were well taken into account during the planning and implementation processes.	• The evidence of consultation through needs assessments, studies, and evaluations, that identify needs and lessons learned prior to programming and during the CP, updated periodically to guide the programme • Separate programmatic areas are integrated in planning with cross cutting aspects such as gender and youth • The choice of target groups for UNFPA supported interventions is consistent with identified and evolving needs as well as national priorities • Extent to which the interventions supported by UNFPA were targeted at most vulnerable, disadvantaged, marginalised and excluded population groups, and retargeted as needed • Extent to which the partner organizations and targeted people were consulted in relation to programme design and interventions throughout the programme.	• National policy/strategy documents • Bangladesh UNDAF (2012-2016) • Bangladesh Country Programme Results Based Framework • Monitoring Tools • AWPs, SPRs, COARS • Needs assessments and studies • Evaluations • PD, RH and Gender data • Key Informants from Government and Development/Assistance partners, academic institutions • Targeted beneficiaries and others living in remote and less developed areas	• Documentary analysis • Interviews with Government Partners • Interviews with UNFPA CO staff • Interviews with implementing partners • Interviews/Focus groups with beneficiaries and communities in targeted sites • Observation and data collection in targeted areas
Good Practices and Lessons from the 7th Country Program Evaluation(February 2011) reflected in the Country Programme Document (July 2011) **1. Program design and integration:**			

- A reduction of numbers of projects and applying alternative modes of cooperation could be of better use of funds and personnel.
- A balanced approach is important between systems building (e.g. health system) and immediate assistance (e.g. GBV) and built upon strong linkages with the GoB and other assistance actors.
- A project, or a set of interventions, geographic area, or targeting specific groups, may restrict the focus and miss a number of proximate causes and effects and thus be incomplete in their concept.
- If trainings, research and studies do not lead to programmatic or policy decisions, than their added values are questionable.
- Design and planning of pilot projects should ensure, before commencing, that they are carried out with an added value for national policy makers at the right time to feed into national deliberations.

2. Quality Assurance and Monitoring:

- A well thought out Results and Resources framework and common programmatic strategies are vital to a clear direction for the CP and for ongoing monitoring.
- A functional quality assurance system combined with relevant programming and monitoring is essential to achieving high quality.
- A well-functioning monitoring system is inbuilt in each intervention and its responsibility assigned among UNFPA staff regardless of whether partners have an M&E system, to further build their capacity as well.
- Strong coordination and cooperation are important to avoid the functioning of programmatic areas in relative isolation in regular coordination meetings but also that responsible staff link with colleagues working in other areas.
- Lessons and good practices need to be well captured in designing a program and in sharing across the programmatic areas.

3. Reaching the most vulnerable groups:

- An effective communication strategy, to avoid a “hit or miss” approach, should be based on the most effective methods for each target group (e.g. individuals, communities) and identification of partners which would be the best caretakers of the communications.
- Productive cooperation between the public and private sectors (e.g. MoHFW and Urban Health) need quality assurance and regulation to maintain a consistent and effective performance.
- The personal interaction of households with home visitors seem to be very influential, but the outcomes need to be studied.
- By not including a wider range of NGOs and Civil Society Organisations (CSO) important perspectives and potential may be missing in UNFPA’s advice to national policy and strategy design.

A1.1 Reproductive Health and Rights

Overview of Interventions (AWPs):

Essentially the Reproductive Health interventions fall under the following AWPs and SPRs, although incidences of overlap and duplication have been noted in the classifications.[7]

- ***R201*** *(Accelerating Progress toward Maternal and Neonatal Mortality and Morbidity Reduction)*
- ***U201*** *(SRH Information and Services through DGHS/ SRH, FP information and services through DGFP /Ensuring RH service delivery in Nayapura and Kutupalong refugee areas/ Joint GOB-UN_MNH Initiative/ICT4RH)*
- ***U202*** *(Director General of Family Planning/Midwifery/Fistula)*
- ***U203*** *(Minimum Initial Service Package - MISP/RH/FP and disaster management)*

The following outputs are meant to contribute to the CP outcomes for RH as follows:
CP Outcome 1 *– Increased and equitable utilization of high-quality sexual and reproductive health and HIV information and services, with a focus on family planning and skilled care.*
Output 1.1*: Improved quality and accessibility of sexual and reproductive health information and services, with a focus on family planning and skilled care.*
Output 1.2: *Improved knowledge, awareness of, and attitudes towards sexual and reproductive health, rights and HIV among the service providers and community members, including young people, in selected districts, urban areas and refugee camps.*

CP Outcome 2 *– Increased availability in emergencies and in early recovery settings of gender-sensitive, high-quality reproductive health services and services to combat gender-based violence.*
Output 2.1: *Strengthened national capacity for emergency preparedness and response in order to address reproductive health and gender issues, including gender-based violence, during natural disasters.*

- ✓ ***Evidence of consultation through needs assessments:*** *The following assessments/evaluations are pertinent to the SRHR and relevant to intervention areas and indicators:*

The 8th Country Programme Situation Analysis (November 2010): *The UNFPA 8th Country Programme Situation Analysis stresses the fact that MDG 5 indicators are lagging behind. (Notably there are no targets mentioned for Adolescent birth rates, CPR and unmet FP needs.) "In this context, two major issues require obvious attention: 1) the persistently high maternal mortality and morbidity; 2) the stagnant contraceptive prevalence rate (CPR), with low utilization of Long Acting and Permanent Methods (LAPM) of contraception. In addition, this section covers the broader reproductive health issues that are central to UNFPA mandate, including 3) high risk of sexually transmitted infections (STIs), HIV and AIDS, and 4) poor adolescent sexual reproductive health." (page 26) Maternal mortality is referred to as complications from pregnancy and delivery.*

[7] An analysis of the AWPs indicates the following issues, overlaps and duplications in the RH and Humanitarian programmatic area: a) the Outcomes and Outputs are not clearly referenced (as per number sequence and where they emanated from) in earlier AWPs; b) AWPS from U201 are combined in some cases with U202 - including U201/202 AWP for Urban Primary Health Care Services Delivery Project (UPHCSDP); c) There are several different project titles with same code of U201, including with - RTM International (humanitarian); - ICDDRB - U201/202 AWP for Urban Primary Health Care Services Delivery Project (UPHCSDP) - ICT4RH with Care Bangladesh; d) the follow-on interventions from R201, Joint Project, are part of U201 starting in 2013; d) Humanitarian U203 is also combined with U201 and U202. Further, there are no SPRs from 2012, and some from 2013 do not contain substantive information (e.g. Care 2012-2013) while some are missing altogether, likely due to delays in program start-ups and continuity.

The 7th Country Programme Evaluation (February 2011): General guidance and recommendations: *Given that UNFPA has spread its capacity too thinly it might be wise to identify a focus within the Reproductive Health component utilising the mentioned three prioritisation criteria, whereby population growth is of particular importance in Bangladesh. Hereby, until the capacity of the UNFPA CO is built up to adequately take on board a wider scope of RH/maternal health)* ***Reduction of Fertility*** *(as opposed to the entire Reproductive Health agenda) which is a main element in UNFPAs mandate and also contributes to the MDG5, and a focussed support of the* ***Gender agenda*** *appear as they main issues to pursue in a consolidated approach."*

- **Maternal Neonatal Health:** The MNHI was in process since 2007 with EU and DFID funding. Funding was obtained from CIDA for another five year period from 2012- 2016.

A **Project Completion Review (PCR), 2012,** from the previous stage of the MNHI project was factored into onward planning.[8] The report states that the MNHI has delivered an impressive amount of work in four years (in four districts), including development of local level plans; generating considerable buy in and ownership among senior managers from the health and family planning directorates and from the MoHFW's Planning Wing; increased the awareness and appreciation between the GoB and NGOs of their respective added values; ran parallel demand and supply side initiatives and put into place accountability mechanisms for public services to their target populations; integrating some project expenditures (except those implemented directly by the UN) in the Operational Plans for which line directors of the MoHFW are responsible; and, included some hitherto neglected populations living in tea states, in Chars or in tribal areas, and community support systems are being built that may increase the chances for those communities to access regular and emergency MNCH care. The report cautions that none of the above changes are yet institutionalized or sustainable and, importantly, the project is yet to demonstrate delivery of more and better RMNCH services as a result of MNHI interventions through an improved M&E strategy. There are numerous lessons and five broad recommendations. There has not been a mid-term review of MNHI in the 8th CP.[9]

The three partners in MNHI are UNFPA, UNICEF and WHO. The main indicator is the operation of the EmONC. UNICEF takes a life cycle approach, lots of newborn issues are covered. There are 4 outputs, UNFPA is in charge of two, evidenced based, LLP, planning, and capacity building. UNICEF has 2, access to quality care and M&E, demand creation for equitable access. They are working on demonstrating quality management models, death reviews were introduced in 2010 but are not in Barisal, scaled to 7 MNHI districts. There are special newborn units in the DGHS and some in DGFP. There is an action plan for demand creation with the Ministry of Health. There are 11 indicators for demand creation (read through the MNHI reports). With UNFPA, broadly there is a good understanding.[10]

An **endline survey summarized in 2013**, demonstrates improvements in ANC, facility based delivery, PNC and community awareness in the four target districts. A significant increase was noted in use of contraceptives 7 months after the last pregnancy up from 26.3 to 49.3%.[11]

The program incorporated a number of further assessments: 1) **Post 8th CP initial planning stages:** In 2015 the **"EmONC Needs Assessment Study",** was published in final form, although data was collected in May to October 2012 in the first year of the CP.

- **Family Planning:** Inputs are well targeted to support FP through the national health services, which is the largest provider of contraceptives in Bangladesh.[12] In 2011, a "Improving the Uptake of Long Acting and Permanent Methods in the Family Planning Program – A National Strategy 2011-2016" was approved by the DGFP. The **Family**

[8] Accelerating progress towards Maternal and Neonatal Mortality and Morbidity Reduction in Bangladesh The Maternal & Neonatal Health Initiative Project Completion Review, Final Narrative Report, Javier Martinez, Ladly Faiz, Joan Venghaus, DFID, May 2012

[9] Another project completion report: The Joint GOB-UN MNH Initiative Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction Project Completion Report July 2007 – June 2012, December 2012, EU, UKAID

[10] Key Informant Interviews, October 2015

[11] MNHI Endline Survey Summary, HDRC, 2013.

[12] Key Informant Interviews, October 2015.

Planning 20/20 emanating from the 2012 London Summit on Family Planning has set high goals for usage of contraceptives and provided impetus for Bangladesh's commitment to 20/20.

"*On specific components of SRHR such as family planning UNFPA are active and often co-ordinating members of the architecture. For example UNFPA co-chairs the FP2020 Reference Group, participates on all of the working groups, is an active member of the Reproductive Health Supplies Coalition and for procurement UNFPA also works closely with USAID (the other major global procurer) though a number of mechanisms to improve family planning commodity supply at country level and these links have been strengthened recently. The agency is currently on a learning curve to work within the 'total market' but relationships with and systems for working with the private sector (initially INGO) are developing. UNFPA is a key player in delivery of results – it is the biggest global procurer of family planning commodities and, for example, up to* ***2015 UNFPA is expected to deliver 28% of the UK's FP 2020 commitment*** *to meet the needs of 10m additional family planning users. UNFPA has a partnership role with a large proportion of international players and will therefore be playing a part in a large proportion of global results*."[13]

Bangladesh is now a Family Planning country, there is 62% CPR, but 10-12% are likely to be out of the loop and not easily reachable, thus 25% of those who can be reached still have to be reached. There is strong evidence in the BMMS of 2010 that contraceptive use is directly related to reduction of MMR. UNFPA is a key donor and partner as well as the World Bank (direct funding) and USAID (through NGOs) for Family Planning in Bangladesh. The DGFP promotes "One child is good, but not more than two" slogan, it is a suggestion but is catching on, it is not a law yet, still a choice. Consumption trends and stock status are available in the DGFP LMIS website for condoms, oils, injectables and implants[14]. Data is still insufficient on the actual contraception demanded and the accompanying services such as counselling and local level planning. This weakens the FP efforts. Stockouts on supply of contraceptives are said not to occur during this CP, however LAPM for example is not available at all levels such as community and district.

A **needs assessment for strategic planning for Reproductive Health Commodity Security (RHCS)** was supported by UNFPA in 2011 and published in 2012.[15]
The dominance of short-term methods (OCs, injectables and condoms) is probably the main reason behind Bangladesh's high contraceptive discontinuation rate. However, about 4 out of 5 MWRA who use modern methods use short-term methods. For the discontinuation rate to improve, major adjustments will be necessary. The 2011-2016 DGFP national strategy "Improving the uptake of long-acting and permanent methods in the family planning program" states that as many as 86% of the couples who want more children want to space the next birth beyond 49 months, a clear indication of LAPM need. The DGFP target is to reduce unmet need from 17% to 10% by 2016. At the program level several gaps have been identified including the following:

- Lack of family planning campaigns at national and regional levels focusing on LAPM;
- Lack of coordination between government and NGO interventions;
- Lack of continuity of promotional activities;
- Under or non-utilization of other government sectors (examples: MoLGRDC, MoWCA, MoSW, MoRA, etc) and private sector resources to promote LAPM;
-

A study **"Assess the Constraints to Promote Long-Acting and Permanent Contraceptive Methods (LAPMs)**[16], 2013, reported that problems with increasing acceptance of LAPMs is both from the demand and supply side. The programme has failed to create demand due to socio-cultural problems and lack of proper BCC approach through use of media communication, counseling, and involvement of community and religious leaders. Although most of the LAPMs are for women, their husbands in most of the cases are not counselled properly, especially about its advantages and some probable side effects. The husbands are also not informed of the advantages of vasectomy, which is the safest among all the

[13] The DFID - UNFPA Portfolio Delivery Review (PDR), 6 May 2014, The Department for International Development United Nations and Commonwealth Dept, Abercrombie House, East Kilbride, Glasgow, G75 8EA, UK, page 27.

[14] http://scmpbd.org/index.php/lmis-dashboard

[15] UNFPA, Improving Access to Essential RH Commodities for Women and Men in Bangladesh: Strategic Directions for Reproductive Health Commodity Security (RHCS) 2012-2016, March 2, 2012 Patrick Friel, Jahir Uddin Ahmed.

[16] Assess the Constraints to Promote Long-Acting and Permanent Contraceptive Methods (LAPMs), National Institute of Population Research and Training (NIPORT), Azimpur, Dhaka; Conducted by: Human Development Research Centre (HDRC), Dhaka: August 2013

LAPMs. The complications due to lack of a quality approach has also increased. Complications have negative impact on their families causing discontinuation, and discourage others to use that method. The complications thus prevent their friends, relatives and neighbours to accept it. Poor counselling and shortage of manpower and and shortage of medical and surgical requisite (MSR) for LAPMs also are great obstructions towards quality service provision.

- **Midwifery: (Inputs:** Strengthening advocacy and policy dialog on Midwifery, and capacity building of service providers on Midwifery through: revision of the National MH Strategy and finalizing the Midwifery strategy, supporting midwifery trainings, and assessing newly selected nursing institutes and clinical training sites, conducting TOTs, conducting post-basic and refresher Midwifery training, among others, and including training and supervision for the CSBAs (including baseline and endline surveys and midterm and final evaluations of certificate in Midwifery program).

A **formative evaluation of the Certificate in Midwifery Education Program**, 2014, sums up challenges in planning.[17] The RH Component continued to support the Midwifery Program to address the continued need for skilled attendance at birth, to support the Prime Minister's commitment and to strengthen efforts to achieve the targets of MDG 4 and 5. The Honorable Prime Minister's commitment to the UN Secretary General's Global Strategy for Women's and Children's Health was to develop and deploy 3,000 midwives by 2015. The severe shortage of nurses and midwives in Bangladesh has been well recognised for at least 10 years by the Government, academics and UNFPA. It is clear that multiple partners have been working at the national level and at education sites, in order to attempt to meet the Government's commitment to develop 3,000 midwives by 2015 and 7,000 more in the future. [18]

Based on the Strategic Directions for Nurse-Midwives for Midwifery Services (DNS, 2008) later complemented by the Draft Midwifery Strategy (BNC) the Bangladesh Nursing Council (BNC), the Directorate of Nursing Services (DNS), with the support of the WHO and the UNFPA developed two educational pathways for producing competent midwives: (a) The 6-months post-basic Certificate in Midwifery program as a short-term solution which commenced in pilot areas in September 2010. The participants for this training were selected from nurses who are in service. (b) The 3-years direct-entry Diploma in Midwifery program which started in December 2012. The students admitted to this program have completed HSC educational qualifications (UNFPA Bangladesh 2013b).

The 6-months post-basic Certificate in Midwifery program - Actual and potential issues in program implementation were identified by UNFPA. (UNFPA Bangladesh 2013b). These included the severe shortage of nurses in general and in the public sector (around 17,000), issues with the selection of course participants, a perception of poor utilisation and maintenance of MW skills once deployed back into the health services workforce, absent MW posts and up-to-date job description, governance issues e.g. role delineation, functional communication and other collaboration systems, transparent and functional monitoring and reporting systems, and sound accountability processes.

A number of **risk factors** identified by Key Informants somewhat match the above[19]: 1) the human resources shortages in the health service sector; 2) the limited capacity of the nursing schools; and, 3) the lack of a committed Midwifery oversight body.

1. A **risk factor** in the deployment of midwives (as well as giving nurse midwives + 6 months more decision making responsibilities for referrals to EmONC), is the general nursing shortage that plagues the health sector. The planned use of midwives solely for midwifery may be at risk due to need of the health facilities to divert them into general nursing duties, and lack of supporting staff to help them carry out their duties. Plans for midwife deployment should factor in the human resources situation of the national health services in the logic of the program design. (Examples include Cox's Bazaar District Hospital, also currently serving as the Medical College Hospital, where 90 nurses are required but only 56 are working, and Barisal Medical College which is severely overcrowded.) A risk factor in the training of the CSBAs, who include FWAs, FWVs and HAs, is that they are spread very thinly to begin with, and (is there an assessment of what the training will do in terms of their workloads?)

[17] "Certificate in Midwifery Education Program Bangladesh (Government of Bangladesh & Partners) Formative Evaluation Report"
June 2014 Prepared by: Penny Haora RM MPH PhD (Consultant) and Nurjahan Begum MSc (Consultant)

[18] (Prime Minister of Bangladesh 2010

[19] Documentation review and Key Informants, October 2015.

2. The nursing schools have assumed the duties of the 3 types of training. The Barisal Nursing College has two batches of the Midwife direct entry diploma and suffered a few dropouts from the first batch (6 out of 24). The dormitories are limited and 7 students are living in rooms designed for 2, which they describe as unsanitary and lacking enough room for study which forces them to study outside of their rooms.[20] The Dhaka Nursing College lacks dedicated teachers for the program, and thus teachers are trying to cover both nursing and midwifery teaching burdens.

3. The Department of Nursing Services and the Bangladesh Nursing (and recently added "Midwifery") Council are dedicated bodies but are not solely devoted to Midwifery and solving the complexities of the training and deployment.

The Midwifery Results Framework indicator: Number of district hospitals and upazila (sub-district) health districts with minimum required number of certified midwives (CP Output 1 Indicator) Baseline: 20; Target 70%. A number of key informants mentioned needs for the midwives at the Union level as well, some saying that this is the place of greatest need, in order to establish the Union services as reliable and places where women are able to seek support for the ANC and births.[21]

- **Urban Health:** The **Urban Health Project**, supports UNDAF Pillar 6, Pro-Poor Urban Development, and output areas are found under AWPs U201 and U202. Under U201, "System Strengthening of FP Services", working with Urban Primary Health Care Services Delivery Project (UPHCSDP) Local Government Division (LGD)[22], in10 corporations and 4 municipalities, partnership areas through 11 local NGOs, interventions in **2013 to 2015**, included couple registration, training for medical personnel, including overseas training, to provide clinical contraceptive services, support for comprehensive health care centers (CRHCCs) to provide seven comprehensive methods, procurement of equipment, and printing record keeping materials. Under "System Strengthening of Maternal Health Services", the CRHCCs are to be equipped to function 24/7 to increase delivery in the facilities. Training for nurse/midwives aims to strengthen CRHCC quality. Reduction of MMR is also addressed through training for cervical and breast cancer screening.

The **Urban Health project** was developed in view of population demographics and needs of the urban poor. The ADB provides huge loans. Estimates of rural-urban migration which used to be 11.7 per 1000 population in 2000 increased to 24.5 in 2010. In 2010, rural-urban migration rate per 1000 for women was 27.4%, while that of men was 21.6.[23]The increase in female in-migration might be due to job opportunities in the garments industry. The urban population in Bangladesh is now estimated to be 30% of the total population, i.e., 48 million people, up from 24% in 2000.[24] By the UN definition, 55% of urban dwellers live in slum areas.[25] It is estimated that by 2020, 40-60% of urban dwellers might be living in slums or in the street. The Bangladesh Urban Health Survey of 2013 indicates contrasting disparity between slum and non-slum population, for example the TFR for slum dwellers is 2.5, compared to 1.9 for non-slum areas. Urban health in Dhaka is largely dependent on NGOs to deliver services, which charge fees to sustain their functions. Those classified as poor receive red cards to obtain free services. Previous criticisms of the urban health services include the lack of coordination among the NGOs. [26]

There are 3 UNFPA staff in the Urban team, UNFPA is funding 2.49 million for 5 years in the URBAN Project. According to the budget breakdown, a large percentage went to outreach workers incentives – 34%, 10% for day to day operational expenses and maintenance of equipment equipment, and only 1% for awareness raising. Important reasons for provision of ambulances are transportation of pregnant women specially slum women from their houses to the facilities and refer to higher hospitals in case of complications, which saves number

[20] Focus Group discussion with Barisal Medical College Midwifery Students, October 2015
[21] Key Informant Interviews, October 2015.
[22] AWPs with Local Government Division, 2013, 2014 and 2015
[23] Gender Statistics of Bangladesh 2012, BBS. p 16.
[24] Worldometers 2015
[25] UNdata, slum population as percentage of urban percentage, 2014.
[26] Key Informant interviews, October 2015.

of lives of women specially the poor women. Also, it is a lengthy process for the government to procure ambulances.. UNFPA has stopped supply of medicine, which are now being supplied by government fund. The main foci are now on awareness creation, information services, quality assurance and adolescent issues.[27]

- **Obstetric Fistula: The 8th CP plans through DGHS:** Strengthening advocacy and policy dialog on Fistula and Fistula service delivery and rehabilitation, including dissemination and roll out of the National Fistula Strategy; basic and refresher training for medical personnel and CFAs, supporting the fistula rehabilitation center, procurement of drugs, furniture and basic equipment for centers, and drugs and supplies for Medical College Hospital and district hospitals

The **UNFPA 8th Country Programme Situation Analysis (November 2010)** addresses Obstetric Fistula (OF) in one section: "Maternal morbidity is equally high. For instance, the first ever needs assessment and situational analysis conducted in the country (GoB, UNFPA and EngenderHealth Study 2003) estimated that approximately **71,000 women are currently living with obstetric fistula in Bangladesh**, which implies the prevalence of 1.69 per 1,000 ever married women." (Page 27, primary reference……) Situation analysis of Obstetric Fistula in Bangladesh, Sep 2003) (This number is still used today, more than 10 years later.[28]) The suggested strategy in the Situation Analysis for addressing OF consisted of a regional center of excellence, a surveillance system and advocacy. (page 40)

The **7th CPE** reports that UNFPA's assistance to the Directorate of Health has helped establish a fistula centre in the Dhaka Medical College with support from the Islamic Development Bank and a rehabilitation centre for poor clients. There was expansion to 10 medical colleges due to the high demand. It is being incorporated in the health SWAp of Bangladesh (there is no evidence of this in the HPNSDP). A total of 2,387 patients successfully were treated. However, a number of patients were either rejected or the operation were not successful. The 7th CPE report mentions weaknesses as lack of a media campaign, inadequate referral links from community to services, unavailability of trained surgeons, and ineffectiveness of counselling for husbands and patients. The rehabilitation procedure in the center was considered mainly successful. There were no recommendations in the 7th CPE regarding obstetric fistula and strengthening the weak areas.

Bangladesh was included in a Five Country Study funded by USAID "Profiles and experiences of women undergoing genital fistula repair: Findings from five countries". [29]In this study, 10.9% of women in Bangladesh reported their leakage began following a medical procedure unrelated to pregnancy. The successful role out of ANC and PNC campaigns and consequently many more women receiving these services has significantly reduced the incidence of new obstetric fistula while some of the more recent cases are attributed to poor surgical procedures for hysterectomies and uterine prolapse. The trend in fistula is directly related to the provider, the birth attendant, the surgeon, 24% probably occurs at upazila and district and in the growing private sector with bad surgeries for c-section and hysterectomies.[30]

- **Cervical and Breast Cancer (CBC) Screening:** UNFPA has provided support to Cervical and Breast Cancer Screening in Bangladesh since 2008 through the DGHS and Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka.

Top 20 causes of deaths in Bangladesh from the Health & Demographic Survey 2008, BBS - Tumors and cancer appear as 6th while pregnancy related problems appear as 17th. Continuing serious incidence and prevalence of the cancers would indicate that more intensive work is needed.[31] Annual mortality from CBC (approximately 13,000) is more than double that of maternal mortality (approximately 6,000). The UNFPA **8th Country Programme Situation Analysis** (November 2010) addresses CBC needs in one statement: "According to the statistics obtained from hospital-based studies, there are approximately **13,000 new cases of cervical cancer with 6,600 deaths each year** (most common cancer

[27] Key informant interviews, October 2015
[28] Key informant interviews, October 2015
[29] Global Public Health, 2013, online: www.ncbi.nim.nih.gov/articles/PMC3805436/;
[30] Ibid.
[31] Key Informant Interviews, October 2015.

among women comprising one fourth of all cancers) in Bangladesh. High case fatality is ascribed to lack of organized population based cervical screening programme until recently." (page 27) The data on breast cancer is not mentioned in the situation analysis. The potential strategy mentions "consolidation" on CBC. (page 40)
Relevant Indicators: policy on cervical cancer, effective screening and treatment, prevention of precancerous cervical lesions.

Cancer screening is done at union level and in mobile clinics. Although numerous localized screening campaigns were conducted with UNFPA support, no nationwide awareness campaign has taken place. A study conducted in two upazilas in 2011 indicated that baseline awareness on cervical cancer prevention and visual inspection using acetic acid (VIA) was low and it was negligible where screening services were unavailable. Awareness was increased fourfold in both upazilas after interventions and half of the women and the majority of the community people became aware of screening and available facilities. Cable line advertisement (25.5%), microphone announcement (21.4%), and discussion sessions (20.4%) were effective for awareness creation on VIA. Television was mentioned as the best method (37.4%) of awareness creation. Conclusion: Television should be used for nation-wide awareness creation. For local awareness creation, cable line advertisement, microphone announcements and health education at Uthan Baithaks/ EPI sessions can easily be adopted by the government.[32]

- **Adolescents and Youth SRHR:** The report **"**Adolescent and Youth Reproductive Health in Bangladesh, Status, Issues, Policies and Programs", Abul Barkat and Murtaza Majid. (USAID, POLICY Project, 2003), was issued. UNFPA's global focus on adolescents is demonstrated in the study "The Power of 18 Billion – Adolescents, Youth and the Transformation of the Future", 2014. All studies emphasize the vulnerability of youth in SRHR and the high risk of early marriage and child bearing. UNFPA undertook a "Summary of End Line Survey on Adolescent Reproductive Health", March 2005 in coordination with the Ministry of Youth and Sports, Department of Youth Development which explores in-depth the perceptions of adolescents and youth with regard to SRHR. A project "Personal Social Education" was undertaken for three years employing a peer education approach in a previous CP which was seen as successful in the report. As in other countries where UNFPA supports it (Afghanistan, Turkey, Armenia) the Y-Peer network does not seem to function in Bangladesh.

A large source of resources for AY appears in project Generation Breakthrough, funded by the Government of the Netherlands, targeted to a limited geographic area, but cross Gender/RH in strengthening adolescent spaces in clinics, school and clubs in communities in the UNDAF district. Through a project focus, funds are devoted to adolescents through Generation Breakthrough in a limited area of the country. It is implemented through three IPs, MoWCA, MoE and Plan International. The aim of the project is to transform prevalent gender norms that condone and accept violence into more respectful, equal and healthy relationships and provide SRHR information and services to the adolescents.

UNFPA developed an Adolescent and Youth Unit which is responsible for supporting the communications and advocacy programmatic area which has a special focus on AY issues through the partnership with a widely read local language newspaper, Prothom Alo and overseeing the Generation Breakthrough Project. The A and Y Unit supports the DGFP by providing technical support to develop guidelines on minimum standards and SOPs for Adolescent Friendly corners available in the government health systems. The SRFR unit has provided financial support to establish 10 AFH corners in MCWC and Union Family Welfare Centers in five districts.

UNFPA is the Secretariat for the UN Interagency Theme Group and A&Y UNITGAY) which is also chaired by the UNFPA Representative and is supported by the A &Y Unit. The Unit is also the focal point on child marriage and provides input into existing projects and initiative addressing this issue. It also coordinates UNFPA's response on all child marriage advocacy efforts and prepares supplementary materials to be used at policy level.

The DSA has formed Social Protection Groups (SPG) to prevent child marriage and GBV in two unions in each upazila, they work with the people who consider the marriage requests, the Imams and local decision makers. There is an elected representative of women, but there is no network at village level, only at upazila. For cases of GBV, women can approach the SPG. They can also go to local court, Shalish, which is a non-formal body in the community. [33]

[32] **"**Role of Print and Audiovisual Media in Cervical Cancer Prevention in Bangladesh", Ashrafun Nessa*, Muhammad Anwar Hussain, Mohammad Harun Ur Rashid, Nargis Akhter, Joya Shree Roy, Romena Afroz; *Asian Pacific J Cancer Prev,* 14 (5), 3131-3137, 2013.

[33] Key Informant Interview, October 2015

Humanitarian: (See EQs 8 and 9) The **Humanitarian U203: (MISP/RH/FP and disaster management)** supported UNFPA training with the Directorate General of Health Services, on the Minimum Initial Services Package (MISP) from 2012 to 2105. Interventions included the integration of the MISP of RH in emergencies into the Ministry of Health and Family Welfare advance preparedness and into the training curricula of health care providers, and strengthening the national capacity to implement the MISP in emergencies. The knowledge base was to be increased on linkages between disasters and RH and Gender. Plans included the distribution of RH in emergency kits and stockpiling of dignity kits. (See EQs 8 and 9.)

- ✓ **Integration of separate programming areas:**

As per **the 7th CPE:** The evaluation of the seventh country programme found that the programme had contributed to developing national capacity for community-based skilled care, treatment for obstetric fistula, and community involvement in combating gender-based violence. It also found: (a) limited synergy among programme components; (b) a lack of clear linkages between policy advocacy and programme interventions; and (c) too many projects for the resources available. The evaluation recommended: (a) clearly defining programme strategies to reach programme objectives; (b) improving linkages between high-level policy dialogues and programme interventions; (c) establishing an adequate monitoring and quality assurance system for the programme; (d) increasing the emphasis on the development of institutional capacity; and (e) increasing the involvement of civil society in the programme. [34] As a result, the CP would likely be trying to integrate programmatic areas more closely but the Final Country Programme Document does not describe exactly how this will take place, although more gender mainstreaming was planned into the PD programmatic area.

In 2015, RTMI supported capacity development included clinical management of rape survivors, training for medical providers on complications of pregnancy and labor, and infection prevention. Support was provided to Community Health Assistants (CHAs) to transfer knowledge to the community and for community mobilization for camp and block management committees and community leaders. Support was also provided for coordination meetings with all stakeholders and operations for a Community Based Outreach Network with community volunteers.

- Potentially strong integration of SRHR and Gender Equality planned in information dissemination in spaces serving adolescents in clinics and clubs.
- Strong integration of SRHR and Gender Equality is seen in the RTMI supported capacity development but the GBV focus was split in the 8th CP between UNHCR and RTMI.
- The project Generation Breakthrough illustrates a strong integration between SRHR and Gender Equality and building on demographic findings regarding the youth bulge.[35] (See additional discussion under Gender Equality.)

- ✓ **The choice of target groups with needs and national priorities: The following priorities were identified in the BGD Implementation Plan HPNSDP 2011-2016 relevant to UNFPA mandate:**

The **top two drivers** for the HPNSDP are as follows:
• Scaling up services for the achievement of the targets of **MDG 1, 4, 5 and 6** by 2015. The existing essential services, hospital services at the secondary and tertiary hospitals including communicable and **non-communicable diseases** are proposed for expansion and improvement according to the need and situation.
• **Addressing population growth with vigorous, fully integrated family planning services**, and crosscutting, multi-sector interventions. Focus is on Long term and permanent family planning methods including the unmet need, with participation of related different stakeholders, both in urban and rural areas.

[34] 7th CPE, as found in the "Final Country Programme Document for Bangladesh", 2012 -2016, page 3.
[35] "Generation Breakthrough", A multi-pronged approach to building healthy relationships for primary prevention of Gender Based Violence and meeting SRHR needs of adolescents in Bangladesh, 2012 – 2016.Project Document

Sexual and reproductive factors are associated with cancer of the uterine cervix and breast. Sexual behavior factors, like young age at first sexual intercourse, multiple sexual partners and poor sexual hygiene, are associated with cancer of the uterine cervix. Human papilloma virus (HPV) has now been identified as the etiological agent responsible for cervical cancer. Bangladesh has the highest level of incidence and mortality rates due to cervical cancer. The prevalence of cervical cancer in Bangladeshi women has been reported to be 25–30/100 000.[36] Despite this reality, the CBC (and Obstetric Fistula) receives very little mention in the BGD 2011 Strategic Plan for HPNSDP 2011-2016, however they are mentioned together last in the priority list for Maternal and Neonatal Health in the HPNSDP Implementation Plan.

- ✓ **Targeting of the most vulnerable:** The selection of the UNDAF districts was carried out by the UNCT and Government partners. A large number of key informants mention that coverage is very low, 11 of 64 districts with many vulnerable people uncovered by UN supported interventions.

Key planning documents (e.g. HPNSDP) and key informants mention those who live in remote rural areas, those who do not/or rarely access health services and other government services such as education, these may include the very poor, those living in slums, those who constitute "floating populations" those without a permanent address, such as people living on boats, homeless people e.g. in the slums, refugees living in camps or in the communities.

Key informants and cited documents mention: those who do not plan or do not have access to skilled birth attendants and facilities in case of complications; those who do not have knowledge of family planning methods (remote, rural, adolescents who are unmarried); those who engage in risky sexual and reproductive behaviour (sex workers, unprotected adolescents and adults, migrant workers in other countries who engage in extramarital sex without protection and their spouses in Bangladesh, LGBT, drug users, newly married couples who do not use contraceptives or who have no knowledge of family planning methods) and those who are not aware of cervical and breast cancer risks, screening and treatment, those who are not aware of obstetric fistula risks, or treatment, possibly constituting destitute women who have lost their marriages.

UNFPA programming targets: UNDAF districts were selected based on a number of agreed criteria by the GoB and the UN agencies. The MNHI since 2007 has included some hitherto neglected populations living in tea states, in Chars or in tribal areas, and community support systems are being built that may increase the chances for those communities to access regular and emergency MNCH care.

The **Initial Monitoring Mission, Joint Government of Bangladesh – United Nations Maternal and Neonatal Health Initiative (MNHI)**[37] July 2015, overall the MNHI project's strategy is both district focused, in that while results are rolled up for reporting purposes, efforts and performance measurement are focused upon each district's MNH situation, and district wide, in that MNHI seeks to reach entire districts as a strategy to reach the most marginalised. Supply side interventions are based on two assumptions. The first is that the poor are more likely to use public sector health services, and this assumption is supported by evidence. The 2014 BDHS reported that of women who had delivered in private facilities the ratio of lowest to highest wealth quintile was 1:8 and only 1:2 for delivery in public facilities, indicating that more poor women used public facilities. It was 1:5 overall. In 2011 these differentials were even higher with the ratio for use of private delivery care 1:13 and public 1:3.

The second assumption that is that strengthening health system accountability for reaching everyone with quality MNH services will improve the system's ability to reach the poor. MNHI respondents noted that to be accountable, health managers need not only the responsibility but also the authority and resources/capacity necessary for planning and delivering services. Based on this assumption the project builds district and sub-district (upazila) health managers' capacity to use evidence to plan all public sector MNH services. This process is hypothesized as being a mechanism for identifying those among whom the MNH need is greatest, the poor and marginalised. To further improve accountability, MNHI also provides managers with resources based upon their plans, albeit with this dependent on vetting and oversight processes which are discussed later.

[36] "Cancer Control in Bangladesh", Syed Akram Hussain[1,*] and Richard Sullivan[2] Jpn J Clin Oncol. 2013 Dec; 43(12): 1159–1169.
Published online 2013 Oct 25

[37] Initial Monitoring Mission, Joint Government of Bangladesh – United Nations Maternal and Neonatal Health Initiative (MNHI) Project Number: A-035190, July 2015 Submitted To: Bangladesh Program Foreign Affairs, Trade And Development (Dfatd) Submitted By:Agriteam Canada Consulting Ltd

For the Maternal Perinatal Death Review (MPDR) it is also postulated that by finding and exploring the causes of all deaths, the most egregious weaknesses of the health system and vulnerabilities within communities will be highlighted which will encourage health systems and communities to correct them. By reaching every pregnant woman with community support and behavior change communication (BCC) and identifying every perinatal and maternal death, none will be missed.[38]

Consultations with Partner organizations and targeted people in design:

Family Planning: USAID is one of the largest contributors to support Family Planning in Bangladesh (approx. $25 million/year) channelling the largest portion of funds through private sources, but some in public pool funds, etc. Regular meetings for coordination and collaboration between USAID and UNFPA have not taken place during the CP until recently in 2015.[39] Outside the national health system there is a range of private sector services, USAID is supporting those. This could be the place where unmarried youth and drop outs are being served. The private sector is giving contraceptives to the poorest people free and there are sliding scales for others. However, there is 62% CPR, but 10-12% are likely to be outside of the service loop and not easily reachable, thus approximately 25% of those who can be reached still have to be reached. [40]
(2014 SPR) HIV and Adolescent SRH & Rights - As chair of UNJT, UNFPA has overall influence on HIV/AIDS related DPs, NGOs as well as NASP. Collaboration with UNAIDS also enhanced enabling environment.
(2014 SPR) Emergency Preparedness and Response - During the TOT, NGO partners (FPAB, Action Aid and CEO of MIRROR) provided their assistance as facilitators. UNFPA CO provided technical and financial assistance. MNHI field offices provided logistics support.

Evaluation of Midwifery Training, 2014. It is clear that multiple partners have been working at the national level and at education sites, in order to attempt to meet the Government's commitment to develop 3,000 midwives by 2015 and 7,000 more in the future (Prime Minister of Bangladesh 2010). The development of a standardised curriculum, syllabus, lesson plans, and assessment tools for a 6 month (26 week) midwifery education course, was undertaken with the involvement of many partners.

Studies and research have provided substantial input from the targeted people who were reached in the studies, see above. In addition the development of the LLD plans included community consultations.

UNFPA is one the few agencies supporting treatment of **Obstetric Fistula**. A number of private clinics and service centers offer fistula surgery, such as Project Hope in Cox's Bazaar. The degree of interaction by UNFPA with these clinics is unclear. UNFPA maintains a close planning and facilitation relationship with Engender Health, a leader in fistula research and advocacy. Engender Health has participated in training UNFPA district staff on Family Planning. Engender Health has 40 centers in Africa and Asia. They specialize in LAPM, informed choice, volunteerism, BCC and policy work; 95% of their funding in Bangladesh comes from USAID but they are very active with UNFPA. They have trained the UNVs for free.

The Government of Bangladesh, with support from UNFPA, has taken initiatives to develop a **cervical and breast cancer screening** program in Bangladesh. UNFPA may tend to coordinate with DGHS and less with BSMMU. Several organizations are working to fight against CBC for the optimum well-being of the cancer patients, UNFPA participated in ICT4D, the others, unclear the degree of consultation with UNFPA.

- Breast Cancer Identifying and Treating Project; Amader Gram and ICT4D (Information and Communication Technologies for Development) initiative of Bangladesh.
- International Childhood Cancer Forum: exploration and setting priorities for an unmet need in Bangladesh.

[38] Initial Monitoring Mission, Joint Government of Bangladesh – United Nations Maternal and Neonatal Health Initiative (MNHI) Project Number: A-035190, July 2015 Submitted To: Bangladesh Program Foreign Affairs, Trade And Development (Dfatd) Submitted By:Agriteam Canada Consulting Ltd
[39] Key Informant interview, October 2015.
[40] Ibid.

- The Bangladesh Women Chamber of Commerce and Industry has committed to Every Women Every Child to raise awareness of cervical cancer.
- Cancer Support Society (CANSUP), an NGO in Chittagong, is working on breast self-examination and cervical cancer screening with technical assistance from the WHO.

A. 1.1 Population and Development

Overview of Interventions: The Population and Development component is designed to improve analysis and use of population data in national and sectoral planning and policies and strategies. The intension is that the Government and NGO stakeholders will better able to accelerate national policies and development agenda, through integration of evidence-based analysis on population dynamics with a focus on achieving the MDGs and pro-poor growth. It thus emphasises utilization of gender and poverty disaggregated data for development planning and poverty reduction. It also supported whole range of activities related to census 2011 i.e. data collection, logistics and data analysis, and preparing technical paper and monographs.

✓ **Evidence of consultation through needs assessments:**

The evaluation of the 7th country programme recommended for improving linkages between high-level policy dialogues and programme interventions; establishing an adequate monitoring and quality assurance system for the programme; and increasing the emphasis on the development of institutional capacity[41]. UNFPA took steps to implement this recommendation in the 8th country programme. A new project with GED of Planning Commission is taken up to create linkage between high-level policy dialogues and program implementation. This project has provision to conduct research on population and gender issues, dialogue the findings of the researchs with national planners and help inclusion of research findings in the national plans. UNFPA has also taken up a new project with Population Council to conduct policy dialogue on population and development not only with planners but also with members of Parliaments and stakeholders. UNFPA later conducted a situation analysis paper for the formulation of the 8th country programme. The situation analysis summarized series of in-house analyses, looked at the MDG targets and the UNDAF (2012-2016). As part of the situation analysis, a national dialogue was organized with different stakeholders including government officials, civil society experts, the private sector, and development partners, and the outcome is the final report. The situation analysis paper therefore reflects findings from various progress reports as well as the discussion during the national dialogue. The situation analysis report recommended that given the UNFPA comparative advantages, the P&D component should stick to its core mandate, “use of population data and information for policies and programmes” in the 8th CP. In other words, the P&D component should re-enforce its focus on three approaches, (a) Research, (b) Evidence-based policy advocacy, and (c) Data for development[42].

✓ **Integration of separate programming areas:**

This component is aimed at contributing to increased analysis of data related to population and development. Data analysis mainly centered around population dynamics, SRH and gender. As per recommendation of the 7th CP evaluation UNFPA continued with the same program with minor adjustment focused towards higher level institutional capacity development of the partners, thematic analysis to data and policy planning to address vulnerable groups in the country.

✓ **The choice of target groups with needs and national priorities:**

✓ **Targeting of the most vulnerable:**

[41] Evaluation of the 7th Country Program of UNFPA Bangladesh, Dhaka, January 2011

[42] Situation Analysis for the Formulation of the UNFPA 8th Country Programme (2012-2016);UNFPA, Bangladesh, Dhaka, November 2010

UNDAF, in recognition of the increasing inequalities in the country identified both geographical focus and group focus in the program strategy, It had identified 20 underperforming districts and 30 cities and towns based on MDG parameters. It also identified gender as a core challenge. UNFPA, in spite of having a Gender component has taken up new adolescent program to address the burning issues through their "Generation Breakthrough" program, while the Population and Development component through its partners emphasizing more analysis of data and publication and dissemination of gender related information for planners. It is also highlighting the issue of demographic "window of opportunity" to address issues of Youth and demographic transition.

Consultations with Partner organizations and targeted people in design: Already mentioned.

Gender Equality

Evidence of consultation through needs assessments: For the Gender component rapid assessments, situation analysis, annual work plan, progress reports, quarterly reports, needs and lessons learned pre and prior to programming and during the CP were updated annually and quarterly across the five programmes. The design of the 'Advancement and Promoting Women's Rights (APWR) project, implemented by Department of Women Affairs (DWA) was based on need assessment in line with UNFPA Eighth Country Programme (8CP 2012-2016) for Bangladesh (following UN Development Assistance Framework/UNDA, 2012-2016) and Bangladesh's Perspective Plan 2010–2021 (Making Vision 2021 a Reality). The UNDAF 2012-2016 is anchored in the national priorities stated in the GoB Sixth Five Year National Development Plan (6FYP); and is based on the outcome of The Millennium Development Goals: Bangladesh Progress Report 2009[43]. Furthermore, UNFPA, Bangladesh's 8CP will also was strategically aligned with all of the priorities under the agreement of the 1994 International Conference on Population and Development (ICPD '94) held in Cairo.

The SPR 2013 and 2014[44] for Advancement and Promoting Women's Rights/APWR (U501 AND 502)[45] indicates that Department of Women Affairs (DWA, MoWCA), project aims to reduce Social and institutional vulnerabilities of women, including the marginalized and disadvantaged. It also attempted to increase the availability of and access to shelters; medical, psychological and legal support; and vocational training for survivors of gender-based violence in selected districts (Sylhet, Cox's Bazar, Jamalpur, Pathuakhali, Dhaka) and progressed towards achieving these objectives based on the needs. In order to achieve the project goals various activities were done, first of which was the stakeholder's consultations for need assessments in selected districts. The second stage was to develop local level planning (LLP) in a participatory manner.. However, most of the activities indicated in LLPs have not been implemented as LLPs are yet to be officially approved by DWA, MoWCA. It has been learnt from gender unit that since the concept is totally new for MoWCA and DWA has done it for the first time with the support of UNFPA. This created some dissatisfactions among the community members that some of their plans are yet to be implemented.

The Protection and Enforcement of Women Rights/PEWR (U502), implemented by Police, Ministry of Home Affairs (MOHA) aimed to involve the Police Force on enforcement of the laws related to and protection of survivors of sexual and gender based violence (SGBV) in Bangladesh. Project activities were carried out at three levels: Within the selected geographical districts of operation under the 8CP—Police Stations/Thanas including Women Help Desk ; (b) Community outreach program by the Police Personnel Thanas; and c) At the national level through police training institutes Bangladesh Police Crime Cell for MIS and SOP for women friendly Police station and coordination through the MoHA secretariat. PEWR is also builds on sufficient need assessments, evaluations and data on VAW prone districts.[46] In order to identify organizational strengths and challenges for integrating gender in the police systems and operations, participatory audit had been undertaken in Police HQ, the Superintendent of Police (SP) offices of 4 project districts, police stations at selected districts where Women Help Desk (WHD) were established. All the 15 WHDs were established between 2013 to first half of 2014. Technical Assistance started to be provided to functionalize the 15 WHDs such as development of SOP and their implementation are ongoing, training of Police officials on GBV and child marriage[47]. The gender audit process was

[43] UNFPA 8th Country Programme, Ministry of Women's and Children's Affairs– Concept and Design of UNFPA Support

[44] Standard Progress Report, 2013 and 2014 (U501 AND 502)

[45] The project was supposed to start in 2012, however, it started in July 2013 and will end in Dec 2016 (*TPP approved 24 July 2013)*

[46] KII with Project Director, PEWR, MOHA

[47] Comments by the Gender Unit

introduced to serve as the assessment to establish baseline and to track the subsequent progress toward gender mainstreaming within the organization, but also as tool for action planning[48]. The SPR, 2014[49] indicates that national and local level consultations were held with relevant stakeholders, rapid assessment on Sexual and Gender based Violence (SGBV) and child marriage in the selected 4 districts and areas under the Dhaka Metropolitan Police (DMP) was done. From which base data on the indicators of PEWR and APWR were collected. Situation analysis on gender responsiveness of police has also been conducted.

However, although both the APWR and PEWR projects of Gender Unit aim in achieving similar CP output[50] and SPRs also indicated about the coordination e.g Project implementation committee and Project Steering Committee Meeting of the projects to enhance knowledge and concept for staffs and other stakeholders on the project theme, goal, objectives and the implementation strategy, they have been done independently or in isolation for each project. It is evident from the field that the two implementing partners hardly have any coordination or referral system for each other even working in the same district[51]. However, as there was no mechanism for coordination, it was hard to orient partners for coordination. Indirect coordination or referral system has been observed (for example WHD of Jamalpur referring GBV survivors to visit DWA office). It has been learnt from the gender unit that Development of formal mechanism for coordination is under process.

The project 'Economic opportunities and sexual & reproductive health and rights – a pathway to empowering girls and women in Bangladesh (EOSRHR)' is implemented by Bangladesh Women Chamber of Commerce and Industry (BWCCI). The project aims to contribute to the country programme output 1: Increased awareness and knowledge of and positive attitudes towards reducing the vulnerability of women, including the incidence of violence against women and child marriage. The project was designed to achieve country programme outcomes as well country priority e.g. to reduce the vulnerabilities of women, including marginalized and disadvantaged. The project output was to improve entrepreneurial and technical knowledge and skills of women, which will allow them to start their own business enterprises in selected areas of Bangladesh. It is also working towards increase awareness and improve knowledge of women related to their sexual and reproductive health and rights as well as creating an enabling social environment for women's economic and personal empowerment at the family and community levels in selected areas of Bangladesh. Prior to the implementation a mapping and baseline survey was conducted among 330 potential women entrepreneurs; synergy has been made among different stakeholders including ministries[52]. Three Inception Workshops were conducted at Central level and several workshops were held at District levels[53].

The ChaNGE (Changing gender Norms of Garments Employees) project, implemented by BGMEA. UNFPA has been supporting BGMEA since 1999 and is committed to carry out the task like rights of women workers, gender equality and rights to make decision for on her own. UNFPA also played an important role by supporting BGMEA in capacity building of officials of different stages Reproductive Health & Reproductive rights and Gender issues. It has aimed to achieve the CP output 1 and close to the APWR, EOSRHR as per the AWP reference (U501). The Annual Progress Report 2014 produced by Gender Unit (Gender Component, Output No. 5, UNFPA BCO, January, 2015) indicates that research/studies on discriminatory practices against women and girls; and disseminating briefing notes for policy dialogues were held prior to the project formulation.

Integration of separate programming areas: After the alignment with current strategic plan (2014-2017), a new component has been added to the country programme and the country office, i.e. Adolescent and Youth, **which** was introduced in late 2014. The Gender unit work closely with the Adolescent and Youth component, focusing on the development of the adolescent and youth reproductive health, STI and HIV/AIDS prevention and gender responsive behavior among the adolescents. This component is also piloting adaptation of GEMS (Gender equity Movements in Schools) curriculum with Ministry of Education, Ministry of Women and Children Affairs and I/NGOs.

[48] Nasreen, Mahbuba, 2015, 'Situation Analysis Report on Gender Based Violence in Bangladesh', UNFPA

[49] Standard Progress Report, 2013 (502 for both MOHA and MoWCA as both the projects were designed to achieve similar objectives

[50] By 2016, increased availability of and access to shelters; medical, psychological and legal support; and vocational training for survivors of gender based violence in selected districts.

[51] Field visit to Jamalpur and Cox's Bazar.

[52] As per the SPR 2013 (July-December, 2013) MoWCA and BWCCI organized these workshops individually.

[53] As per the SPR 2013 (July-December, 2013) MoWCA and BWCCI organized these workshops individually.

The choice of target groups with needs and national priorities: A series of in-house analyses on the key issues of UNFPA"s thematic areas were held, one of which is Gender. Thematic area on gender was developed in November 2010, five years remaining to the MDG target year, 2015[54]. The UN system of Bangladesh envisages the UNDAF (2012-2016) to be centered on the MDGs, as well as the Government was requested to prepare a MDG progress report to be presented during the High-level MDG Summit in September 2010. In this context, it was decided that UN system would work in close collaboration with the government to prepare the MDG progress report and use it as a part of the country analysis for the UNDAF preparation. Within the UN system, UNFPA has been assigned to take the lead in preparing progress report on MDGs 3 and 5. Accordingly, the country office coordinated the preparation of the MDG-3 and MDG-5 progress reports. As a part of the process a national dialogue was organized with a view to incorporating the voices of different stakeholders including government officials, civil society experts, the private sector, and development partners, into the final progress reports[55]. The Gender component is strategically aligned with the UN MDG goal 3 (Promote gender equality and empower women); CEDAW. The interventions of the component also contribute in achieving National Plan of Action (NPA) of National Women Development Policy, 2011 and the 6th Five Year Plan's strategic direction related to gender equity, women's empowerment and advancement issues of Bangladesh government[56]. It must be mentioned here that Bureau of Statistics (BBS, 2011) has conducted a survey on VAW in 2011.

Targeting of the most vulnerable: The target population or participants of UNFPA Gender component for all the interventions were in line with the CP outcome 3 ('Social and institutional vulnerabilities of women including marginalized and disadvantaged are reduced' in line with UNDAF pillar outcomes 7.1 and 7.2 and SP outcome 3).

The target groups of MoWCA and MOHA projects under the Gender component comprise the marginalized and disadvantaged women from selected districts and urban slums to prevent GBV and child marriage and provide support to GBV victims. Creation of enabling/women friendly environment at workplace and in community through working with community gatekeepers had been initiated for economic empowerment of women. To achieve the additional CP outcomes for the Generation Breakthrough project MoWCA (implemented through DWA) and MoE (implemented through DSHE) adolescents were included in the project as they, especially adolescent girls are more vulnerable to GBV and child marriage[57].

The primary beneficiaries of this collaboration between BWCCI and UNFPA-Bangladesh are marginalized[58] women with interest to start self-employment businesses in selected districts. The secondary beneficiaries included their families, particularly men (husbands and fathers), and communities as well as BWCCI's members (women entrepreneurs) in selected districts[59].

About 80 percent workers involved in garment factories are women of approximately 45 lacs workers. These women are economically and socially deplorable and their reproductive health, reproductive rights, rights at workplace are always neglected. They also suffer from gender based violence. Hence the situation needs to be improved by ensuring access to

[54] Annual Progress Report 2014, Gender Unit, January, 2015, UNFPA-BCO

[55] UNFPA, 2010, *Situation Analysis for the Formulation of the 8th Country Programme (2012-2016),* Dhaka, November, 2010.

[56] Annual Progress Report 2014, Gender Unit, January, 2015, UNFPA-BCO

[57] Out of the twenty (20) UNDAF districts and 30 cities/towns, UNFPA proposes twelve (12) districts and one (1) city center as the focus areas for 8th CP implementation; *and* with special attention to reproductive health indicators which are also known to be associated closely with gender outcomes, taking into consideration UNFPA's operational capacities and past/current cooperation provided by UNFPA to the Government (extracted from the concept paper of MOHA).

[58] Women in landless households with below poverty line

[59] Project Proposal on "Economic opportunities and sexual & reproductive health and rights – a pathway to empowering girls and women in Bangladesh", Collaboration between, Bangladesh Women Chamber of Commerce and Industry (BWCCI) And United Nations Population Fund (UNFPA), 2013

quality health services, decision making rights to reproductive issues and equal treatment irrespective of male and female at workplace. Gender issues and rights of the working women is therefore a multispectral issue and obviously MOLE is to oversee that sub-sectoral development projects address women and gender issues as relevant[60]. Therefore the target groups and interventions were relevant.

Activities were also done beyond the project components in some cases. For example the humanitarian intervention was introduced and reflected in misp training in all four intervention districts anwhich t was heavily based GBV. In Jamalpur, some upazilas have already incorporated GBV in their local level emergency preparedness and response plan.[61] . Under MOHA project in Jamalpur the concept of Women Ambassador was introduced as well as student/Youth Networks and informal group for adolescent girls have been formed in order to achieve project goals and ensure sustainability[62]. All five projects under gender had a good attempt to engage men and boys that can be strengthened further in next CP. At the policy level gender unit has contributed to MoLE for the inclusion of GBV and SRHR provision in Bangladesh Labor Rule which is expected to contribute a lot to reduce workplace violence of women and strgenthen SRHR provison for the working women specially the women garment workers. It must be mentioned here that although there are quarterly reports available, cumulative data has not been found and therefore consolidated picture of the data e.g number of training sessions conducted, is difficult to provide. Therefore 3rd quarterly reports data can be used for explaining the situation. As per the plan of BWCCI 3 Counseling sessions on business development, gender and SRHR were organized at Sunamgonj and Moulvibazar in third quarter where 71 participants attended amongst them 4 were male participants[63].

- ✓ **Consultations with Partner organizations and targeted people in design:** All the major interventions under the gender component were developed following participatory approach. They have incorporated views of relevant stakeholders including government, private sector (BGEMEA, BWCCI for example), academic, local leaders, especially religious leaders, media, NGO and beneficiaries. The APWR implemented by MoWCA can be referred here as it has developed Local Level Planning through rigorous consultations with local level stakeholders. It has been reported by the implementing partners that the training modules were also developed and revised in based on the Partners' opinions and needs of the beneficiaries. For example, training manual for women entrepreneurs for BWCCI and JEMS dairy for MoWCA, MoE were being developed and revised as per the recommendations of the implementing partners).

[60] Technical Project Proforma, Reducing Vulnerability and Creating a Gender Conducive Environment for Female RMG workers, submitted by Bangladesh Garments Manufacturers and Exporter's Association, November, 2013.

[61] Comments from Gender unit.

[62] Field visits in Cox's Bazar and Jamalpur

[63] Consolidated Quarterly Progress Report, BWCCI

A 1.2: The objectives and strategies of the programmatic areas of the Country Programme are consistent with the priorities put forward in the UNDAF, and in the UNFPA strategic plans.	• The objectives and strategies of the CP and the AWPs are in line with the goals and priorities set in the UNDAF • ICPD goals are reflected in the CP and programmatic area interventions • The CP sets out relevant goals, objectives and interventions to develop national capacities • Extent to which South-South cooperation has been mainstreamed • Extent to which gender equality, women's empowerment have been mainstreamed • Extent to which resources have been targeted to adolescents and youth	• UNDAF (2012-2016) • Joint and collaborative programme documents • Bangladesh AWPs, SPRs, COARs • UNFPA Strategic Plan, 2008-2011, extended to 2013: Accelerating Progress and National Ownership of the ICPD • Mid-Term Review of the UNFPA Strategic Plan for 2008-2011, extended to 2013, 26 July 2011 • UNFPA Strategic Plan for 2014-2017 • UNFPA: The Way Forward, Business Plan for 2012-2013	- Documentary analysis - Interviews with UNFPA CO and Regional Office staff - Interviews with UNCT members and government stakeholders

A 1.2 Reproductive Health and Rights

The 8th Country Programme for Bangladesh (2012-2016) is closely aligned to the UN Development Assessment Framework (UNDAF) and there is no separate Country Programme Action Plan (CPAP). The programme logic is therefore based in the UNDAF, the Annual Work Plans (AWPs), the Standard Progress Reports (SPRs), the Country Office Annual Reports (COAR), and Atlas project data.

The current UNDAF for 2012-2016, was finalized by the GoB and the UNCT in mid-2011. It is the second UNDAF in the country after the previous (first) UNDAF was extended until 2011. Subsequently, an UNDAF Action Plan was elaborated also in 2011. The current UNDAF was formulated through a participatory multi-stakeholder process that started in early 2010. It was based on the latest MDG Progress Report that came out in 2009 and national development priorities that were defined by the GoB through its 6th Five-Year Development Plan (2011-2015). The UNDAF was relevant, in the sense that it was clearly aligned with the national development priorities of the GoB, specifically with reference to its plans for the achievement of the MDGs, and its targets and strategies as defined in the 6th Five-Year Development Plan.[64]

Alignment of objectives and strategies with the UNDAF: The development of the CP was aligned with the UNDAF from its start. The RHR objectives align with Pillars The Programme Outputs undertaken between 2012 and 2016 are meant to contribute to three UNDAF Outcomes of **Pillar Three**: Social Services for Human Development
Outcome 1 – *Deprived populations in selected areas, particularly women, children and youth benefit from increased and more equitable utilization of quality health and population, education, water, sanitation and HIV services.*
Outcome 2 – *Children, women and youth demand and benefit from effective social protection policies and improved services aimed at eliminating abuse, neglect, exploitation, and*

[64] Evaluation Of The 2012-2016 UNDAF For Bangladesh, Draft Report, Prepared by Joel Beasca and Salma Akhter, UNDAF Evaluation Team September 2015

trafficking.
Outcome 3 – *Deprived community members in selected areas practice key life-saving, care and protective behaviors and raise their demand for quality social services.*

Outputs also contribute to **Pillar Five**: Climate Change, Environment, Disaster Risk Reduction and Response; **Pillar Six:** Pro-Poor Urban Development, and **Pillar 7:** Gender Equity and Women's Advancement, where UNFPA has a major contribution.
Within the UN system, UNFPA has been assigned to take the lead in MDGs 3 and 5. Accordingly, the country office coordinated the preparation of the MDG-3 and MDG-5 progress reports. In this process, a national dialogue was organized with a view to incorporating the voices of different stakeholders including government officials, civil society experts, the private sector, and development partners, into the final progress reports.

- ✓ **Reflection of the ICPD goals in the CP:** The extended UNFPA Strategic Plan (2008-2014) in effect in the planning stages of the CP, prioritizes Maternal Health, followed by Family Planning. The new UNFPA Strategic Plan (2014-2017) again prioritizes MDG 5 which targets the pregnant and delivering woman and her baby. It is at times unclear in practice how maternal health is defined by UNFPA. Discussions with key informants indicates that the operational concept of maternal health focuses on pregnancy to delivery, and significantly less on women suffering the longer term effects of early pregnancy, close birth spacing, an unhealthy or complicated pregnancy and delivery and maternal health morbidity and mortality such as obstetric fistula or CBC.[65]

Obstetric Fistula: The UNFPA "When Childbirth Harms" (2012) fact sheet indicates that prolonged and obstructed labor without timely C-Section is a key cause of OF, thus the prevention of fistula includes high quality RH, including family planning, ANC, skilled birth attendants and EmONC. UNFPA leads the global campaign to end fistula. MDG 5 supports the preventive element of a holistic fistula response. The Campaign has prioritized increased access to fistula treatment by upgrading health facilities and training health personnel.[66]

Cervical and Breast Cancer: Differentiation between cervical and breast cancer detection and treatment - The lumping together of cervical and breast cancer discussions and data may not be instrumental to drawing attention to the individual issues since there are different causal factors, screening procedures and treatment regimes. They are not treated together in developed countries. What is relevant to one type of cancer is not always relevant to the other. One may be emphasized to the detriment of the other.[67] The 8th CP has to some degree recognized the need to promote access to screening and treatment of CBC, while still grouping them together and not recognizing that cervical cancer is an infectious disease, a reproductive health concern, and that screening and treatment for each cancer requires its own complex focus.

"All countries should strive to make accessible through the primary health-care system reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015…. Referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, ***breast cancer and cancers of the reproductive system****, sexually transmitted diseases, including HIV/AIDS should always be available as required." —Programme of Action of the International Conference on Population and Development (ICPD), Cairo, 1994 [emphasis added]*

"ICPD's recognition of care and control for the cancers of women as integral and essential to a comprehensive global approach to women's and reproductive health was truly innovative in the mid-1990s. But over the two decades since the conference, the clarion call to action issued in Cairo failed to resonate. Tellingly, the Millennium Development Goals (MDGs) adopted six years later set targets for reducing deaths in pregnancy and childbirth but made no mention of cervical and breast cancer or other chronic and non-communicable diseases." [68]

[65] Key Informant interviews, October 2015.
[66] UNFPA website
[67] Key Informant interviews, October 2015.
[68] "Cervical and Breast Cancer: Progress, Challenges, Priorities, and Prospects", Andrew Marx, for the : ICPD Beyond 2014 Expert Meeting on Women's Health - Rights, empowerment and social determinants 30th September - 2nd October, Mexico City, Background Paper #6

Goals and objectives to develop national capacities[69]: The RH AWPs were developed jointly with government partners. The capacity needs are so extensive that training and other capacity inputs are all required. The recurring theme in discussions with **Key Informants** is the shortages of staff, and there are strategies to place more staff by DGHS, such as using private professionals to fill in. In light of the systemic weaknesses, the capacity development inputs may be superimposed on a system where they cannot make up for the motivational and resource shortages. With regard to the outcomes and outputs, some possible issues may affect the degree to which they are realistic:

- Changes in attitudes and traditional behaviors (e.g. regarding adolescent and youth sexual and reproductive health, gender based violence) that are extremely complex and require time and long term interventions
- Limited targeting of vulnerable groups or areas possible with the available resources make the outcomes and outputs particularly at national levels difficult to achieve or make substantial progress toward (possibly meaning that outputs are unrealistic).

Mainstreaming of South-South cooperation:

COAR 2012:

- Two UNFPA Youth Forum members and one youth participated in the "Building Youth Leadership: Asia-Regional Training for Youth Advocates" in Bangkok in June 2012 which provided them the knowledge of the ICPD and MDG review process and assess how their commitments have been implemented a the country level. This training strengthened their capacity to effectively lobby with their governments and national delegations on issues related the ICPD PoA, MDGs etc. Later one member of the above training presented a paper on Evidence on rights-based programming for vulnerable groups e.g. adolescents especially girls, youths, at the high-level Inter-Ministerial Conference on Evidence for Action: South-South Collaboration for ICPD beyond 2012, jointly organized by the People's Republic of Bangladesh and PPD in November 2012, Dhaka, Bangladesh.
- A group of Youth (5 persons including two UNFPA Youth Forum for RH members) and a Government Official were sent to Bali Global Youth Forum Forum conference with support from CO and the government and CO affiliated youth groups comprising of young people from various backgrounds with gender balance were engaged in World Population Day, ICPD validation group work, Youth Conference 2012 etc.

Three government officials (Bangladesh Nursing Council, Directorate of Nursing Services and Bangladesh Midwifery Association), one journalist and UNFPA JPO (Midwifery) attended the Asia Pacific Regional Conference organized by International Confederation of Midwives (ICM), Hanoi, Vietnam, 24-26 July 2012. UNFPA JPO (Midwifery) attended the Annual Midwifery Programme Mid-Year Review and Technical Capacity Building workshop held in Addis Ababa, Ethiopia, 17-21 September 2012. Three GOB under MOHFW officials and UNFPA JPO (Midwifery) attended the 20th FIGO World Congress of Gynecology and Obstetrics in Rome, Italy, 7-12th October 2012.

COAR 2013: Four UNFPA facilitated Youth Forum members participated in the "Building Youth Leadership: Asia-Regional Training for Youth Advocates" in Bangkok in 2012 and the members of the UNFPA facilitated adolescent forum has contributed to the development of the action plan on ASRH based on the ASRH strategy. This action plan has been shared and disseminated to the stakeholders in December 2013. As per request of Timor Leste, CO facilitated participation of Prof. Sayeba Akhter and Dr. Fahmida Zabin for mission to Dili, Timor Leste from 11-19 November 2013 to conduct surgery and treatment of obstetric fistula patients as well as to train their hospital staff on fistula surgery.

UNFPA facilitated a Youth forum for advocacy to policy makers and program managers to address the sexual and reproductive health issues of youths and adolescents. The supports included participation at trainings on youth leadership, planning and monitoring of adolescent and youth targeted interventions. This training was organized by UNFPA APRO and financial support was provided by UNFPA Bangladesh. Additionally, Youth forum members participated at a national advocacy workshop, roundtable discussion, workshop for developing strategic and monitoring framework for adolescent and youth based project interventions. This group was also actively involved and engaged in youth consultation for finalization the SAARC Youth Charter. UNFPA provided consultative support to three youth led networks: PLHIV (People living with HIV), Sex workers network and STI networks

[69] Key informant interviews, October 2015

(NGOs working for prevention of sexually transmitted infection especially among the youth and adolescents). Through series of consultative meetings, members of these networks were oriented on linkage of HIV and SRH issues so that they can contribute to create demand for integrated HIV and SRH services.

The State of the World's Midwifery Report (SoWMY 2014) was launched at the ICM Conference in early June 2014. With support from UNFPA, the HRM unit of MOHFW represented the GoB and presented the overall Bangladesh situation with updates on midwifery and shared the 'State of world Midwifery report' at official functions during the International Conference on FIGO SAFOG SLCOG 2014 held in Colombo and showed strong commitment of the GOB. This session presented the key findings of the 2014 report, followed by country perspectives from four countries of the South Asian region that participated in the development of the report: Bangladesh, India, Nepal and Pakistan.

- ✓ **Mainstreaming of Gender Equality and Women's Empowerment:** Gender is mainstreamed to the degree that RH mainly focuses on women's RH and some on men's RH. The gender marker recommended by UNFPA was used during the formulation of the Country Programme and in the AWPs to ensure that the gender issues aer addressed adequately.

Evaluation of the 2012-2016 UNDAF: The parallel agenda for the mainstreaming of the cross-cutting issues and core programming approaches was not adequately addressed in the UNDAF design. Emphasis by the then UNCT on the development agenda over the normative agenda, lack of country experience on UNDAF programming, recommendations made by the previous UNDAF evaluation, inadequacy of technical support and guidance on the thematic concerns, and absence of a QA System on the UNDAF were cited as factors for the skewed design. While the comparative advantage of the UNCT was also defined well in the UNDAF, it was also mainly viewed from the perspective of achieving the deliverables (i.e. outcomes and outputs) that were committed in the UNDAF documents, and not within a purview of mainstreaming the UN's normative agenda.[70]

- ✓ **Targeting of Resources to Adolescents and Youth:**

UNFPA's new strategic plan 2014-17 was formally agreed at the Executive Board in September 2013. This plan affirms that women and youth especially those who are vulnerable and marginalised, in particular adolescent girls, are the key beneficiaries of UNFPA work. The plan has universal access to sexual and reproductive health and realisation of reproductive rights at its core. This core is underpinned by respect for human rights and promotion of gender equality and is informed by changes in population dynamics.

The Strategic Plans monitoring framework has four outcomes (SRHR, adolescents, gender equality/girls empowerment and population) with fifteen outputs under these. Below is the full description of outcomes with example indicators. Outcomes 1 and 4 have the most indicators, and looking at previous financial reports these areas would normally account for the majority of programme expenditure (approx. 80%, which is a figure extrapolated from financial data from 2012 when UNFPA had different results framework – this is therefore an estimate[71]). Thus perhaps monthly 20% goes to the GE and AY.

1. Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access

2. Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health

3. Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth

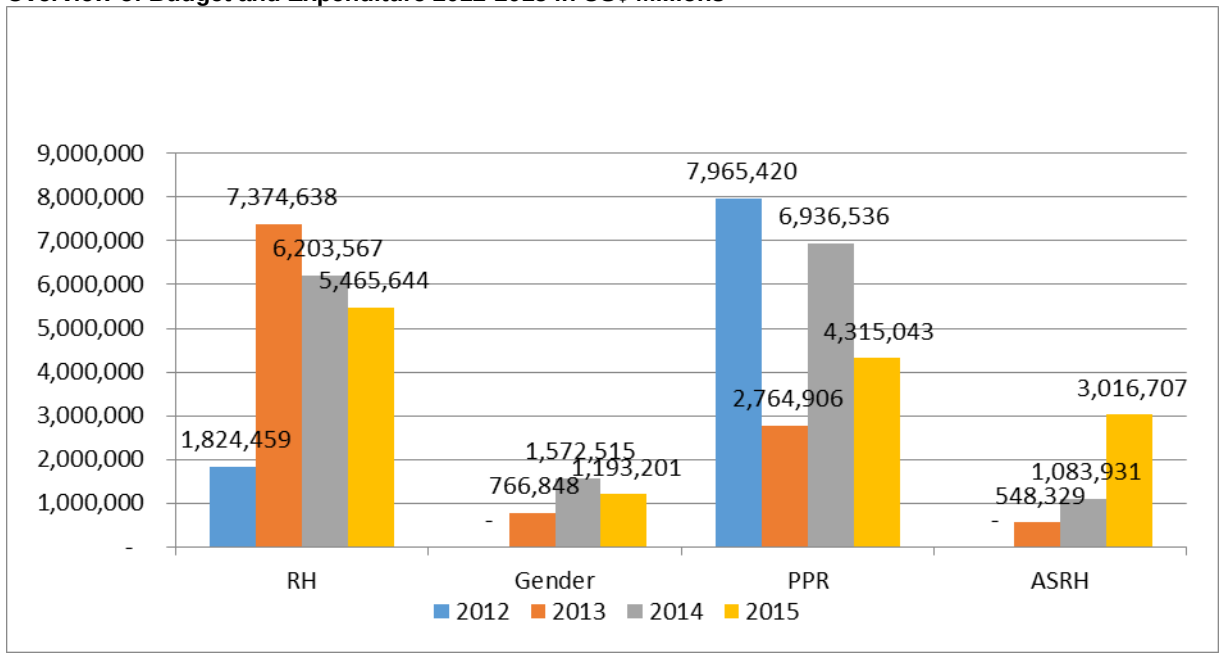
[70] Evaluation Of The 2012-2016 UNDAF For Bangladesh, Draft Report, Prepared by Joel Beasca and Salma Akhter, UNDAF Evaluation Team September 2015

[71] The Joint GOB-UN MNH Initiative Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction Project Completion Report July 2007 – June 2012, December 2012, EU, UKAID

4. Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality

In the CO budget during the CP, Adolescent Sexual Reproductive Health (ASRH) has been only incorporated into RH until 2013. The funding line for adolescents and youth (AY) in the RH Budgets, U201 and U202, appears as part of the DGHS budget: The AY are somewhat cross cutting in the CP with inputs expected from health services staff. The majority of funding in a woman's reproductive life is devoted to pregnancy and birth, with the second largest amount devoted to family planning, but mainly/only after marriage. This may be due to the focus on the MNHI project, a source of substantial funding for a number of years. Fewer funds are devoted to other aspects of women's reproductive health such as CBC and Fistula but they are not insignificant.

Overview of Budget and Expenditure 2012-2015 in US$ Millions



A 1.2 Population and Development

Alignment of objectives and strategies with the UNDAF: The 8th country programme is based on the situation analysis, the programme evaluation, and UNDAF, 2012-2016. The MDG progress report and the government strategic priorities, as expressed in its perspective plan, 2010-2021, and the sixth five-year plan, helped to establish the priorities of the UNDAF. The UNDAF includes a geographical focus as well as a group focus, in recognition of the increasing inequalities in the country. The UNFPA programme follows this 'targeting' strategy and contributes to the UNDAF outcomes.

Reflection of the ICPD goals in the CP: The Government of Bangladesh has been implementing the 6th Five-year Plan which was made with due consideration of ICPD Plan of Actions, Beijing Platform for Action and MDGs to meet the challenges in reproductive health, reproductive rights, youth development, gender inequality, etc. in development efforts. The support provide by this PD Component is providing reliable data on population disaggregated by residence, age-sex, marital status, occupation to prescribe appropriative policy measures for poverty elevation , enhancing employment opportunity for youth and improve the quality and life for people.

Goals and objectives to develop national capacities: The PD Component is in line with the UNDAF priorities (Pillar 7) and the MDGs especially Goals 1-7 and the National Development Plans (e.g. 6th FY Plan, Perspective Plan, etc.). The Component contributed to development and implementation of the country's development policies, plans and program related to population dynamics, such as changing age structure and youth development to capture demographic "window of opportunity" which is the objective of the 6th 5-year plan and perspective plan of the government.

Mainstreaming of South-South cooperation: UNFPA, with assistance from the Philippines CO, facilitated the South-South cooperation for the Planning Commission officials to learn from and exchange views with the officials of the Philippines from different government ministries and offices both at the national and regional levels in integrating PD in its national and sectoral development planning processes. The CO also organized similar visit in 2013 to Vietnam for 12 government planning officials.

Cooperation	Participant/s	Organizer	Location and Dates	Source of Information
2012				
South-South Collaboration for ICPD beyond 2012	Youth Forum	Jointly organized by the People's Republic of Bangladesh and PPD	November 2012, Dhaka, Bangladesh	COAR 2012
"Building Youth Leadership: Asia-Regional Training for Youth Advocates" which provided them the knowledge of the ICPD and MDG review process and assess how their commitments have been implemented a the country level.	Two UNFPA Youth Forum members and one youth	UNFPA Regional Office	Bangkok, Thailand in June 2012	COAR 2012
Bali Global Youth Forum conference with support from CO and the government and CO affiliated youth groups comprising of young people from various backgrounds with gender balance were engaged in World Population Day, ICPD validation group work, Youth Conference 2012 etc.	A group of Youth (5 persons including two UNFPA Youth Forum for RH members) and a Government Official	Global Youth Forum	Bali, Indonesia	COAR 2012

Asia Pacific Regional Conference on Midwifery	Three government officials (Bangladesh Nursing Council, Directorate of Nursing Services and Bangladesh Midwifery Association), one journalist and UNFPA JPO (Midwifery)	International Confederation of Midwives (ICM)	Hanoi, Vietnam, 24-26 July 2012	COAR 2012
Annual Midwifery Programme Mid-Year Review and Technical Capacity Building workshop	UNFPA JPO (Midwifery)	International Confederation of Midwives (ICM)	Addis Ababa, Ethiopia, 17-21 September 2012	COAR 2012
20th FIGO World Congress of Gynecology and Obstetrics	Three GOB under MOHFW officials and UNFPA JPO (Midwifery)	International Federation of Gynecology and Obstetrics (FIGO)	Rome, Italy, 7-12th October 2012	COAR 2012
Exchange views with the officials of the Philippines from different government ministries and offices both at the national and regional levels in integrating P&D in its national and sectoral development planning processes.	Planning Commission officials	UNFPA with assistance from the Philippines CO	Philippines CO	COAR 2012
Census Data Capturing, Processing and Analysis. Through this visit BBS got an idea about how to develop a sustainable system for census operation.	22 BBS officials	Jointly organized by UNFPA Bangladesh and BPS - Statistics Indonesia	Indonesia 6 to 12 November 2012	COAR 2012
Exchange of experience with MPs, meeting with relevant Standing Committee members, sharing policies, strategies, plans/program related to P&D issues along with visits to different government and NGOs offices			Three study tours to Thailand, Philippines and Republic of Korea.	COAR 2012

2013				
Mission to conduct surgery and treatment of obstetric fistula patients as well as to train (East Timor) hospital staff on fistula surgery	Prof. Sayeba Akhter and Dr. Fahmida Zabin	Country Office	Dili, Timor Leste from 11-19 November 2013	COAR 2013
Strengthening the analytical skill in Population Planning for official of Ministry of Planning and UNFPA. These provided opportunities for the senior officials on how other countries addressing the population issues and development needs.	12 government planning officials	UNFPA with assistance from the Vietnam CO	Vietnam 2013	COAR 2013
Orienting project staff. AFPP&D also supported development of the 2013-2016 Advocacy plan for BAPP&D. Finalize TOR for BAPP&D.			support from AFPP&D through APRO	COAR 2013
UN- Global Geospatial Information Management (UNGGIM)	3 BBS high officials and one UNFPA staff		Cambridge, UK	COAR 2013
A week-long XXVII International Population Conference	Joint Chief and Project Director, GED	International Union of the Scientific Study of Population (IUSSP).	Korea on 26-31 August 2013	COAR 2013
2014				
The State of the World's Midwifery Report (2014) was launched at the International Confederation of Midwives (ICM) Conference in early June 2014. This session presented the key findings of the 2014 report, followed by country perspectives from four countries of the South Asian region that participated in the development of the report: Bangladesh, India, Nepal and Pakistan.	MOHFW represented the GoB and presented the overall Bangladesh situation with updates on midwifery	Conference sponsored by the International Federation of Gynecology and Obstetrics (FIGO), the South Asia Federation of Obstetrics and Gynecology (SAFOG), and the Sri Lankan College of Obstetrician and Gynecologists,	2014 held in Colombo, Sri Lanka	UNFPA Annual Report 2014

		(SLCOG)		
"Integrated Geospatial and Statistical Information". Received international exposure on Integrated Geospatial and Statistical Information	6 officials of BBS		Beijing, China during 9-12 June 2014 and at UN HQ, New York, USA during 4-8 August 2014	SPR 2014 up to March 2015
Census Data Capturing and Geo-Database Creation	15 BBS officials from Census Wing and SID	Indonesian National Statistical Office		SPR 2014 up to March 2015
Asia/Pacific Regional Conference 2014 at Thailand	Assistant Chief of GED	Help Age International and UNFPA	Thailand (1-4 Sep 2014)	SPR 2014 up to March 2015
Training of Economic Policy Research Institute	Deputy Chief of GED		Thailand 6-17 Oct 2014	SPR 2014 up to March 2015
Study visit to enhance the level of knowledge and understanding of Parliamentarians on P&D related issues	4 MPs, 4 Parliament Secretariat officials and one staff	Eastern Asia University of Thailand	27 Nov-3Dec 2012	SPCDP SPR Jul-Dec 2012

Annual Report 2014: 2014, UNFPA Bangladesh Country Office undertook a Demographic Impact Study, by a team of renowned international and national experts, in response to the request from Planning Commission for inputs to the Seventh Five Year Plan of Bangladesh (2016-2021)

CSPR 2014 upto March 2015: ***6 officials received international exposure on Integrated Geospatial and Statistical Information:*** BBS high officials have attended two international workshops on "Integrated Geospatial and Statistical Information" held at Beijing, China during 9-12 June 2014 and at UN Headquarters, New York, USA during 4-8 August 2014. BBS Officials got the opportunity of sharing country experience of geography and geospatial information on census and survey activities and for collecting, processing, storing, integrating, aggregating and disseminating the data on appropriate platforms. The gained knowledge and understanding of geospatial and statistical Information management helped BBS in establishing a GIS Platform to integrate statistics with geospatial information system in Bangladesh.

- ***15 BBS officials gained better understanding on Census Data Capturing and Geo-Database Creation from Indonesia:*** A week long study tour in Indonesia conducted and a total of 15 officials from Census Wing and SID attended the study tour, where the Joint Secretary, Development led the team in Indonesian National Statistical Office. The study tour incorporates orientation on overall conducting census in three phases (pre-during-and-post census).

SPR – GED 2014 – Asia/Pacific Regional Conference 2014 at Thailand (1-4 Sep 2014) organized by Help Age International and UNFPA. Assistant Chief of GED attended. Training of Economic Policy Research Institute (6-17 Oct 2014) in Thailand, Deputy Chief of GED attended.

Mainstreaming of Gender Equality and Women's Empowerment: The PD component aims at enabling the government and non-government stakeholders to accelerate national development, with a focus on achieving the Millennium Development Goals which include MDG3 (Promote Gender Equality and Empower Women) and pro-poor growth. One of the two component output seeks in increase capacity to integrate population and gender concerns, including emerging issues, into national and sectoral plans and policies.

Targeting of Resources to Adolescents and Youth: The situation analysis for the 8th CP identified that dependency ratio of the country starting from 2011 will be decreasing steadily, and Bangladesh is expected to enter the demographic window. This is a situation when proportion of children under 15 years falls below 30%, and the proportion of people 65 years and older will still remain below 15% of the total population. This will be the best period for realizing the demographic dividend, with the lowest levels of combined child and adult dependency in its history. This potentially "golden" period will last till the middle of this century. The PD component contributed with a background policy paper on the impact of demographic transition as input to the formulation of country's 7th Five Year Plan for 2016-2020 and also through its partners (GED, SEID, DPS and Parliament projects) disseminate this information to required action in the national and sectoral plans and policy matters.

A 1.2 Gender Equality

Evidence that the objectives and strategies of the CP and the AWPs are in line with the goals and priorities set in the UNDAF: A series of in-house analyses on the key issues of UNFPA"s thematic areas were held, one of which is Gender. The CPAP and AWPs are in line with the goals and priorities set in the UNDAF and UNFPA Strategic Goals for gender. The UNDAF was developed in November 2010, five years remaining to the MDG target year, 2015. The UN system of Bangladesh envisages the UNDAF (2012-2016) to be centered on the MDGs, as well as the Government was requested to prepare a MDG progress report to be presented during the High-level MDG Summit in September 2010. In this context, it was decided that UN system would work in close collaboration with the government to prepare the MDG progress report and use it as a part of the country analysis for the UNDAF preparation. Within the UN system, UNFPA has been assigned to take the lead in MDGs 3 and 5. CP outcome 3 ('Social and institutional vulnerabilities of women including marginalized and disadvantaged are reduced' in line with UNDAF pillar outcomes 7.1 and 7.2 and SP outcome 3)[72].

Evidence that ICPD goals are reflected in the CP and programmatic area interventions: UNFPA, Bangladesh's 8thCP is strategically aligned with all of the priorities under the agreement of the 1994 *International Conference on Population and Development* (ICPD 1994) held in Cairo. Since the ICPD in 1994 till 2014 Bangladesh focused on several indicators in collaboration with international development partners (e.g. UNFPA) related to population growth and structure, reproductive rights and reproductive health, interrelationships between population, sustainable development, gender equality, equity and empowerment of women, population distribution, population displacement etc[73]. The 8th CP of UNFPA is built on the experiences of earlier country programmes and reflects the ICPD agenda and the Beijing Plan of Action, the MDG situation analysis and United Nations Development Assistance Framework (UNDAF), in response to the Government's national development goals including the Millennium Development Goals. The programme has also taken into account the findings and recommendations of the 7th country programme (CPE 2011) and guided by UNFPA's Strategic Plan (SP: 2008-2013 and 2014-2017)[74].

Evidence that the CP sets out relevant goals, objectives and interventions to develop national capacities: The results and resource framework (RRF) of the 8th CP clearly identified the outcomes and outputs with relevant indicators and resource requirements. The UNFPA country programme is organised around three mutually re-enforcing programme components: i) Reproductive Health, ii) Gender, and iii) Population and Development[75]. The TPPs/Project Proposal, SPR, Annual progress reports indicate that all of the interventions under the gender components having clear goals and objectives towards and include capacity building of implementing partners as well as the beneficiaries.

Extent to which gender equality, women's empowerment have been mainstreamed: The programme is nationally executed with the Government of Bangladesh and based on national priorities (MDG 3, National Plan of Action of National Women Development Policy, 2011, 6th Five Year Plan's strategic direction[76]) with regard to gender equity, women

[72] UNDAF (2012-2016)

[73] Nasreen, Mahbuba, 2015, Situation Analysis on Gender based Violence in Bangladesh, UNFPA, 2015

[74] Terms of Reference for the development of the 8th Country Programme of Assistance to the Government of Bangladesh (2012-2016).

[75] Nasreen, Mahbuba, 2015, Situation Analysis on Gender based Violence in Bangladesh, UNFPA, 2015

[76] Annual Progress Report 2014on 8th Country Programme, Gender Component, Output No. 5, UNFPA BCO, January, 2015

empowerment and advancement issues. It is also having close partnership with other United Nations agencies, NGOs and the private sector. 17 implementing partners with 19 projects from eight ministries, five NGOs and two autonomous bodies (Bangladesh Garments Manufacturers and Exporters Association – BGMEA and Dhaka University), are carrying out the activities to achieve the above outputs and contributing to the outcomes related to gender equality and women's empowerment issues. The Economic Relations Division (ERD) of the Ministry of Finance is the overall coordinating agency for the UN agencies, including UNFPA's 8th County programme[77].

A 1.3: The objectives and strategies of the Bangladesh Country Programme are consistent with Government policies, strategies and guidelines, the MDGs, and are planned with sufficient knowledge of the sub-national structures and stakeholders in the selected areas.	• Extent to which objectives and strategies of each programmatic area are consistent with relevant national and sectorial policies and MDG goals • Extent to which the objectives and strategies of the CP have been planned with the national partners • Extent to which interventions have been implemented with Government and community partners and through national systems	• National policies, strategies and guidance on RHR, gender, PPR, humanitarian assistance • National MDG strategy and national MDG reports • Joint plans and agreements (MoUs, field level agreements, etc.) • Government and other national stakeholders	• Review of relevant national documents • Review of regional and global instruments accepted by the Government • Key Informant interviews in provincial and district offices

A 1.3 Reproductive Health and Rights

Consistency with national and sectorial policies and MDG goals:

The priorities for Health Population & Nutrition Sector Strategic Plan **(HPNSDP, 2010- 2016) are Maternal and Neonatal Health, Reproductive and adolescent health and Population and Family Planning.** Priority indicators in the HPNSDP 2011 relevant to UNFPA's mandate include: infant mortality rate, maternal mortality rate, total fertility rate and prevalence of HIV in MARPs (every two years).

Family Planning: There is national planning for Family Planning but no specific district planning. The Government of Bangladesh has developed a *National Strategy for Improving Uptake in Long Acting and Permanent Methods (LAPM) in the Family Planning Program* (2011-2016).[78] The National Family Planning Technical Committee of DGFP is working toward getting approval for implants (**Etonogestrel contraceptive implant**, sold under the brand names **NexplanonT** and **Implanon). Implanon NXT was recently approved. Implanon was approved earlier and currently used in the national programme.** Research has shown that the hormones in it do not affect the breast milk or growth of the child. This method could be moved to #2 qualifying as one without many restrictions and need for follow-up. Implanon is for 3 years and Jadelle (the two rod implant) is for 5 years. Jadelle will be gradually discontinued from the national programme and is reversible.[79]

Obstetric Fistula: SPR 2013: As of the end of 2013, there still was no endorsement of the National Fistula Prevention Strategy by the MOH&FW and subsequent translation of strategy for proper implementation. Also, the timely release of funds and proper resources involved for quality implementation has been a long-standing issue. In addition, as in other

[77] Nasreen, Mahbuba, 2015, Situation Analysis on Gender based Violence in Bangladesh, UNFPA, 2015

[78] Bangladesh Demographic and Health Survey 2014, page 26.

[79] Key Informant Interviews, October 2015

areas, the chronic delay in recruitment of technical staff for the project has hampered this area of work.

Cervical and Breast Cancer. For the 8th CP and UNDAF (2012-2016) UNFPA took the lead on MDG 3 to promote gender equality and empower women - the CBC cancer burden is a relevant challenge to MDG 3 in Bangladesh. For MDG5 - Cancer control can help improve overall maternal health and "universal access to reproductive health". MDG 6, Combat HIV and AIDS, malaria and other diseases, in preventing HPV infection, contribute to overall health system strengthening.[80] Global focus on the MDGs, specifically MDG 5 there is a steady decrease in maternal deaths, but the same progress cannot be seen in combatting deaths from cervical and breast cancer, which together take more lives than maternal causes and may soon approach maternal causes as a critical driver of mortality in women of reproductive age in developing countries.[81]

Bangladesh is a signatory of WHO resolution on cancer prevention and control, which urges the member states to develop and implement a national cancer control strategy for reducing the incidence and impact of cancer. A cancer control plan has been developed in 1992 by the Bangladesh Cancer Society. A consensus workshop has been organized by NICRH on the development of National Cancer Control Plan with the support of WHO in 2005 for the first time. The government formulated 'National Non-Communicable Diseases Strategy and Plan of Action' and 'National Cancer Control Strategy and Plan of Action in 2007 with the help of the technical support from the WHO and a national cancer control taskforce will be formed with Directorate General of Health Services (DGHS) to implement the National Cancer Control Strategy and Plan of Action 2009–2015 through Medical College Cancer Control and District Cancer Control committees and different agencies. This taskforce will also coordinate the work of all agencies that contribute to cancer control in the country. In addition, they will identify and recommend priorities to National Cancer Control Council**.[82]**

- **Objectives and strategies planned with national partners:** DGHS and DGFP claim collaborative planning and validation of their leadership role. [83] Local Level Planning is built into the MNHI and also occurs for development of the Disaster Management Plans (see EQs 8 and 9).

- **Plans to implement interventions through national systems:** Majority of RH funds are committed through DGHS and DGFP.[84]

A 1.3 Population and Development

- **Consistency with national and sectorial policies and MDG goals:** The PD Component is in line with the MDGs especially Goals 1-7, the National Development Plans (e.g. 6th FY Plan, Perspective Plan, etc.) and the sectoral plans of 8 ministries. The Component contributed with population data related to population dynamics required for developing country's development policies, plans and programmes[85].

The PD Component has supported Bangladesh Bureau of Statistics (BBS) in conducting the 2011 Population and Housing Census, and generated the district and upazilla (sub district) level data and the draft analytical reports. The data available are desegregated by gender, location and poverty. Because of this experience, the Government of Bangladesh requested UNFPA to monitors progress of MDGs in the country. UNFPA through its PD component and the project support provided to General Economic Division (GED) of the Planning Commission carried out this activity.

[80] World Heart Federation.org - The MDGs and Cancer

[81] Institute for Health Metrics and Evaluation (HME): The Challenges Ahead: Progress and setbacks in breast and cervical cancer, 2011

[82] "Cancer Control in Bangladesh", Syed Akram Hussain and Richard Sullivan, Jpn J Clin Oncol. 2013 Dec; 43(12): 1159–1169. Published online 2013 Oct 25

[83] Key informant interviews, October 2015.

[84] AWPs and Atlas spreadsheets

[85] 2014 UNFPA Annual report.

- **Objectives and strategies planned with national partners:** Strategy focus by UNFPA is more on human resource development so that appropriate people involved in planning are informed and trained on population issues so that they can address those in development planning.[86] In relation to this, the PD partner BBS, are trained on state of the art technologies to collect appropriate data for planning and monitoring of national development goals, including MDG. The PD partner GED and SEID of the Planning Commission who are involved in national and sectoral planning are training the planners of different ministries on use of population issues so that they can use those in planning. The PD partner Department of Population Sciences addresses the issue of human resource development. It also makes user-friendly publications for building public opinion, and helps formulate population policies and strategies and address discriminatory provisions towards women and girls. The partnership with the Parliamentary Secretariat enhances the capacity of the Parliamentarians and its Secretariat officials to integrate population and gender concerns, including emerging issues into national policies and laws.

- **Plans to implement interventions through national systems:** Almost all of the PD interventions are implemented through national system. The BBS is an old partner of UNFPA; it is the national statistical organization under the Planning Ministry. BBS is obligated to provide timely and appropriate data for planning and monitoring of national development goals. UNFPA has two projects with BBS, one with its Census Unit and the other with the GIS Unit; both of the units are for the "Generation of Evidence and Knowledge Management". UNFPA support strengthens the capacity of BBS through large number training of the staff and equipment for the improvement of data collection quality, and utilization of census data in planning for development. UNFPA project with the Department of Population Sciences of Dhaka University that provides high quality training in population studies and produce top quality statistical reports on population and related issues. Government agencies, national and international NGOs and organizations, individual academics turn to this centre for advice on training and research findings on issues relating to population and development. Under this thematic area the interventions include supporting production of 137 traditional Census reports, secondary analysis of 2011 Population and Housing Census and producing thematic population monographs Census, making Census data and analysis available online to users, strengthening quality of SVRS, needs based research to fill the data gaps (study on elderly, causes and consequences of child marriage, VAW Round II, urbanization and migration), and strengthening BBS HQ and local level offices with equipment and training.

For the thematic area of "Policy Advocacy" UNFPA works with four national level organizations – Bangladesh Parliamentary Secretariat (BPS), General Economic Division (GED) and Socio-economic Infrastructure Division (SEID) of the Planning Commission and an international organization Population Council. The project with BPS aims to strengthen the Bangladesh Parliament Secretariat's capacity to pursue and ensure formulation appropriate P&D related policies and legislations as well as making necessary amendments in the existing ones and also to monitor of their implementation. It focuses on adaptation of critical policy measures in health, employment, education and human rights. The project with GED is to increase capacity of GED to integrate population and gender concerns into the development planning and appraisal processes and in the sectoral plans and policies. The project with SEID is aimed for mainstreaming population, development and gender concerns into sectoral plans. The project with Population Council is aimed at enhancing national capacity for integrating demographic concerns and post-2015 development agenda into development planning of the government. Population Council is to prepare factsheets and policy briefs to sensitize mainly the civil society on post ICPD issues and how to harvest demographic dividend. Under this thematic area the interventions include - Strengthening Parliamentary Advocacy through strengthening BPS, BAPPD and the three sub-committees to speak on UNFPA issues; policy dialogues on critical population and development issues related to reproductive rights, and gender equality, budget analysis; and producing advocacy materials – factsheets and policy briefs using census and other research/study outputs.

For the thematic area "Capacity Development", all of UNFPA projects under PD programmatic area were provided support. The interventions include - institutional Capacity Assessment of GED, SEID, BBS, Visioning exercise for DPS of Dhaka University; professionalizing the P&D issues through training and orientation to government planning and Parliament Secretariat officials, producing population science graduates; development and implementation of Training Plan for BBS; and strengthening BBS institutional capacity with equipment, software support.

A 1.3 Gender Equality

Extent to which objectives and strategies of each programmatic area are consistent with relevant national and sectorial policies and MDG goals: The gender intervention under the 8th CP contributes to achieving UN's MDG 3: *Promote gender equality and empower women* through its project interventions with DWA/MoWCA, Police/MOHA, multi-BWCCI and BGMEA. Activities of gender component are consistent with National Plan of Action (NPA) of National Women Development Policy, 2011, such as ensuring human rights

[86] AWPs and Key Informant Interviews, October 2015

and fundamental independence of women, eradicating violence against women, economic empowerment of women, women's health and nutrition and protection of women and children in collaboration with other UN agencies and development partners/INGOs. Gender interventions also planned to contribute to the 6th FYP's strategic direction with regard to gender equity, women's empowerment advancement issues[87]. However, gender and disaster management was one of priority areas of the NPA, which has not been considered in the gender intervention of UNFPA 8th CP except providing Minimum Initial Service Package (MISP) through DWA APWR project, but considering the importance of it gender unit has already taken initiative to address GBV in emergency situation, some interventions have been planned already to implemented under this CP , from 2016 . **Extent to which the objectives and strategies of the CP have been planned with the national partners:** All the TPPs, concept notes and project proposals under the gender component have been planned and formulated in consultation with national level implementing partners. Some of the interventions were based on National level consultations with diversified stakeholders such as for DWA project APWR formulated Local Level Planning in the intervention areas. All project have been formulated upon huge consultation with NGO stakeholders that helped UNFPA to prioritise national priority in the project design. **Extent to which interventions have been implemented with Government and community partners and through national systems:** The project interventions of Gender component is mostly with government such as DWA/MoWCA, Police/MOHA. Under the 8th CP another multi-bilateral project namely "Generation Breakthrough" (jointly funded by EKN) is being implemented by two wings of two ministries DSHE of MoE and DWA of MoWCA. The other partner includes an INGO called Plan International.		
EQ2 To what extent did UNFPA contribute to sustainably improving access to and demand for high quality sexual and reproductive health and HIV services, especially for the most vulnerable groups?			
A.2.1. The quality and accessibility of sexual and reproductive health (SRH) information and services, and knowledge of SRH and HIV, in selected districts, urban areas and refugee camps is strengthened. (from CP Output 1 and Output 2)	• Number of maternal and child welfare centers and comprehensive reproductive health care centers (CRHCC) providing emergency obstetric care (EMoC) 24 hours a day, 7 days a week **(**CP Output 1 Indicator) Baseline: 30%; Target: 100% • Number of district hospitals and upazila (sub-district) health districts with minimum required number of certified midwives (CP Output 1 Indicator) Baseline: 20; Target 70% • Numbers of targeted districts and urban centers facilitating access to fistula repair surgery (Baseline:0, Target: 1) • Numbers of diagnosed women in targeted districts and urban centers who access treatment for Cervical and Breast cancer • % of public service delivery points providing at least 3 modern family planning methods including one Long Term method (CP Output 1 indicator) Baseline: 70%; Target: 90% • Contributions to Outcome indicators - % of deliveries attended	• Information system data on indicator numbers • Survey data • Monitoring reports • Health system staff and other health providers • The most at risk populations (MARP) and vulnerable women and youth in areas with greatest disparities	• Document review • Key Informant Interviews with Ministries of Health and Family Welfare, Education, and Disaster Management • Key Informant Interviews with Local Government, Rural Development and Cooperatives, CRHCCs • Key informant Interviews with relevant ministries, NGOs and donors working with underserved groups (see stakeholder matrix) and local authorities • Interviews with health

[87] Annual Progress Report 2014 on 8th Country Programme, Gender Component, Output No. 5, UNFPA BCO, January, 2015

	by skilled providers – Baseline: 80%; Target: 100%; modern method contraceptive prevalence rate – Baseline 80%; Target: 100%; Adolescent birth rate, (15-19) - Baseline: 80/1,000; Target: 100%		professionals • Interviews with Academicians and NGOs • FGD with service users or non-service users

- **Provision of emergency obstetric care in maternal and child welfare centers (MCWC) and comprehensive reproductive health care centers (CRHCC):**

The MNHI was in process since 2007. Thus there can be expected to be cumulative results in the 8th CP. **Post 8th CP initial planning stages:** In 2015 the **"EmONC Needs Assessment Study",** was published in final form, although data was collected in May to October 2012 in the first year of the CP. This study, aiming to support MDGs 4 and 5, covered 24 districts of Bangladesh that included 4 districts (Maulvibazar, Narail, Jamalpur, and Thakurgaon) in Phase I of MNHI, 7 districts (Bagerhat, Barguna, Panchagarh, Patuakhali, Rangamati, Sirajganj, and Sunamganj) in Phase II of MNHI, and 13 other low socioeconomic districts (Bandarban, Bhola, Cox's Bazar, Gaibandha, Habiganj, Khagrachhari, Khulna, Kurigram, Netrakona, Nilphamari, Rangpur, Satkhira, and Sylhet) identified by the United Nations Development Assistance Framework (UNDAF).

The "EmONC Needs Assessment Study" found a 40% met need for obstetric complications. The contribution of the public facilities for met need was much higher (32%) than that of the private nfp (2%) and fp (6%) facilities. While in 3 districts (Maulvibazar, Rangpur and Thakurgaon), the met need was above 60%, the corresponding figure was below 20% in another 4 districts (Bagerhat, Satkhira, Sirajganj and Sunamganj).

- The met need for EmONC in the Phase I MNHI districts was much higher (about 56%) than that in the Phase II (about 25%) and UNDAF (about 42%) districts.
- Proportion of all expected births through C-section is an indicator to determine if enough lifesaving procedures were performed for women who actually needed that intervention. Our facility assessment found about a 12% C-section rate among the expected number of births in the study districts. C-section rate was the highest in private fp facilities (7.8%) compared to public (2.9%) and private nfp (0.9%) facilities. The study found that, in six districts (Khulna, Narail, Rangpur, Satkhira, Sylhet and Thakurgaon), C-section rate was more than 15% and, in five districts (Bandarban, Bhola, Khagrachhari, Netrokona and Sunamganj,), the figure was less than 5%, which, in fact, was above and below the expected C-section rates for a region.
- The direct obstetric case-fatality rate (DOCFR), i.e. percentage of women with obstetric complications who died in a facility among all women admitted with obstetric complications in that facility) is an indicator of the quality of care in EmONC facilities, which is expected to be less than 1% as per WHO guideline. Overall, DOCFR was found to be about 1% in the study districts. Among all types of facilities, MCHs had the highest DOCFR (2.6%) while, in DHs and other health facilities, the figure was <1%. Surprisingly, no maternal death was found in the MCWCs. In 6 districts (Khagrachhari, Khulna, Rangpur, Satkhira, Sirajganj and Sylhet), DOCFR was higher than the tolerance limit (>1%). DOCFR was much lower in the Phase I MNHI districts (0.4%) compared to that in the Phase II (0.8%) and UNDAF (1.2%) districts.

C-sections – In Dhaka, one facility visited had 40% C-sections, due to referrals, and in Barisal, a similar high number in the district hospitals. This might explain why DOCFR is not present in MCWCs, if the cases reach the UP and DHs. [88] The Phase I MNHI districts had the higher proportion of C-section (13.9%) than the Phase II MNHI (7.8%) and UNDAF (12.5%) districts.

The **Project Completion Review and subsequent report by DFID** (2012) are relevant since they were not available to the 7th CPE and the 8th CP Assessment. The reports validate mainly positive progress from the MNHI but caution that results and sustainability are not yet achieved. (see Relevance above.)

[88] Key Informant interviews and site visits with data collection, October 2015.

The **Initial Monitoring Mission, Joint Government of Bangladesh – United Nations Maternal and Neonatal Health Initiative (MNHI)**[89] July 2015, report found the following.

Reaching the most vulnerable through LLP: MNHI's approach to reaching the marginalised is predicated on the premise that stronger health and community systems will be able to identify the needs of and reach everyone with MNH information and services, including the poor and excluded. Based upon this MNHI supports district and sub-district health managers to use data to develop evidence based plans or LLPs. Senior health managers and civil society representatives review LLPs and ensure they adhere to national and community priorities. Once plans are approved, funds are transferred to districts using MoHFW systems. The process is highly appreciated, has brought together DGHS and DGFP, added human resources based upon a rational assessment of need, appropriately equipped and renovated facilities, put in place emergency transport, and been the impetus for scaling up MNH services and reaching some previously neglected populations.
Support for human resources: has allowed health managers to open bottlenecks to better service provision, maintain cleanliness and, as an unintended result, shown that locally engaged staff are more accountable.
Notifications of maternal and perinatal deaths: the first component of MPDR, have raised awareness of maternal and perinatal deaths and provided data that has been used to improve MNH services.
Capacity Development Training: Appropriate MNH short courses have been provided for many health staff and community based workers (including Community Skilled Birth Attendants or CSBAs).
Community Clinic functioning. ComSS interventions are building on and enabling the MoHFW Community Clinic system to function better, as well as adding capacity by training and supporting Community Health Volunteers (CHV). There is evidence of improved MNCH knowledge and health-seeking, as well as better satisfaction with services in most districts where this data is collected. However the ComSS strategy is dependent on MNHI facilitation and financial support. ComSS also reaches entire populations to capture the marginalised. While CHVs data is supposed to be used to prioritize support to the marginalised, the monitoring team feels that the one-size-fits-all character of the CHV strategy does not adequately target vulnerable populations.
Rights Advocacy: MNHI promotes women's right to maternal health. Other gender equality efforts are limited to the Women Friendly Health Initiative and ensuring that there is at least one women representatives in CSGs.

Issues in demand for SRHR services: [90]
Shortages of staff in the sub-district level. The Union level is meant to coordinate normal deliveries but there is only one paramedic, who is there 3 days a week and is supposed to reside there. But they don't sometimes and the community has no confidence that they will find her there. They then by-pass the union, there are 4,500 Unions health facilities (underused). There is a revised Maternal Health Strategy that says 3 paramedics should be there, however, to establish even one new position and recruitment has to go through a huge bureaucracy.
Sub-standard facilities. At the **Union Level Family Welfare Center (FWC) - Patuakhali district** –Since 2013, UNFPA has been helping with training of staff and providing equipment and essential medicines (saline, oxytocin, vitamins, folic acid, misoprostol, newborn antibiotics and eye drops, etc.) The government essential services package is not adequate. There are only 2-5 deliveries a month. Only 30% of deliveries take place at a facility and 70% at home, higher than national average. The situation of the clinics was so deteriorated that UNFPA intervention was needed.
Need for more advocacy. In Patuakhali, there are only 3 campaigns a year and should be quarterly, need monthly really. There is no social barrier only the habit of using traditional healers. The TBA is the most reliable to be present but they are the cause of maternal mortality as well. Every quarter there is a meeting with 50 mothers at Union level to discuss the challenges for them. The registered FWAs and local political leaders encourage the women to use the health system and the benefits of facility delivery. It is unclear whether all options for advocacy are used, such as coordination/collaboration with the Red Crescent.
Inadequate transportation. The main barriers are the road conditions and transport options. Transport is an important obstacle to emergency response and avoidance of prolonged labor, the HA are supposed to inform them about the transportation, they can have an ambulance but they are not always sufficient in number, they have to pay for other transport but

[89] Initial Monitoring Mission, Joint Government of Bangladesh – United Nations Maternal and Neonatal Health Initiative (MNHI) Project Number: A-035190, July 2015 Submitted To: Bangladesh Program Foreign Affairs, Trade And Development (Dfatd) Submitted By:Agriteam Canada Consulting Ltd

[90] Key informant interviews and site visits, October 2015

not the ambulance.

- **Indicator: Number of maternal and child welfare centers and comprehensive reproductive health care centers (CRHCC) providing emergency obstetric care (EmONC) 24 hours a day, 7 days a week (CP Output 1 Indicator) Baseline: 30%; Target: 100%**

(previous CP RF indicator) % of women aged 15-49 years who gave birth in the two years preceding the survey and who know the danger signs of pregnancy (bleeding, high fever, prolonged labour, convulsion, headache and blurred vision) **MNHI 2013 Survey** report DGHS, DGFP, LGD Baseline = 49%; Current = 50%; Target = 60% in the project areas.

Data from 2014 Compiled Standard Progress Report for RH:

Output 1.1 indicators	Source	Frequency	Partners	Baseline 2012	End of 2014	End of 2016
Percentage of maternal and child welfare centres (MCWC) and comprehensive reproductive health care centres (DH, UHCs) providing emergency obstetric care 24 hours a day, seven days a week	Facility Assessment/ Survey through Dos in 11 UNFPA supported MNHI districts	Annual	DGHS, DGFP, LGD	CRHCC:60%DH: 80%, MCWC 50% URBAN-80%	CRHCC:100% DH: 100%, MCWC:100% UHC: 51% URBAN-100%	70% (overall)

The 2014 SPR: Data above indicates good progress toward outcomes. UNFPA took the lead in the H4+ Partnership, which supported development of the National Reproductive Maternal and Newborn Health (RMNH) Workforce Assessment report by the Human Resource Management (HRM) Unit in the MoHFW, which was published in March 2014. Midwives as a dedicated workforce in Maternal and Newborn Health (MNH) are an integral part of the long-term strategy to address the human resources gap identified in the report.[91]

176 were trained to be Skilled Birth Attendant through OGSB (10 batches). About 1500 staffs of different categories received training on skills in EmONC services, e.g. AMTSL Prevention of PPH, Safe Blood Transfusion, Infection Control, etc. In addition number of Doctors and paramedics received refresher training. 6 batches (# 73) have completed training on post-partum IUD (PPIUD), 570 participants completed training on use of Misoprostol; 178 marriage registrars in MNH districts have been oriented and gained knowledge on impact of Child marriage and Violence on Reproduction Health.

25 awareness raising/orientation sessions on maternal health, safe motherhood Neonatal health, Breast feeding and family planning including poet Partum Contraception and also on ASRH by the partner NGOs both at clinic and community level for eligible couples and pregnant women and their families. These orientation sessions created sensitization among the target groups as reflected by increase in numbers of client's attendance in the CRHCCs. Total 302 awareness raising sessions on Maternal health, safe motherhood Neonatal health, Family Planning/ECP, Breast feeding were conducted by the CHAs in refugee camps in this period. BCC/IEC material developed in the previous years were used during awareness sessions. [92]

- **Indicator: Number of district hospitals and upazila (sub-district) health districts with minimum required number of certified midwives (CP Output 1 Indicator) Baseline: 20; Target 70%**

Data from 2014 Compiled Standard Progress Report for RH: This data does not match the Results Based indicator above – RTMI data is relied upon which is a very limited population

Output 1.1 indicators	Source	Frequency	Partners	Baseline 2012	End of 2014	End of 2016

[91] http://www.unfpabgd.org/images/files/HBCI_Bangladesh%20RMNH%20workforce%20assessment%202014.pdf

[92] 2014 Standard Progress Report

% of DHs and UHCs with at least 1 certified midwife performing deliveries	MNHI districts,	Annual	DGHS	0	0	30%
IP related indicators (RTMI)						
Delivery conducted by skilled providers	Project report-RTMI	Annual	RTMI	94.88%	100	

The 2013 SPR: Enhanced capacity of Midwifery Training Institutes to train skilled care for maternal health: The 3-year Diploma of Midwifery program started in December 2012 with 525 students in 20 educational sites across the country. The cohort entered the second semester, which is entirely dedicated to midwifery and introduced practical placements in the clinical facilities. Another batch started in December 2013 in an extended number of 27 educational facilities.

The **6-months post-basic Certificate of Midwifery program** for existing nurse-midwives started beginning of the year in 10 educational sites. UNFPA funded 6 sites, WHO 4. Ten sites remained unfunded by the GoB (one batch funded in 2012). This issue had been dealt with by decision of the board of the Bangladesh Nursing College that nurses from the private sector could be included in the future. Before the next batch started in 20 sites in November 2013, the GoB recruited 4,200 mostly younger nurses for Government Service who could be included in the current batch.

Faculty development continued as planned and 20 teachers from Nursing Institutes attended a Master Trainers course for Midwifery education in March with technical support and capacity development to the BNMC. From these, 20 highly skilled midwifery teachers had been identified who could be trainers of trainers for the Diploma in Midwifery curriculum in the future. UNFPA supported two ToTs at the end of the year, one for each curriculum, the Certificate and Diploma in Midwifery. UNFPA gave technical assistance and **supported capacity development of the BNMC** to improve midwifery educational sites to be equipped in order to improve their skills labs, libraries and computer labs. Also, an evaluation of Certificate in Midwifery programme was started (desk review, most data collection). To date, more than 700 (710) nurse-midwives enhanced their skills with 6-months post basic Midwifery training. Also, the **Nursing & Midwifery Act** is under revision with the MoHFW. In addition, the **Strategic Directions** for Midwifery has been revised and submitted to the BNMC Board.

Through integrated and coordinated effort of the DGHS, the Bangladesh Nursing and Midwifery Council (BNMC), the Directorate of Nursing Services (DNS) and the Bangladesh Midwifery Society (BMS), the activities implemented to achieve the program objectives contributed to: a) Further progress in the development of a professional midwifery workforce in the country, and b) Skilled and competent midwives working autonomously within a supportive environment are able to ensure safe delivery as well as to contribute in reduction of maternal and child mortality and morbidity.

There is a general lack of capacity of the Nursing Colleges & Institutes to host the Diploma in Midwifery students from all over the country. Also, it is difficult to minimize the age at recruitment of nurses below 42 years for the Certificate in Midwifery programme. In addition, there usually an insufficient number of normal deliveries for education of nurse-midwives in the Certificate in Midwifery programme (minimum 20 assisted by each student). Furthermore, creation of supportive working environment with well-equipped and standard hygienic clinical training sites for midwifery students sorely deficient. Finally, development and availability of faculties (lecturers and clinical instructors) is strewn with major bottlenecks. The creation of Midwifery posts at different level of service centers has been a step in establishing the midwifery profession. This includes support for policy dialogue on midwifery at all levels. The creation of a midwifery post cadre can significantly reduce maternal mortality, so advocacy for creation of the post is a priority. Also, quality of midwifery education and practice which includes system of supportive supervision is of great importance. In addition, quality skilled base midwifery training is essential for providing quality care.[93]

The 2104 SPR: As a result of targeted advocacy activities by the UNFPA Country Office for more than a year, the commitment of the Prime Minister to "have 3000 trained midwives by 2015, and 7000 of them in a few more years", the Finance Ministry finally approved. The Ministry issued a letter that confirms the creation of 3000 posts for midwives, starting from fiscal year 2014-2015 with 600 posts each year until the end of fiscal year 2018-2019. There will be four midwives per each 417 Upazila Health Complex (1668 midwives) and one midwife per each of 1332 Union Subcenters (1332 midwives). (Thereby setting a more realistic target and supplying the unions as well-new indicator needed here?)

[93] Compiled Standard Progress Report, Reproductive Health, 2014.

The strategic direction paper for midwifery has been endorsed and now in process of printing. Together with the Directorate in Nursing Services, UNFPA is working on the finalization of the job description for midwives and also recruitment and retention rules for these health professionals. Also, the Nursing & Midwifery Act is under revision with the MoHFW.

UNFPA assisted the BNC to conduct 6-month, post-basic Certificate in Midwifery training in 16 Nursing Colleges and Institutes to educate Nurse-midwives. 20 teachers enhanced their capacity of being midwives teacher through the TOT of master trainer.
700 students in 27 Nursing Colleges and Institutes received technical support from UNFPA to be educated as 3-year direct entry Diploma midwives. An international midwife teacher joined the UNFPA RH team funded by AusAid through the Australian Volunteer for International Development programme to improve the quality of midwifery education. UNFPA supported the educational sites with financial support along with procurement of equipment for skills labs which have distributed to all nursing institute by end of September 2014.

Aiming to improve the effectiveness of project implementation the URBAN undertook several trainings for programme personnel and service providers of implementing partner LGD working at City Corporation and Municipality Health department and Partner NGOs of UPHCSDP for Medical Officers, Nurses and for developing midwives. To ensure at least one trained Midwife per CRHCC 06 months midwifery training has been arranged for 28 Nurses in MCHTI in two batches (October 2013 to March 2014 and June 2014 to December 2014) .

Programs for skill building and continuous knowledge up gradation of both facility staffs & outreach workers was undertaken in Rohinga camp. 6 persons (2 Medical Assistants and 4 Nurses) received basic training on Safe delivery & newborn care in Dhaka. In addition, 176 community people/religious leader received orientation and increased knowledge on maternal health, FP and adolescent's health.

Two major surveys were completed: 1) Baseline for new districts & midterm for old districts; and 2) EmONC Needs Assessment for 24 priority MNH/UNDAF districts; drafts reports were ready by end December 2013.

MNHI has followed the rights-based approaches, involved Community-based Organization and stakeholders from different sectors during the planning process, which contributed significantly towards increased participation, sharing knowledge and accountability. In other words, best use of knowledge has made to achieve organizational objectives of UNFPA. UNFPA support to procure essential drugs contributed to improve Emergency Obstetric Care (EOC) services in 71 MCWCs. (28% C-sections)

Number of MCWCs	Total number of deliveries	Total number of C-sections
71	44805	12568

Improved knowledge and awareness on midwifery services: The International Day of the Midwives 2014 was observed. UNFPA supported a workshop on Dissemination of State of World Midwifery 2014. Base line survey on **KAP of Midwifery Services in Bangladesh:** To formulate future effective and result oriented midwifery program, UNFPA conducted a KAP study in this regard. The findings and recommendations of the survey report would be disseminated to sensitize and orient of policy makers, program manager and implementers for taking necessary measures for to enhance the midwifery program with sustainability and to meet the aspirations of the nation.

An **Evaluation of Midwifery Training** supported by UNFPA was published in 2014, with data collected from November 2013 to March 2014.[94] Key findings included:
6 month midwifery training – Optimal program performance has been lacking, largely due to severe constraints on "system capacity" as a whole, including that of educational institutions, central government departments, and the severe shortage of nurses. While maternal and infant mortality have reduced and skilled attendance rates have increased, the improvements have been insufficient. Despite a semblance of political will, optimal program impact has been hampered, in the short term, by a general lack of recognition for midwives and support for the midwifery role – an absence of midwifery posts, suitable job descriptions, a coherent deployment plan, and a suitable legal practice framework, leading to non-existent "midwives" in the current workforce.
- The Certificate in Midwifery curriculum, including lesson plans, resource folder, student log books and other materials, were generally well accepted by midwifery teachers and

[94] Certificate in Midwifery Education Program Bangladesh; (Government of Bangladesh & Partners) Formative Evaluation Report June 2014; Prepared by: Penny Haora RM MPH PhD (Consultant), Nurjahan Begum MSc (Consultant)

students. Teachers (resource persons) in the program participated in a Training of Trainer (TOT), which was unanimously reported as engaging and useful.

Discussion with nurse midwives with certificate at Barisal Medical College: They received training from UNFPA and are extremely satisfied after they returned to work, their status was increased in that they can effectively refer complicated cases either to surgery for C-section generally and newborns to pediatric department, in case of the premature or newborn distress. There is 24/7 EmONC. They are largely used for midwifery and not for Epi – injuries, infections and contagious diseases. Despite the crowding in the hospital, they manage to deliver 15+ babies a day, without problems in the normal births. They are more revered by doctors now and take part more in the decisions. , The worst problems in the hospital is the overcrowding by family members and infections.

Focus Group discussions with midwifery teachers indicated that: They participated in TOTs, in 2013 and 2014. At least one group received training from UNFPA staff or consultants from New Zealand, it was 28 days. Overall it was excellent but there was not enough time for enough exposure to more practical training. The materials (unspecific) were not enough. They think they evaluated the course at the very end of the course but it has not been evaluated since they returned to their work. The course was interpreted from English which was a liability but they received new information and techniques which were very positive outcomes. These have now been included in the syllabus for the college.

1. Proper ante natal care using head to toe
2. Post-natal assessment
3. Technique for abdominal palpitation to assess the fetal size and growth, detect deviations from the normal, locate the fetal parts to indicate position and presentation, and listen to the fetal heart through a stethoscope. This procedure includes measuring the fundamental height with a tape measure, they learned to do this a different way from the clavicle, which is more precise, rather than starting at the sternum.
4. They understood the need to have more normal births and fewer C-sections.

The teachers were not able to fully answer our questions regarding the training skills they developed, but they said that they observed new training methods and they used and/or developed lesson plans. The technical support from UNFPA included the training module, a resource folder, lesson plans and honorarium and DSA.

Focus Group Discussion with Barisal Midwifery Students: There is a first batch (18 down from 24, 6 dropped out as they found better opportunities) graduate in December, and the second batch (25) next year. They were selected competitively out of the high school. The understanding of the students is that they will be placed in positions already established. However, they do not know whether the posting is automatic and where and when they will be placed, but they accept that they can be posted anywhere at district, upazila or union. However, they need to complete an exam through the DNS before placement.

The quality of teaching at the college is very good but the practical at the medical college hospital is not adequate, they are not spending enough time in the delivery room and they get used to help with the nursing to service the overcrowding. They want more exposure to duties in the labor ward, and among the newborns, and with the ob/gyns, and less in the classroom. They would also like a digital classroom to access more information. They think that due to insufficient exposure to the “real” world, they need a six month internship after the 3 years. There is too much in the syllabus, they suggest a BS in midwifery. They will be doing largely normal births and will refer the complicated cases to the nurse midwives. They said there is no scope at all for them to do the emergency referrals and complicated births. The living conditions are very unsuitable for them, there are 7 girls in a room meant for 2, it is not sanitary and also a security risk as they have to go outside their rooms to study.

Key Informant perspectives on positive outcomes of the Midwifery program: The first batch of 600 will be placed and at the end of this year to make good on the PM commitment, they must be deployed even before they take the certificate test. The curriculum and lesson plan is considered final. There will be some mentorship to support the new graduates, the clinical level nurses can be used as mentors. Generally, participants are very happy with UNFPA support and there is a high probability of sustainability. All other cadres have been oriented, such as Civil Surgeons, medical officers, on the new roles and responsibilities for the midwives. The PM has approved a change of uniform for the midwives. In terms of the CSBAs, those that have 18 months of training, the FWA and FWV, the ICM has studied their qualifications, and JICA wants to support them. In terms of

monitoring, there are 38 institutes under the DNS and BNMS and there is good coordination among them.

Key Informants express concern regarding the training and placement of Midwives:

- The batches of midwives being produced and assigned need a residence and security, this needs to be guaranteed.
- One main issue in the placement of the midwives is seniority. The supervising nurses are nurse midwives, and there is a need to clear new duties and responsibilities with them.
- There was possibly not enough planning to create the institutional changes needed to exploit their accumulated knowledge (pertains to all 3 categories of trainees)
- There was basically no buy in by many stakeholders that midwives and nurses are different, even some NGOs do not see the difference. The new plan "Nursing and Midwives Action Plan" did not say anything about the differences. There needs to be real agents of change in the government for perception of midwives.
- Support from the government needs to be forthcoming to deal with the challenges; a working group would be helpful to strengthen the DNS in midwifery and to support for a faculty positions dedicated to midwifery; at the Directorate level, needs to be a special one for midwives, and to secure a Division focus and coordination with the Assistant Director of Nursing at the District level.
- To strengthen the central level there still needs to be more monitoring and awareness building.

Urban Health report, 2013: In the Urban area, services improved with the support from UNFPA and served the following clients for MNCH & FP services. 25 Comprehensive Reproductive Health Care Centers (CRHCC) are providing 24/7 days basis EmOC services. URBAN Project:
1. To promote institutional normal delivery supporting service providers and field workers can show good results
2. Public Private Partnership helps better implementation of health services programme
3. Accessibility of poor to RH services can be increased by creating awareness among them
4. Retention of trained service providers ensures quality and quantity of services

Urban - ANC Visit = 133,842; PNC = 46,597

NVD = 17,896; CS - 9,803; Total Delivery = 27,697 (54% C-sections – referrals from sub-areas?)

PILL = 47,854; Condom = 54,398' Injectable = 40,499; IUD = 2,550; Implant = 5,632; Male Sterilization = 860; Female Sterilization = = 1,776; ASRH Care = 53,413

Focus Group - Women and MCH staff[95] Urban Slum Dwellers (approximately 15 women pregnant and post-partum, some obviously child marriages, and MCH staff (3), Nayatola satellite clinic, Dhaka slum). The health staff showed us the contraceptives they bring to each clinic, condoms, pills and injectables, no patches, they have no supply outages, there are stock registers, the request for them is getting higher every day. Services they are receiving include antenatal care 4 to 5x during the pregnancy, tetanus and pathology – medicine, malaria, etc. free of cost, nutritional advice, family planning advice. The young newly married girls may know about family planning before their weddings if they are from Dhaka, some information is available to them in the slums, the migrants to Dhaka probably do not have this information.

- Randomly selected pregnant and post-partum women described their treatment, pregnant described where they will give birth, hospital, and how they will get there, rickshaw or by foot, they are all in the same neighbourhood
- Randomly selected pregnant said they will bring their babies for postnatal care.

[95] Site visit and Focus Group Discussion, October 2015

- Random women said they told their friends about the services and some use them now.
- Randomly selected women discussed their FP, in general they will have only 2 children, no one had more than 2 children, one will wait five years after her first child to have the second child and use birth control, this is endorsed by her husband, others will have 2 and then use birth control, unspecified.
- Walk into the slum area, randomly selected one room family dwelling, woman with 2 children, she has stopped having children but has not selected LAPM, uses a patch.

Key informants mention strengths of the Urban Health program, in terms of serving the poor it is effective if they are informed of the means to access services. There is a huge demand from the urban poor for services, they have red cards and can use the private facilities too. There is good cooperation from the LGD, they are good development partners.

Issues in Urban Health[96]:

- The LGD continuously requesting UNFPA for replacement of 10 ambulances for the 10 partnership areas as they save hundreds of lives, but the issue is still to be addressed. It is important to keep the maternity centers well equipped as the key to quality care and this assistance is requested from UNFPA although it is not sustainable.
- A big issue is how to reach the MaRPs, including the LGBTs. There are satellite clinics in Dhaka and the sex workers have permits but most do not and those that do are unlikely to show it. There are red areas where these people could be found. The UNFPA CP has not fully incorporated work with these populations.
- Another important missed population is the "floating" population in the sense that they do not have homes and sleep on the streets.
- The 15-19 year old group who are unmarried may not know how or be able to access FP information and they need to be able to access counselling.
- The urban slum population is growing day by day and a strategy is needed to reach them upon their arrival.

Access to Fistula Repair Surgery:

In 2014 (until November) a total of 251 fistula repairs were done. The cumulative figure is 3,576 since 2004.[97]

The 2013 SPR: Strengthen fistula care service delivery in targeted Medical Colleges, District Hospitals & private facilities: The knowledge and skills of 12 doctors improved through basic training and the knowledge and skills of 24 nurses increased through refresher training (basic/specialized) on clinical management of obstetric fistula cases. In 2013, 308 obstetric fistula patients treated, (as of November). In addition, to 10 fistula centres improved capacity to provide better services through the supply of logistics. Finally, the "International Day to End Obstetric Fistula" was observed both nationally and at district level at 10 MCHs to build awareness and advocacy.

Strengthen rehabilitation of cured fistula patients: In 2013, 33 fistula patients were rehabilitated (total to date since 2007: 416). Also, 20 fistula patients/ survivors received basic training to work as CFA (Community Fistula Advocate) and 20 CFA received refresher training. In addition, 20 new CFA received cell phones for better communication in the community as well as to inform service centers, receiving grant money worth to BDT 20,000 to start & run IGA activities. Furthermore, rehabilitee gained knowledge and skills through training on sewing, agriculture & confectionary and received supporting materials (BDT 17,650) from project: e.g. cow, sewing machine, confectionary, vegetable seeds, grocery items, education materials & BCC materials for community mobilization. Through integrated and coordinated effort of the DGHS, the activities implemented to achieve the program objectives contributed to:

[96] Key informant interviews, October 2015

[97] UNFPA Annual Report, 2014

 Awareness-raising at the grassroots through root level government service providers as well as through community fistula advocates
 Screening and diagnosis of fistula cases by trained doctors and nurses.
 Capacity development of doctors through basic and specialized training of doctors for successful repair of fistula cases.
 Rehabilitation and mainstreaming of fistula survivors through skill development.

Contributing to developing strategies for reducing maternal morbidities: The National Fistula Strategy draft was finalized and in process of dissemination. In addition, the National Fistula Campaign was designed to create awareness towards ending Obstetric Fistula. Also, the timely release of funds and proper resources involved for quality implementation has been a long-standing issue. In addition, as in other areas, the chronic delay in recruitment of technical staff for the project has hampered this area of work. The proper referral through proper community awareness remains a major challenge. Furthermore, the retention of trained human resources has been caused constant discontinuity issues. Finally, the approval of the National Fistula Campaign design is still a pending problem. What is most needed is more intensive advocacy at the ministry level. In addition, coordination with all stakeholders needs to be strengthened through regular performance review meetings. Furthermore, recruitment of technical staff is crucial for smooth implementation of the planned activities as well as for better coordination within implementing partners.[98]

The 2014 SPR: The Action plan for National Fistula Strategy was endorsed along with communication strategy. Inauguration of National fistula centre- "The centre of excellence" at Dhaka Medical College held on 9th June in presence of honourable State Minister, Health. Secretary Health, DG-Health and all concerned. UNFPA supported to organize a campaign on obstetric fistula using print and electronic media with the aim to create awareness on causes, prevention and treatment of obstetric fistula among women and their family members.

The GoB are scaling up the fistula corners, with the intention to put them in each district. There is evidence of this in Barisal and Patuakhali. The surgeons In Patuakhali are getting experience with fistula surgery in Barisal MC, the fistula is affecting mostly the neglected and poor, the rehab center is absolutely needed. They have a plan to dedicate 3- 4 beds but it is not a full-fledged plan yet.[99] Thirty seven (37) fistula survivors were trained and received grants and logistics to start a self-dependent and dignified life. Technical and logistic support was provided to 10 MCH to support for fistula repair. Total 304 patients were treated for fistula repairmen. Technical and logistic support was provided to 10 MCH to support for fistula repair. Total 304 patients were treated for fistula repair.

The Barisal Medical College receives from UNFPA operation instruments, theatre lights, and materials and medicines. There are a total of 3 surgeons in Barisal who can do the surgery, if there are complexities they seek advice from a neurosurgeon. The treatment for post-partum women included contraceptives and counselling, also there are facilities for maintenance of adolescent health. There is a one stop crisis center for rape cases. She said that the CSBA's are competent and can catheterize the patient, she said that the home delivery by TBAs may be the cause of most fistulas. A rally was held in the district and helped to bring public attention to the issue, even for illiterate people. After the rally, possibly more women came for surgery but certainly more cases were ID'd. There was also a seminar for medical doctors there were about 35-40 there, about 50% are interested in learning the surgical techniques, she believes that they would devote the time to learn and promise to do the surgeries afterwards. The retention of the surgeons would be better if they are taught in the workplace.[100]

Some of the issues affecting the prevention and treatment of Fistula:[101]

- The knowledge of fistula is very limited in Bangladesh. Most of the women are abandoned. UNFPA is effectively trying to publicize the issues.
- There needs to be recruitment of both male and female surgeons for three months to focus on the surgery and perform the surgeries. Only 250 ob/gyn surgeons have been trained and follow-up is needed to find out how they are using the skill if they are.

[98] The Compiled Standard Progress Report for 2013, Reproductive Health, UNFPA
[99] Key Informant Interviews, October 2015
[100] Key Informant Interview, October 2015
[101] Key Informant Interviews and site visits, October 2015

- In terms of rehabilitation, the only center is in Dhaka, thus obviously more are needed, as of now the nurses and surgeons are the ones who have to try to help the women to cope with the psychosocial issues and they don't have time. There should be a center for all the 10 medical college hospitals
- People from more remote areas and the very poor may not want to come to the surgical providers and if they have the surgery, they want to leave right away but in fact three months of checking up are needed to ensure that the tissue heals over. They are not able to have the post-op check-ups in the community as they are private clinics and they cannot afford to pay. Thus the rehabilitation center is critical.
- Constraints in the rehabilitation is that women do not want to stay for a whole month and they go home without a complete skill. If they stay and learn to sew, receive a sewing machine and if they master agriculture they may receive a cow, but they need to stay the course. Another possibility is to establish strong referral ties to the GoB livelihood strategies.
- There are not enough prevention efforts targeting adolescents.
- The patients are sometimes not ID'd (not registered) and cannot be followed up very easily once they return home.
- Monitoring by UNFPA is not enough and has only sporadic meetings.

Site observation: The fistula center at Dhaka Medical College consists of the pre-op, the surgery, a recovery and some consultation rooms. Technical support is received from UNFPA, USAID, and one national NGO (BWHC). There may be a majority of older women, some above child bearing age, some had lived with the fistula for the past 20 to 25 years. Due to the fistula they lost their marriages and have largely survived on their own. Among the younger womens, one was on the verge of losing her marriage unless she was cured by the second surgery. Another had lost her marriage. Remarriage may be difficult or impossible. Those who were recovering, some from first and others from second surgeries, they were very pleased to be given another chance. Many were from remote areas, such as the most northern districts. They became aware that it was possible to have a cure through their local health services.[102]

There are basically three levels of care: prevention, case-ID/surgery and rehabilitation. Prevention is the best approach so as not to alter the lives of the women. Case-ID and surgery require decentralization of the service, a long term goal. Prevention is being done through awareness campaigns but it is not enough. The main causes of fistula are the home delivery, and lack of catheterization during prolonged labor. On the prevention side, the remote areas produce the most cases, they may be unidentified for a long time, therefore outreach is essential, once identified, there may be difficulties in getting them to Dhaka and they may drop out of the surgery queue. There are 72,000 cases identified, all requiring surgery, and many more not identified. The barriers for case ID are mainly 2 – the patient does not like to tell about the problem and the health workers are not doing outreach like they should be.[103]

The most pressing problem on the cure side is the shortage of available skilled surgeons. The training for the complicated surgery is referred to Dhaka Medical College hospital (center of excellence) to senior surgeons, and the source of training is usually foreigners, by the experts master trainers from from different Medical colleges from Bangladesh and specialized training is being conducted by expert surgeons from Bangladesh and from Ethiopia. The surgeons could travel to the districts but they may prefer not to as they have other surgeries. The attitude of many is that they are not particularly interested in this type of surgery, it takes 2-3 hours for the simple and more for the complicated.[104]

Site Observation: The Fistula rehabilitation center managed by IP BWHC has served 119 clients in 2014 and 209 in 2015. First they collect any overload of patients from the hospital when they show up and the pre-op is full, they also go to the pre-op to find out the history of the patient and to counsel them. They also received the patients referred from district level

[102] Site observation and discussion with fistula patients, October 2015

[103] Key informant interviews, October 2015

[104] Key Informant Interviews, October 2015

by the Community Fistula advocates (CFA) and take them to hospital for treatment. As they are recovering over the period of a month they receive livelihood support, sewing, and agriculture. Among them, some are selected to be ambassadors, this is voluntary. Awareness groups are organized and each member gets 300-400 taka and when they are able to refer someone for surgery in coordination with the local health service, they receive 500 taka plus transport if they accompany the woman to Dhaka. There are 161 community advocates according to an informal survey.

- **Numbers of diagnosed women in targeted districts and urban centers who access treatment for Cervical and Breast cancer**

With UNFPA support, progress was seen during the **7th CP,** particularly with regard to the research on the loop electrosurgical excision procedure (LEEP), 'See and treat' protocol is a well-accepted, feasible and useful option for management of high-grade cervical intraepithelial neoplasia (CIN) in Bangladesh. It reduces the number of visits to the clinic and failure to receive treatment.[105] Work on this achievement is not mentioned in the 7th CPE. With UNFPA support a "Cervical and Breast Cancer Screening Programme, Standards and Guidelines" manual was produced in 2008* and its use evaluated. The BSMMU was considered a center of excellence. It is not clear to what degree sustainability was attained during the 7th CP. There is now piloting of the use of the preventive vaccine for cervical cancer in girls,. UNFPA provide acetic acid for cervical cancer testing (VIA) and Sweden provided binopolscopes (50) there are not even enough for all the districts. The detection for breast cancer is still only palpitation and encouragement of self-examination. There is an approved curriculum for training with basic guidance to address cervical and breast cancer screening and treatment approach but there is no national strategy.[106]

2013 Standard Progress Report: Strengthen cervical and breast cancer service delivery in targeted FWCs, Medical Colleges, District Hospitals and private facilities: The capacity of 62 service providers (8 doctors, 38 SSNs, 16 FWVs in 12 batches) was improved to provide basic VIA and CBE Screening. Also, 55 service providers (48 SSNs, 7 FWVs) refreshed knowledge and skills on VIA & CBE Screening (10 batches). In addition, 6 doctors acquired basic training on Colposcopy (1 batch); 13 doctors acquired advanced training on Colposcopy (2 batches); 5 NOS Upazila Level 1 day orientation on VIA & CBE Screening Programme; NOS Upazila Level 3 days Long VIA Camp on VIA & CBE Screening Programme. Furthermore, the supply of the essential glacial acetic acid was bolstered nationwide at VIA & CBE Centers. Through integrated and coordinated effort of the DGHS, the activities implemented to achieve the program objectives contributed to:

- Mass awareness of community people through camps and orientation of root level health care service providers
- Screening and diagnosis of cervical and breast cancer cases by trained doctors and nurses.
- Capacity development of doctors through basic and specialized training (colposcopy) of doctors for successful treatment of diagnosed cases.

2013 SPR: The most challenging aspect of the work being done in CBC is the insufficient and ineffective monitoring and supervision by the government and local supervisors. Also, it is difficult to implement the quality assurance of services, especially at poor performing sites. In addition, the challenge of establishment of a proper supply chain between central level to union level could not be adequately overcome. Furthermore, the placement and retention of trained service providers in other places instead of the VIA Centers required a great deal of attention and not adequate solution. Finally, the proper set-up and functioning of VIA centers at service point was challenging. With regular coordination meetings among the Government, BSMMU & UNFPA, progress can be more efficient and effective. Also, strengthening of referral system and referral services will serve the best interest of the program. The development of organized screening involving grass-root level providers can provide a big boost in the CBC activities and outputs. In addition, the motivation, supervision and inviting commitment of supervisors at all level of health care service delivery system can be very complimentary to the program as a whole.

Base line survey on KAP of Cervical and Breast Cancer in Bangladesh: To formulate future effective and result oriented C&BC program, UNFPA conducted a KAP study in this

[105] "Screening for and management of high-grade cervical intraepithelial neoplasia in Bangladesh: A cross-sectional study comparing two protocols", Ashrafun Nessa1, Mohammad Harun Ur Rashid2, Noor E-Ferdous1 and Afroza Chowdhury, *J. Obstet. Gynaecol. Res. Vol. 39, No. 2: 564–571, February 2013*

[106] Key Informant Interviews, October 2015

regard. The findings and recommendations of the survey report would be disseminated to sensitize and orient of policy makers, program manager and implementers for taking necessary measures for to enhance the midwifery program with sustainability and to meet the aspirations of the nation. A wide sample was covered in September 2014 tapping households with women of age 20 to 65 years and husband/adult male of the family; Service facilities service providers; and Community opinion leaders. The study covered the catchment areas of all tiers (FWC, Upazila Health Complex, MCWC, District Hospital, Medical Collage Hospital and BSMMU) of public health facilities in all 7 divisions of the country where C&BC screening services are available. The study confirmed the poor awareness of screening for both cancers, and is lower for breast cancer (women in the households (5%); men in the households (4%) and women in the service centers (14%), than cervical cancer (8% women; and 8% men in the households; women in the service centers (31%). [107]

"UNFPA Report CBC" – October, 2014. Data collected September 2014. The service facilities are underutilized; very few women are now availing the services on screening for Cervical and Breast cancer. The need is to design communication strategies to accelerate the rates of acceptance of the screening services by the women of ages 20 to 65 years. **Knowledge and awareness about cervical cancer:** Forty percent of the rural women and thirty six percent of the rural men are aware (heard about) of cervical cancer; the level of awareness is little higher in the urban (9-10% more) than in the rural areas. Comparatively, majority (54%) of those who came for a service in the health delivery institution heard about cervical cancer. Overwhelming majority of the women (87%) and men (69%) heard about cervical cancer from their relatives and neighbors and the next person is the doctor (women 11% and men 33%). Awareness about screening of cancer of the cervix is poor: 8% women; and 8% men in the households; but it is high for the women in the service centers (31%).

Knowledge and awareness about breast cancer: Thirty four percent of the rural women and twenty eight percent of the rural men are aware (heard about) of breast cancer; the level of awareness is little higher in the urban (2-8% more) than in the rural areas. Again, majority (54%) of those who came for a service in the health delivery institution heard about breast cancer. Overwhelming majority of the women (92%) and men (68%) heard about breast cancer from their relatives and neighbors and the next person is the doctor (women 6% and men 28%). Awareness about screening for breast cancer is equally poor: women in the households (5%); men in the households (4%) and women in the service centers (14%).

The 2014 SPR: UNFPA supported screening for C&BC in DH and Upazila health complexes Services

	Total number of screened	Total number of positive cases
VIA tests performed	195067	10214 (5.2%)
CBE tests performed	195464	2057 (1.06%)

A number of district level screenings took place. One camp for detection is likely to see 1,000 women and in some places 1,600 which is a huge overload. There is a big procedure, registration, acidic acid testing, 50% do not proceed to the hospital, Huge distrust among the remote populations. In the hard to reach areas, 60% of cases detected did not show for treatment. Once they are gone, they are lost, they change their phone numbers.

Data on follow-up:[108] The following is some raw data indicating that failure to attend colposcopy clinic is a major issue in treating cervical cancer. Years Number of Patients (%)
2012 330 (4.3)
2013 3040 (40.1)
2014 4218 (55.5)
Total 7594 (100)

Colposcopy Findings
Categories Number of Women (%)
Normal 28 (0.4)

[107] "Final Report on the Baseline Study (KAP) on Cervical and Breast Cancer in Bangladesh for Designing a Campaign", Research Evaluation Associates for Development Ltd (READ), report to UNFPA, 2014.
[108] Data collected by BSMMU, 2014.

CIN-I 51 (0.7)
CIN-II 15 (0.2)
Squamous Cell Carcinoma 3 (0)
Adeno Carcinoma 1 (0)
Unsatisfactory/Repeat 2 (0)
Histopathology not necessary 7339 96.6)
Failure to attend colposcopy clinic 155 (2.0)
Total 7594 (100)

Some issues with inadequate follow up include:

- Budget cuts at UNFPA, UNFPA had introduced a survey in 2013 and then dropped it. The BSMMU had trained 85-90 medical staff in the upazila health complexes, only half of what was originally planned. However, all of the money was not utilized presumably due to HR issues. The government then provided some training.

- The cancers are considered non-communicable diseases and that is why they are so neglected (as opposed to the US where breast cancer cure is a large campaign with everyone including football players wearing pink for a month.)

A finding emanating from a number of studies is that much greater coverage of vulnerable women is needed to ID and capture cases for effective treatment. The treatment path falls short where women do not appear for treatment and follow-up due possibly to factors identified in a 2014 KAP study as: Financial or economic problems: Cost of treatment and medicines high; Health services or facilities problems: Health facilities do not have acceptable standards and services; Socio cultural problems due to lack of publicity or communication education: Fear of shame from the society/people and complacence or indifference or opposition of the husbands. [109] A significant number of screened positive women from the sub-district did not attend colposcopy clinics, and about half of them could not be reached by telephone. (Although their mobile numbers were collected and used, they may have changed or stopped services.[110]) One stop services' along with referral of difficult cases to 'MCH colposcopy clinics' may reduce failure of treatment in remote rural areas.[111] There are 13,000 new cases of irregular tests for cervical cancer and 6,000 with cancer. A large percentage of these may not show up for treatment after detection and then about 50% of them will die.

- **Public service delivery points providing at least 3 modern family planning methods and one long term method:**

SPR 2014 data: % of public service delivery points (DH, MCWC, UHC, UH&FWC) providing at least three modern FP methods, including one long-term or permanent method, at a given point in time Baseline assessment of SDPs under DGHS/DGFP, LGD Annual DGHS, DGFP, LGD Baseline= 70% Status = 80% Target = 100% Excluding Community clinic

The 2013 SPR: There is no reporting on Family Planning and contraception in this report. **The 2014 SPR:** Orientation workshops were conducted for District, Union and Upazilla stakeholders on the maternal health and family planning services that would be provided in the upgraded UH&FWCs. Capacity was developed among providers to improve knowledge on clinical contraception, ASRH and prevention of Post-Partum Haemorrhage. UNFPA Supported 8 regional Family Planning Clinical Supervision Teams/ Quality Assurance Teams (FPCST/QAT) to improve performance and quality of clinical contraception services.

[109] "Final Report on the Baseline Study (KAP) on Cervical and Breast Cancer in Bangladesh for Designing a Campaign", Research Evaluation Associates for Development Ltd (READ), report to UNFPA, 2014.

[110] Key informant interview, October, 2015.

[111] Cervical Cancer Control in Bangladesh, Summary of Progress 2002-2015. Powerpoint presentation, Ashrafun Nessa, Department of Obstetrics & Gynaecology, Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh, 2015.

Printing and dissemination of Family Planning manuals enhanced capacity of FP service providers in providing FP services. District Health Managers were provided with RBM training. National and District level Managers obtained knowledge on Long Acting and Permanent Methods (LAPM) and Interpersonal communication and managements skills on ASRH/FP. The performance of Long Acting and Permanent Methods (LAPM) are as follows:

IUD = 244,855 Implants =310,931 NSV = 101,989 BTL = 114,749

UNFPA supported a **National Family Planning Campaign** in twelve low performing Upazilas of nine districts (in 3 selected upazillas in each district covering all unions) in seven divisions and two city corporations in Sylhet and Chittagong divisions to create demand of modern contraceptives among the young couples (ages 15-24) and improve awareness on ASRH issues among the unmarried adolescents by using electronic (TV, radio and social), print, outdoor media and community level interventions. UNFPA also supported to organize and implement country wide observance of World Population Day and family planning service weeks. Partnership experience with Engender Health for training of service providers for post-partum Family Planning programme in MNHI districts was successful.

According to **Key Informants**, some of main causes of non-acceptance of modern methods and discontinuation includes the following:

1. Ignorance of causes and effects are prevalent as is religious fundamentalism
2. Women take the burden of family planning and men generally want more children, there is not enough outreach to the men; Imams provide only general guidance in their speeches at the mosque, and tell the couple to wait 3 years between births. Some who do not access family planning are not given a choice by their husbands.
3. Abortion is widespread, 600,000 illegal and 600,000 “menstrual regulation” so 1.2 million a year.
4. The responsibilities in the health services are not taken seriously, inadequate attention to their jobs on the part of almost everyone, for example, the FP inspectors are not really inspecting sufficiently the work of the FWAs and FWVs and CSBAs. The Health Assistants are not dedicated, they only work 9-1 5days a week, but they do not even know their job descriptions, and do not do follow-up, they have poor reporting.
5. The Upazilla Health and Family Planning Officers, under the DDFP are well trained but they do not use their training and there is no follow up on the training.

Union Level Family Welfare Center (FWC) - Patuakhali (Amragasia UH&FWC) –Since 2013, UNFPA has been helping with training of staff and providing equipment and essential medicines (saline, oxytocin, vitamins, folic acid, misoprostol, newborn antibiotics and eye drops, etc.) The government essential services package is not adequate. On average 300 pregnant women are serviced (per?) 80-100 for ANC per month (I could not get the numbers), There are 2-5 deliveries a month. There is only one FWV, one FWA, and one medical assistant. FWAs are not posted in the Union level Health facility. But FWAs may visit the UHFWC for meetings and also to visit the FWV and FP Inspectors. The service providers in a UH&FWC are the SACMO (Sub Assistant Community Medical Officer) and the FWV (Family Welfare Visitor). Only 30% of deliveries take place at a facility and 70% at home, higher than national average. UNFPA has helped to reclaim the facility but they need advocacy – it is not enough, there are only 3 campaigns a year and should be quarterly, need monthly really. Transport is also a problem for the clients and the FWA/V’s are not enough.

The demand for modern FP methods is not high enough either, a 79% contraceptive acceptance rate is the goal. People who use the modern methods is nationally 65% but it is only 20% at the union for modern methods. The poorest people – some can still buy condoms, and the others don’t know. The people are often not registered and they are not known to the clinic. There is a monthly report to the Upazilla Family Planning Officer on the facility’s service statistics. In regard to maternal and newborn mortality, they meet to discuss if this happens.

The general shortages of staff in the health service impact the provision of FP services. For example in Cox Bazaar Union, there is a population of 50,000, to serve these people there are only 7 FWA who work 6 days a week, 3 days in the clinic and 3 days for field visits, there are 7-8 unions and only 83-85 FWAs in the district. There is no medical officer and no pharmacists at the union level. There are 76,000 eligible couples in the upazilla, the CAR is 74% at Union (this is an urban union) and 75% at the Upazilla. The information for SRH

ages 10-19 is missing from the clinic setting. It is right next to a school and there could be an adolescent corner, but it is very small.

Monitoring missions by UNFPA Family Planning staff report some similar findings.

- **Contributions to increase in % of deliveries attended by skilled providers:**

UNDAF Indicator: Proportion of deliveries attended by skilled health providers disaggregated by wealth quintiles and residence
Baseline: 24% (2010/2011); Target: 50%; 42% (2014)

Data collected in October 2012 –"EmONC Assessment Study", published 2015: Overall, in 24 study districts, about 31% deliveries were conducted in health facilities, out of which about 19% were normal vaginal delivery, 12% C-section delivery, and only 0.2% assisted vaginal delivery. Majority of the vaginal deliveries (16%) were conducted in the public facilities while only around 2% and 1% took place in the private Family Planning (fp) and nfp facilities respectively. In 4 districts (Sylhet, Khulna, Rangpur, and Thakurgaon), above 40% of births took place at health facilities. On the other hand, in Sunamganj and Bandarban districts, only about 10% of expected births took place in health facilities. When compared by district category, the proportion of births in facilities of the UNDAF districts (33%), was higher than those in the Phase I (30%) and phase II (19%) MNHI districts.

Although the Cox Bazaar's Union FWC has a two bed delivery room and two bed recovery, clean, basically stocked, the FWVs and FWAs do deliveries there but very few, the birth rate at the union clinics are only 17%.

- **Contributions to increase in % of modern method contraception prevalence rate (CPR):**

UNDAF Indicator: Contraceptive prevalence rate (modern method) wealth quintiles and residence": Baseline: 47.5% (2007); Target: 63%; 54.1%(2014)

LAPM strengthened: In order to effectively reduce unmet need for family planning and increase rights based family planning, UNFPA Bangladesh provided technical assistance to DGFP for the strengthening of quality assurance systems across the country. UNFPA started assistance to Post-Partum Family Planning – as an example, in Thakurgaon District Hospital, there was no case of PPIUD before UNFPA support started. In just 6 months after UNFPA assistance, the ratio of mothers who opt for PPIUD increased to 25% from 0%, during 2014. UNFPA also supported 10 FP Clinical Supervision and Quality Assurance Teams (FPCST-QAT), which ensure quality of care in LAPM and MCH Services by monitoring standard procedures in FP-MCH services.[112]

The 2014 SPR: UNFPA supported to develop a six year Costed Implementation Plan (CIP) for the National Family Planning programme which will help Policy makers to strategize actions to achieve FP 2020 goals.

The national CPR is 62% and has remained unchanged and the LAPM stands at 8%. It is not changing very fast compared to the past. The contraceptive prevalence rate (CPR) has risen from 7.7% in 1975 to 62% in 2014. Fifty-four percent of married women use modern methods, and only 8% use a long-acting or permanent method. Thirty percent of contraceptive users stop using a method within 12 months; discontinuation rates are much higher for short term modern methods than for longer-term methods. Overall, approximately 25% of married women do not have access to the desired services for family planning, a substantial need.[113]

[112] UNFPA Annual Report Bangladesh, December 2014, page 16
[113] Ibid.

The **2014 Bangladesh Health Facility Survey** supported by the GoB and USAID covers FP.[114] While there are positive findings compared to several years ago, there remain numerous weaknesses in the availability of FP services. The 2014 BHFS obtained information on availability of family planning services from all the sampled public, private, and NGO health facilities. Family planning services are considered available if a facility provides, prescribes, or counsels about family planning. The following are findings.[115]

Modern methods of family planning: Eight in ten facilities (81 percent) offer at least one type of temporary modern family planning method; this percentage remains the same when community clinics (CCs) are excluded from the analysis. On average, district and upazila-level public facilities (94 percent), union-level public facilities (83 percent), CCs (82 percent), and NGO facilities (88 percent) are much more likely than private hospitals (21 percent) to offer modern family planning. Among the public facilities, however, DHs (60 percent) and USCs/RDs (61 percent) are less likely to offer modern methods of family planning compared with other public facilities. Rural facilities (82 percent) are slightly more likely than urban facilities (72 percent) to offer a modern method of family planning. Facilities in Dhaka, at 67 percent, are much less likely than facilities in other divisions (from 75 percent in Rajshahi to 94 percent in Khulna, Rangpur, and Sylhet) to offer modern methods of family planning.

Long-acting and permanent methods of family planning: Long-acting and permanent methods are less widely available in Bangladesh health facilities. Overall, only about half (48 percent) of all health facilities offer any long-acting or permanent family planning methods, i.e., IUCDs, implants, or male or female sterilization. However, as expected, the percentage of facilities that offer long-acting or permanent family planning increases (to 69 percent) when CCs are excluded from the analysis. Among district and upazila-level public facilities, as many as 98 percent of UHCs and 96 percent of MCWCs offer long- acting or permanent methods of family planning; however, only 57 percent of DHs offer any of these methods. Almost 8 in 10 NGO facilities offer long-acting or permanent methods of family planning. Urban facilities (68 percent) are more likely than rural facilities (46 percent) to offer a long-acting or permanent methods. Facilities in Barisal, at 36 percent, are less likely than facilities in other divisions (from 41 percent in Dhaka to 63 percent in Rangpur) to offer long-acting or permanent methods.

Twenty-nine percent of health facilities (36 percent, excluding CCs) offer male or female sterilization services, that is, health workers in these facilities can actually perform the procedure in the facility, or else they discuss this option with clients and then refer clients elsewhere to obtain the service. Generally district and upazila-level public facilities (87 percent) and NGO facilities (51 percent) are more likely than union-level public facilities (28 percent), CCs (26 percent), or private hospitals (14 percent) to offer male or female sterilization services. Urban facilities (52 percent) are more likely than rural facilities (27 percent) to offer male or female sterilization services.

- **Contributions to reduction of Adolescent birth rate:** No significant reductions in adolescent birth rates were documented in project areas.

UNDAF Indicator: Adolescent birth rate per 1,000 women = Baseline:127 (2007) Target: 80; 113 (2014)

Adolescent fertility in Bangladesh is still one of the highest in the world, with 113 births per 1,000 women below 20, the highest in South Asia. Fertility figures indicate little change in teenage childbearing since 2011, and 2014 data shows that 31% of adolescents age 15-19 in Bangladesh have begun childbearing; about one in four teenagers has given birth. As expected, the proportion of women age 15-19 who have begun childbearing rises rapidly with age, from 9% among women age 15 to 58% among women age 19. Early childbearing among teenagers is more common in rural than in urban areas (32% versus 27%, respectively). Bangladesh ranks second in the world in numbers of women aged 20-24 who had given birth by the age of 18.[116]

[114] Bangladesh Health Facility Survey, 2014, Preliminary Report, National Institute of Population Research and Training (NIPORT), Ministry of Health and Family Welfare, Dhaka, Bangladesh, Associates for Community and Population Research {ACPR), Dhaka, Bangladesh, ICF International, Rockville, Maryland, Government of the People's Republic of Bangladesh, US Agency for International Development (USAID), Bangladesh, April2015

[115] Ibid. pages 36 to 44.

[116] UNFPA, Adolescent Pregnancy, 2013, page 15.

Other: Contributions to HIV prevention: (Adolescents and Youth)

The UNFPA Bangladesh Annual Report 2014: The National Communications Guideline on linkage of HIV and SRH has been introduced to sensitize the service provider on importance of integrated SRH and HIV services. This guideline is expected to generate demand for integrated HIV and SRH services. Self-help group members from PLHIV (People living with HIV), STI and sex workers networkers are now more sensitized and oriented about their rights for accessibility and availability of services for reproductive health, prevention of gender based violence and associated stigma and discrimination. Awareness among the government officials of Ministry of Health and Family Welfare increased about the sexual and reproductive rights for marginalized adolescents and young people. National AIDS/STD Programme officials were advocated on mainstreaming of HIV through inter-ministerial coordination and collaboration for these marginalized adolescents and young people. A strategic plan on MARA (Most at Risk adolescents), MARYP (Most at Risk Young Population) and EVA (Especially Vulnerable Population) was developed in collaboration with UNICEF.

Challenges: Bangladesh is one of the only 4 countries in the region where the epidemic is indeed increasing. Probably because the country has so far contained the spread of HIV below 0.1% in the general population and below 2% among Key Affected Populations (KAPs), this national prevalence estimates masks higher HIV prevalence in specific geographical locations – for instance, among people who inject drugs (PWID) estimated national prevalence is 1.1%, but among male PWID in Dhaka is 5.3%. The SRH needs of key populations including PWID (people who inject drugs), SW (sex workers), MSM (men who have sex with men), Hijra (transgender) fall outside the usual discussion on Sexual and Reproductive Rights and Health and Gender, even when they are the most vulnerable to sexual and physical violence, stigma and discrimination. Also, many
of identified HIV positive people in the country are returnee migrant workers and their partners. Studies show higher unmet need among sex workers, as well as high levels of violence against KAPs including sex workers, MSM and transgender people. Violence affects negotiation power over condom use. Sexual violence increases the risk of contracting or transmitting HIV and other STIs.[117]

At the end of 2013, it was estimated that 9,545 people were living with HIV, an increase from the 8,000 estimated in 2012; however, because of low reporting, the number potentially could be as high as 977,000.[118] Although HIV prevalence in the general population in Bangladesh is low, at 0.1 percent, reported new infections have increased by a factor of about 1.5 within the last five years alone.[119] Bangladesh is thus one of four countries in the Asia-Pacific region where reporting of the epidemic continues to increase. Main routes of transmission are through heterosexual unprotected sex and sharing of used needles and syringes.[120]

The SPR 2013: Sensitization of Youth Forum on advocacy for rights to prevent HIV: Members of youth forum more sensitized & aware about roles and responsibility for leadership, peer education and skill for advocacy to materialize their rights to prevent violence and consequent transmission of HIV.

Round table discussion for national consensus on HIV linkages: Advocacy through print media (with National Daily) on mainstreaming of HIV (Health and other ministries, and stakeholders attended). The objective of the round table discussion was to develop national consensus on linkages of HIV and provide policy advocacy at ministry level for multi-sectoral response through mainstreaming of HIV.

The 2014 SPR: With support from UNFPA, The National Communication strategy on SRH and HIV linkage has developed in participation of DPs and stakeholders working in the field of SRH and HIV/AIDS. This strategy expected to demand for integrated HIV and SRH services. Revision of New training curriculum is going on which will be adopted and rolled out during 2015-2016. 47 Manager and providers improved their knowledge on linkage of HIV and ASRH in (Cox's Bazar, Sylhet). The approved National Plan of Action on ASRH was translated, printed in both English and Bangla version and then disseminated.

[117] UNFPA Bangladesh Annual Report, 2014

[118] UNICEF data and Global Fund to Fight AIDS, Tuberculosis and Malaria. *Standard Concept Note: Bangladesh*. Dhaka, March 2014.

[119] Ibid.

[120] National AIDS/STD Programme. *Third National Strategic Plan for HIV and AIDS Response 2011-2017 (Revised)*. Dhaka, April 2014.

The 2014 SPR: Advocacy and technical support of steering committee was completed on linkage of HIV and SRH at ministry level. In addition, consultation with networking organization completed. Sensitization and demand creation done for the members of PLHIV, STI, Sex workers networks for integrated services. Finally, members of UNFPA facilitated youth forum actively involved and engaged through youth consultation, advocacy meeting and observance of international days.

Policy makers, planners and implementers were sensitized oriented on importance of linkage of HIV and SRH. Accordingly ministry has taken initiative to introduce HIV related services (counselling and commodity supply) at STI outdoor facilities at district based hospitals. Further, in the PMTCT guidelines, linkage of HIV and SRH are introduced. Through this initiative, HIV issues are being addressed at selected maternal health clinics.

National HIV-AIDS and SRH Communication Strategy Bangladesh: has so far been finalized to sensitize stakeholders on importance of integrated SRH & HIV services. Further, this guideline is expected to generate demand for integrated HIV and SRH services. Improved knowledge and awareness on HIV and AIDS: The World AIDS Day 2014 was observed. Involving relevant development partners and NGOs, NASP organized rally involving more than one thousand people, day observance and certificate/ crest awarding ceremony for best practices at BICC where State Minister of MOHFW, GOB higher officials of GOB, UNFPA, UNAIDS and WHO attended the ceremony as the chief guest and special guests accordingly. UNFPA also supported 3 NGOs and one private university to organize rally at district level and seminar on HIV/AIDS at their premises to increase awareness on HIV/AIDS among the people with focus on adolescents and youth.

In collaboration with UNAIDS, UNFPA provided orientation of 27 UN staff on HIV/AIDS basics, prevention and care.

Issues in the CO attention to HIV and AIDS[121]:

- There is very little core attention anymore either, only for technical support directly with PLHIV for KAP. A regional advisor came and assessed the CO inputs.
- There is supposed to be an action plan including LGBT, mapping the needs and a communication strategy, there is a steering committee and an additional secretary in the government.

The 2014 SPR General Recommendations:

1. Strengthening postpartum family planning services to reach the LAPM shared targets
2. Establishing adolescent friendly health services corner at target MCWC and UH&FWCs
3. Based in LLP recommendations, MNHI will be more focused on hard-to-reach areas and marginalised and underserved population
4. Active involvement of community/refugee people (particularly youths and Adolescents) in the program has a positive impact in changing health seeking behaviour.
5. Good coordination among stakeholders, donors, and GoB officials helps in improving and strengthening the health service delivery system.
6. BCC activities are not strong enough on long acting family planning methods and EmOC services
7. More orientation is needed to increase awareness on RH issues.

[121] Key Informant Interviews, October 2015.

A.2.2 The awareness of and demand for reproductive health and family planning services among Adolescents and Youth are increased (CP Output 2.2)	• Number of health facilities accredited as adolescent-friendly centers that offer services to young people, including the unmarried (CP Output 1 indicator) Baseline:30% Target 70% • Number of adolescent clubs that are functioning and providing target populations with SRHR and HIV information in the targeted areas for Generation Breakthrough. (Baseline: 0, Target: 90) • Number of schools using the GEMS in school curriculums (Baseline: 0; Target: 350) • Number of schools in the Generation Breakthrough target areas with functioning adolescent SRHR spaces. (Baseline: 0; Target: 350)	• Studies and surveys of youth and adolescents SRH • Ministries of Health and Education and other relevant ministries • UN agencies and NGOs working with underserved groups • Assessments of training needs and training outcomes • Regional youth initiatives	• Document review • Training programme and materials review • Interviews with UNFPA CO staff and regional staff • Key informant and FGD with key ministries, NGOs, and academic institutions • Evaluation data collection visit to upazilas • FDG with youth groups in youth clubs and those using the adolescent friendly centers

Some interventions on behalf of Adolescents and Youth have taken place under the RH AWPs as support to DGHS and DGFP services to enhance support for Adolescent Sexual and Reproductive Health (ASRH) issues in their work, to establish adolescent friendly health service (AFHS) corners at clinics and health centers and the development of SOPs for AFHS, and provision of capacity building on adolescent SRH at district level. With the Gender programmatic area, advocacy efforts to eliminate the practice of child marriage are connected to interventions for family planning methods for adolescents through DGFP.

Progress has been made to promote Reproductive Health education, awareness and regulation, indicating national interest in investing in adolescents and youth. The National Adolescent Reproductive Health Strategy (2006) will be broadened to become an Adolescent Health Strategy. The Ministry of Education has approved a Gender Equality Manual for Schools (GEMS), and a National Plan of Action on eliminating child marriage has been drafted. The Ministry of women and children affairs supports youth clubs meant to support school drop outs where Gender Promoters raise awareness. Recently, the UN has established a Youth Advisory Panel.

The **UNFPA Youth Forum on reproductive health** was active in various advocacy activities throughout the year, most notably during the safe motherhood campaign, and were engaged in various round table discussions and policy dialogues, to raise awareness among policy makers about the SRHR needs of young people. Particularly the issue of early marriage and safe motherhood was addressed by them in 2012.

Interventions coordinated by a designated Adolescent and Youth unit was established in November 2014. The GB project however, commenced in 2013, under the Gender unit.
under AWP **U602: Generation Breakthrough (GB)** which addresses RH Outcomes 1 and 2 and Gender Equality Output 1. *Increased awareness and knowledge of and positive attitudes towards reducing the vulnerability of women, including the incidence of violence against women and early marriage.* Sexual and reproductive health information is being provided in schools, madrassas and adolescent clubs in four districts (Dhaka, Barisal, Barguna and Patuakhali) and services and with partners, the Ministries of Education, and Women and Children Affairs, and Plan International.

In **2013**, planned interventions included training for students and on reproductive health and GBV prevention, advocacy interventions for key influencer groups, strengthening information and referrals through a Helpdesk. Adaptation and implementation of the Gender Equiety Movement in Schools (GEMS) module was underway.. In **2014**, the printing of training materials and strengthening the information and referral systems continued. The 2014 AWP was revised to clarify the funding for specific interventions such as media campaign messages, development of interactive games, perception building training for staff, setting up and training help desk staff, printing of the GEMS diary for students,

international exposure visits for staff, and start-up of the program management committee with the ministries. In **2015**, combined interventions with the Gender Equality programmatic area (U501, see below), while interventions continued under **U602**.

The GB will be implemented in 300 schools, 50 madrassas and 150 adolescent clubs with implementing partners Ministry of Education, Ministry of Women and Children Affairs and Plan International.

- **Health facilities accredited as adolescent friendly that offer services to young people including the unmarried:**

SPR 2014: Refugee camps: With support from UNFPA, RTM has been running adolescents and youths corners in SSKs of both camps. There are BCC materials having RH related information available in the corners. Some game materials and musical instruments were also available for their recreation. Total 1614 numbers of girls and 2123 boys have attended the corners**.**

25 Adolescent and youth corners are functioning in 25 CRHCCs where Adolescents are receiving ASRH related information and device. Adolescents are attending information and education sessions in groups in their available timing. 21 Medical Officers and 21 Counsellors have been trained on ASRH issues, who are responsible for education and counselling sessions.

The Mid-term Review of the national Health Population and Nutrition Sector Development Programme (HPNSDP) was completed in 2014, which has a focus on adolescents and youth.

Focus Group with Adolescents in the Adolescent Corner, Nari Maitree Health Center – Group of 10-15 year olds, 12 girls and the instructor (appeared mainly not slum dwellers). The ages were ascertained, school children, they receive information in the center on HIV and AIDS and STDs, menstruation, reproductive systems, changes during puberty, problems with early marriage. They spend one month coming to the center 4 x a month; the center offers other services such as musical instruments, singing, games and computers. The corner is open every day, there are about 25% boys, they meet in separate groups. There are about 90/week.

- A show of hands indicates that all want 1-2 children; randomly selected were able to explain about the population issues in Bangladesh and the personal financial burdens for raising children
- Random girls explained that they were very happy to have access to the information provided in the center as they are not given this in school, they receive no advice there.
- They do not have specific RH books at school but they have some information from religious books. Most share information with their mothers.
- Random girls said their most appreciated information was on rights of women, menstruation issues, STDs, questions about RH matters that concern them.
- Some girls wished to know more about women's rights, women's rights to achieve their potential, some were unsure whether men and women are considered equal in Bangladesh.

Adolescent Girls Focus Group, Kupatalong Refugee Camp. Adolescent Life Skill session, with approximately 14 female youth, aged 10-16 – in room with some games and musical instruments

- They receive core training, 5 days x 2 hours x 3 months
- The information they find valuable includes the rights of women, the legal age of marriage, the need for birth spacing and to limit children
- They were able to answer questions on legal age of marriage, need to limit births for health (but not for population control)

- Most want to have 2 children
- They aspire to professional careers such as nurses, doctors, and teachers (we were told they go out for high school and can go out for college)
- The information they receive is easy to understand, there are illustrated guides, they include some contraceptive information
- They know where to go to report GBV abuses.

- **Adolescent clubs that are functioning and providing SRHR and HIV information to targeted areas for Generation Breakthrough (GB):**

The goal is to develop 150 clubs in four districts, Dhaka, Braisal, Barguna and Patuakhali, however, 60-70% are functioning to various degrees, but only about 10% of attendance is drop outs. There has to be negotiation with DWA, to do a survey and find out about the dropouts, why they don't use the clubs. The computer use is by far and away their greatest draw; 70% of them have games. There are many places with no clubs and need them.

Focus Group discussion with Adolescent Club in Mirajagonje, Patuakhali District – (8 youth, 11 to 17, 4 boys and 4 girls) They come to the club to learn about the negative impact of child marriage, learn about SRH but for the boys to use the computer. They could answer correctly about the need for population control, the legal age of marriage, the health risks of early pregnancy, and they knew about the GBV help line. They said they came to the club for 2 hours, 2 days a week. They suggested that there should be more creative ways to involve the parents and also to give the messages like through folk singing, theatre.

- **Schools using Gender Equity Movement in Schools (GEMS) in school curriculums:** As of October, 2015, this number was still zero. However, the number optimistically will be 350 next year before the end of the CP as the preparations are nearly completed and the GEMs approved.

- **Schools in Generation Breakthrough target areas with functioning adolescent Groups:** The program design indicates that each school will have adolescent groups (based on age and grade) where they can. discuss issues raised through a GB project in a safe space.

The adolescent spaces are almost ready to go, the space and the responsible teachers are designated, just need the approval of the educational games, etc. from the MoE. The board games and question boxes are already printed.

Key informants praise the GB interventions in terms of facilitating and cultivating national interest in investing in AY. Additionally, community interest in programmes which meet the SRH needs of AY has been capitalized upon. For the Generation Breakthrough the MoE has been generally very positive, compared to the past. The level of acceptance in the community/parents is also very strong. The delay in getting GoB approval was bad but worth it to have positive government at this point. The hotline in Dhaka is very popular and already overloaded, there is one month of data on the calls.

Other positive points include:
- The teacher training for 3 days was very fruitful, about 99% of the schools involved are government schools, less than 2% are not. There are 350 schools x about 700 students. The teachers were master trainers, but this info is not in the teaching schools. There is generally Phys ed, Home Ec in 6-8th grade but teachers have a hard time speaking these things to students. So the entire perspective of the teachers has been changed. And thus there is **already a positive result**.
- The master trainers spoke of very delicate issues these included physical development issues, the Madrassa teachers react and they agree. Extramarital sex is not allowed but there is discussion of STDs. There seems to be little resistance

- The rights of women are being appropriately disseminated. Even cybercrime is discussed. The key is that the Islamic Foundation gives the Imams 45 days of training, there is pressure on reduction of child marriage and early births.
- The Government of the Netherlands wants to target to prevent child marriage and increase benefits to women and keep them in school. All the issues are here. The government also has a scholarship for girls, ongoing, ADB support. This is a good investment, lots of benefits.
- The Civil Surgeon opened the Helpline in Barisal and it has been operating for 8 months the kids have lots of questions. The people answering the questions are expert psychologists.

Issues in Adolescent and Youth interventions:[122]

- For the adolescents they do not know where to go to get advice so there is no preparedness for marriage, this is much more important than the couple registers, then it is possibly too late. Imams will only be a bit useful.
- Lack of capacity and inadequate interest at the MoE in the GB project, resulting in slow project progress
- Reluctance and sensitivity of some government officials to address ASRH and GBV issues in programmes
- Limitations in operational support for the remaining clubs and call centers. In terms of the clubs, it is difficult to get the DWA and MoE to get them together. They need things to draw in the youth
- Many key Informants say that not enough resources are targeted in terms of prevention of early marriage and pregnancy, and promotion of RH rights.
- For GB, they are challenged with training of the teachers, who are already selected, and how to monitor the information transfer in schools.
- There is a plan for a roll out to the many schools.
- A UNFPA is not yet working with the private pharmacies, but they can serve as an FP instrument
- The girls who work do not tend to want early marriage and for those who marry early and have babies, there is no place to keep the babies while they complete school, they drop out, 66% marry before 18 and drop out. Another reason for dropping out is the toilets, there are is only 1 for 200 kids and there has been an improvement in having one for girls and one for boys. Also there is usually no running water. There is a SEQAEP project, people surrounding the school help the kids.
- There is not enough involvement of parents. Kids are totally dependent on their parents. There is a high rate of suicide among girls who go against the wishes of their parents in terms of boys. The School management committees can also obstruct, they are locally influential persons, parents show up but don't speak. There has to be a separate meeting for parents. This is a bottleneck to the success of the project. There should be a parent's day, make an adolescent fair and invite all parents, use audio visuals. There should be a parents' workshop every year to reduce the tensions between parents and kids.
- The Clubs are set up, 60-70% of 90 but only 10% of attendance is drop outs. There has to be negotiation with DWA, to do a survey and find out about the dropouts, why they don't use the clubs. The computer use is by far and away their greatest draw; 70% of them have games. There are many places with no clubs and need them.
- One of the main difficulties is the lack of acceptance of the words that are used (e.g. sex) and thus a different approach has to be used. There are also some differences between

[122] Key Informant interviews and site visits, October 2015

the madrassas and the schools but it is changing, still mainly a vocabulary problem. • When it comes to exam time, it is very difficult to work in the schools, GB has not reached the students yet but it will continue to be an issue. • There is also non-participation by government counsellors at Union level who are elected and the technical officers do not have an impact on them, thus they need help for advocacy, something like school fairs to invite them to.			
A.2.3 UNFPA has contributed to the establishment of mechanisms to ensure ownership and the sustainability of effects.	• Dedication of budget lines to RH in national budgets • Evidence of national leadership in planning and implementation of projects and programmes to promote ICPD SRHR objectives • Existence of exit strategies with government partners that illustrate hand over of activities	• Surveys, workshop proceedings • National ministries budget information • UNFPA staff • Implementing Partners • Beneficiaries	• Documentary analysis • Interviews with UNFPA CO staff • Interviews with implementing partners • Interviews/Focus groups with beneficiaries Document review • Visit to target upazilas

- **Dedication of budget lines to RH in national budgets (increase):**

Allocation for SRH is included in the overall health budget. There is no separate/specific allocation for SRH, but estimated that it is approximately 2.5% of national health budget. It has not been increased from the previous year.[123]

The 2014 SPR: Local Level Planning (LLP) in eleven MNH districts played a pivotal role in program implementation; government has taken it as evidence and initiated LLP-based fund disbursement to some other districts. Government has agreed upon recruitment of Human Resources (private) working in the public facilities to mitigate shortage of HR as interim solution, e.g. doctors, nurses etc.

- **Evidence of national leadership to promote ICPD SRHR objectives:** With district-level interventions, the RH Component provided support to strengthen and implement LLP in 13 target districts, training and management of private-CSBAs, to build capacity of service providers on screening of cervical and breast cancer, treatment & referral, including raising awareness and increasing demand for services

URBAN Project
1. Coordinated efforts and continuous support by all Development Partners of UPHCSDP and GoB
2. Continuous cooperation by different training institutes under DGHS, DGFP and NGOs
3. Community participation in project activities, especially of elected local representatives

[123] UNFPA Annual Report, Finalized December 2014

RTMI
• Continued support and technical assistance from MOHFW, UNFPA and UNHCR (field and Dhaka office).
• Trained and experienced staff working in all the service delivery points run by RTM International.
• Good coordination among GoB officials within and outside camps (Service Providers of MOHFW working in camps, camps, CICs, RRRC, CS, DDFP, UH&FPO, TFPO).
• Uninterrupted supply of commodities for FP services.

Midwifery
Prime minister's commitment regarding development and deployment of 3000 midwives by 2015 created enthusiastic environment for rapid progress in midwifery programme in Bangladesh. Higher level GoB personnel are very much positive in this issue.

Evaluation of Midwifery Training, page 14. The development and implementation of the Certificate in Midwifery program has until recently been funded by the Government of Bangladesh (10 training sites), WHO (4 training sites) and UNFPA (6 training sites), with a total of 20 sites currently functioning (see Appendix 5). The curriculum, lesson plans and assessment tools were developed with the technical support of consultants from Auckland University of Technology, New Zealand. This curriculum was revised during a master training in March 2013, by the consultants and training participants many of whom are teaching in the program. The GOB is planning to phase out the 6 month midwifery education by the end of 2015 when the first graduates (about 525) of the Diploma in Midwifery Course will enter the job market (UNFPA Bangladesh 2013b).

- **Existence of exit strategies that illustrate hand over of activities:** None noted.

EQ3 To what extent have the interventions supported by UNFPA in the field of Population and Development (PD) contributed to the integration of evidence-based analysis on population dynamics in national policies at national and local levels?			
A.3.1 National capacity to collect and analyze data by sex, age, economic status and location is strengthened (CP output 1)	• Evidence that staff of BBS at all levels use up to date data collection and validation techniques. • Regularly updated population data disaggregated by sex, age, economic status and location are available. • Number of issue-specific monographs produced (baseline and target) • Regularly updated nationally representative data on gender-based violence and harmful practices are available. (Baseline: 0; Target:2)	• Bangladesh Bureau of Statistics • Planning Commission • Department of Population Studies, DU • District Development Committee • Parliament Secretariat	• Key Informant Interviews • Review materials

The Population and Development programmatic area has one outcome with two output areas[124].
Outcome 1: Government and non-government stakeholders are better able to accelerate national policies and development agenda, through integration of evidence-based analysis on population dynamics with a focus on achieving the Millennium Development Goals and pro-poor growth
Output 1: Strengthened national capacity to collect and analyse data disaggregated by sex, age, economic status and location.
Output 2: Increased capacity to integrate population and gender concerns, including emerging issues, into national and sectoral plans and policies.

Essentially the Population and Development interventions under the PD programmatic area are:

- Capacity development for the collection and analysis of high quality sex disaggregated data, and Policy advocacy for evidence based policy planning and programming

UNFPA project interventions fall under the following AWPs:

P101 (Population and Housing Census 2011. Project with Bangladesh Bureau of Statistics – BBS)
U701 (Strengthening the national capacity to collect and analyze data disaggregated by sex, age, economic status and location. Project with Bangladesh Bureau of Statistics - BBS)
U702 (Strengthening the capacity of teaching and research faculties at the Department of Population Studies (DPS), Dhaka University - DU)
U102 (Strengthening Parliament capacity in integrating population issues into development – Project with Bangladesh Parliamentary Secretariat - BPS)
U102 (Strengthening capacity of General Economic Division to integrate population issues into development planning process – Project with General Economic Division – GED, Planning Commission)
U102 (Enhancing capacity of SEI Division to integrate population and gender issues into sectoral planning – SEI)
U102 (Enhancing national capacity for integrating demographic concerns and post-2015 development agenda into development planning – Population Council).

For the Generation of Evidence and Knowledge Management, UNFPA and Bangladesh Bureau of Statistics (BBS) jointly undertook the project to strengthen the capacity of BBS through improvement of data collection quality, analysis and enhancement of the quality of the utility of census data in planning for sustainable development. UNFPA also have project with the Department of Population Sciences that provide high quality training in population studies and produce top quality research on population and related issues. Government agencies, national and international NGOs and organizations, individual academics turn to this centre for advice on training and research on issues relating to population and development.

For the thematic area Policy Advocacy UNFPA works with four organizations – BPS, GED, SEID and Population Council. The project with BPS aims to strengthen the Ministry of Planning's capacity to develop and plan as well as strategically formulate policies and legislations, and monitor of their implementation. It focuses on adaptation of critical policy measures in health, employment, education and human rights. The project with GED of Planning Commission is to increase capacity of GED to integrate population and gender concerns such as SRHR, adolescent and youth development including other emerging issues into national plans and policies.

The project with SEID of Planning Commission is aimed for mainstreaming population, development and gender concerns into sectoral plans. The project with Population Council is aimed at enhancing national capacity for integrating demographic concerns and post-2015 development agenda into development planning of the government. Population Council is to prepare policy briefs for dissemination through seminars at different levels. Under this thematic area the interventions include:

- Strengthening Parliamentary Advocacy through strengthening BPS, BAPPD and the sub-committees to speak on UNFPA issues
- Policy dialogues on critical population and development issues related to reproductive rights, and gender equality, budget analysis
- Producing advocacy materials – factsheets and policy briefs using census and other research/study outputs

[124] UNFPA Result and Resource Frame work for Bangladesh (8th CP, 2012-2016)

For the thematic area Capacity Development, all five of the six UNFPA projects under PD programmatic area were provided support.

- **Evidence that staff of BBS at all levels use up to date data collection and validation techniques.**

Through 5th, 6th and 7th country program UNFPA provided support for preparation of digital GIS maps. With ongoing support from UNFPA, the GIS Unit of BBS took initiative to improve its capacity in data collection, data analysis, data dissemination and report writing. It is creating geo-database with small area Atlas, updating digital mauza/mahulla EA maps using GPS validation of land marks of education of health establishments. It has also introduced online data entry system for SVRS and central sample vital registration system (SVRS) data analysis lab. These indicate that BBS uses up-to-date data collection and validation techniques. The Thematic maps are produced by the GIS Unit. These are used by other departments and Units within BBS, and about 10-12 organizations outside BBS[125].

KII informed that all these work require sophisticated equipment and digital hardware that are provided by UNFPA. They have machines to capture data from coded data in pages to computerized database. However, new data generation techniques are always coming to the world market new digital equipment used to shorten the time between data collection and data use.

A large number of trainings took place through this project. Most of the participants were BBS staff, but there were also participants from other agencies like Planning Commission, DRLS, and various Ministries. Content of the training included topics on GIS map editing, updating etc. The training also covered issues on gender, refresher on sample vital registration system (SVRS), use of software to enter data to update map. Only two workshops on Integration of Statistics & Geospacial Information was held with participants from different wings of BBS, Ministries, SOB. SPARRSO, DU, ERD, IMED, LGED and Planning commission. Bulk of the training were on Enumerators/supervisors and SVRC[126].

BBS officials were oriented to shift the perception of the agency away from the concept of data generation to more towards data analysis and policy development. But that type of orientation was for few officers and the duration of the course was for only a couple of days.

UNFPA supported the Population and Housing Census 2011 project. This project is of 6 years duration (2010-2015); two years extension of the project period is made as UNFPA wanted to do some additional data analysis, and do a few monographs, and do some training on basic statistics and set up a in-house press so that information can be printed and disseminated quickly.

- **Regularly updated population data disaggregated by sex, age, economic status and location are available.**

Using the sample vital registration system (SVRS), the 23 old district offices of BBS regularly collect population and demographic data disaggregated by sex, age, economic status and locations These data are made available through BBS website and statistical year book. Quality of the updated data will improve with full functioning of all the 71 BBS offices across the country[127].

With UNFPA support, the 2011 Population and Housing Census generated the district and upazilla (sub district) level data and the draft reports are uploaded in the BBS website. Availability of demographic data by age and sex, location and poverty has increased.

In 2014 UNFPA Bangladesh initiated partnership with UN ECLAC to support Bangladesh Bureau of Statistics with online dissemination of census micro data. This initiative will

[125] Technical Assistance Project Proposal (TPP of 2012), Part B, GIS Unit of BBS

[126] Quarterly reporting on training and workshop activities, GIS Unit, BBS

[127] Key Informant Interview with GIS Unit, BBS.

facilitate online data users mapping of socio-economic and demographic inequalities. The partnership with UNECLAC completed its task and helped BBS to install and upload the system in the www.bbs.gov.bd and thereby made available the 2011 census micro data, records and the results online for its users.

- **Number of issue-specific monographs produced (baseline and target)**

Altogether 14 monographs are planned. Four of these monographs will be prepared by a consultant hired by UNFPA, and others will be prepared by experts from BIDS, ISRT, DPS/DU, and Statistics Department of Rajshahi University. The monographs are on (1) Education and Literacy – BIDS, (2) Adolescents and youth – BIDS, (3) Characteristics of International Migrant HH – BIDS, (4) Elderly Population – ISRT, (5) Disability- ISRT, (6) Pop Dist and Internal Migration - Dept of Stat/RU, (7) Pop Density and Vulnerability - Dept of Stat/RU, (8) Urbanization – Dept of Stat/RU, (9) Marriage and Family – Dept of Stat/RU, (10) Fertility - Dept of Stat/RU, (11) Pop Composition: Age and Sex – Local Consultant, (12) HH Amenities – Local Consultant, (13) Housing Condition – Local Consultant, (14) Labour force status, occupation and industries - Local Consultant. BBS is confident that all these monographs will be available before the project ends. It should be noted that none of these monographs will be written in-house at BBS[128].

- **Regularly updated nationally representative data on gender-based violence and harmful practices are available. (Baseline: 0; Target:2)**

UNFPA Bangladesh continued to support the intuitional capacity development of BBS for analysing and using disaggregated data on gender-based violence. By end 2014, BBS developed a plan and budget to undertake the next round of the national Violence Against Women Survey (2015). Data capture for this survey is in the process, and the report is expected soon. The previous VAW Survey 2011 was also supported by UNFPA (published in 2013).

UNFPA Bangladesh continued to support BBS with a number of training for BBS staff on data analysis and report writing. By the end of 2014, BBS was developed a roadmap to produce 14 monographs from the Census data – one of which is to focus on adolescents and youth.

A.3.2 Increased capacity to integrate population and gender concerns into national and sectoral plans and policies (CP Output 2)	• National and Sectoral plans produced using sex, age, economic status and location data. • Number of revised policies approved that are aligned with ICPD and other international frameworks on women's rights(no baselines and targets). • Number of national and sectoral plans that are evidence-based, gender-sensitive, and incorporate population and development linkages (no baselines and targets) • Number of national and sectoral plans that reflect population and gender	• Planning Commission • Department of Population Studies, DU • Research Institutions • Relevant UN Agencies • Relevant CSOs and NGOs	• Key Informant Interviews • Review materials

[128] Key Informant Interview with Census Unit, BBS

	concerns. - Number of research papers that contain policy implications and recommendations on emerging issues, such as demographic dividend		

- **National and Sectoral plans produced using using sex, age, economic status and location data.**

In 2014, UNFPA undertook a Demographic Impact Study (DIS), by a team of renowned international and national experts, as part of UN/UNFPA's contributions in response to the request from GED of Planning Commission for background papers for the Seventh Five Year Plan (2016-2021). According to the DIS, the population of the country can be expected to grow by at least another 51 million people by 2061. This will make the country's population density to reach unprecedented level. If population growth is to be limited within 50 million, the average number of children per woman will have to be below "replacement" level and remain there for some decades. Increasing the age at marriage and achieving gender equality more broadly will be required. The DIS mentioned that "demographic window of opportunity" is opening in Bangladesh over the past two decades but will start closing within the next decade. Less than 50% of the increase in the population of working age in recent decades has been absorbed into the economy and found "decent work". Given this trend, the creation of employment opportunities for the existing underemployed population as well as for new labour force entrants over the coming decades is the main development challenge facing Bangladesh. The next plan period and the following one will provide a favourable opportunity to make investments in general and vocational education, particularly focusing on youth. The rapid growth of the elderly population will present a fiscal challenge to the government; unless coverage of the social safety net is expanded and benefits are raised, poverty among the elderly is likely to increase, according to the DIS. The study also provided policy recommendations on fertility and mortality transition, migration, urbanization and on sustainable development.[129]

UNFPA support the institutional capacity development of the Planning Commission of Bangladesh (especially its GED, SEID, and BBS) to better integrate and mainstream P&D linkages and gender concerns into national development plans and sector policies.

To sensitize and train the officials, five days training was arranged by SEID. The officials were of the planning division, and staff engaged in Planning from other ministries. The training was provided by DPS of Dhaka University. The staff trained show positive change among the staff in their understanding on gender and population issues, and they have applied their lessons learned in the work. It was pointed out that because of the training, the pro-forma of DPP and TPP have been modifies to include a sections on gender and children. The modified pro-forma has added value to the proposal. Filling-up these sections in the pro-forma has become mandatory, and beneficiaries of the proposed projects in terms of women and children has to me clearly mentioned. Altogether 280 officials are trained (20 in each batch, 12 batches). This year one batch of the training will be short because of fund constraint. Fund constraint occurred because of strong local currency against US dollar during the agreement period that provided less local currency against US dollar commitment. The project with SEID also made documents (hand book) on gender and population issues. SEID has undertaken three policy dialogues, for which, policy papers were prepared with recommendations. Two the papers that are worth mentioning are on (a) women friendly working environment, and (b) harnessing women labour.[130]

GED is also conducting training for the planning commission staff (planning wing) and some officials of other ministries and projects of important agencies for developing their capacity on gender and population issues. These trainings were for 5 day (1/2 day each day). There were fifteen sessions in each course. The trainers were experts from Bangladesh. Altogether there have been 18 batches, 20 trainees in each batch. These trainings helped the trainees to get sensitized and they could able to relate planning with population

[129] The Impact of the Demographic Transition on Socioeconomic Development in Bangladesh: Future prospects and Implications for Public Policy, Geoffrey Hayes and Gavin Jones, A background paper prepared for the Bangladesh Planning Commission of the General Economic Division in support of the development of the 7th Five-Year Plan 2016-2020; produced with financial support from EU.

[130] Key Informant Interview with SEID of the Bangladesh Planning Commission.

dynamics. The issue of demographic dividend was elaborately discussed and gave the participants a very clear conception. It was observed that training participants discuss demographic dividend in various forums. Eight policy papers and policy dialogues were organized by GED. Already two publications (monographs) of the planned three are printed (300 copies) and disseminated to all Ministries. These are also put in the website. Two important research papers on emerging issues and their relevance to national planning were produced by GED. These are (a) "ICPD Bangladesh Country Report" prepared by Professor Azharul Islam. It was based on secondary information, and the draft is submitted to GED. Another report (b) "Systematic Review of Sexual and Reproductive Health of Young Population, and the sector of Investment to Harness the Demographic Dividend" will be soon made ready and its inception report is submitted. It will be done by the Bureau of Economics of Dhaka University. The health and population sector strategy for the next 5 years focuses on 14 sectors. To facilitate this UNFPA conducted the "Demographic Health Study", with financial from this Project. [131]

The training provided by GED and SEID are no doubt very useful and created positive impact among the trainees. However, the training arranged by the two Units of the Planning Commission seems to be of similar duration and may have the same content. Although the training arranged by GED is provided by "experts from Bangladesh", while those arranged by SEID is provided by DPS of Dhaka University. UNFPA mentioned that they have needs assessment done to set up training contents; however training contends may be biasedly arranged by the trainer. Also that systematic follow-up may be a rare arrangement for these trainings. As these issues are outside the preview of the current evaluation, we suggest that UNFPA look in these matters in future, particularly the issues of training needs assessment and post training follow-up. Also if the two training are of similar content they can be merged and a center having excellence in this area may be designated to take up this activity with more professional attitude.

The Department of Population Studies of Dhaka University offers two-year (4 semesters) professional post-graduate degree program, called Master of Population Sciences (MPS) Professional Degree Program. There are 65 masters degree students. A certificate course entitled "Diploma in Population Sciences" was introduced. This course is offered once every year, with maximum of 25 students. These trainees are professionals and they play the role of bridge between field and practitioners. The department also introduced bachelor degree program, with 25 students.[132] The current project has provision to conduct a research on "Aging" with 6,200 samples. Twelve issues related to aging population are to be analyzed. This will produce a national level policy document and the report will be released soon. When the evaluation was proceeding, the field investigators were undergoing training on data collection instrument and preparing for fieldwork. A national level study on causes and consequences of Child marriage is also underway. There will be 11,000 samples, and training of enumerators and supervisors for data collection is currently underway. The department every year (since 1998) observes "World Population Day". On this day dissemination papers are printed and circulated among all department chairs, and other interested groups. The department will issue for the first time a document entitled "State of Bangladesh Population". The document with 7 chapters is at press. Secondary data, particularly from BDHS is used to prepare the chapters[133].

With UNFPA support, the Bangladesh Association of Parliamentarians on Population and Development (BAPPD) has been formed under the Chairmanship of the Speaker of the Parliament. Through its support to the Parliament Secretariat, UNFPA organized various policy dialogues by the parliamentarians including on SRHR, adolescents and youth, and child marriage. The project also mapped out the gaps related to different elements of maternal health related policies and services in the country, and produced a policy brief for the parliamentarians. Three sub-committees are formed to carry forward the advocacy work related to prevention of Child Marriage, Maternal Health and Safe Delivery, and Youth Development. Key activities proposed by the sub-committees are to:

- Make necessary amendment on Dowry Prohibition Act, 1980 along with the Early Marriage Restraint Act 1929.
- Review the current Youth Policy and make evidence based amendments
- Organize consultation meetings with Standing Committees on Education, Health and Family Welfare and Finance.[134]

[131] Key Informant Interview of GED, Planning Commission

[132] Brochure on "Diploma in Population Sciences, 2011" Department of Population Sciences, University of Dhaka.

[133] Key Informant Interview with DPS, Dhaka University.

[134] Power Point presentation on SPCPR – Parliamentarian Action at Country Level, made by Additional Secretary (HR) of BPS and PD, SPCPD.

- **Number of revised policies approved that are aligned with ICPD and other international frameworks on women's rights (no baselines and targets).**

National policy development and their revision is a lengthy process and the initiative is taken by the government. During the 8CP the PD sections produced a number of policy briefs and had organized policy dialogues on issues like demographic transition and demographic dividend, elderly, child marriage, internal migration and heath budget allocation[135]. Since no relevant policy development and change initiatives have been taken by the government during the period and therefore the intended end results not fully achieved. And there was also no specific target for this programme period

- **Number of national and sectoral plans that are evidence-based, gender-sensitive, and incorporate population and development linkages (no baselines and targets)**

SEID and GED are responsible for developing annual development plans for 35 ministries. GED is mandated for development of government's mid and longer term national plans and strategies, while the SEID is primarily responsible for approving the annual development projects of 17 development ministries. The role of SEID related to UNFPA's mandate is to ensure integration and gender concerns in the development project proposals. All the projects developed by these two Divisions follow the project pro-forma requiring information that are evidence-based, gender-sensitive, and incorporate population and development linkages. The Key Informant of SEID suggested that inclusion of gender sensitive information in the pro forma of the development projects is an achievement by itself. This will eventually make the projects and sectoral plans. During the UNFPA CP period the 7th five year plan is produced, and support is provided a background paper by producing the Demographic Impact Study. Support is also provided by conducting the "Demographic Health Study" in order to develop the Health Strategy.

- **Number of national and sectoral plans that reflect population and gender concerns.**

The national 7th Five Year Plan has already been finalized and endorsed by the Cabinet. This plan reflect the population and gender concerns. No other national plans are developed during the five year period. Itis expected that all the sectoral Plans of the 8 ministries will be produced as part of implementation of the 7th FYP will address population and gender concerns.

- **Number of research papers that contain policy implications and recommendations on emerging issues, such as demographic dividend**

The UNFPA's project with SEID has undertaken three policy dialogues for which 3 policy papers were prepared with recommendations. Two the papers that are worth mentioning are on (1) women friendly working environment, and (2) harnessing women labour.

Eight policy papers and policy dialogues were organized by GED as part of the UNFPA project activity. The project have already produced two monographs of the planned three and disseminated to all Ministries. These are important research papers on emerging issues and their relevance to national planning.[136] There are two other research papers in the

[135] Information provided by PD department of UNFPA CO.

[136] Policy dialogues papers as listed in the GED SPR 2013 and 2014 are, (a) Transition of Demographic Dividend's Deciding Future Development Strategies, (b) Aging Population, (c) Analyzing Demographic Situation in Bangladesh: Mapping out the Challenges into Development Processes (18 Dec 2014), (d) Managing the Population Momentum Issues

process, (3) “ICPD Bangladesh Country Report” by Professor Azharul Islam, and (4) “Systematic Review of Sexual and Reproductive Health of Young Population, and the sector of Investment to Harness the Demographic Dividend”. It will be done by the Bureau of Economics of Dhaka University. These two reports will be ready soon. The Health and Population Sector Strategy for the next 5 years focuses on 14 sectors. To facilitate this UNFPA conducted the (5) “Demographic Health Study”, with financial from GED Project. GED also funded the Demographic Impact Study (DIS).

The DPS project has provision to conduct a research on (6) “Aging” with 6,200 sample elderly persons. Twelve issues related to aging population are to be analyzed. This will produce a national level policy document and the report will be released soon. A national level study on causes and consequences of Child marriage is also underway. There will be 11,000 samples, and training of enumerators and supervisors for data collection is currently underway. There is doubt whether the second research on child marriage will be completed during the UNFPA CP period.

This project with Population Council intends to carry out activities to enhance national capacity for integrating demographic concerns and post-2015 development agenda into development planning of the government. The project is to prepare 8 policy briefs (with front sheet). Already 4 of these papers are done, and two dissemination seminars stage. The papers will be on Health and Family Planning Needs (Family Planning, Midwifery in Health System, Urban Health, Maternal Morbidity and health system) and on Sustainable development (Demographic Dividend, Climate Change and Migration with Gender Focus, GBV and Socio-economic Impact, and Health Care Financing).

As mentioned earlier 14 monographs are planned to published by BBS during this CP period. Altogether around 38 papers/documents of various kinds will have been produced during the UNFPA CP period (policy papers/brief =19, monographs = 16, research paper = 1, Studies = 2).

A.3.3 Mechanisms to ensure ownership from national partners are in place for future operation of the program.	• Dedication of budget lines to PD in national budgets • Indications of leadership in projects and advocacy to promote ICPD objectives • Numbers of UNFPA PD interventions that can be carried on by partners without UNFPA support • Evidence of an exit strategy in UNFPA programming documents in the field of PD	• Bangladesh Bureau of Statistics • Planning Commission • Department of Population Studies, DU • District Development Committee • Research institutes Parliament Secretariat	• Key Informant Interviews • Review materials

- **Dedication of budget lines to PD in national budgets**

UNFPA CO informed that no such target was there in the 8th Country Programme related to increase budgetary allocation to PD. However the PD section proactively advocated for increasing budgetary allocation in human resources to harvest demographic dividend, and also for maternal health programme. The 7th Five-Year Plan propose higher budgetary allocation for human resource development.

Facilitating Economic Development in Bangladesh (21 Dec 2014), (e) Factors Preference for Education and Health Services in Slum areas in Bangladesh (21 Dec 2014). A dissemination workshop was organized by GED entitled “Population Dynamics, Demographic Dividend and Capacity Building Assessment of GED for Integrating Population issues into Development Plans (Jan 2014).

- **Indications of leadership in projects and advocacy to promote ICPD objectives**

The Government of Bangladesh implemented the 6th Five-year Plan which was developed with due consideration of ICPD objectives to meet the challenges in reproductive health, reproductive rights, youth development, gender inequality, etc. The 7th Five Year plan is also made considering the ICPD, MDG and SDG objectives. The PD Component partner BBS providedg reliable data on population disaggregated by residence, age-sex, marital status, occupation to prescribe appropriative policy measures for poverty elevation, enhancing employment opportunity for youth and improve quality and life of the people. These data were use in developing the national plans. UNFPA informed that the role of BBS as described in the Bangladesh Statistical Act 2013 and in the National Strategy for Development Statistics is to generate national statistics and make those available to the planners and policy makers for their further analysis, interpretation and use. With their background BBS cannot play leadership role in promoting ICPD objectives, and this is the reason why GED, SEID and UNFPA CO had engaged the experts to conduct secondary analysis of available BBS data and statistics and produce policy briefs and policy papers for evidence based policy formulation and promote ICPD objectives. Thus

GED of the Planning Commission is using an external consultant (Professor Azharul Islam) to prepare "ICPD Bangladesh Country Report", and they may use the findings as background information for the national plans. The Department of Population Studies of Dhaka University which has the academic strength could be another option to take leadership to promote ICPD objectives.

As part of Bangladesh Association of Parliamentarians on Population and Development (BAPPD), some members of the Parliament have proactively mobilized themselves under the leadership of the honorable Speaker and have shown their commitment to carry forward the advocacy work related to ICPD objectives. Some of them are visiting the countryside and advocating for the prevention of Child Marriage, Maternal Health and Safe Delivery, and Youth Development. They are also vocal for establishing Child Marriage free Upazilas, and showed their willingness bring in amendment of Dowry Prohibition Act, 1980 and the Early Marriage Restraint Act 1929. They are also willing to review the current Youth Policy and channel in more resources for Education, Health and Family Welfare.[137]

- **Numbers of UNFPA PD interventions that can be carried on by partners without UNFPA support**

All the key informants interviewed from the IPs of PD component does not see any intervention in their project that can be implemented without UNFPA support, unless the government earmark resources. Only in case of Census Unit of BBS they mentioned that the new Press that is being installed in BBS will decrease cost of printing substantially.

UNFPA however look at the issue differently, they mentioned that the 135 census traditional reports are produced using BBS's in-house capacity and this can/will be carried out with or without UNFPA support. Similarly BBS is not capacitated to make other datasets available online using REDATAM with probably small facilitation support. The GIS unit of BBS established with UNFPA's support is currently functioning with almost no support from UNFPA. The DPS of Dhaka University is now offering master's and diploma in Population Sciences without UNFPA's support and this part has already been institutionalized within University.

- **Evidence of an exit strategy in UNFPA programming documents in the field of PD:** None

EQ 4. Gender Equality - To what extent have the interventions supported by UNFPA in the field of gender equality (GE) contributed toward reducing the social and

[137] Interview with PD of UNFPA project with the Bangladesh Parliament.

institutional vulnerabilities of women and girls, including the marginalized and disadvantaged, with special focus on the elimination of SGBV?			
A4.1 Increased awareness and knowledge of and positive attitudes towards reducing the vulnerability of women, including the incidence of violence against women and early marriage (CP Output 1)	• Numbers of child marriages in targeted districts • Numbers of services from DWA officials to the survivors of GBV in the Women Support Center • Numbers of Local Level Plans in target districts with GBV interventions • The number of interventions that target men and boys with information regarding GBV and early marriage	• AWPs and SRPs • Progress and monitoring reports of implementing partners • Annual Reports by Gender unit • Consolidated Quarterly report • Data at district level	• Document review • UNFPA CO staff key informant interviews • Key informant interviews with implementing partners, other UN bodies • Focus groups with beneficiaries • Field Visits

A 4.1 Evidence of number of activities held related to prevention of child marriage in targeted districts: It is difficult to indicate the number of child marriages decreased as a result of the UNFPA intervention alone. However, the data collected by the gender unit and DWA officials indicate that approximately 200 child marriages were prevented by the SPG in 4 target districts. In addition over 2000 religious leaders were oriented[138]. It must be mentioned here that due to unavailability of the cumulative data and number of session conducted in all quarterly reports in this section data on the last Consolidated Quarterly Report (April-June, 2015) have been used. The data used in the UNFPA Bangladesh Country Programme (2012-2016) M @ E Framework aligned with the Strategic Plan shows that as per the cp Impact Indicator median age at marriage for women and girls (20-24 years) the BDHS 2011 data shows that it was 16.4 and 2017 SP target is 18[139]. It has been mentioned in the Consolidated Quarterly Report of Gender Unit that to prevent GBV and child marriage various steps and activities have been done through the interventions of MoWCA and MOHA. It has been reported that a total of 20 community dialogues have been conducted in 35 upazila. Total number of 1186 community people becomes aware about the negative consequence of SGBV and child marriage. In addition 13 networks have been established in the selected districts: Sylhet (4), Jamalpur(3), Coxsbazar(3), Patuakhali(3). In Jamalpur, Sylhet and Cox's bazar 4networks are fully functional, and remaining needs further support, need to improve in coordination and reporting. Patuakhali networks require follow up meeting and motivation of UWA officer. Other networks' activities are under process. Network members made commitments to refer victims to GO/NGO facilities whenever required.

A total of 27 NGOs/CBOs/ Youth groups (Clubs)/Women's Associations in the network active for SGBV and Child marriage prevention have been formed. In Patuakhali district Jatiyo Mahila Shangstha is active for child marriage prevention, SGBV prevention and women's empowerment. Directorate of secondary and Higher Education (DSHE) is working at school level to raise awareness on Child Marriage issues. Partner of UNFPA Plan Bangladesh through CWFD is working closely in SRH and child marriage issues. Union parishad and BRAC are working to mobilize rural community by improving their knowledge.

18 Police stations have sensitized a total 943 under 17 students, and formed student networks in Jamalpur and Sylhet. Police are receiving information through text messages from the network members regarding the incident of GBV and child marriage[140]. Twenty Action plans have been prepared by youth forums for July-December 2015. Youth leaders and volunteers are working to prevent child marriage and SGBV at education institutes and communities. They are working as change agents in the community. Joint meetings were conducted in office of the Superintendent of Police in four districts, where 81 participants were from District Administration, Service providers of SGBV/child marriage, MoWCA, NGOs, Civil Society, Civil Surgeon, District Ansar and VDP officer, Civil Society members, district Judge and Media.

[138] FGD with Gender Unit, UNFPA

[139] UNFPA Bangladesh Country Programme (2012-2016) M @ E Framework aligned with the Strategic Plan, updated on 15 December, 2014

[140] Key Informant Interview, October 2015.

In Jamalpur total number of 290 Adolescent girls and 200 parents (especially mothers) improved their knowledge on the negative consequences of child marriage. Approximately 824 Religious leaders were sensitized (Imam, Marriage register, Purahit, district register on CM issues and they are committed to arrange anti child marriage campaign in their respective Upazila. A young educated marriage register of Fenchuganj Upazila started campaign to increase awareness on CM by own initiative after participating in the workshop. Islampur upazilla parishad of Jamalpur has planned to utilize the union parishad budget for anti-child marriage campaign, as an outcome of kaji and imam sensitization training.

Sensitization of key leaders of different religions (Imam, Kaji Purahit) and learning on the t role of religious leaders resulted in enhancing positive commitments and participants prepared plans for action for six months.[141]

SPG members and local administration prevented a total of 33 child marriages in Patuakhali-7(Dumki-3, Golachipa-4), Jamalpur-18, Sylhet-8 (South surma-4, Goainghat-3, companiganj-1). One SPG members rescued an abducted girl. One of the SPG members (in Companiganj Upazila) has taken the responsibility of educating a 14 year old school girl who was going to be a victim of child marriage. During the KII with the Superintended of Police/SP (implementing partner of UNFPA) and Deputy Commissioner (partner of UNICEF) in Jamalpur mentioned that Jamalpur Sadar Upazila is completely free of child marriage and they have declared that the whole district will be a child marriage free district soon. In Jamalpur UNFPA intervention is the first initiative to prevent child marriage. SP of Jamalpur proactively distributed 8000 copies of an appealing letter to prevent child marriage and prepared number of volunteers as "change makers" to motivate community members. Each village "child marriage prevention committee" has been established spontaneously. From the follow up result it has been reported that as of September, 2015 Qazis did not agree to registrar 47 child marriages and convinced parents not to arrange these marriages[142].

Seven school-based Student/Youth Networks, with 30 students (taking 6 students from each class) in each network, has been formed. Kazi's (Marriage Registrars) and Imam's were provided with Gender Sensitive Training in the intervention areas for not registering or arranging child marriage. Five networks have both boys and girls, 2 are solely boys' network. They are mainly engaged in class monitoring for Child Marriage Prevention and baseline data (number of students, any of them are married, plan to reduce child marriage etc.) for each class data collection have been completed by June, 2015. In 2016 January, they will reassess on the progress of their efforts along with police to share the progress thay have made. There is no base line data on child marriage. However, 29 child marriages were prevented over the months of September to November in the district[143].

Evidence of Numbers of services from DWA officials to the survivors of GBV in the Women Support Center: There are two WSC in Cox's Bazar and Sylhet. Cox's Bazar WSC is fully supported by APWR project. Cox's Bazar, Patuakhali and Sylhet districst have referral system, with OCC. From April 2015 to June, 2015 (2nd quarter of the project) 18 new cases, and 24 children have been registered in Cox's Bazar WSC and received shelter support. 84 cases have been solved through helpline support. The 18 cases of Cox's Bazar WSC have been resolved through arbitration. In Sylhet WSC, 5 new cases and 8 children received shelter supports. 5 cases of Sylhet WSC have been resolved through arbitration. Knowledge on Counseling is better among the WSC personnel, compared to other participants. Based on pre-test, 42% scored below the average. But after the training, 50% scored above the average[144].

The Progress Report of WSC Cox's Bazar (from July to September, 2015) presents that following data for the services provided to survivors of GBV: Survivors admitted in this quarter: 32; Food support 77 (New 19+19 children; old 18+21 children); Psychological support: 32 (within shelter 19 & outside 13); Medical support: 77 (new 19+19 children; old 18+21 children); Legal support: 32 survivors (within shelter 19 & outside 13 and 13 cases in court); Vocational training: ongoing activities for 37 women (new 19+old 18); Non-formal education: ongoing (39 (new 19+ 18+ 02 children); Security: 2 Superintendent and 3 Security have been appointed for 24 hours; dispute resolution through salish: 29 (within 19 and outside 10 and 2 years imprisonment for 1 perpetrator. It has also been informed that WSC is making list of Upazila and Union wise information on GBV for all 8 Upazila, registering and reporting. Follow up visit is also paid for the resolved cases. Twenty nine cases were under follow up mechanism during the reporting time. There is a 24/7 Help Line and 68

[141] Consolidated Quarterly Report (April-June, 2015) of Gender Unit, UNFPA

[142] Key Informant Interview, October 2015

[143] Key Informant Interview, October 2015

[144] Consolidated Quarterly Report (April-June, 2015), UNFPA

women provided direct legal support through telephone. A total of 37 women were referred to Thana (Police station), Union Parishad, One Stop Crisis Centre and others out of 69 women requested for legal support. The rest were given shelter to WSC. Success stories of GBV survivors have been regularly published in newspapers[145]. All women are given skills training in making handicrafts, quilt by a regular trainers. However, market linkage is limited. Women in WSC do not get regular health checkup or support. An advocate was appointed with a monthly salary of 18,000 to 20,000. However, as evidence of false cases was found, WSC staffs call panel lawyers on contract basis when required[146]. (Moved to Another section below)

Challenges: Through establishing WSC, UNFPA has made noteworthy efforts and playing crucial role in context of preventing GBV and supporting the survivors. However, sustainability of the project required careful steps by the government. . It must be mentioned here that UNFPA supported WSC for 5 complete years during the 7th CP, reached the consensus that the MoWCA is ready to take over the WSC, which is yet to be done. During the formulation of project phase out strategy should be mentioned very clearly to avoid such problem.

Due to lack of proper handover of the project there was a dislocation of 16 women GVB survivors who were also forced to leave the NGO operated shelter. Those who had places to go returned and the rest were kept in different human right based NGOs.. In October, 2012 the employees of WSC were absorbed under the DWA implemented project. However, due to technical difficulties in fund disbursement no financial supports were received from UNFPA for 6 months, thus it was difficult to run the WSC. Furthermore, fund disbursement is always slow. US $88,000 was returned from the agreed budget to UNFPA. The reason for the budget cut was not known by the WSC which faces a shortage of budget since July 2015 and results in feeding low quality food to women survivors of GBV with children, since from 130 Taka per meal per survivor 88 Taka is being allocated. An application was sent to UNFPA for an increase in the taka.[147] However, as per the TPP under 7th CPof UNFPA that as per the agreement with government, MoWCA was supposed to take over within 7th CP and at the end of 7th CP. However, MoWCA did not take any action as agreed with UNFPA. It was well disseminated in advance to the NGO that UNFPA will stop supporting WSC, and MoWCA and other stakeholders will take over, so if there is any discontinuation or dissatisfaction UNFPA is not responsible for it.

Evidence that Local Level Plans in target districts with GBV interventions have been completed and implemented: One of the major activities under the MoWCA implemented Advancement and Protection of Women's Rights (APWR) project was developing Local Level Planning (LLP) on SGBV, child marriage and other issues. In all the intervention districts LLPs have been developed in a participatory manner involving relevant local and national level stakeholders and submitted the plan to DWA, MoWCA for approval. The target of developing District and Upazila level plans was 39, which have been achieved [148]. However, 'Sensitization of Religious leaders' related AND work with students/youth focusing on boys was were included in the AWPs of DWA (with sensitization f religious leader) and MOHA (with youth/students).. Seventy Social protection group meetings hold at union and upazila level. Total of 33 meeting has been conducted with religious leaders at upazila level (Imam, Kaji, Purohit). The project has been successful in addressing the Local Level Planning related to health sector program (OCC in Sylhet and Cox's Bazar) and building capacity with regard to running Women Support Center (in Sylhet and Cox's Bazar). However, as the DWA was not centrally oriented on local level planning on GBV and reproductive health and related areas, it was difficult for them to have a clear mandate of the issue and to internalize the LLP concept on their core programme[149]. Frequent transfer or changes of Govt officials was the constraint to approve and implement the LLP as new officials were not acquainted with LLP.

[145] Progress Report of WSC Cox's Bazar (from July to September, 2015 in Bangla), UNFPA (Implementing Partner, DWA)

[146] The WSC in Cox's Bazar is having tremendous effects on GBV survivors. Since 2008 till September, 2015 a total of 1025 women received legal supports (within shelter 444 and outside shelter 581); 882 given shelter (women 444 and children 438); with the legal support from WSC 48 women filed case in court of which 35 are resolved. A total of 767 cases resolved through *salish* (village court), Project Manager, WSC, Coxs'Bazar.

[147] Key informant interview, October 2015.

[148] Annual Progress Report2014 on 8th Country Programme, Gender Component, Output No. 5, UNFOA BCO, January 2015

[149] Key Informant interview, October 2015.

Evidence that the number of interventions that target men and boys with information regarding GBV and early marriage: As per the CP indicator it has been documented that in case of '% of makes aged 15-60 and females aged 15-49 is selected areas who are aware of the negative effects of violence against women' MoWCA reporting about 94% of male engagement and 82% of female engagement[150]. **Evidence that the number of interventions that target men and boys with information regarding GBV and early marriage:** As per the CP indicator it has been documented that in case of '% of makes aged 15-60 and females aged 15-49 is selected areas who are aware of the negative effects of violence against women' MoWCA reporting about 94% of male engagement and 82% of female engagement[151].			
A 4.2 Existing facilities/shelters (WSC, OCC, DH, UHC), medical, psychological and legal support, and training for Income Generating Activities (IGA) for survivors of gender-based violence in programme areas are strengthened to promote greater access and use. (CP Output 1)	• Number of functional facilities that provide services for survivors of GBV in selected areas (Output indicator for Output 2 - Baseline: 2; Target 4) • Number of GBV survivors who use the IGA facilities • Number of health facilities that provide screening and referral services for survivors of GBV (CP Output Indicators for Output 2 Baseline 3; Target 41) • Numbers of women reporting GBV at WHD, WSC, DH, and UHC. • Numbers of adolescents who use adolescent friendly SRHR/GBV services in project areas. (corresponding Project output 2) • The number of responses by police to reported incidences of GBV in targeted areas. • Numbers of women who report violence in the workplace to the VAW unit in the factory in the targeted factories	• AWPs and SPRs • Baseline data • SOP for the VAW cell • Standard Operating Procedure (SOP) for offering comprehensive support to SGBV survivors • Annual Progress Reports • SRHR and gender related training modules of the existing service package of BWCCI	• Document review • UNFPA CO staff key informant interviews • Key informant interviews with implementing partners, other UN bodies • Focus groups with beneficiaries • Field Visits
A 4.2 Evidence of functional facilities that provide services for survivors of GBV in selected areas: It is evident from the progress on Gender output 4 indicators (CP output 1) that the outputs were intended to be achieved through the project outputs of MoWCA (APWR) and MOHA (PEWR). One of the major parts of APWR project is related to WSC. The activities conducted in 2014 included capacity building of WSC staff, advocacy, social mobilization, review Standard Operating Procedure (SOP) for WSC operation, comprehensive			

[150] Annual Progress Report 2014 on 8th Country Programme, Gender Component, Output No. 5, UNFOA BCO, January 2015

[151] Annual Progress Report 2014 on 8th Country Programme, Gender Component, Output No. 5, UNFOA BCO, January 2015

technical support to WSC in 2 districts. The data presented in the Annual Progress Report 2014 on 8th Country Programme (prepared in January 2015) indicates that a total of 105 new survivors have been registered in the WSC (Cox's Bazar 78 with 69 children and Sylhet 27 with 29 children). Out of these 76 (Cox's Bazar 67 and Sylhet 9) have been resolved through arbitration by the WSCs. APWR project supported Dhaka WSC (supported by Government revenue budget) to incorporate a child corner.

Evidence of GBV survivors using the IGA facilities: Forty three GBV survivors have been involved in income generating activities in their locality with the support of Cox's Bazar WSC. Such initiatives helped them to reintegrate in the society. It is evident that all women GBV survivors are given skills training in making handicrafts, quilt by a regular trainers (as observed in Cox's Bazar). However, market linkage is limited.

Evidence of health facilities that provide screening and referral services for survivors of GBV: Number of functional facilities that provide services for GBV survivors have increased from 2 (in the baseline year 2012, DWA) to 7 by the end of 2014 with a target of having 11 of them[152]. In context of number of health facilities that provide screening and referrals services for survivors of GBV was 3 in the baseline year to DH: 31%, UHC: 20% (DWA baseline) in 2014 with an aim of increasing 355 and 25% chronologically.

Evidence of women reporting GBV at WHD, WSC, DH, and UHC: The current (2014) status of percentage of women has adequate knowledge on 'where to report' in case of GBV (DWA/MoWCA and MOHA) is for rural 60% and urban 40% (this is the baseline as there was no baseline data on it). The number of districts where functional referral mechanisms established between DWA officials at field level/WSC, health facilities and police for SGBV survivors (DWA & MOHA) has been remained the same as the target was only 4 (2 physical structure exist supported by UNFPA and other two districts service provided through establishing linkage of DWA with other GO-NGO stakeholders. there is no plan for increasing. All the WSC and DWA staff have received training on Standard Operating Procedures (SOP). Women Help Desks (WHD) have been established in all the selected districts as per standard guideline (MOHA) who are recording, reporting and investigating GBV cases. Targeted 15 WHD established in project areas. Though the SOP draft has been finalized in last June 2015, based on the basic information, all the 15 WHD is operating functionally[153].

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There is a 24/7 Help Line and 68 women were provided direct legal support through telephone. A total of 37 women were referred to Thana (Police station), Union Parishad, One Stop Crisis Centre and others out of 69 women requested for legal support. The rest were given shelter to WSC. Success stories of GBV survivors have been regularly published in newspapers[154]. All women are given skills training in making handicrafts, quilt by a regular trainers. However, market linkage is limited. Women in WSC do not get regular health checkup or support. An advocate was appointed with a monthly salary of 18,000 to 20,000. However, as evidence of false cases was found, WSC staffs call panel lawyers on contract basis when required[155].All women are given skills training in making handicrafts, quilts by a regular trainers. However, market linkage is limited. Women in WSC do not get regular

[152] UNFPA BCO Progarmme 2012-2016 M && E Framework aligned with the Strategic Plan, updated 15 December, 2014

[153] Quarterly Consolidated Report, 2nd Quarter, April-June, 2015, Gender Unit, UNFPA

[154] Progress Report of WSC Cox's Bazar (from July to September, 2015 in Bangla), UNFPA (Implementing Partner, DWA)

[155] The WSC in Cox's Bazar on GBV survivors. Since 2008 till September, 2015 a total of 1025 women received legal supports (within shelter 444 and outside shelter 581); 882 given shelter (women 444 and children 438); with the legal support from WSC 48 women filed case in court of which 35 are resolved. A total of 767 cases resolved through *salish* (village court), Project Manager, WSC, Coxs'Bazar.

health checkup or support. An advocate was appointed with a monthly salary of 18,000 to 20,000. However, as evidence of false cases was found, WSC staffs call panel lawyers on contract basis when required[156].

Evidence of number of adolescents using adolescent friendly SRHR/GBV services in project areas: Students networks have been formed in the districts and are functioning at Jamalpur and Sylhet (MOHA). Seventeen Police stations have sensitized a total of 943 students under 17 student networks in Jamalpur and Sylhet. Police are receiving information through text messages from the network members regarding the incident of GBV or child marriage. A total of 20 action plans have prepared by youth forums for July-December 2015 in Sylhet. Youth leaders and volunteers are working to prevent child marriage and SGBV at educational institutes and communities. They are working as change agents in the community. It has been reported that in Jamalpur total number of 290 Adolescent girls and 200 parents (especially mothers) improved their knowledge on the negative consequence of child marriage (DWA). Prior the conduction of awareness sessions at school for students, their knowledge level on GBV and child marriage was 34.39%. After the session, knowledge level improved to 54.94%. Knowledge level has been increased by 20.55%. Large number (206) of volunteers was selected from 30 academic institutes and 10 Youth Forum have been developed with the help of Police and academic institutes[157]. However, under the MOHA project evidence on increasing adolescents' knowledge in SRHR have not been found or recorded as it was focused only GBV and child marriage. It must be mentioned here that to enhance the capacity of Police on GBV and SRHR, the existing service training module revision is under process.

Evidence of responses by police to reported incidences of GBV in targeted areas: A total of 196 cases are reported in district WHD complaint 1, GD- 1, FiR-11, 2 cases were referred to medical facility and later to Police station. Counseling provided to 2 cases, 1 girl is settled with her husband at Jamalpur. All expressed that they are satisfied with service of police at Jamalpur.

Evidence of women reporting violence in the workplace to the VAW unit in the factory in the targeted factories: The BGMEA implemented project aimed on prevention of GBV at workplace, which is a paradigm shift from service delivery (project under 7th CP) to capacity development of implementing partners and workers. It aims to prevent GBV in garments factories, and enhance knowledge of the owners and factory workers on access to information and SRHR and GBV services. UNFPA is working with 40 selected garment factories in two of the biggest divisions, Dhaka and Chittagong, through BGMEA covering 125,000 workers (women 80% and men 20%). Among other activities Violence Against Women (VAW) cell in BGMEA, to implement the High Court Directives on anti-sexual harassment in workplace has been setup; a Standard Operational Procedures (SOP) for the VAW cell has been developed, regular gender audit of the garment factories to assess the gender congenial environment in the selected factories has been implemented[158]. Under the BGMEA intervention 80 awareness sessions were conducted at 40 factories, (32 in Dhaka and 8 in Chittagong) through which 4000 workers have been made aware SGBV and SRHR. All the targeted workers and officials in 40 factories improved their understanding about SGBV and SRHR. Sixty percent of the training recipients of 40 factories know the measures to be taken in case of GBV and SRHR. However, as it was mainly observed by the facilitators from verbal evaluation session, there was no formal pre and post test system for reporting of incidences[159]. Because of late start of implementation it is mentioned in the TPP that gender unit will implement in the last quarter or 2015 and first two quarters of 2016.

ANNEX: Gender Equality Programmatic area

[156] The WSC in Cox's Bazar effects on GBV survivors: Since 2008 till September, 2015 a total of 1025 women received legal supports (within shelter 444 and outside shelter 581); 882 given shelter (women 444 and children 438); with the legal support from WSC 48 women filed case in court of which 35 are resolved. A total of 767 cases resolved through *salish* (village court), Project Manager, WSC, Coxs'Bazar.

[157] Quarterly Consolidated Report (April-June, 2015), Gender Unit, UNFPA

[158] Nasreen, Mahbuba, Situation Analysis on Violence Against Women in Bangladesh, UNFPA, 2015

[159] Quarterly Consolidated Report (April-June, 2015), Gender Unit, UNFPA

Table 1: Number of activities to prevent Child marriage by UNFPA implementing partners[160]

Interventions	Achievements
Advancement and Promoting Women's Rights/APWR (DWA, MoWCA)	• Approximately 200 child marriages were prevented by the SPG in 4 target districts. In addition over 2000 religious leaders were oriented[161]. • 20 community dialogues have been conducted in 35 upazila • Total number of 1186 community people becomes aware about the negative consequence of GBV and child marriage • 13 networks have been established in the selected districts: Sylhet (4), Jamalpur (3), Coxsbazar (3), Patuakhali (3)[162]. • A total of 27 NGOs/CBOs/ Youth groups (Clubs)/Women's Associations in the network active for GBV and Child marriage prevention have been formed. • In Patuakhali district Jatiyo Mahila Shangstha is active for child marriage prevention, GBV prevention and women's empowerment. • SPG members and local administration prevented a total of 33 child marriages in Patuakhali-7(Dumki-3, Golachipa-4), Jamalpur-18, Sylhet-8 (South surma-4, Goainghat-3, companiganj-1). One SPG members rescued an abducted girl. One of the SPG members (in Companiganj Upazila) has taken the responsibility of educating a 14 year old school girl who was going to be a victim of child marriage.
Protection and Enforcement of Women Rights/PEWR (MoHA)	• There is no base line data on child marriage in any of the districts. However, 29 child marriages were prevented over the months of September to November in Jamalpur district[163]. • 18 Police stations have sensitized a total 943 under 17 students, and formed student networks in Jamalpur and Sylhet • 20 plans have been prepared by youth forums for July-December 2015 • Joint meetings were conducted in office of the Superintendent of Police in four districts, where 81 participants were from District Administration, Service providers of GBV/child marriage,

160 It must be mentioned here that due to unavailability of the cumulative data and number of session conducted in all quarterly reports data on the last Consolidated Quarterly Report (April-June, 2015) have been used in this section.

161 FGD with Gender Unit, UNFPA

162 In Jamalpur, Sylhet and Cox's bazar 4 networks are fully functional, and remaining needs further support, need to improve in coordination and reporting. Patuakhali networks require follow up meeting and motivation of UWA officer. Other networks' activities are under process. Network members made commitments to refer victims to GO/NGO facilities whenever required.

163Key Informant Interview in Jamalpur, October 2015

	MoWCA, NGOs, Civil Society, Civil Surgeon, District Ansar and VDP officer, Civil Society members, district Judge and Media • In Jamalpur total number of 290 Adolescent girls and 200 parents (especially mothers) improved their knowledge on the negative consequences of child marriage. • Approximately 824 Religious leaders were sensitized (Imam, Marriage register, Purahit, district register on child marraige issues and they are committed to arrange anti child marriage campaign in their respective Upazila. • A young educated marriage register of Fenchuganj Upazila started campaign to increase awareness on child marriage by own initiative after participating in the workshop. • Islampur upazilla parishad of Jamalpur has planned to utilize the union parishad budget for anti-child marriage campaign, as an outcome of kaji and imam sensitization training. • Seven school-based Student/Youth Networks, with 30 students (taking 6 students from each class) in each network, has been formed in Jamalpur. Five networks have both boys and girls, 2 are solely boys' network. They are mainly engaged in class monitoring for Child Marriage Prevention and baseline data (number of students, any of them are married, plan to reduce child marriage etc.) for each class data collection have been completed by June, 2015. • In 2016 January, they will reassess on the progress of their efforts along with police to share the progress they have made. • Jamalpur Sadar Upazila is completely free of child marriage and they have declared that the whole district will be a child marriage free district soon. In Jamalpur UNFPA intervention is the first initiative to prevent child marriage. • SP of Jamalpur proactively distributed 8000 copies of an appealing letter to prevent child marriage and prepared number of volunteers as "change makers" to motivate community members. Each village "child marriage prevention committee" has been established spontaneously. • From the follow up result it has been reported that as of September, 2015 Qazis did not agree to registrar 47 child marriages and convinced parents not to arrange these marriages[164].	
The Generation Breakthrough	• Directorate of secondary and Higher Education (DSHE) is working at school level to raise awareness on Child Marriage issues. Partner of UNFPA Plan International through CWFD is working closely in RHRand child marriage issues • Union parishad and BRAC are working to mobilize rural community by improving their knowledge	

164Key Informant Interviews with the Superintended of Police/SP, Jamalpur, October 2015

Table 2: Services provided to the GBV survivors by WSC (January165, 2015 and April-June, 2015)166

Services provided by WSC	Coxs'Bazar	Sylhet
Women and children registered & received shelter support (old and new cases)	January, 2015: 78 women and 69 children April 2015 to June, 2015 (2nd quarter of the project): 18 new cases, and 24 children	January, 2015: 27 women and 29 children April 2015 to June, 2015: 5 new cases and 8 children received shelter supports
Cases solved through 24/7 helpline support	84	-
Cases resolved through arbitration	18	5

Table 3: Services provided to the GBV survivors by Coxs' Bazar WSC (July 2015-Septemeber 2015)167

Services provided by WSC	Over a Quarter
Women and children registered & received shelter support (new cases)	32
Cases solved through 24/7 helpline support (outside WSC)	68168
Cases resolved through arbitration	29
Food support	77 (New 19+19 children; old 18+21 children)
Psychological support	32 (within shelter 19 & outside 13)

165 Annual Progress Report 2014 on 8th CP , Gender Equality Unit, Output 4, UNFPA BCO, January, 2015

166 Consolidated Quarterly Report (April-June, 2015), UNFPA

167 Progress Report of WSC Cox's Bazar (from July to September, 2015)

168 Within WSC19 and outside 10 and 2 years as well as imprisonment for 1 perpetrator

Legal support	32 (within shelter 19 & outside 13 and 13 cases in court)
Medical support	77 (new 19+19 children; old 18+21 children)
Vocational training	37 women (new 19+old 18)
Non-formal education	39 (new 19+ 18+ 02 children)
Security	2 Superintendent and 3 Security (for 24 hours)
Follow up visit	29 cases
Referral to Police station, Union Parishad, OCC	37

Table 4: Awareness of adult male and female and boys on GBV and relevant issues (Implemented by DWA, MoWCA; MOHA, BGMEA, BWCCI)

CP indicators	Baseline (2012)	Current status (end of 2014)	Target (end of 2016)
'% of men aged 15-60 and females aged 15-49 is selected areas who are aware of the negative effects of violence against women' (DWA)	0	Male: 94% Female: 82%	Male 95% Female: 85%
'% of males aged 10-60 and female aged 10-49 in selected areas who agree that a husband is justified in beating his wife for at least one reason' (DWA)	0	Male: 5% Female: 1%	Male: 2% Female: 1%
Number of NGOs/CBOs/youth groups (clubs/women's associations in the network active for GBV and child marriage prevention (DWA)	0	20%	25%
Number of district and Upazila GBV plans developed with focus on multisectoral involvement (DWA)	0	39%	39%
Percentage of workers (M/F) and officials who received	0	0	Baseline data collected and

training/participated in the workshops on GBV and RHR& R related issues and improved their understanding about those issues (BGMEA)			training started
Percentage of project participants who have knowledge about legal age of marriage and the risk of early pregnancy (BWCCI)	63%	80%	90%

Source: Annual Progress Report 2014 on 8th CP , Gender Equality Programmatic area , Output 5, UNFPA BCO, January, 2015

Table 5: Adolescent friendly RHR/GBV services in project areas[169]

Activities	Number
Student Networks Jamalpur and Sylhet	17
Action plans have prepared by youth forums for July-December 2015 in Sylhet	20
Number of adolescents improved their knowledge on negative consequences of child marriage in Jamalpur	290
Parents (especially mothers) improved their knowledge on the negative consequences of child marriage	200
Prior the conduction of awareness sessions at school for students, their knowledge level on GBV and child marriage was	34.39%
After the session, knowledge level has improved	54.94% (knowledge level has been increased by 20.55%)
Number of volunteers selected	206 (from 30 academic institutes)
Number of Youth Forum developed	10

169 Quarterly Consolidated Report (April-June, 2015), Gender Unit, UNFPA

A.4.3 UNFPA has contributed to the establishment of mechanisms to ensure ownership and the sustainability of effects.	• Dedication of budget lines to Gender Equality in national budgets. • Evidence of leadership in planning and implementation of projects and programmes to promote ICPD objectives • Existence of exit strategies with government partners that illustrate hand over of activities	• Surveys, workshop proceedings • National ministries budget information	• Document analysis • Interviews with UNFPA CO staff • Interviews with implementing partners • Interviews/Focus groups with beneficiaries Document review • Visit to target upazilas

A 4.3 Evidence of dedication of budget lines to Gender Equality in national budgets: In the context of United Nations reform and "One United Nations", UNFPA is currently co-chair of the United Nations Inter-Agency Task Force on the follow-up to the 2006 Secretary-General's In Depth Study on Violence Against Women. UNFPA supports the Coordinator of the Task Force and is devoting resources to joint programming efforts in 10 selected pilot countries, one of which is Bangladesh[170]. The Country Programme strategy emphasized that gender perspective to be introduced in the plans, budgets, circulars and other areas submitted to the BCO. Progress has been made in terms of incorporation of gender equality perspective into local budgets. Gender equality issues have been taken, directly and indirectly as across cutting issues in the UNFPA interventions across all components.

The Government introduced the Medium Term Budget Framework (MTBF) in 2008 for attaining public financial management reform objectives and ensuring increased efficiency in the use of public money. In 2009 the Ministry of Finance initiated use of the Recurrent, Capital, Gender and Poverty (RCGP) model for analysis with scope for multi-year planning. All expenditure items under different ministries were disaggregated to indicate the percentage of allocation benefiting women and also addressing poverty. A Gender Responsive Budgeting (GRB) with fourteen criteria of performance on women's advancement and gender equality was introduced, which provided an essential element of promoting gender equality. The Ministries are to provide estimates of budget allocation for gender equality and poverty related activities within the sectoral policy. The resource allocation for gender is to be aligned with the identified priority areas by the ministries and to be consistent with actions based on 14 set criteria. The approach continued during the SFYP and all the Ministries have been covered by GRB. Since 2009, the Government has started reporting on the progress of gender responsive budget. The ECNEC in collaboration with MOWCA has issued guidelines for Gender Responsive Planning and Review, guiding on how to address gender in technical assistance and investment project documents[171].

Evidence of leadership in planning and implementation of projects and programmes to promote ICPD objectives: Bangladesh is one of the 179 member states who signed the 20-year Programme of Action on Population and Development adopted during the United Nations International Conference on Population and Development held in Cairo during 5-13 September 1994 and known as ICPD-PoA. Many of the population and development goals identified in the ICPD-PoA were then incorporated into the UN Millennium Development Goals (MDGs). In order to follow-up and pursue the post 2014 ICPD agenda at the country level, the General Economic Division (GED) of the Planning Commission has decided to

[170] UNFPA Strategy and Framework for Action to Addressing Gender based Violence, 2008-2011, Gender, Human Rights and Culture Branch, UNFPA Technical Division

[171] UNFPA Strategy and Framework for Action to Addressing Gender based Violence, 2008-2011, Gender, Human Rights and Culture Branch, UNFPA Technical Division

carry out a comprehensive review to document the key actions and the progress made so far on the implementation of key elements of the PoA; identify the facilitating factors, gaps and constraints limiting implementation, the unfinished agendas and other emerging issues that require future attention[172]. The interventions of Gender Components have also been designed in order to support ICPD agenda.

Existence of exit strategies with government partners that illustrate hand over of activities: The mechanisms developed through the interventions of Gender components were developed from sustainability perspective. Therefore, UNFPA works within government system. The major advantage of having government as implementing partner is that programmes or project interventions become integral part of the country's own initiative. For example, WSC (DWA) of Dhaka and Sylhet have been absorbed in revenue budget (in Sylhet UNFPA is providing only TA support. Employees are also expecitng to be absorbed under the revenue); development of GEMS diary (DSHE) has been approved by the MoE and NCTB (National Curriculum and Text Book Board).

EQ5. Efficiency - To what extent has the UNFPA Bangladesh CO made good use of its human, financial and technical resources to pursue the achievement of the outcomes and outputs defined in the CP?

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
A 5.1 Beneficiaries of UNFPA support received the resources that were planned, to the level foreseen, and in a timely manner	• The planned inputs and resources were received as set out in the AWPs and agreements with partners • The resources were received in a timely manner according to project time lines and plans, or plans adjusted accordingly • Inefficiencies were corrected as soon as possible	• Annual reports from partner Ministries, and implementing partners • Audit reports and monitoring reports • UNFPA (including finance/administrative departments) • UNFPA project documentation, COARS • Partners (implementers and direct beneficiaries)	• Interviews with ministry level/secretariat general-level staff to review the coordination and complementarity features of implementation • Review of financial documents • Interviews with UNFPA and IP administrative and financial staff. • FGDs with beneficiaries of funding (including NGOs)

✓ **Planned inputs received as set out in AWPs and agreements with partners:**

The gap between committed foreign aid and disbursement has been considerable in the last few years. This gap has widened due to the country's inability to utilize the funds effectively and efficiently. The reasons include delays due to donors' complicated disbursement procedures, problems in tender processes and delays in consent by development

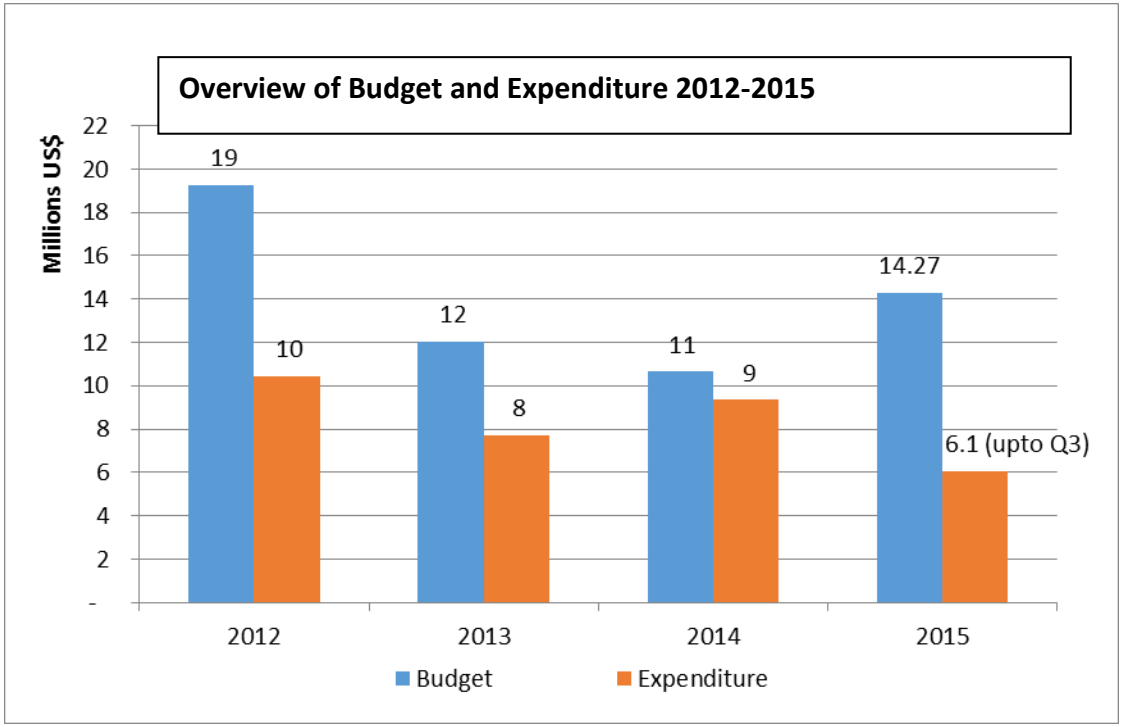
[172] Terms of Reference for Consultancy Services to produce the Bangladesh ICPD 1994-2014 country report, UNFPA

partners; delays in employment of consultants; delays in starting project implementation; lack of coordination among the co-financers; absence of practical work plans; complexities in land acquisition; and revision of detailed project plans (DPP).[173]

In regard to the 8th CP, significant delays in approval of programs by the government caused delays in implementation:

Generally across the programmatic areas, the **timeliness of delivery of inputs** compared to plans has been affected by delays in the approval of the Technical Program Plan (TPP) by the government at the onset of the CP. Some interventions were slowed or delayed for long periods of time, particularly in 2012, as indicated by the dearth of SPRs or lack of substantial progress information in them. The following chart on disbursement of funds for the CP indicates a lag in expenditures relative to the budget. The first compiled SPRs for RH were produced in 2013.

Overview of Budget and Expenditure 2012-2015 in US$ Millions[174]



In 2014, DFID published **"The DFID - UNFPA Portfolio Delivery Review (PDR), 6 May 2014"** [175] a summary of annual reviews of all of its programs against the logframes, the MNHI

[173] Changing Foreign Assistance Scenario in Bangladesh, Keystone Quarterly Review 2014

[174] UNFPA Bangladesh Country Office, 2015

received a grade of B, "Outputs and outcomes moderately did not meet expectation" out of a possible A++, A+, A, B and C, with the MHNI falling into the 35% of rating. "In Bangladesh, the lack of an appropriate M&E framework and weak impact assessment methodology meant the project was unable to demonstrate measurable changes in the availability of healthcare. This was flagged to UNFPA in 2010, but staff capacity issues within UNFPA meant M&E capacity was not contracted-in until 2011. In Bangladesh, the focus was on delivery inputs and processes rather than results, analysing available data emerging from the project and deriving lessons for policy dialogue with Government and its health partners.

In Bangladesh, the project underspent considerably (£3m on a total budget of £11m) because of delays to the planned start date and unrealistic budgeting. In Bangladesh, staff capacity issue in the UNFPA country office meant there was a delay in securing the necessary M&E expertise required for the programme. In Bangladesh, the assessment made at design stage of the time and effort it would take to introduce the changes necessary given the constraints that existed within existing health systems was judged to be unrealistic. In reality, Phase 1 took 42 months instead of the planned 18 months. In Bangladesh, the individual mandates, administrative systems and the need to refer decisions for relatively minor budget changes back to HQs for the three UN agencies working together affected planned implementation and caused delays to joint implementation.

Delays due to political events: Breaks in continuity of interventions due to episodes of political unrest including frequent hartals, one lasting three months in early 2015.

UNFPA also experienced human resources shortages, internal reorganization and funding issues:

- Staffing shortages and reorganization in the CO particularly during 2012 and 2013 and a Human Resources realignment into 2015
- Funding cuts of UNFPA core funds in 2013-2014.

It was not a seamless transition from 7th CP to 8th CP, because of lengthy TPP approval process. The GED project for instance had to start their project in 2013, while the real project start-up was supposed to be in 2012. In case of the Census project, the TPP changed/modified frequently delayed project activities. Representative from one of the major donor of the project agreed with this. The European donor which supports a big part of the Census project, pointed out that requested budget modification from the partner contained incorrect information, and as a result the process of approval from their home office required more time than expected.

There were significant delays not only in the signing of the annual work plans (AWPs), but also receiving accurate FACE forms on time, disbursement from the UNFPA has had a cascade effect along with the disbursement systems of DGHS and DGFP differing and the frequent turnover of not only GOB, but also UNFPA project staff. [176]

RH Compiled SPR 2014: Staff shortage/turnover/transfer- Frequent turnover of service providers at district and upazilla level hamper the 24/7 RH services

- Lack of supervision from different levels to the service center and community level
- Financial reporting
- Delay in fund disbursement to districts
- Delay in procurement (Delivery kits and NSV kits)
- Delay in implementing ICT4RH project
- Lack of coordination between health and family planning wing at upazilla and district level

[175] The DFID - UNFPA Portfolio Delivery Review (PDR), 6 May 2014, The Department for International Development United Nations and Commonwealth Dept, Abercrombie House, East Kilbride, Glasgow, G75 8EA, UK

[176] **RH Compiled SPR 2013**

- Week BCC activities on long acting family planning methods and EmOC services
- Retention of trained service providers
- Dis-continuation of contracted Partner NGOs in URBAN project
- Distance from the referral facility and availability of surgical team on 24/7 basis at the referral site in Refugee camps.
- Sometime implementation delayed due to busy schedule of local level and national level government officials
- Organizing IEC Technical committee meeting also takes time due to busy schedule of the officials of MOHFW

✓ **Timeliness of resources received and adjustment of plans:**

The CO with Implementing Partners continually adjusted their plans since 2012. Key Informants indicate some degree of acceptance and perceived normality of delays in implementing programmes in Bangladesh. Almost all the PD projects pointed out that they will receive less fund in local currency compared to what has been committed by UNFPA; this is because of change in exchange rate as the Bangladesh currency was going stronger compared to the foreign currency. One of the partners (SEID) mentioned that they will cut a training batch because of shortfall of fund, while another (GIS) mentioned that they will arrange for government fund to complete their planed training agenda.

Corrections of inefficiencies: UNFPA has at this point in the CP considerably strengthened its human resources base and alignment of duties.[177] However, some staff shortages are apparent to stakeholders such as in the district office at Cox's Bazaar where there are a number of strategic coordination duties to manage programme interventions.[178] In 2012, the CO developed a recruitment strategy but the restructuring of staff did not anticipate the time needed to attract new staff members. In 2014, it was determined that a full time Humanitarian Officer was needed and one was hired at the end of 2015.

Funds were not disbursed until the 3rd quarter of 2012 and the AWPs were adjusted. Almost all the inputs under the Gender component were received and resources were made available. However, LLPs under the DWA implemented APWR projects are yet to be translated into reality. Most of the projects started almost a year later due to political disturbances in the country, which has taken longer time for commencement. However, in some cases access to resources were delayed due to less prompt administrative decision making roles. For example, GEMS diary has not yet been published and waiting for wide circulation. Although the adolescents clubs have been established in intervention districts, they do not have specific activities to perform. Fund disbursement is also less prompt in some cases.

Evidence that inefficiencies were corrected as soon as possible: (COARS and Quarterly reports, 2015) In 2013 the country office has taken initiative to improve the monitoring of the country programme by developed a monitoring framework based the CP RRF and including baseline and targets for all indicators including identification of activities and milestone for qualitative indicators. Country office also has organized training on RBM for all staff members as most of the staff members are new and do not have adequate understanding on RBM and M&E. The training was facilitated by the senior programme officer (M&E). CO was intensively involved with UNDAF monitoring system and made the CP monitoring system synchronised with UNDAF. UNDAF Monitoring framework has been developed using DI-Monitoring including Financial monitoring system. The CP outputs have been divided in to several sub outputs with process indicators in order to monitor regular progress of activities. This has been included in the CP monitoring framework. The IPs have included all necessary indicators in the AWPs and WPMT for regular monitoring. The CO has also developed a web portal for monitoring, reporting and exchange of information, which facilities monitoring of individual projects.[179]

[177] Office Management Reports, 2012, 2013, 2014, 2015 Annual Planning, Bangladesh

[178] Key Informant Interviews, October 2015

[179] Country Office Annual Report, 2012, 2103.

In 2014, the majority of the staff and partners were trained on Results Based Management. [180] UNFPA Country Programme (2012- 2016) has 17 output indicators to report. In 2014, 16 of them were due reporting, and the Country Office was able to report against all these 16 indicators. [181]

Quarterly Consolidated Progress Reports, 2015: This report tracks total expenditures and implementation rates and rates progress as good, moderate or poor. The reports also mention the performance of IPs in delivering interventions and in using funds.

A 5.2 UNFPA was successful in using its resources to leverage other resources to meet the CP objectives	• Evidence that the resources provided by UNFPA triggered the provision of additional resources from the government at national and sub-national levels and from communities • Evidence that the resources provided by UNFPA triggered the provision of additional resources from other partners, including regional partners • Agreements called for contributions from partners and these were honored.	• UNFPA staff (including finance/administrative departments) • Partners (implementers and direct beneficiaries) • Annual reports from partner Ministries, and implementing partners, audit reports and monitoring reports	• Review of reports • Interviews with ministry level/secretariat general-level staff • Review of financial documents at the UNFPA and interviews with administrative and financial staff. • Key informant interviews with UN partners, regional actors

Office Management Plans, 2012, and 2013: Key Result 1 and contribution to UNFPA priorities: Effective resource mobilisation Contribution: *UNFPA developed the resource mobilizations plan for the 8th country programme and submitted to APRO and HQs. Based on the plan UNFPA strive to mobilize additional resources to supplement an compliment the country programme. UNFPA has Mobilized additional US$ 20 million from CIDA for MNH programme and recently mobilized another US$ 6.5 million from the Netherlands for implementing an ASRH project linked with GBV. Project has been designed and approved by the Netherlands embassy and now awaiting approval from Government Ministries i.e. Ministry of Women and Children Affairs and Ministry of Education. National NGOs will be also partner in implementing this project.*

The following evidence indicates that the government and communities provided additional resources:

There are examples of provision of additional resources:

- The project Generation Breakthrough has inspired community resources.
- PD partner (GIS) mentioned that they will arrange for government fund to complete their planed training agenda.

- **Evidence that the resources provided by UNFPA triggered the provision of additional resources from the government at national and sub-national levels and from communities**

[180] Office Management Plan, Mid-term review 2014

[181] UNFPA Bangladesh Annual Report, 2014.

EU and UNFPA have similarity in their logframe, as such EU decided to fund UNFPA's BBS project (both census and GIS). In 2009-10 negotiation took place between the two organizations that convinced EU to take decision to fund the projects.

- **Agreements called for contributions from partners and these were honored:**

UNFPA Annual Report 2014: Those education sites for midwifery training which were supposed to be funded by the Government remained unfunded and therefore did not operate in 2014. Faculty including lecturers and clinical instructors are severely understaffed.

To ensure 24/7 EmONC services as per Prime Minister's commitment, availability of human resources especially skilled staff is still a big challenge.

Quarterly Consolidated Progress Reports, 2015: This quarterly report tracks total expenditures and implementation rates and rates progress as good, moderate or poor. The reports also mention the performance of IPs in delivering interventions, providing their contributions to interventions and in using funds. The reports mention lapses in program implementation, overall the IPs if they had poor ratings, achieved a better rating the next time.

A 5.3 Administrative and financial procedures and requirements as well as the mix of implementation modalities promoted an integrated approach and facilitated a smooth execution of the programme	• Appropriateness of the UNFPA administrative and financial procedures for the implementation of agreed interventions • Appropriateness of the IP selection criteria • Appropriateness of the mix of implementation modalities to promote an integrated approach	• UNFPA staff (including finance/administrative departments) • Implementing Partners • Annual reports from partner Ministries, and implementing partners, audit reports and monitoring reports • Sub-national staff and beneficiaries	• Interviews with high level and management level staff • Review of financial documents at the UNFPA and interviews with administrative and financial staff. • Beneficiaries of funding (including NGOs)

- ✓ **Administrative and financial procedures for implementation of agreed interventions:**

In 2013 NEX audit was completed and uploaded in NEXAMS. The CO has undergone an internal management audit in 2015 and this report should be available soon. [182]

Guidelines for transferring funds to Government Implementing Partners (GIP) are necessary in the light of the proposed Harmonized Approach to Cash Transfer (HACT) by UN Agencies specifically UNDP, UNICEF, WFP and UNFPA. The new procedure (HACT) for transferring cash to Government Implementing Partners simplifies and harmonizes the procedures and reduces the high transaction burden on the institutions as they do not have to respond to different requirements of UN Agencies. (2010)

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The Policy Procedures for Programme and Financial Monitoring and Reporting policy outlines the programmatic and financial workplan-related and high-level monitoring and reporting processes which must be undertaken on all programmes supported by UNFPA. Its aim is to ensures that UNFPA offices develop and use quality and results-based progress

[182] Key Informant Interview, October, 2015

information to manage the implementation of UNFPA-funded programmes and interventions. It includes information on the workplan progress report, Funding Authorization and Certificate of Expenditure (FACE) forms, annual review meetings, annual reporting and progress reporting on co-financing. - See more at: http://www.unfpa.org/admin-resource/programme-and-financial-monitoring-and-reporting-0#sthash.GbOnIyiG.dpuf

The effective development of the AWP is an issue plaguing country programmes. An analysis of the AWPs indicates the following issues, overlaps and duplications in the RH and Humanitarian programmatic area: a) the Outcomes and Outputs are not clearly referenced (as per number sequence and where they emanated from) in earlier AWPs; b) AWPS from U201 are combined in some cases with U202 - including U201/202 AWP for Urban Primary Health Care Services Delivery Project (UPHCSDP); c) There are several different project titles with same code of U201, including with - RTM International (humanitarian); - ICDDRB - U201/202 AWP for Urban Primary Health Care Services Delivery Project (UPHCSDP) - ICT4RH with Care Bangladesh; d) the follow-on interventions from R201, Joint Project, are part of U201 starting in 2013; d) Humanitarian U203 is also combined with U201 and U202. Further, there are no SPRs from 2012, and some from 2013 do not contain substantive information (e.g. Care 2012-2013) while some are missing altogether, likely due to delays in program start-ups and continuity.

- ✓ **IP selection criteria: CARE selection example:** A rigorous process is undertaken to select IPs

Methodology of the capacity assessment: The UNFPA Implementing Partner Capacity Assessment Tool (IPCAT) designed by UNFPA HQs was used for physical assessment of CARE. It has nine dimensions: 1) Governance and Leadership; 2) Human Resources; 3) Programme; 4) Monitoring and Evaluation; 5) Financial Management; 6) Procurement Systems; 7) Comparative Advantage; 8) Knowledge Management; and 9) Partnerships. Each of the dimensions carries a weight, which is used to calculate the final assessment score (weights are shown on each assessment sheet). Each of the dimensions has number of checklist/questions. Senior officials from respective sections of CARE were contacted for an interview and also various documents as per requirement were reviewed.[183]

On the other hand, in some cases such as for Family Planning, IPs are too numerous and difficult to coordinate. The reduction of the IPs (there are 17 or 18 ministries that are partners) may allow the IPs to monitor effectively. UNFPA is not selective enough on the IPs.[184]

- ✓ **Mix of implementation modalities to promote an integrated approach:**

UNFPA has employed a range of tools and resources to promote programme objectives. These included:

- Technical assistance and expertise in all the areas related to the programme using local and external consultants and experts, as well as some resources of the UNFPA regional and global programmes;
- Behavior change communications, multi-media and public events to promote key messages and create awareness of issues.
- Assessment, studies and research on topics that were key pressing issues in development which then served to guide follow-on actions by UNFPA and other stakeholders
- Capacity development through facilitation of education programmes, training activities
- Support for recruitment of project personnel in accordance with the annual work plans
- Support to procurement of goods, supplies and equipment, research and studies, consultancies and services for the programme needs, at request of the implementing partners in

[183] ICT4RH Implementing Partner NGO, Final Recommendations from Selection Committee, March 2013

[184] Key informant interviews, October 2015

accordance with UNFPA regulations, rules, policies and procedures

- Support to minor renovations of key facilities that provide reproductive health services
- Administrative, operational, and technical support by the CO to the implementing partners to carry out planning, implementation and monitoring.

Communications strategy: The COAR 2013 and the Office Management Plan 2014 Mid-year Review mentions the development of a communications strategy "*CO Communication and advocacy strategy/action plan has been drafted. This will be finalised after sharing with relevant staff".*

EQ6. Coordination - To what extent has the UNFPA Bangladesh CO contributed to the functioning and consolidation of UNCT coordination mechanisms?			
A 6.1 The UNFPA Bangladesh country office has actively contributed to UNCT working groups and joint initiatives.	• Evidence of active participation in UN working groups • Evidence of the leading role played by UNFPA in the working groups and/or joint initiatives corresponding to its mandate areas • Evidence of exchanges of information between UN agencies • Evidence of joint programming initiatives (planning) • Evidence of joint implementation of programmes	• Minutes of UNCT working groups • Programming documents regarding UNCT joint initiatives • Monitoring/evaluation reports of joint programmes and projects	• Documentary analysis • Interviews with UNFPA CO staff • Interview with the UNRC • Interviews with other UN agencies

The Country Programme Outputs undertaken between 2012 and 2016 are meant to contribute to three UNDAF Outcomes of **Pillar Three**: Social Services for Human Development

Outcome 1 – *Deprived populations in selected areas, particularly women, children and youth benefit from increased and more equitable utilization of quality health and population, education, water, sanitation and HIV services.*
Outcome 2 – *Children, women and youth demand and benefit from effective social protection policies and improved services aimed at eliminating abuse, neglect, exploitation, and trafficking.*
Outcome 3 – *Deprived community members in selected areas practice key life-saving, care and protective behaviors and raise their demand for quality social services.*

Outputs also contribute to **Pillar Five**: Climate Change, Environment, Disaster Risk Reduction and Response; **Pillar Six:** Pro-Poor Urban Development, and **Pillar 7:** Gender Equity and Women's Advancement, where UNFPA has a major contribution.

- ✓ **Evidence of active participation in UN working groups:**

The structure of the UNCT corresponds to the UNDAF. There is a Local Consultative Group between government and heads of agencies, 60 agencies, and co-chaired by ERD. Under that are 18 working groups.

UNFPA is a participant in a number of working groups led by the UN and/or government. These include:

- UNFPA was leading the Gender Equity and Women's Advancement Pillar 7 from the beginning of 2013 (ended in 2013) and now co-leading with UNWOMEN and lead of outcome

7.2. (The UN working group on pillar 7 organized meetings on a regular basis. The main purpose of the meeting was to set priorities for Pillar 7's work in 2015 (what to focus on, what can we work on together and how we want to do it). The working group noted that in 2015 there are some "non-negotiables " or work that Pillar 7 has to do , but there are also opportunities to be explored for the group to work together on policy priorities identified in 2014[185]. Six organizations participated in the meeting: UNESCO, UNDP, UNFPA, UN AIDS, IOM and UNWOMEN)

- Regularly attended in the UNDAF M&E group meetings. Attended Pillar 7 (1) and LCG WAGE Meeting (1), participated national review of Beijing+20 review (gender equality) hosted one review meeting on women & health under Beijing +20 review.[186]
- It was UNFPA's idea to form the adolescent and youth advisory group, it has diversified to become a larger group and includes government and others. There are already the fruits of this, survey work on child marriage.
- Harmonized approach to cash transfers, HACT, UNFPA participating.
- UNFPA will take a leading role in the health cluster which is a good opportunity to participate in an emergency/disaster assessment and respond. (UNICEF is the lead for 4 clusters, child protection, education, nutrition, and WASH.)
- UNFPA is an active member of the Development Partners Consortium that supports the national Health Population and Nutrition Sector Development Program.

✓ **Leading role played by UNFPA in the working groups or joint initiatives:**

Examples of UNFPA leadership are numerous, some examples are:

- UNFPA leadership is seen to be supportive of the UN Delivering as One, the UNFPA Representative acted as RC in February 2015.
- UNFPA advocated for increased investments in health sector, including for adolescents and youth, especially in the context of the 7th Five Year Plan that is under formulation.
- UNFPA co-chaired the Humanitarian Country Task Team (HCTT), the disaster management group has a wide membership including NGOs and government.

Key challenges in UNFPA leadership and active participation in UN Working Groups[187]:

- There is a climate of strong competition among the donor and UN community in regard to setting the agenda in meetings and in the development directions, some actors are very dominating. One reason is the diminishing ODA that is coming the way of Bangladesh due to its emerging higher economic status.
- The UN brand is very powerful and is undersold, because of the project orientation.
- The UN does not always appear coordinated among its members and since it is not playing as large a role as in the past, the importance of the UN speaking with one voice takes on greater importance

[185] UNDAF Pillar 7 Workplan, 22 April, 2015, UN Women Conference Room

[186] Office Management Plan, Mid-term review 2014

[187] Key Informant interviews, October 2015.

- The group of UN people representing their organizations make an impression on how the UN is viewed by others, are they aggressive and convincing, do they argue among themselves?
- The UN has to advocate for the development/humanitarian perspective and it requires strong voices to be heard.
- Overall there are too many groups, UNCT goes by results, but there is little cross fertilization, coordination.
- UNFPA was less visible three years ago in the UN groups, possibly due to human resources shortages in the CO, but is much better in the last 1.5 years
- In 2012 UNWomen came in as a resident UN organization, and there was a paradigm shift in the vision and leadership of the Gender Equity and Women's Advancement pillar and theme, there is partnership but also some issues with mandate interpretation.
- Agencies need to respect each other's capacities.

✓ **Evidence of exchanges of information between UN agencies:**

- The UNCT and the Pillar meetings offer venues for information exchange. In the Pillar 7 meeting held on 22 April, 2015 the group has decided that they will play role within the mandate of pillar 7 of UNDAF: information sharing; providing technical feedback; coordinating to avoid duplication in action and focus individual efforts in a way that adds to overall outcomes; effective engagement with external partners; membership allows for pooling existing resources and working deeper on an issue; the group also encourages breaking out of silos and leveraging the comparative advantage of all agencies combined. There is a large agency representation and participation, which is a value add in itself. For example, it has been discussed in the meeting that Pillar 7 is a platform for Information sharing and decision was taken to 'Devise a common roadmap for substantive coordination a joint strategy for Ending VAW with actionable steps'. Discussion to develop joint road map to be convened by sub group -UN Women, UNDP, UNFPA, UN AIDS, IOM.

- In our visit to the UNHCR office in Cox's Bazar that in the district coordination meeting in September, UNHCR informed the local DC that they don't know what is in UNFPA partner RTMI budget; while they know what is in the budget of other organizations working in the Rohinga refugee camps. UNHCR also did not share their budget document with UNFPA.

✓ **Evidence of joint implementation of programmes:**

- **The Ministry of Health and Family Welfare, UNFPA, UNICEF and WHO through the MNHI Joint Program:** The three UN agencies have taken the bold and challenging step of implementing a project together, for the first time in Bangladesh, and they have in the process enabled improved working relationships between DGHS and DGFP in districts, unions, upazilas and community clinics;

- **The Ministry of Disaster Management, UNFPA, NGOs, and UNHCR:** The case of UNFPA working together at the Rohinga refugee camps in Cox's Bazar is a unique example to joint implementation programme with another UN agency.

- **UNFPA and UNICEF are uniting to stop child marriage.** As a result of advocacy efforts by UNFPA, along with UNICEF and DfID, the Prime Minister made a pledge in July 2014 during the Girls Summit to eradicate child marriage under 18 by 2041, and child marriage below 15 by 2021. UNFPA, together with UNICEF, is currently supporting the

Government of Bangladesh to develop a National Framework and a five-year costed action plan to end Child Marriage, in response to the Prime Minister's pledge.[188] The costing is developed with the exclusive support from UNFPA

Key challenges in joint implementation of programmes:

The Joint Programme on Reduction of Violence against Women (MDG Spain fund), which was concluded in 2013. However, the group identified that there is not enough data to evaluate the *Effectiveness* or UN's contribution towards the results. The focus of the evaluation will be on *Efficiency* – how have our systems and practices worked together to achieve the results. It will look at the Pillar as a structure to strengthen the ability to work together. The evaluation will summarize the findings and information that come out of the evaluations and reviews sent from individual agencies[189].

MNHI – The **Initial Monitoring Mission, Joint Government of Bangladesh – United Nations Maternal and Neonatal Health Initiative (MNHI)**[190] July 2015, report found the following **Results:** The project is progressing towards intermediate outcomes, as measured by MNCH service volume, a reasonable proxy. Comparison of baseline and endline data from the first phase indicate that the project's approaches improve key MNCH indices over and above national progress and increase equity. However, there is no definitive data regarding the current phase in which the project scaled up to eleven from four districts with less funding.

1. **Insufficient joint actions to address urgent issues** - There are nine entities working on GBV. There are some urgent calls to action such as for **response to GBV** which require building upon the body of evidence that says that 87% of women in Bangladesh are in danger; there is no data to say that women who work are exposed to less violence. There is insufficient analysis of why the violence takes place, and there are not enough mitigation measures to make domestic violence more difficult.

A 6.2 The UNFPA country office has contributed to avoid overlaps and promote synergies among the interventions of the UNCT.	• Nature of the contribution of UNFPA to the elaboration of the UNDAF • Extent to which the UNDAF reflects the priorities and mandate of UNFPA in Bangladesh • Evidence of overlaps and/or absence of overlaps between UNFPA interventions and those of other UNCT members • Evidence that synergies have been actively sought in the implementation of the respective programmes of UNCT members	• UNDAF • CP Documents • UNCT • UNFPA Country Office • Monitoring/Evaluation reports of joint programmes and projects	• Documentary analysis • Interviews with UNFPA CO staff • Interview with the UNRC • Interviews with other UN agencies • Interviews with implementing partners

Preliminary findings from the Evaluation Of The 2012-2016 UNDAF For Bangladesh: [191]

[188] UNFPA Bangladesh Annual Report, 2014

[189] UNDAF Pillar 7 Workplan, 22 April, 2015, UN Women Conference Room

[190] Initial Monitoring Mission, Joint Government of Bangladesh – United Nations Maternal and Neonatal Health Initiative (MNHI) Project Number: A-035190, July 2015 Submitted To: Bangladesh Program Foreign Affairs, Trade And Development (Dfatd) Submitted By:Agriteam Canada Consulting Ltd

[191] Evaluation Of The 2012-2016 UNDAF For Bangladesh, Draft Report, Prepared by Joel Beasca and Salma Akhter, UNDAF Evaluation Team September 2015

The review found that the UNCT is on-track in achieving 6 out of the 12 outcomes that were planned for the in the current UNDAF. The data showed potential contribution of the UN System to the attainment of national priorities related to inclusive growth, social services, and environmental sustainability. At the same time, there were no similar metrics in the UNDAF design that could show its effectiveness in addressing the thematic issues. It turned out that the UNDAF had been weakly designed to mainstream the UN's normative agenda, and a basic flaw was the absence of a country analysis on the cross-cutting issues that was missed out during its planning phase. While the normative agenda was actually being addressed in practice through the various interventions of UNCT member-agencies, the assessment pointed out that there was no common standard and approach being followed in the UN system.

- ✓ **Contribution of UNFPA to elaboration of the UNDAF:** UNFPA has been active in leading the Pillars. UNFPA has been identified an active partner in the UNDAF to lead the Pillar outcomes 7.1: increased participation of marginalized and disadvantaged women in selected districts and urban slums in wage employment and any other income generating activities; and 7.2: social and institutional vulnerabilities of women, including the marginalized and disadvantaged, are reduced[192]. UNFPA has already been assigned as the convening and lead agency for the UNDAF pillar 7 (gender) as well as outcome 1/output 1 (health) of pillar 3. UNFPA has been designated as the UN Focal point among the nine participating UN agencies for the UN joint programme "Addressing Violence Against Women in Bangladesh". The joint programme involved 11 Ministries of the Government of Bangladesh[193].

- ✓ **Reflection of the priorities of UNFPA in Bangladesh in the UNDAF:**

The UNDAF is tracking at least (6) indicators out of 12 which are relevant to ICPD: Proportion of deliveries attended by skilled health providers disaggregated by wealth quintiles and residence; Contraceptive prevalence rate(modern method)wealth quintiles and residence; % of women aged 15-49 who gave birth in the 2 years preceding the survey receiving post-natal care within 2 days of delivery; Adolescent birth rate per 1,000 women; Median age at first marriage for girls (aged 20-24) of the last two quintiles in Bangladesh; % of women/girls aged 15-49 in the selected areas who have experienced any forms of violence in the past 12 months.

UNDAF was developed in November 2010, five years remaining to the MDG target year, 2015. The UN system of Bangladesh envisages the UNDAF (2012-2016) to be centered on the MDGs, as well as the Government was requested to prepare a MDG progress report to be presented during the High-level MDG Summit in September 2010. In this context, it was decided that UN system would work in close collaboration with the government to prepare the MDG progress report and use it as a part of the country analysis for the UNDAF preparation.

- ✓ **Evidence of overlaps or absence of overlaps of UNFPA interventions and those of other UNCT members:**

MNHI division of labor: Within the MNHI, UNICEF and UNFPA split the territory on adolescents and there is no duplication but no strong unification either. Lessons learned indicate that the three agencies will sit and make a joint strategy.[194]

There are evidences of **overlapping among UN bodies** in the context of gender. For example, UNFPA has long been working on RH related issues with women and adolescents, it has already been identified as women and adolescents focused development partner. Whereas UNICEF is working with children, below the age of 18, who again falls in the category of adolescents. On the other hand, UN Women is directly working with women and as per the UNDAF is responsible for pillar 2. There is a lack of common understanding. There is no

[192] Annual Progress Report 2014 on 8th Country Programme, Gender Component, Output No. 5, UNFOA BCO, January 2015

[193] Evaluation of the 7th Country Programme, UNFPA Bangladesh, February, 2011

[194] Key Informant Interview, October 2015

specific matrix to avoid these overlapping issues. As per the UN Women it's common concern is women, UNFPA should focus on adolescents and UNICEF on children. A mapping can be done on who is doing what[195]. It has been observed in the field that there tension exists between UNICEF and UNFPA related to prevention of child marriage, which is often embarrassing for the implementing agencies and other stakeholders[196].

- ✓ **Evidence that synergies have actively sought in implementation of the respective programmes of UNCT members:**

The group members of pillar 7 identified that prevention of violence against women remains very relevant. Although there well documented strategies for prevention exist, they are not consolidated. Therefore there is a need to bring key stakeholders to develop common evidence base and messaging as has been done for the issue of preventing child marriage. The group decided to Devise a common roadmap for substantive coordination a joint strategy for End VAW with actionable steps; Stronger links to be established with Social Protection Task Force; and Pillar leads to bring up the request at next UNCT to re convene the SPTF[197].

EQ7. Added Value – To what extent has UNFPA made good use of its comparative strengths to add value to the development results of Bangladesh?

A 7.1 The main comparative strengths of UNFPA Bangladesh have been identified and built upon in designing and implementing the UNFPA country programme	• Comparative strengths of UNFPA, both corporate and in-country, particularly in comparison to other UN agencies, have been identified and built upon • The results observed in programmatic areas that have been achieved with UNFPA's contribution are described. • The perceptions of national stakeholders in regard to UNFPA's added value have been collected and used for future programming.	• The CP and COARs • UNFPA Bangladesh Strategy • Databases showing results, or analysis of data • Reports from partners and other development agencies	• Key informant interviews • FGD with sub-national actors and beneficiaries • Document analysis

Reproductive Health and Rights:

- ✓ **Identification and building upon the strengths of UNFPA:**

Key Informants mentioned the following strengths:

- Global Studies - the UNFPA study on the youth bulge was a critical added value.
- UNFPA has identified Bangladesh as one of the priority countries in UNFPA globally, and enables all four modes of engagements (policy advice, capacity development, knowledge management, service delivery).

[195] KII with UN WOMEN (Tapati Saha)

[196] Field visit in Jamalpur.

[197] UNDAF Pillar 7 Workplan, 22 April, 2015, UN Women Conference Room

- The comparative strength of UNFPA is that it works with the government based on both the country priorities as well as ICPD agenda.
- UNFPA has carved out a strong corporate recognition with the government.
- Garment factories may be a deterrent to child marriage, thus UNFPA's work with the private sector is critical.
- UNFPA's influence and energy is strong in Family Planning
- UNFPA leadership in adolescent and youth SRHR
- UNFPA's work in midwifery is paying off

The PD component is pioneer in assisting BBS the main national agency to conduct Census which is recognized internationally. The demographic data is generated by trained personnel using up to date equipment. The data which is produces are disaggregated by age and sex, location and poverty. BBS is assisted to analyze data and produce monographs and reports which are available to wide range of people through its website.

The results observed in programmatic areas that have been achieved with UNFPA's contribution are described: The 8th Country Progarmme of UNFPA focused on three interrelated components: i) Reproductive Health, ii) Gender, and iii) Population and Development. A new component titled 'adolescent and youth' has been added as per the strategic plan (2014-2017) of Bangladesh country office of UNFPA. Through continuation of these components, UNFPA is supporting Bangladesh in a unique way. However, harmonization with other UN and development partners would require more attention to focus the untapped area within the mandate of UNFPA.

The perceptions of national stakeholders in regard to UNFPA's added value have been collected and used for future programming: Most of the interventions under gender component are being implemented by government, which is a good example of mainstreaming and sustainable effort There is also large agency representation and participation, which is a value add in it. Implementing partners show keen interest to continue their activities with UNFPA[198].

Key Informants mentioned the following challenges for UNFPA in building upon its strengths, which are not conclusive evidence or triangulated and should not be taken as such in this matrix:

- UNFPA needs: a more evidenced based approach coming out of the projects
- UNFPA is involved in too many areas and difficult to assess results.
- The important fact is that Bangladesh is receiving the last gasp of ODA, there will be less and less due to remittances which are topping 4.5 billion, thus it is important to look for strategic niches, for UNFPA – RH rights, gender, normative.
- In context of gender and adolescents' issues UNFPA has to compete with two other UN organizations: UNICEF (who has been working through the government system since long) and UN WOMEN (formerly was UNIFEM and recently active in focusing on women issues). UN WOMEN (formerly was UNIFEM and recently active in focusing on women issues). It must be mentioned here that UN Women is comparatively new in Bangladesh and does not work with government but supplement through research. There is a clear divison of labour among UNFPA, UNDP and UN Women in the UNDFA. UNFPA is responsible for UNDAF pillar 7.2 (GBV issues) whereas UNDP nad UN Women are responsible for Pillar 7.1. Their role is more normative, economic and political. UNFPA is able to leverage the resources, complement and supplement. Being UN bodies the organizations can refer to each other as per the relevance

[198] KII with Project Directors, MoWCA, MOHA and others project staff.

- UNFPA faces challenges in getting results in its area of strength Family Planning which need strengthening and UNFPA has the capacity to take on the task
- UNFPA could play a more active role, can do more in different districts from which it works now
- UNFPA should further strengthen its advocacy and strengthen the program level and program integration.
- There is a big issue in the words in SRHR, the tendency is to use RH and to leave off the S and the R, UNFPA should be advocating to have these words used all the time.
- UNFPA could play an important role in providing the right info to the Ministry of Foreign Affairs.

✓ **Description of results achieved with UNFPA's contribution: (see EQs 2, 3 and 4 above)**

- Availability of demographic data by age and sex, location and poverty had increased and made accessible for general use.
- BBS uses up-to-date data collection and validation techniques.
- National and Sectoral plans show evidence of use of data disaggregated by age and sex, location and poverty.
- The project with GED making good use of findings from research reports in national planning.
- New generation of professionals with diploma and Masters degree in Population Studies contribution to the program.
- Parliamentarians showing ownership in tackling issues of gender and early marriage.

A 7.2 These comparative strengths are acknowledged and inform UNFPA cooperation with other development partners, particularly other UN agencies	• Perception by Bangladesh national stakeholders of the comparative strengths of UNFPA • Evidence that UNFPA comparative strengths are reflected in its cooperation with other development partners	• Government partners • UN agencies • Other development partners	• Interview with the UN RC • Interviews with other UN agencies • Interviews with Government partners

Perception by Bangladesh national stakeholders of UNFPA strengths[199]:

UNFPA's added value in Reproductive Health is that they do not say it is our system, the government always gets priority, other donors like to say it is their system.

The implementing partners at different levels expressed their satisfactions about UNFPA working with government. "This is the most useful method from sustainability and mainstreaming points of view, even there are bureaucracies slowing down the process[200]. Some mentioned UNFPA has a good branding in Bangladesh and thus even budget of

[199] Key Informant Interviews, October 2015

[200] KII with Plan International, 15 October, 2015.

Gender component is comparatively lower, they feel comfortable to work with[201]. Government agencies as implementing partners are also satisfied for direct intervention and establishing, supporting WSC (DG, DWA), WHD (AIGP, Police and PD, MOHA). However, sudden curtail of funds (from DWA) and overlapping programmes on similar issue (on child marriage) by UN bodies with other partner in the same district (Police by UNFPA and DC by UNICEF) were questioned.

All of the Bangladesh national stakeholders of PD component of UNFPA are satisfied with the support they receive. All of them want the support to continue until they reach a stage when they will able to run their own program with their own resources.

Evidence that UNFPA comparative strengths are reflected in its cooperation with other development partners

The 7th Country Programme Evaluation analysis notes that in view of the major issues needing attention, UNFPA capacity has been spread too thinly, and suggests pursuing reduction of fertility and issues pertaining to the gender agenda. The capacity issues in the CO are cited as reasons to limit the scope of the Country Programme interventions.[202] Capacity issues, however, are not elaborated upon.

The 8th Country Programme Situation Analysis also prioritizes intervention areas.[203] However, neither the 8th Country Programme Assessment nor the 8th Country Programme Document discuss in depth the UNFPA potential added value and its strengths in its mandate areas in relation to the gaps and tasks identified to achieve development goals in Bangladesh. These documents also do not mention the strengths of other UN agencies or other stakeholders relative to UNFPA capacity to address these priorities. For example, UNICEF is a much larger agency with strong technical expertise, and mandate overlaps with UNFPA in a number of areas including maternal and adolescent health and gender equality. There is evidence that the agencies address these overlaps and capacity issues through negotiated discussions rather than in a systematic manner.[204]

Without firm analysis, there may be a tendency to base interventions on what has been done historically or on the availability of funds or projects that donors wish to fund, as mentioned in the 7th CPE.[205] Further, and as discussed in the coordination section (EQ 6), the ability of UNFPA to highlight and push for its added value by validating the levels of expertise, capacity, and leadership potential in the Country Office, are important given the competitive development and assistance agency scenario that exists in Bangladesh. This is particularly critical where mandates and expertise of UN or other agencies are overlapping, for example, with UNICEF and UN Women, and where collaboration/coordination as well as negotiation is needed to determine who will do what to avoid overlap and duplication of resources.[206]

The capacity of UNFPA to take the lead and to achieve a wide range of goals and objectives with numerous interventions is questioned by a number of stakeholders both outside and inside the UN. UNFPA funding is seen to be meagre compared to the substantial needs in sexual and reproductive health and rights and Gender Equality in particular. A number of stakeholders maintain that UNFPA should look for strategic niches and seek stronger results and evidence based approaches. By covering too many intervention types, UNFPA may run the risk of diluted ownership by the government and lack of scaling up the intervention. In this regard, Family Planning stands out as the area of interventions in RHR where UNFPA has the greatest strength compared to other agencies working with the Government and additionally where it has the capacity to make strong contributions toward results. [207]

[201] FGD with BGEMA DPD and staff, 14 October, 2015.
[202] Evaluation Of The 7th Country Programme UNFPA Bangladesh, Final Report, "Lessons Learned", pages 67-70
[203] UNFPA 8th Country Programme Situation Analysis, 2011, Page 26
[204] Key Informant interviews, October 2015
[205] Key Informant interviews, October 2015
[206] Key Informant interviews, October 2015
[207] Key Informant Interviews, October 2015.

EQ8. To what extent did the UNFPA 8th Country Programme in Bangladesh take into account the country's vulnerability to disasters and emergencies, both at the planning and the implementation stages?			
A 8.1 The disaster proneness of Bangladesh is well reflected in UNFPA programming documents	• Evidence that goals and objectives reflect UNFPA's Global Humanitarian Response Strategy • Evidence that UNFPA's role in preparing and responding to disaster and emergencies in SRH and GBV is clarified • UNFPA has applied to activate Fast Track Procedures to expedite CERF funding if it is needed (or other sources as relevant, such as APRO, bi-lateral, etc.) • Evidence that UNFPA's Emergency Preparedness and Contingency plan is in alignment with and developed in consideration of the UNDAF, National Disaster Management Plans and IASC joint plans • Evidence that preparedness and response to major hazards and potential emergency situations have been considered in planning documents •	• AWPs and SPRs • 8th Country Programme Situation Analysis 2010 • UNDAF • UNFPA's Humanitarian Response Strategy first and second generations and Fast Track Policies • Evidence of receipt of CERF funds, other funds • National disaster management plans • UN Joint Plans	• Documentary review • Interviews with GoB disaster preparedness and response staff in the DGHS, Ministry of staff • Interviews with UNFPA staff, and members of the UN and national humanitarian response coordination groups • Interviews with other key responders, such as donors and NGOs, regional actors

- **Evidence that the Country Programme goals and objectives reflect UNFPA Global Humanitarian Response Strategy**

UNFPA issued a **Humanitarian Response Strategy "Second Generation"** in 2012 building upon the gains made in the previous strategy.

Strategic Plan (SP) 2008-2014 - SP Outcome 1: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access.

SP Output 5: Increased national capacity to provide sexual and reproductive health services in humanitarian settings

The **SP 2014- 2017** does not include Output 5 rather humanitarian concerns (seem to be) are cross cutting. The UNFPA business model emphasizes: Using performance indicators aligned with the approach agreed through ongoing Inter-Agency Standing Committee (IASC) work on a common Humanitarian Response Monitoring Framework, as part of the newly developed Humanitarian Programme Cycle.

UNFPA's Emergency Preparedness and Contingency Plan was revised in 2014 from the 2012 version and is aligned with global strategies and policies. It is noted that the disaster profile includes social instability, as well as natural disasters. The plan covers previous "ad hoc" responses to disasters and emergencies. It builds upon the InterAgency **Emergency Response Preparedness Plan**, 2014, plan which uses the IASC and interagency country risk profile.

"UNFPA's Standard Operating Procedures (SoPs) should guide the work of the Country Office and Field Offices within the first 2 weeks of the response. These SoPs are aligned with the 2nd Generation Humanitarian Strategy guidance, which delineates the key responsibilities of the different organizational units of UNFPA. Therefore, they should be read in conjunction with the Regional Office and Headquarters SoPs, and revised regularly to ensure alignment between the three." [208]

The UNFPA Global Strategic Plan (SP) 2008-2014 covers SP Output 5: Increased national capacity to provide sexual and reproductive health services in humanitarian settings. The SP 2014-2017 promotes humanitarian concerns to be cross cutting. UNFPA issued a Humanitarian Response Strategy "Second Generation" globally in 2012 and emphasizes alignment with the Inter-Agency Standing Committee (IASC) work on a common Humanitarian Response Monitoring Framework, currently being field tested.[209]

The 2011 UNFPA Bangladesh Emergency and Contingency Plan is well structured according to UNFPA standards, containing the essential elements including attention to vulnerability of women and girls in disasters. The plan was revised in 2014 and is well aligned with global strategies and policies and also refers appropriately to regional policies.[210] The plan covers lessons from previous responses and builds upon the **InterAgency (IASC) Emergency Response Preparedness Plan**, 2014 and uses the Inter-Agency Country Risk Profile for Bangladesh agreed by the Humanitarian Coordination Task Team (HCTT), in which seven main hazards were ranked as having a high seriousness which resulted from the combination of perceived impact and likelihood. The IASC emergency preparedness plans ensure pre-positioning of UNFPA-supported Reproductive Health Supplies and dignity kits.[211]

In 2012, a National Disaster Management Act was passed. The National Disaster Management Policy describes the broad national objectives and strategies while the 2010–2015 National Plan for Disaster Management outlines the institutional mechanisms. The guidelines for government at all levels (e.g. Best Practice Models) are also available. Interventions planned with the Directorate General of Health Services (DGHS) included training with DGHS on the Minimum Initial Services Package (MISP) from 2012 to 2105. Interventions included the integration of the MISP in emergencies into the Ministry of Health and Family Welfare advance preparedness and into the training curricula of health care providers, and strengthening the national capacity to implement the MISP in emergencies. The knowledge base was to be increased on linkages between disasters and RH and Gender. Plans included the distribution of RH in emergency kits and stockpiling of dignity kits. Due to delays in programme approval from the Government, the annual targets were not achieved in 2012 and targets for 2013 and 2014 were revised. [212] (Please see chart with interventions in the evaluation matrix in the annexes.)

The UNFPA Bangladesh 7th Country Programme Evaluation (CPE) mentions: "*UNFPA supports the response to Flood and Cyclones during the 7th CP through the provision of hygiene kits and (ambulance) boats, etc., some capacity building activities (MISP training), and Post Cyclone AILA response (UN Joint assessment, CSBA refresher training in AILA affected areas along with the distribution of RH kits). In recognition of the rather ad hoc response, the CO recruited a humanitarian response officer who arrived in early 2010 to set up more sustainable system to respond to the recurring emergencies in Bangladesh." [213]*The MISP training was not specifically assessed in the 7th CPE. The 8th Country Programme situation analysis (2010) recommends continuation of MISP implementation, mainstreaming RH and gender into disaster management and emergency response and pre-positioning RH commodities.[214]

A strong programme logic in emergency and disaster response was lacking in the design of the 8th Country Programme, given the need to support SRH and GBV inclusion in the national, UNDAF and the IASC plans and interventions. The 2011 UNFPA Bangladesh Emergency and Contingency Plan specified in-depth standard operating procedures but these were largely not covered in the programme design. The main intervention budgeted for was the MISP training and related coordination activities under **Reproductive Health - Humanitarian** annual work plan through the DGHS. Mainstreaming interventions for emergency preparedness and response were not strong in the programme plans or the

[208] UNFPA Emergency Preparedness and Contingency Plan, 2014, page 14
[209] https://interagencystandingcommittee.org/iasc-transformative-agenda
[210] UNFPA Emergency Preparedness and Contingency Plan, 2014, page 14
[211] UNDAF Pillar 5, Outcome Results reports, 2013, and 2014
[212] 2012, 2013 (revised), 2014 (revised), 2015 Annual Work Plans for DGHS
[213] UNFPA Bangladesh 7th Country Programme Evaluation, February 2011
[214] UNFPA 8th Country Programme Situation Analysis, 2010

implementation. The soft interventions such as building strategic partnerships, are not clearly mentioned in the annual work plans.

According to the 2011 UNFPA Bangladesh Emergency and Contingency Plan, the Country Office (CO) is tasked with setting up Preparedness and Emergency Teams, co-chaired by the Humanitarian Officer and the Deputy Representative. A UNFPA Country Office Disaster and Emergency Preparedness Team was not fully operational in the CO in the early years of the 8th Country Programme. The need for a dedicated staff (JPO) for Humanitarian Response and Disaster Management was identified in 2013, a staff member stepped in temporarily in the interim, and a dedicated staff was finally hired in late 2015.[215] While staff did their best to cover the gaps, important activities such as procuring and stockpiling safe delivery kits for emergency response were not addressed before 2014.[216]

- **Evidence that UNFPA has applied to activate Fast Track Procedures to expedite CERF funding**

Accompanying the Humanitarian Response Strategy, UNFPA issued "Fast Track Policies and Procedures" in 2012 and updated them in 2015. UNFPA country offices that are operating in particularly challenging local contexts and need to make time-critical interventions are eligible and can request authorization to use the Fast Track Procedures. *Bangladesh is likely to fall under the eligibility criteria because it is considered to be particularly vulnerable to disasters.*

The eligibility criteria cover the following situations:
(i) Humanitarian Crisis: A humanitarian crisis has been declared by the national authorities and support offered by the Office of Coordination for Humanitarian Affairs or by the UNCT. The FTPs are applicable to all levels of UNFPA humanitarian response i.e. level 1, 2 and level 3 that is declared by the IASC through the Emergency Relief Commissioner.
(ii) Fragile Contexts: This will apply to country situations referred to within the UNFPA Framework for Engagement in Fragile Contexts to mean circumstances where "there is fundamental failure of the state to perform functions necessary to meet the basic needs and expectations of its citizens either due to incapacity or unwillingness p.5". This incapability may be prevalent over the entire national territory or in only parts of it. In a security compromised setting, where staff, assets and/or operations are exposed to increased vulnerability, the Fast Track Procedures may need to be activated to mitigate actual or potential risks.

For the purpose of operationalizing FTP's in fragile context, UNFPA management will refer to the OECD/DAC annual list of Fragile Situations1, and the INFORM Model for assessing risk for humanitarian crises and disasters. In case a country office is applying for Central Emergency Response Fund (CERF) funding, it is highly recommended that the office consider applying for the activation of FTPs, if this has not been previously sought, as the receipt of CERF funding does not automatically trigger FTPs."

Receipt of CERF funding: Background: The CERF is designed to be used in fragile contexts and has been evaluated to work well in these contexts. CERF pre-positions donor funding for UN agencies (but not for NGOs). Gender considerations are typically integrated into CERF practice. The three largest recipient agencies of CERF funds are UNHCR, WFP and UNICEF.[217]

Other funds that may be available include UNFPA Emergency Fund (EF) up to US $50,000, APRO Regional Fund for Emergencies, Bilateral Resource Mobilization, and the UN Flash Appeal.

UNFPA did not accept CERF funding in 2014, for a situation analysis and (reportedly) stepped aside to let others who wanted and needed the funds to take the funding.[218]

UNFPA has just (Oct. 2015) received CERF funds ($225,000 for 9 months, i.e., until July 2016) for interventions addressing the needs of undocumented refugees, which means that it

[215] Country Office Annual Reports, 2013 and 2014, and Key Informant interviews, October 2015
[216] Key informant interviews, October 2015
[217] Multi-lateral Aid Review: Assessment of the Central Emergency Response Fund, February 2011.
[218] Key Informant Interview, October 2015.

likely has applied for the Fast Track. A rapid needs assessment is planned for Nov. 2015. Based on this needs assessment, interventions will be planned for 2016.

UNFPA drew from Humanitarian U203 funds to support response to the 2014 floods (purchase and delivery of Safe Delivery kits). Was CERF available? Was a larger more diverse/needs oriented response possible with CERF funds?

- **Evidence that UNFPA's Emergency Preparedness and Contingency plan is in alignment with and developed in consideration of the UNDAF, National Disaster Management Plans and IASC joint plans**

The CP Outcomes corresponds to **the UNDAF Pillar Five**: Climate Change, Environment, Disaster Risk Reduction and Response, Outcome 1. The plan speaks of the development of community resilience and adaptation.

- Outcome 1: *By 2016, populations vulnerable to climate change and natural disaster have become more resilient to adapt with the risk.*
- Outcome 2: By 2016, vulnerable populations benefit from natural resource management (NRM); environmental governance and low- emission green development.

UNFPA 8th CP Bangladesh: The following CP Outcome/output are relevant to vulnerability to disasters and emergencies
RH Outcome 2: Increased availability in emergencies and in early- recovery settings of gender-sensitive, high-quality reproductive health services and services to combat gender-based violence
RH Output 3: Strengthened national capacity for emergency preparedness and response in order to address reproductive health and gender issues, including gender-based violence, during natural disasters.

The Government of Bangladesh Disaster Management Policies - In 2012, a Disaster Management Act was passed, creating the framework for Disaster Risk Reduction (DRR) and Emergency Response Management (ERM) in Bangladesh. The National Disaster Management Policy is a strategic policy document describing the broad national objectives and strategies for disaster management. The 2010–2015 National Plan for Disaster Management outlines the systemic and institutional mechanisms for DRR and ERM. The guidelines for government at all levels (Best Practice Models) are available to guide the Government's DRR and ERM. The Government issued "Standing Orders on Disaster" by the Ministry of Food and Disaster Management (former name) in 2010, a 248 page document detailing the roles and responsibilities of the national response network.

Reproductive Health: SPR 2014: The HPNSDP recognizes that in order to address the high vulnerability of Bangladesh to natural disasters requires a strengthening of "the level of readiness at all tiers of the health system and improve the capacity of the sector for coordinated post-disaster management". The RH Component supported these efforts for the integration of the Minimum Initial Service Package (MISP) of reproductive health in emergencies into the MOH&FW advanced preparedness plan as well as the training curricula's of health care providers.

The IASC Joint Plan is the **Emergency Response Preparedness Plan, 2014,** developed among the IASC and other agencies. It provides practical guidance to assist IASC members, other UN agencies and NGOs in preparing to respond to potential emergencies with appropriate humanitarian assistance and protection. It focuses on practical and concrete preparedness and response actions and responsibilities and it seeks to harmonize the overall coordination in regard to emergency preparedness and response at inter-agency level. It is developed in view of the national systems of disaster and emergency management and seeking to increase coordination among the agencies providing assistance. UNFPA's **Emergency Preparedness and Contingency Plan** was revised in 2014 from the 2012 version and was developed in tandem with the InterAgency **Emergency Response Preparedness Plan**, 2014, plan which uses the IASC and interagency country risk profile and reflects the components of this plan.

- **Evidence that preparedness and response to major hazards and potential emergency situations have been considered in planning documents**

(From the 2014 Revised **UNFPA's Emergency Preparedness and Contingency Plan, which draws from the** Joint Emergency Response Plan in 2014, based on the IASC ERP guidance**)**

Bangladesh Risk Profile
In order to identify the hazards most relevant for Bangladesh, a risk assessment was conducted with government officials and members of the Humanitarian Coordination Task Team (HCTT) ranking context-specific hazards by their foreseen impact and likelihood of occurrence. The table below shows the main risks, their estimated likelihood, impact, and scale. It also draws attention to those risks whose seriousness levels rank in the medium/high range. The outcome of the risk assessment was a commonly agreed Inter-Agency Country Risk Profile for Bangladesh. On the basis of this classification of risks, seven main hazards were ranked as having a high seriousness which resulted from the combination of perceived impact and likelihood.

- **Consideration of vulnerability of women and girls to disasters and emergencies in programming documents:**

UNFPA has conducted a **Literature Review on Gender and Natural Disasters** in Bangladesh, published in 2012.[219] The purpose of the review was to inform the implementation process of the National Disaster Management Plan (2010-2015) and Standing Orders for Disasters, making Bangladesh better prepared to respond to the impact of disasters in a more effective way. The GoB has revamped coordination with the UN, donors and NGOs in this sector through the Disaster Emergency Response sub-working group and is working to integrate women and girls particular concerns. The Literature Review also provides a good reference point for consultation on evidence-based research, not from other countries but specifically from Bangladesh. A clear recommendation drawn from the research is that disaster management and development need to go hand in hand in order for development to be sustainable and disaster management to be effective. In a country such as ours, where natural and man-made disasters impact our population too frequently, development planning cannot overlook the importance of disaster management. And in turn, disaster management will be stronger and more efficient if it is further integrated into development strategies.[220]

In the development of the Joint Emergency Response Plan in 2014, based on the IASC ERP guidance, and covering earthquakes, cyclones, floods and water logging events, UNFPA submitted a set of comments that had not been considered in the plan, which clarified the protection mechanisms needed for women, girls and pregnant women under the Health, WASH, Shelter and Nutrition headings, including some preventive actions as well as response.[221] The comments appear to be fully incorporated into the final final plan from November 2014.

- ✓ **PD contribution: Preparedness and response to major hazards and potential emergencies considered in planning documents:**

Preparedness and response to major hazards and potential emergencies is reflected in the situation analysis sections of the considered in planning documents of UNFPA. Outside planned relief activities UNFPA coordinate with local and national disaster management committees by having BBS share required data of the affected people by age and sex, location and poverty.

UNFPA Annual Report 2014: As a follow up to the 2011 Census, population data at sub district levels and below 2011 has already been produced. These data is currently being used to identify disaster-prone areas and those populations affected by disasters, into e.g. the Vulnerability Index. In 2014 there was a severe flood that affected north-western and central regions of the country. A joint need assessment was conducted by Humanitarian Coordination Task Team, and UNFPA actively participated in the needs assessment. For contingency planning, UNFPA generated a district-wise disaggregated population data as baseline information.

Consideration of vulnerability of women and girls to disasters and emergencies in programming documents:

[219] Literature Review on Gender and Natural Disasters in Bangladesh, Sheepa Hafiza, UNFPA Bangladesh, Directorate General of Health Services, Ministry of Health and Family Welfare, 2012.
[220] Ibid, preface.
[221] UNFPA's comments not considered in the final ERP (no addressee, or date)

Considering the vulnerability of women and girls to disasters and emergencies in programming documents, the response does not seem to be inadequate. It is only restricted in storing supplies of delivery kits for pregnant women who would deliver in certain area within seven days. The scope of store and supply can be expanded to include dignity kits as well.

- ✓ **Gender contribution:**

Evidence that preparedness and response to major hazards and potential emergency situations have been considered in planning documents: The concept and design paper of the MoWCA on APWR for UNFPA 8th Country Programme submitted by Ministry of Women's and Children's Affairs under the heading 'Mainstreaming Emergency Preparedness' clearly stated that UNFPA will work closely with MoWCA and other government partners to mainstream emergency preparedness into the regular development programmes. Focus of UNFPA support under this project will be capacity building within MoWCA/DWA to coordinate prevention and protective services as regards to SGBV in light of the increased vulnerability of women and girls during and in the aftermath of emergencies and disasters. It has been mentioned that a key feature of the UNDAF 2012-2016 is a new focus **on targeting – both geographically and in terms of the most deprived groups. Subsequently, a total of 20 priority convergence districts** have been selected on the basis of poor performance across the following MDG-based parameters: MDG-based ranking; indicators of poverty/extreme poverty, education, literacy, health and sanitation, nutrition and food insecurity, and **risks associated with environmental degradation and climate change, including risks or salinity, flooding, cyclone, drought, water-logging, chemical hazard, and riverbank erosion**. In addition, 30 cities and towns will be targeted to address urgent issues of urban poverty for 3 million of the poorest people; these are selected according to population size, UN implementation capacity, geographic distribution and a host of socioeconomic criteria[222]. However, although disaster and emergency has been considered in the planning document, no activity was designed in line with this.

Evidence that vulnerability of women and girls is considered in regard to disasters and emergencies: Bangladesh is prone to hazards and frequent disasters. Climate change is aggravating the situation. Disasters are also having a gender dimension: although disasters affect women and men both, the burden of coping falls heavily on women's shoulder. Women and girls in poorer categories become more vulnerable during disasters[223]. Study[224] indicates that violence against women and girls increases during disasters. Despite the facts and plan UNFPA has not included the gender based vulnerability or gender based violence during disaster and emergency. Inclusion of MISP (in the 4 intervention districts in 2014) does not address the complete agenda of gender and disaster. It has been reported by the Gender unit of UNFPA that GBV issues during emergency has been discussed at local level (MoWCA, MOHA), however, partners were not given any orientation in it. Even within the gender unit out o7 8 staff only one has training on gender and emergency. In the Kanil village of Jamalpur women have to face frequent flooding and river erosion and they have to be prepared on their own to face another one. Women's own initiatives and experience make them to take decisions.

A 8.2 UNFPA response to disasters/emergencies actually addressed (or is likely to address) SRH and GBV needs of affected populations	• SRH and GBV are incorporated into the National, District and/or Local contingency plans and updated regularly • SRH and GBV incorporated into National, District and/or Local Level Joint Needs Assessment (JNA) • Addressing GBV in emergency situation incorporated in training module of IP (police and DWA)	• Training schedule and training evaluations (district level) • JNA report, IASC ERP Plan, and health sector plan • Training module of police and DWA • National, District and Local Level Disaster Preparedness and	• Documentary review • Interviews with UNFPA staff • Interviews with police, DWA • Interviews with other UN agencies

[222] 8th Country Programme, Ministry of Women's and Children's Affairs- Concept and Design of UNFPA Support, 2012

[223] Nasreen, Mahbuba, 1995, 'Coping with Floods: the Experiences of Rural Women in Bangladesh', unpublished PhD Dissertation, Massey University, New Zealand.

[224] Nasreen, Mahbuba, 2008, *Violence against women during Flood and Post Flood Situations in Bangladesh*, Action Aid

		Response and Contingency Plans	

The Humanitarian U203: (MISP/RH/FP and disaster management) supported UNFPA training with the Directorate General of Health Services, on the Minimum Initial Services Package (MISP) from 2012 to 2105. Interventions included the integration of the MISP of RH in emergencies into the Ministry of Health and Family Welfare advance preparedness and into the training curricula of health care providers, and strengthening the national capacity to implement the MISP in emergencies. The knowledge base was to be increased on linkages between disasters and RH and Gender. Plans included the distribution of RH in emergency kits and stockpiling of dignity kits.

UNFPA interventions in the humanitarian field during the current country programme can be grouped in two main categories[225]:

1. Response to protracted crisis
2. Emergency preparedness and response.

1. Response to protracted crisis

Bangladesh hosts Rohingya refugees (who fled from Myanmar) since the 1980s. There are approximately 32,000 Rohingyas in the two official camps of Cox's Bazar district:

- The camp of Nayapata in Teknaf;
- The camp of Kutuapalong in Ukhia

Besides the official refugees, there are 400 to 500,000 undocumented refugees outside of the camp (mostly in Cox's Bazar, but also in Chittagong and Bandarban). UNFPA currently works only with official refugees (i.e., in the camps). Types of interventions:

- ✓ Provision of RH services to registered refugees. Skilled attendant at delivery offered in birthing units in the two camps. UNFPA has supported the training of 1 doctor and 4 nurses in each camp on the following: (i) FP and RH issues; (ii) complicated delivery; (iii) neonatal care management
- ✓ Outreach networking services for FP: one paramedics funded by UNFPA (in each camp?) provides ANC, PNC and FP methods (contraceptives, long term methods, IUDs, etc.). Commodities are supplied by DGFP.
- ✓ Adolescent corners: one in each camp; open every day. Propose recreational activities; provide information on RHR, FP, consequences of early marriage, etc. From 2015, three-month life skills education training provided to boys and girls (14 boys and 14 girls selected in each camp); adolescents trained on safe motherhood, STDs, STIs, etc.
- ✓ Awareness and orientation trainings on FP: informal courtyard activities with women at reproductive age
- ✓ Training on GBV for staff and orientation for refugees (awareness and prevention): this became a responsibility of UNHCR in July 2013. UNFPA not in charge of this anymore. What remains a UNFPA activity: response to GBV, i.e., treatment of rape cases: services provided to victims in birthing units.

2. Emergency preparedness and response

UNFPA has worked on capacity building for service providers. Other response:

- UNFPA prepositioned RH and hygiene kits (through DGHS).

[225] Documentary Review and Key Informant interviews, October 2015.

- In 2012, UNFPA financed a literature review on gender and natural disasters in Bangladesh.
- UNFPA takes part in meetings within the Health cluster (co-chaired by Director of Communicable Disease Control and WHO). UNFPA also takes part in LCG on DER and District Disaster Management Committees.

✓ **Evidence of increase in stakeholders knowledge for implementing the MISP**

Stakeholders knowledge in implementing the MISP: Although Bangladesh is a very disaster prone country, the MISP training was not implemented until 2014 – what about previous CP? Training on MISP has been conducted for:

- ✓ District and sub-district level RH and FP providers;
- ✓ Officers of DWA;
- ✓ Officers of Ministry of Home Affairs (police officers)
- ✓ Department of Disaster Management officers (Ministry of Disaster Management and Relief)
- ✓ Bangladesh Red Crescent society
- ✓ Local NGOs
- ✓ Youth (through local clubs and college students)

SPR 2014 - As part of national capacity building on Emergency Preparedness and Responses to address SRH and GBV issues a 5-day long ToT on "MISP for Reproductive Health in Crises" organized by the project with Technical Assistance from UNFPA. District level health and family planning managers, service providers, Department of Disaster Management, Bangladesh Red Crescent Society, UNFPA field staff from 7 districts received the TOT (total 38) in August 2014. Further, during November 2014 the project organized MISP training for two Upazillas each of Borguna and Patuakhali districts (Betagi, Amtoli, Kalapara and Golachipa) and 27 participants received the training from DGHS/DGFP/DDM/NGOs/Youth representatives.

Evaluation of MISP Training[226]: Report on MISP TOT (organized in all gender intervention districts and selected MNHI districts by gender and RH unit), August 2104, Dhaka, indicates that the MISP is a new idea for some participants, the Pre Test the average result of the participants was 23%, and after the TOT in the Post Test the result was 89%.
Field Trip Report, November 2014, Kuakata, Patuakhali with 27 participants, comprehensive workshop report with participant evaluation, the pre test the average result of the participants was 37% and after training Post Test result was 56%.

Field Trip Report of June 2015, one of the most disaster prone, Sirajganj district MISP training for 20 participants, indicates satisfaction on the part of most participants. The average result of the participants in the Pre-test was 4.8 and Post Test result was 6.61 out of 10. Achievement of training objectives judged by participants was only 56% in terms of excellence, thus room for improvement.

Field Trip Report of June 2015, MISP training for 25 participants in Sunamgonj district, the average result of the participants in the Pre-test was 35% and Post Test result was 62%. A factor in low scores in the tests according to participants is difficulty to understand the questions in English.

[226] Field Trip Reports, MISP training

Source of chart: Country Office

Goals /Objectives Humanitarian Assistance and Disaster Management	Interventions as per the 8th Country Programme Annual Work Plans Standard Operating Procedures as per the 2011 Emergency and Contingency Plan	Interventions From 2012 – 2015 (to date)
Country Programme Outcome 2, Output 3 – Interventions under the DGHS		
Increase knowledge base and linkages in disasters and emergencies between RH and gender	Conducting and disseminating research on RH and GE linkages in disasters and emergencies	Literature Review on Gender and Natural Disasters in Bangladesh, published in 2012 Printed Bangla version of MISP Online training manual (1500 copies – being distributed to the training participants and also at the WPD 2015 participants)
Strengthen national capacity to implement MISP in emergency response	Response incorporated into DGHS emergency plan	National Disaster Management Plan 2010-2015 does not reflected MISP/SRH/GBV issues. But UNFPA initiated discussions to incorporate the MISP/SRHR/GBV issues in the Bangladesh Emergency Response Plan 2015. At district level – DGHS Patuakhali/Borguna districts in 2014 (27 participants) and Sunamganj and Sirajgang districts (45 participants) organized in 2015; MISP training in Bagerhat district will be organized from 21-23 December 2015 Under Gender Component – more than 200 district level service providers, managers, police officers trained/ oriented on MISP in 4 districts e.g. Cox's Bazar, Sylhet, Jamalpur and Patuakhali (MOHA and MOWCA projects)
	MISP integrated into curricula for community health care providers;	Upon receiving TOT in Bangkok in 2013 and 2014 by UNFPA and partner NGOs staff on MISP/SPRINT -- training curriculum was prepared in the context of Bangladesh perspective. In 2016

		formal training curricula / workshop agenda will be placed to DGHS for approval.
	Essential MH and FP commodities pre-positioned	
	Increased number of service providers oriented to the MISP and training coordinated with SPRINT	MISP training - Initially it was not targeted but in 2015 under DGHS the target was per district 25 - 30 x 3 districts , so far 45 trained and another 30 – 35 will be trained in Bagerhat district in December. From 2016 specific target per district will be mentioned. 4 districts in 2014 UNFPA coordinated the training. In Bangladesh under SPRINT/IPPF also organized training under direct execution.
	Translation and printing of training curricula	The MISP still conducted in English in 2014 and 2015 as per workshop reports. The MISP online manual translated in Bangla in 2012 and reprinted in 2015 for use by the training participants and for use of other stakeholders/partners for better understanding. There is a demand that training curriculum also to be translated in Bangla. This process will be undertaken in 2016.
	Procurement and positioning of RH kits (RH kits mean Safe Delivery kits? Are there other RH kits?)	Yes for the flood response in the north and in Cox's Bazaar in 2014. As per the 5th Addition (2011) of Inter Agency Emergency RH kits – there are 0 to 12 kits available but CO procured only ERH kit 2B (clean delivery kits), as there were not severe disaster happened when tertiary level facilities are damaged. Prior to 2014, no kits were procured as there was no focal person assigned since the post was vacant.

2011 UNFPA Bangladesh Emergency and Contingency Plan – Standard Operating Procedures

Building Strategic Partnerships with government, UN partners and NGOs

Government	- Conduct geographic targeting of development activities based on areas most vulnerable to natural disasters. - Utilization of government distribution channels for provision of emergency RH services and distribution of essential items (clean delivery kits, etc.)	- Yes, DGHS in the 2014 floods, and pre-positioning
UN partners	-Integrated capacity building - Integration of EP&R issues into UNDAF - Joint assessments and resource mobilization efforts. - With WHO - coordination through Health Cluster. - With UNICEF - mainstreaming women and girls concerns into WASH Cluster. - With IOM - address protection and security issues.	
NGOs	- Use global and regional MoUs as basis for partnerships and identify new partnerships required for effective response - Activate pre-established partnerships for the emergency response	
Capacity building built into Annual Work Plans	MISP training and orientation and refresher for UNFPA staff and Implementing partners, and field workers FWAs and FWVs, etc.	
Advocacy	- integration of gender-differentiated needs and essential reproductive health care through participation at inter-agency coordination meetings, such as the UN - DMG (HCCT) or the DER, or other forums -Involve media -Adapt tools such as “Women are the Fabric”, global publication **Added 2014 -** -Advocate for inclusion of RH & Gender concerns into national disaster risk reduction mechanisms, response plans, etc - Advocate for the formation of sub-cluster on GBV in humanitarian settings under UN protection cluster	
Needs Assessments	-Annually to ensure preparedness measures in place -When emergency occurs to roll out the MISP using demographic indicators - Active participation in joint assessments	
Resources Mobilization	Use of UNFPA Emergency funds, APRO funds, Bi-lateral funds, CERF funds (life-saving), UN Flash Appeal UNFPA drew from Humanitarian U203 funds to support response to the 2014 floods (purchase and delivery of Safe Delivery kits). CERF funds were not required as funds	

	were allocated in DGHS for meet the procurement of ERH kits from Regular Resources. UNFPA has applied for Fast Track and received CERF funds in 2015 for assessment of the undocumented refugee situation
Others: M&E; Media and Communications; Programme Interventions	- Internal accountability for funds - Reporting and evaluating - Focal points assigned for response - Integration of emergency issues into regular programming

Goals and Objectives **Annual Work Plans**	**Interventions** **2013**	**Interventions 2014**	**Interventions 2015**
Output 1: Improved quality and accessibility of SRH and HIV information and services in selected districts			
Capacity building of service providers on RH	Numbers versus target are reflected in RTMI's SPR in 2013 to 2014		clinical management of rape survivors, training for medical providers on complications of pregnancy and labor, and infection prevention
Strengthening Maternal Health service delivery	Goals versus inputs?		coordination meetings with all stakeholders
Strengthen services for Adolescents	What existed what needs to be strengthened?		
Programme monitoring	Specific monitoring goals and how they were met?		
Programme evaluation	Evaluation milestones expected and how met?		
National Needs Assessments	What is expected here and how met?		
Output 2: Improved knowledge and awareness toward SRH and HIV among service providers and			

community members			
Strengthened Advocacy on RH	What was planned and what was carried out – reasons for not carrying out what was planned? Reflected in RTMI's SPR in 2013 to 2014		Support was provided to Community Health Assistants (CHAs) to transfer knowledge to the community and Community Based Outreach Network with community volunteers
Increased knowledge base on GBV	Evidence that knowledge has increased?		
Strengthened awareness for adolescents	Evidence that awareness has increased?		

- ✓ ***Evidence that UNFPA's role in preparing and responding to disasters and emergencies in SRH and GBV is clarified***

Input to the UN HCTT regarding needs assessment for the 2014 floods in the north of the country was provided after the Joint Needs Assessment (JNA) as evidenced by the following compiled account.

UNFPA Response to August 2014 Floods[227]**:** Nine districts in the north-west of the country were heavily impacted by 3-4 weeks of floods which triggered a Joint Needs Assessment (JNA) by the Humanitarian Coordination Task Team (HCTT). According to the Draft JNA report a total estimated number of affected population is 1,867,636, the estimated displaced population were 232,236 and affected displaced households were 54,919. Food, shelters and livelihoods are the main concern and access to health centres for disrupted.

The JNA did not contain some (most) critical FP/RH data, e.g. number of pregnant women. (The UNFPA global initiative to incorporate MISP and RH concerns into UN preparedness and response has been ongoing since 2008.) UNFPA estimated approximately 1.5% of the total affected populations are pregnant, which indicates 28,000-29,000 are estimated pregnant. UNFPA district field offices assessed the SRH and SGBV situation in 6 districts (Sirajgonj, Jamalpur, Kurigram, Lalmonirhat, Gaibandha and Sunamgonj) and shared the SitRep on 30 August 2014. The UNFPA CO decided to procure 22 Emergency RH Kits 2A (containing 4,400 Clean Delivery Kits) to be distributed to the pregnant women as immediate life savings response and ensure safe delivery. The kits were air-freighted and arrived at Dhaka from UNFPA Emergency Procurement Unit in Copenhagen on 5 September and cleared at the custom on 9 September. The needs/ requirements were discussed with the District Managers (i.e. Civil Surgeons/ DDFP) - 3,400 kits were distributed, an additional 1,000 kits were pre-positioned in Cox's Bazaar.

[227] UNFPA CO Report on Flood 2014, UNFPA Response to the Joint Needs Assessments (gaps); Draft Findings, Joint Needs Assessment, Flooding in Northwest Bangladesh, August 2014. List of Priority Interventions (data and origin not mentioned); Letter to DGHS, Emergency, Mr. Talukder from Iori Kato, Deputy Representative, Subject: UNFPA's Emergency Response to recent flood affected pregnant women – Distribution of Individual Clean Delivery Kits for home deliveries

The Joint Needs Assessment does identify lack of safe and private spaces for women and girls for hygiene and sanitation, The DRAFT JNA report recommends the provision of hygiene/dignity kits, however, UNFPA's response to this is not documented. The report flags the heightened possibilities for rape and gender based violence due to overcrowding in shelters, and flagged preventive measures that could be taken.

The UNFPA CO provided inputs to the draft JNA report; provided inputs to OCHA on "4W" tools, and attended the Health Cluster Meeting convened jointly DGHS/MOHFW and WHO on 15 September for this flood. Further, on request of the meeting CO provided information on the gaps of reproductive health related services due to flood. UNFPA's concerns are reflected in the Health Cluster meetings of September 15, 2014 whereas work on the Health Contingency Plan was underway in March 2014.[228] Follow up by UNFPA staff in October 2014, indicated that a minimum of RH services were seriously disrupted and shifted to another area and that deliveries were proceeding as normal. UNFPA's contribution was reflected in a powerpoint presentation by WFP and Oxfam on the Emergency Relief and Recovery Assistance by Development Partners (January 2015), although significantly smaller in monetary terms than WFPs, UNICEFs, and UNDPs. It is likely that UNICEF provided dignity/hygiene kits.

Response to the Draft JNA by UNFPA: SRH/FP and SGVB issues are not reflected In the JNA. Any onset of emergencies UNFPA and partners should ready to support SRH and SGBV services with a coordinated approach to prevent and manage the consequences of sexual violence; prevent excess maternal and newborn morbidity and mortality; and plan for comprehensive RH services to saves lives and prevents illness, especially among women and girls. Therefore, information on these two issues need to be incorporated. As per UNFPA's recent field-based information estimated pregnant women is 6,967 and affected household is 90,198 in six districts e.g. Sirajgonj, Jamalpur, Kurigram, Lalmonirhat, Gaibandha and Sunamgonj. Following data need to be required:

RH
1) Age/sex disaggregated data of the flood affected population
2) # of pregnant women (early pregnancy - first 6 month of pregnancy)
3) # of pregnant women (last trimester)
4) # of women required services for post-partum
5) # of breast-fed women
6) # of hygiene kits required for WRA
7) Service gaps/discontinuation of FP method

Gender
8) # of Case on SGBV (rape/sexual harassment/sGBV victims).
- If so, any responses to support the victim, especially health sector response to GBV/SGBV is available?
-any service gaps/what the service the victim is needed?
- # of case reported to police or women affairs officer or anywhere else
service provider/NGO/agency has prioritized GBV issue in their data collection and response system.

9) # of child marriage occurred during flood
10) Security/Protection for women and girls in the shelter camps/center

UNFPA produced a list of Priority Interventions for SRH in emergencies to be incorporated into the InterAgency **Emergency Response Preparedness Plan**, 2014. The draft ERP plan was reviewed and UNFPA's additions were incorporated into the final plan.

The Deputy Representative sent a report to the Representative summarizing the steps taken. Approximately $25,000 of funds were utilized from the DGHS U203. This letter mentions

[228] Health Cluster Meeting Minutes, March 2014, September 2014,

that UNFPA MNHI project staff were re-mobilized right after the flood to the affected areas.

- MNHI staff beyond their normal duty stations, are currently working in 6 districts out of the 9 districts covered in the Joint Needs Assessments.
- UNFPA had pre-positioned 3,326 RH kits late last year 2013 to districts that include some of the affected areas by this flood, which are currently being utilized in the flood affected districts. A letter was sent from UNFPA to DGHS, Emergency to advise them of UNFPA's contribution.

UNFPA Response to Flash Floods in Cox's Bazar, Bandarban and Chittagong Districts and "Cyclone Komen" on 31st July 2015[229]

According to the joint needs assessment report of 20 July by HCTT on Flash Floods in Cox's Bazar, Bandarban and Chittagong Districts (June-July 2015), the south-eastern districts of Cox's Bazar, Bandarban and Chittagong were worst affected. Government information identifies 29 upazilas (sub-districts) as most affected. A total of over 1.8 million people were impacted over brief periods. 22 people have died due to landslides, electrocution, drowning and capsizing boats, and over 20,651 have been injured. The numbers of people who remain displaced remains uncertain. All rivers in the three districts affected by the flooding have returned to normal levels.

According to the Bangladesh Meteorological Department, Cyclonic storm "KOMEN" crossed Chittagong coast near Sandwip on 31 July, 2015 and surpassed over Noakhali and adjoining land area as a land depression. Massive preparedness measures taken by the Ministry of Disaster Management and Relief relocated over 2,59,700 vulnerable people in 288 cyclone shelters in Cox's Bazar district and deployed 636 Medical Teams in the south-eastern part of coastal belt to manage health issues in terms of flash floods, landslides and cyclonic storm.

In both the above situations, according to UNFPA district office in Cox's Bazar, almost all UH&FWC (Union Health and Family Welfare Centers) were affected for a while but have now returned to normal working conditions. Health facilities are now fully accessible for SRH/ maternal health services. There were no reports on GBV and no pregnant and lactating women were affected directly during flash flood and cyclone Komen.

Preparedness and Responses,

UNFPA CO has ordered 39 **Emergency RH Kit - 2A** (Clean Delivery Kit – Individuals) which consists of 7,800 pieces through PSB which is expected to arrive by end of this month.

National capacity building on MISP - more than 300 government/NGOs/Youth officials consisting of MOHFW, Disaster Management Department, Ministry of Women and Children Affairs, Ministry of Home Affairs (Police Department) were trained/ oriented during last quarter of 2014 in 7 Flood/Cyclone-prone UNFPA intervention districts. Trained personnel are ready to be deployed in case of need. A table on the role of UNFPA in various scenarios was developed for **UNFPA's Emergency Preparedness and Contingency Plan, 2014.**

- **Evidence that preparedness and response plans are updated regularly**

For **disaster management in Patuakhali District**, there are many preparations as this is a very disaster prone area. The topic is taken very seriously and government staff are benefitting from training and refresher training on the MISP and other topics. There was nothing on SRHR in the previous manual but there will be in the one that is forthcoming. He is the coordinator and there is a monthly meeting of the district committee. Are they prepared for a big disaster? Yes, the schools are the shelters and the space is planned as for Barisal, spaces for pregnant and adolescents, the students and locals have rehearsed (photos). (UNICEF coordinates the committee in Barisal including UN agencies, NGOs and the Red Crescent.)

Emergency Preparedness in Barguna and Patuakhali Districts – The previous district plans did not address SRHR or GBV but the plan which is just about to be finalized covers these topics. The contingency plans allocate part of the shelters for pregnant and lactating women and part for adolescent girls.

District Disaster Committee meeting of both Patuakhali and Barguna were held on May 13, 2015 to manage any emergency event such as a cyclone. One control room is opened at

[229] UNFPA BGD Situation update on Flash floods and Cyclone Komen in Bangladesh, report to APRO, 6 August 2015

the DRRO office which is the focal point (phone numbers) for both districts. The Civil Surgeon is concerned about the pregnant women – the District hospital is ready to provide services. All UH and FPO are instructed to ready ambulances with fuel and the health facilities to take maximum casualties. The local branches of NGOs, WFP, Save the Children, Muslim Aid, SDA Jagonari, Suchilon, etc. all have preparedness measures. The leave of GoB employees will be cancelled so they may participate in rescue. Shortages of essential drugs including IV fluid and water purifying tablets, requests are sent to DGHS for urgent supply. The following readiness activities are noted.

Patuakhali:

- UNOs are instructed to hold upazilla and union disaster committee meetings immediately and to alert community people
- Volunteer groups are ready to support under the Red Crescent Society
- WFP representative - the present stock is 160 MT of biscuits
- Save the Children have non-food items for immediate action
- 115 medical teams can be formed
- 298 shelters are open and ready to provide support

Barguna:

- A total of 5580 volunteers are ready to provide support in Pathhogata, Amtali and Sadar Upazillas
- Shopkeepers advised not to sell dry food outside Barguna until further notice
- 46 medical teams have formed
- 334 shelters are open
- Union disaster management committees will alert communities

Gender contribution: Addressing GBV in emergency situations incorporated in training module of police and DWA: The GBV issues in emergency situation in training module of IPs have been well incorporated in DWA and Police training modules.

Issues raised by Key Informants regarding the preparedness plans and activities include the following: While the contingencies may appear adequate from a management point of view, the actual response by the communities should be considered. In the case of the cyclone shelters, they tend to be overcrowded and unsanitary thus people who do not have to use them will seek shelter with relatives, they may not be able to access medical services or other relief measures. Those that do use them will face crowding and unsanitary conditions, and a possible subsequent loss of dignity. There are issues regarding how the poorest will be protected in an emergency. Most agencies have a set package of responses ready to deploy, and they are not tailored in terms of the needs, thus ironies occur with the possible abundance of hygiene kits but no water or not enough toilets.

EQ9. To what extent was (or is) UNFPA, along with its partners, able (or likely) to respond to crises during the period of the 8th Country Programme (2012-2016)?			
A 9.1 The capacity of health-care providers in emergencies	• Evidence of increase in stakeholders knowledge for	• National health survey data,	• Document review

and in early recovery settings to provide gender sensitive, high quality sexual and reproductive health services, and services to combat Gender Based Violence is strengthened	implementing the MISP • Evidence of UNFPA participation in coordination groups around disasters and emergencies • Evidence that partnerships have been established and nurtured with Government and other actors for a coordinated response – share of responsibility taken by UNFPA • Estimated coverage of needs by the reproductive health kits, safe delivery kits or appropriate items distributed during emergencies • Evidence that training and capacity development has resulted in higher quality more gender sensitive services in emergencies • Evidence that that effectiveness of contributions was monitored and a follow-up analysis compiled • Evidence that measures were accompanied by high level advocacy to promote the goals and objectives of the UNFPA global humanitarian and country level plans	HMIS, local health provider data • AWPs, SPRs, COARS • Monitoring reports • Ministry of Health • NGOs working in target upazilas • Beneficiaries and users of the public and private health providers	• Data analysis • Interviews with key Ministries • Interviews with UN partners, implementing partners and health care providers • Site visits

Disasters Management in Bangladesh is the responsibility of the Ministry of Disaster Management and Relief. Within the Ministry, the Department for Disaster Management (DDM) has a policy and advisory role. A list of additional bodies which support disaster management in country is herewith enclosed. It should be noted that many of these institutions are only activated when an emergency is declared by the government (SOD 2010):

- **The National Disaster Management Council** is headed by the Honourable Prime Minister and is responsible for formulating new policy and delivering directives on all concerns.
- **The Inter-Ministerial Disaster Management Coordination Committee** is responsible for implementing policy and is headed by the Minister of Disaster Management and Relief.
- **The National Disaster Management Advisory Council** is headed by an experienced person nominated by the Prime Minister.
- **The National Platform for Disaster Risk Reduction** coordinates and provides necessary facilitation to relevant stakeholders.
- **The Focal Point Operation Coordination Group of Disaster Management** is led by the DG of DDM to review and coordinate the activities of various departments/agencies related to disaster management and also to revive the Contingency Plan prepared by concerned departments.
- **The NGO Coordination Committee of Disaster Management** headed by the DG DDM, reviews and coordinates the activities of concerned NGOs.
- **The Committee for Speedy Dissemination of Disaster Related Warning/Signals** is headed by the DG DDM to examine, ensure and find out the ways and means for the speedy dissemination of warning/signals among the people.

The **Local Consultative Group Mechanism (LCG)** is one of the key structures through which the Government engages in dialogue with development partners[230]. There are 18 thematic LCG Working Groups (in addition to the LCG Plenary) including the Disaster and Emergency Response (DER) which is co-chaired by the Secretary of Disaster Management and the UN Resident Coordinator.

- The DER is mandated to ensure effective coordination of national and international stakeholders around all aspects of the disaster management cycle.
- DER membership consists of senior decision makers from UN agencies, donors, and a representative of both the INGOs and NGOs.
- The DER is co-chaired by the UN Resident Coordinator and the Secretary, Ministry of Disaster Management and Relief.

The Local Consultative Group on Disaster and Emergency Management (LCG on DER) had 14 meetings as of January 2015 and the body is constituted of high level government and development partners, including many donors. It has purported to have improved humanitarian coordination, institutionalized Joint Needs Assessment, enhanced earthquake preparedness, implemented Disaster Management act 2012 in operationalizing data bases for volunteers, and made gains in addressing slow onset disasters such as waterlogging among others.[231] UNFPA contributed the need to consider RH issues as cross sectoral issues, such as the effect of salinity on pregnancy, etc. (UNFPA is not on distribution list? Unclear if UNFPA has contributed to Health Cluster Field Emergency Workers and Doctors and Nurses Manual - mentioned in April, 2015; UNFPA contingency of Safe Delivery kits not mentioned in the flood preparedness work in Cox' Bazaar, July 2015)

Within the LCG DER, **the Humanitarian Coordination Task Team (HCTT)** is a working group which provides an operational level forum for coordinated disaster preparedness, response, and recovery across sectors. The HCTT will act as an advisory group to the DER providing advice, taking forward agreed actions on behalf of, and feeding back to, the wider LCG DER group. The HCTT also acts as coordination platform of the thematic clusters. Membership of the HCTT includes: all cluster lead agencies, two donor representatives, three elected representatives of the INGO Forum Emergency Sub Group, one representative of the NGO community and IFRC. In Bangladesh, clusters were formed, with the Government's approval, to engage on disaster preparedness[232]. Currently, the clusters that were formed are: WASH, food security, early recovery, health, nutrition, education, logistics, child protection and shelter. Inter-cluster coordination takes place through the HCTT. (minutes)

Joint Response to Cyclone Komen in Bangladesh, August 2015: There is a brief HCTT minutes but do not find follow-up.

UNFPA has not assumed leadership in the clusters but will be taking the co-lead of the Health Cluster.[233]

The **Sexual and Reproductive Health Program in Crisis and Post-Crisis Situations (SPRINT)** project, supported locally by the Family Planning Association of Bangladesh (FPAB) and also part of regional initiatives IPPF South Asia, and ADPC, is receiving support from DFAD Australian Aid. The SPRINT Country Coordination Team, hosted by the Department of Disaster Management, with the aim of coordinating all RH in emergencies, consists of representatives from UNFPA, WHO, DGHS, BRCS, BRAC University, ADPC, and sector specialist, among others.

This is a relatively new body, organized February 2014, and has had 3 coordination meetings. Minutes in August 2014, suggested that SPRINT should be part of a health cluster, and SPRINT MISP training may overlap with UNFPA's MISP and would have to be coordinated. Minutes in July 2015 suggested more frequent meetings, stronger advocacy, revitalization of a Reproductive Health Cluster, to coordinate with DGHS, provide cash in emergencies, cover the needs of the disabled, and providing psychosocial support.

[230] http://www.lcgbangladesh.org/HCTT.php.

[231] LCG on DER, meeting minutes, January 27, 2015, April 2015, July 2015

[232] This does not imply formal UN Cluster activation.

[233] Key Informant Interview, October 2015.

Building partnerships
In the aftermath of natural disasters and the outbreak of armed conflict or political violence, immediate action is required to save and prevent the loss of lives. In order to have the capacity to promptly respond to acute needs emerging from a sudden natural disaster, UNFPA will work through strategic partnerships for collaboration, information sharing, and programme implementation, as summarized in a table found in **UNFPA's Emergency Preparedness and Contingency Plan, 2014**.

Partnerships with UNHCR and RTMI in Protracted Refugee Situation[234]. UNFPA's IP in the two camps have qualified staff. UNHCR facilitates the referrals of complicated cases to the District Hospital in Cox's Bazaar and also to Chittagong District Hospital, and covers transport, medicine. The Ministry of Disaster Management is in charge of the Refugee Health Unit. Approximately 10-15 patients a month go for C-sections. There are actually about 40% that receive C-sections. There were 2 ambulances contributed by UNFPA but only one is functioning and is covering both camps.

Coordination at the camp level is done by RTMI/UNFPA with the Refugee Health Unit. There was a gap in oversight in April 2015 as someone got sick from UNFPA. A gender advisor visited the camp but coordination suffered for one month, however, now the office in CB is re-established. Other than this gap, there has been good coordination through monthly meetings in CB, everyone attends. HCR provides suggestions to UNFPA and RTMI. Coordination over addressing issues could be more regular between the agencies, however, UNFPA has not been consistently present over the past 4-5 months and they have only one person to cover the whole district. The UNFPA office needs to supervise RTMI better and UNFPA should be there. The Ministry of Disaster Management has a refugee repatriation officer who they deal with. UNFPA should be present as RTMI cannot take a decision alone, for example, if there is a budgetary issue.

A major issue in the camps is the mixed marriage cases where a registered refugee has married a local person or an undocumented refugee. In this situation the spouse will not receive services unless it is an emergency. In these cases, UNFPA should advocate, as RTMI cannot do it. The undocumented will not get ANC card and sometimes they are on their own. IOM with ICRC and BDRC are providing for the undocumented refugees. There are 200,000 (or 250,000) undocumented Rohingya living in the Cox's Bazaar and Chittagong areas. There are also many undocumented living right outside the camps in makeshift camps and they receive services from public health facilities. UNFPA is not working with IOM and key informants in Cox's Bazaar think that UNFPA should work with IOM. For example, now they are proposing that an operating theatre be developed in the camp area to serve the camps and the undocumented so they do not have to go to Cox's Bazaar. RTMI can coordinate this OT locally. UNFPA's advocacy support is needed. The Upazilla Health complex has only 50 beds, it is a huge burden presently for the hospital, there is a need to discuss this idea with the local MoH. This action really needs to be taken now by the Dhaka based management.

RTMI has worked in the camps for (7) years and over that time, there has been a huge improvement, only 10% of births now take place in the sheds (group houses), it used to be 28%. Some prefer to use their own TBA, and more reinforcement is needed to get them to use the health structures. The CSBAs go door to door with messages on contraceptives, and get some incentives from UNFPA. There was a survey "Rapid Situation Analysis on RH and GBV and Youth and Adolescents", TAI is working on male involvement. They are discussing messages on LAPM. The IUDs and implants are a challenge, a paramedic comes once a month for IUD, the government is approving a new type of implant and training will be given.

In terms of Disaster Management and preparedness, there is a camp coordinator, and very good coordination for cyclone prep among the MoH, UNFPA, WFP, IOM for undocumented, and UNFPA. There is another forum for coordination of a health cluster.

RTMI data: Project Outcome:

Country Programme Output indicators	Baseline	Target for the year (January to December, 2014)	Updated indicator values for the year (1st January to 31 December, 2014)
Output 1			

[234] Key Informant Interviews, October 2015

Delivery conducted by skilled providers	100%	94.88%
Newborn care provided by skilled providers	100%	94.88%
Complicated delivery cases and newborn		
referred for better service	100%	100%
Timely reported rape cases received PEP	100%	100%

Wider acceptance and use of contraceptive methods and practices by the targeted beneficiaries leading to increased Contraceptive Acceptance Rate(CAR). 100% 66.40%

Output 2
Attendance of adolescents and youths in the A&Y corners: At least 1200 in each camp; Total 1614 numbers of girls and 2123 boys
Reproductive Health and Rights:

- ✓ **SRH information and MISP included in the national emergency preparedness and response plans and contingency plans:**

SPR 2014 – Output 3: Reproductive health and gender issues are incorporated into the national emergency preparedness and response plan – Yes

- **Estimated coverage of reproductive health kits, safe delivery kits or appropriate items distributed during emergencies (see chart above)**

SPR 2014 – 3,400 kits distributed

- ✓ **Evidence that training and capacity development has resulted in higher quality more gender sensitive services in emergencies:**

The following **interventions under AWP U201** "SRH Information and Services through DGHS/Ensuring RH service delivery in Nayapura and Kutupalong refugee areas/ Joint GOB-UN_MNH Initiative/ICT4RH" were undertaken to contribute to CP Output 1.1 and Output 1.2:

In 2012 and 2013, with IP Research Training and Management International (RTMI) interventions centered on **two refugee camps in Cox's Bazaar**, with training for nurse-midwives on Family Planning (FP), counseling, maternal health, safe delivery and post abortion, among others, in view of national standards and using a client centered approach through BCC campaigns and following referral systems. Interventions included reduction of gender-related barriers and gender based violence and targeting youth and adolescents. These interventions were carried forth in 2014 with inclusion of re-training and follow up and mentoring of RH service providers, special training for nurse-midwives and medical assistants on safe delivery, providing orientation to community leaders, running two birthing units and ensuring comprehensive FP services for the camp population.

In 2015, RTMI supported capacity development included clinical management of rape survivors, training for medical providers on complications of pregnancy and labor, and infection prevention. Support was provided to Community Health Assistants (CHAs) to transfer knowledge to the community and for community mobilization for camp and block management committees and community leaders. Support was also provided for coordination meetings with all stakeholders and operations for a Community Based Outreach Network with community volunteers.

Various stakeholders and levels of governance have benefited from MISP training, including central, district and sub-district government staff, the Bangladesh Red Crescent society, Local NGOs, and Youth (through local clubs and university forums). Types of training included Training of Trainers (ToT) and comprehensive workshops. UNFPA and partner staff benefited from regional ToT training in Bangkok for Sexual and Reproductive Health Program in Crisis and Post-Crisis Situations (SPRINT) in 2013 and 2014. Targeted areas for the training included some of the most vulnerable districts as indicated by the UNDAF, including Barguna, Patuakhali, Sirajganj and Sunamgonj. At district level, through the DGHS in

Patuakhali/Borguna districts in 2014, training was held for 27 participants, and 45 participants in Sunamganj and Sirajgang districts organized in 2015. MISP training in Bagerhat district will be organized from 21-23 December 2015. Under the Gender programmatic area, more than 200 district level service providers, managers, police officers were trained and oriented on MISP in 4 districts e.g. Cox's Bazar, Sylhet, Jamalpur and Patuakhali (Ministries of Home Affairs and Women and Children's Affairs projects).[235]

Evaluation of the training was conducted through pre- and post-tests measuring knowledge gained. Improvements were obvious in all workshops, however, it was noted that tests were administered in English and some participants had difficulty understanding the questions.[236] There is no evidence that the training was followed up at a later date to ascertain usefulness, or to what degree the ToT has resulted in replication of the workshop.

The MISP/ SPRINT training curriculum was prepared in the context of Bangladesh perspective. In 2016 formal training curricula and workshop agenda will be submitted to DGHS for approval. A printed Bangla version of the MISP Online training manual (1500 copies – being distributed to the training participants and also to the World Population Day 2015 participants).

Although Bangladesh is a very disaster prone country, the MISP training was not implemented in the current Country Programme until 2014, mainly due to staffing shortages. The training targets, and numbers trained out of those who needed to be trained are difficult to ascertain from programme documents, and there is no master plan for the MISP training. Without a master plan it is difficult to assess the rationale and coverage of the MISP and the means by which training was targeted to priority departments, districts and individuals.

A 9.2 National capacities to integrate demographic data in disaster response plans are strengthened	• Evidence of partnership between the DDM/MoDMR and the Bureau of Statistics • Evidence that data on affected populations are available and integrated in national response plans	• Comprehensive Disaster Management Program II (CDMP) • Department of Disaster Management (DDM)/MoDMR (Ministry of Disaster Management and Relief	• Interviews with National Project Director of CDMP • DG of DDM

- ✓ **Evidence of partnership between the DDM/MoDMR and the Bureau of Statistics:**
- ✓ **Evidence that data on affected populations are available and integrated in national response plans: (see flood response above).**

The Department of Disaster Management (DDM) under the Ministry of Disaster Management and Relief was set up in November 2012 following enactment of the Disaster Management Act 2012. The Department has the mandate to implement the objectives of Disaster Management Act and to execute the directions, recommendations by the Government in connection with disaster management as well as the national disaster management principles and planning. The DDM headed by the Director General focuses on networking and collaborating with the various Ministries, Departments and Scientific, Technical, Research, Academic institutions, Development Partners, UN Agencies and non-government Organizations within and outside the Government working on various aspects of disaster risk reduction and response management.

Key informant mentioned about lack of visibility of UNFPA's disaster response and their contribution or involvement in the national disaster management strategy and objectives.

[235] Data provided by the Country Office, December 2015

[236] UNFPA MISP Workshop reports, 2014, 2015

UNFPA as a development partner should share what they have to offer to the national disaster preparedness plan; and DDM may able to offer them better suggestion which will be more beneficial to the country. The contribution of the resident representative of UNFPA as co-chair of a LCG for DRR meeting held after a flash flood in Chittagong and Cox's Bazaar district was well acknowledged and praised for getting commitment of the LCG members for immediate food relief for the affected people.

Stronger communications with the DDM could provide opportunities for UNFPA with its P&D partners to collaborate on disaster preparedness and response.

UNFPA implementing partner BBS contributes by giving "Base Data" for preparation of the national response plan. The DDM also take assistance of BBS data for the "safety net" program. The key informant pointed out that they have excellent relationship with BBS and when invited that attend meetings and workshops at each other's office. After a disaster, DDM gets "Base Data" from BBS about the affected area. This data is generated at the Union level by BBS, and then forwards upward to DDM HQ in Dhaka. The information of the affected area include number of affected population and other damages like infrastructure, houses, crop, cattle, poultry etc. The "Base Data" is sent from the Upazila via e-mail quickly. The DDM is depending on the Base Data for planning their relief and rehabilitation is work.
UNFPA coordinates with district and national disaster management committees by having BBS share required data of the affected people by age and sex, location and poverty.

In 2014, UNFPA Bangladesh also generated a district-wide disaggregated population data as baseline information for contingency planning.[237]

[237] UNFPA Bangladesh Annual Report, 2014

Annex 8 Interview Guides

General Introduction and Closing - 1. Human connection
• Spend a few minutes to understand how the interviewee is today. Is the interview convenient or problematic in any way? Is s/he really busy and we should make the interview shorter than agreed? • Explain briefly something about yourself, where do you come from, other interviews you are doing that also frame this present interview, etc. • Thank the interviewee for the time dedicated to this interview.
2. Inform the interviewee of the objective and context of the interview
• Purpose of the evaluation - Clarify briefly the purpose of the evaluation. • Confirm the time available for the interview. • Stress the confidentiality of the sources or the information collected. • Explain what the objective of the interview (context) is. This not only shows respect, but is also useful for the evaluator, as it helps the interviewee to answer in a more relevant manner.
3. Opening general questions: refining our understanding of the interviewee's role
Before addressing the objectives of the interview, the evaluator needs to ensure that s/he understands the role of the interviewee vis-à-vis the organization, the programme, etc., so as to adjust the questions in the most effective way.
4. Ending the interview
• If some aspect of the interview was unclear, confirm with interviewee before finishing. Confirm that nothing that the interviewee may consider important has been missed: "Have I missed any important point?" • Finish the interview, confirming any follow-up considerations - e.g., if documents need to be sent and by when, if the evaluator needs to provide any feedback, etc. • Mention when the report will be issued and who will receive it • If relevant, ask the interviewee for suggestions/facilitation about other key persons (referred to during the meeting) that could also be interviewed. • Thank the interviewee again for the time dedicated to this interview.

UNFPA Bangladesh - Reproductive Health and Rights – Adolescent and Youth SRH - Humanitarian
Key Informant Interview Guide for Donors, Implementers of the Programme and Implementers of Similar Programmes

UNFPA staff, Ministry of Health and Family Welfare, Ministry of Education, DWA, staff from health clinics in the districts, refugee camps and communities (key informants) participating in MNHI and Urban Health, NGO Implementing Partners, UN agencies, Donors

Use General Introduction - Purpose of the evaluation
I am (we are) part of a four person team to evaluate UNFPA's 8th Country Programme of Assistance to the Government of Bangladesh (2012-2016) to help UNFPA plan the next country programme. It is an independent evaluation and this is a confidential interview to understand how well UNFPA has positioned itself with the communities and national partners to add value to the country development results. The goal of the evaluation is to draw key lessons from past and current cooperation and provide clear options for the future. We will be talking to many stakeholders including beneficiaries and visiting project sites in Dhaka, Jamalpur, Patuakhali, Barisal and Cox's Bazaar.
Core interview: objectives of the interview guide transformed into questions
1. **Objective: Rationale for the project and activities undertaken (needs assessments, value added, targeting of the most vulnerable, extent of consultation with targeted people, ability and resources to carry out the work, gender sensitivity)** **Possible questions:** a. How did you decide to undertake this work, what were the indications that it would be effective and would reach the target population? b. Are assessments or survey results available? c. Who was consulted regarding the design? d. What other actors have been involved, how does this activity contribute to that of others? 2. **Objective: Relevance of the project/activities to the UN priorities, government policies, local structures, to changes in the political and institutional situation** **Possible questions:** a. How well does the activity/work support the government's priorities and work within the national structures that are in place? How well does it work within private structures? b. How well is the work designed to achieve the outcomes/results in the UNDAF? (more equitable utilization of quality health and population, education, water, sanitation and HIV services, key life-saving, care and protective behaviors and raise demand for quality social services) 3. **Objective: Effectiveness of the approaches/activities/projects used to improve access to high quality RH and FP services and for the most vulnerable.** **Possible questions:** a. What are the indications that the approach is working or making progress toward goals established for 2016 (e.g. anecdotes which provide illustrations of positive, negative or unintended effects, or quantitative and qualitative evidence) (numbers being reached, products produced/purchased and the extent of impact, evidence of usage of knowledge, increasing networks, etc.) b. What are the barriers/challenges to increasing demand and access to services, and how are they being addressed? c. Are the capacities in place among stakeholders to be able to carry out the activities/project without support from UNFPA? Is there an exit strategy?

d. Are financial resources available?
e. Will the results of the project last after is it over?

4. **Objective: Efficiency of use of UNFPA resources (partners, staff, money, global experience)**

Possible questions:

a. Did your work receive the needed support from UNFPA in terms of advice, staff inputs, money or technical assistance, what were the strengths and weaknesses?
b. Did you receive any other donor support in connection with the UNFPA work? Did UNFPA promote greater connections and resources from the government or national actors?

5. **Objective: Functioning of coordination mechanisms**

Possible questions:

a. Do you work with other UN agencies and NGOS and/or can you say how well the activities are coordinated, overlapping?
b. Are there gaps in the population needs which would not have been identified by the UN system, collectively?

6. **Objective: The value of UNFPA work to national development**

Possible questions:

a. How big of a difference is UNFPA making in RH in Bangladesh, what contributes to its effect, what detracts?
b. Can UNFPA input be improved or strengthened?

7. **Objective: Interviewee recommendations**

UNFPA Bangladesh - Reproductive Health and Rights -
Focus Group Interview for Adolescents and Youth - Participating in Adolescent Spaces, Centers and Clubs

Opening general questions: refining our understanding of the interviewee's role

I am part of a four person team to evaluate UNFPA's 5th Country Programme of Assistance to the Government of Bangladesh (2012-2016) to help UNFPA plan the next country programme, we are looking at how effectively UNFPA has helped young people to understand the issues in health.

Can we introduce ourselves?

Core interview: objectives of the interview guide transformed into questions

1. **Objective: Rationale for the project and activities undertaken**

Possible questions:

a. How old are you? Are you in school? (note sexes and ages)
b. Please describe your participation in the intervention, how often do you visit the adolescent space?
c. What activities are offered in the space?

2. **Objective: Relevance of the project/activities to the UN priorities, government policies, local structures, to changes in the political and institutional situation**

Possible questions:

a. What SRH information have you received in the space? What information have you received about gender equality/ How useful was this information?
b. What is your knowledge on key concepts? (Ask questions regarding issues of child marriage, legal age for marriage, numbers of children desired and reasons for wanting the number of children, rights for sexual and reproductive health, etc.)

3. **Objective: Effectiveness of the approaches/activities/projects used to improve access to high quality RH and FP services and for the most vulnerable.**

Possible questions:

a. How will you use the information in your lives?
b. Are you satisfied with the way the information is presented to you? Are you satisfied with the space and what it offers?
c. What information do you want that is not offered?

4. **Objective: Efficiency in the use of UNFPA resources (partners, staff, money, global experience)**

Possible questions:

a. What problems do you have in accessing the space? ? Do you know others who would like to participate but cannot access the space?
b. How is the quality of the presentation of the information? Do you understand the information?
c. Did you give feedback on the services and space and see improvement?

5. **Objective: Functioning of coordination mechanisms**

Possible questions:

a. Does your school advise you of the space and activities that are available?
b. Do you tell your class mates about the space? Who is not attending who should be attending?

6. **Objective: The value of UNFPA work to national development**

Possible questions:

a. Do you think that adolescents coming to the spaces would help with reproductive rights in Bangladesh? How?

7. **Objective: Interviewee suggestions/recommendations (collect recommendations and review them)**

UNFPA Bangladesh - Reproductive Health and Rights -
Focus Group Interview for Midwifery Students and Midwifery Instructors

Opening general questions: refining our understanding of the interviewee's role

I am evaluating UNFPA's work with the Ministry of Health, the Department of Nursing Services, Bangladesh Nursing and Midwifery Council (BNMC), the Medical Colleges and Nursing Colleges.

Can we introduce ourselves? What is your role and function? What activities you have participated in or services you have received that are supported by UNFPA?

Core interview: objectives of the interview guide transformed into questions

1. Objective: Rationale for the project and activities undertaken

Possible questions:

a. What were, and are the priority needs for nursing in Bangladesh? How does your training or teaching fit in?
b. Is the program you are teaching or was your training well planned?

2. Objective: Relevance of the project/activities to the UN priorities, government policies, local structures, to changes in the political and institutional situation

Possible questions:

c. How relevant are the curriculums or training contents and design?
d. How effective/up to date are the teachers and the training instructors? Materials and methods?
e. How will your training and education benefit the health system in Bangladesh?

3. Objective: Effectiveness of the approaches/activities/projects used to improve access to high quality RH and FP services and for the most vulnerable.

Possible questions:

f. What has been the impact of your training or the education program?
g. What was strong and effective? What needed improvement?
h. What was helpful for you regarding your objectives for nursing or your career?
i. Is there adequate access to practical midwifery experience?
j. Are there enough teachers and teaching materials?

4. Objective: Efficiency in the use of UNFPA resources (partners, staff, money, global experience)

Possible questions:

k. Was the design of the program, duration, location, etc. well planned?
l. Were there areas which were not useful and could have been left out? Were there are areas where you needed further information to be effective?
m. How was the training monitored and evaluated? Did you give feedback and notice improvement?

5. Objective: Functioning of coordination mechanisms

Possible questions:

n. Do you receive assistance from other agencies or individuals? Do they work together?

o. What is your support from the DNS and BNMS?

6. Objective: The value of UNFPA work to national development

Possible questions:

p. How big of a difference will your work make for nursing and midwifery services?

q. Where do you expect the new midwives to be placed and will that be effective?

7. Objective: Interviewee suggestions/recommendations (collect recommendations and review them)

UNFPA Bangladesh - Reproductive Health and Rights -
Focus Group Interview for Recipients of RH Services in Health Centers and Communities (Refugees, Slum Dwellers, Health Service Clients)

Opening general questions: refining our understanding of the interviewee's role

I am evaluating UNFPA's contribution to SRHR assistance in Bangladesh. I want to understand how helpful this work has been for you and your community.

Can we introduce ourselves? (Ages, sex. etc.) Can you explain when you started to receive services? What activities you have participated in or services you have received?

Core interview: objectives of the interview guide transformed into questions

1. **Objective: Rationale for the project and activities undertaken**

Possible questions:

a. What were, and are your priority needs for your reproductive health?
b. How well have you been consulted about your needs?

2. **Objective: Relevance of the project/activities to the UN priorities, government policies, local structures, to changes in the political and institutional situation**

Possible questions:

c. What information have you received? Was the information you received important to help you make RH decisions?
d. Were you able to access the services you need? If not, what is the barrier?

3. **Objective: Effectiveness of the approaches/activities/projects used to improve access to high quality RH and FP services and for the most vulnerable.**

Possible questions:

e. What decisions have you made about birth spacing, contraceptive usage? Is your husband involved in this decision?
f. What are the issues for you regarding your choice of contraceptives? (types of contraceptives chosen, questions about pros and cons)
g. What information or services are you still lacking?
h. How do you think the services can be improved?

4. **Objective: Efficiency in the use of UNFPA resources (partners, staff, money, global experience)**

Possible questions:

i. Did you receive the services when you needed them to prevent pregnancy or during pregnancy?
j. Where there delays, shortages of contraceptives? Did you receive what you expected?
k. Were you consulted afterwards about your use of the items and services?

5. **Objective: Functioning of coordination mechanisms**

Possible questions:

l. Do you receive assistance from other agencies or individuals? Do they work together?

6. Objective: The value of UNFPA work to national development

Possible questions:

m. How big of a difference has this work made in your life and the lives of your families?

n. Can the services be improved or strengthened?

UNFPA Bangladesh – Gender Component
Key Informant Interview Guide for Implementing Partners of the Programme

UNFPA Gender staff, Director General and Project Director, Department of Women Affairs (DWA); Ministry of Women and Children Affairs (MoWCA);

Project Director, Ministry of Home Affairs (MOHA); Project Director, Directorate of Secondary and Higher Education (DSHE), Ministry of Education (MoE); Additional Inspector General of Police; Project Director, Bangladesh Women Chamber of Commerce and Industry (BWCCI); Project Director: Bangladesh Garments Manufacturers and Exporter's Association (BGMEA); BBC MEDIA; Plan International; Staff Women Help Desk (WHD); One Stop Crisis Centre (OCC); Deputy Commissioner (DC) Jamalpur; Superintendent of Police, Jamalpur and Cox's Bazar; Woman village ambassador (Jamalpur)

Core interview

1. **Objective: Degree and quality of involvement in the particular programme / project (i.e. the particular stage in which they got involved, awareness of objectives, needs, etc.)**

Possible questions:

- How long have you been involved in this programme / project?
- In which stages have you taken part? (design, implementation, etc.)
- What do you think about the pursued objectives / target groups?
- Could you describe the activities undertaken and your role within the implementation process?

2. **Objective: Relevance of the programme / project objectives for government priorities, targeted groups, etc.**

Possible questions:

- How did you decide to undertake this work, what were the indications that it would be effective and would reach the target population?
- How well does the activity/work support the government's priorities and work within the national structures that are in place? How well does it work within private structures?
- What can you say about the gender sensitivity of the programme activities?

3. **Objective:Cooperation, coordination and relations with UNFPA, donors, other implementing partners (from public, private sector, NGOs) and beneficiaries**

Possible questions:

- What other actors have been involved, how does this activity contribute to that of others?
- How would you describe your relations with UNFPA and the support provided by them?
- How would you describe your relations with other implementing partners?
- How would you describe your relations with the beneficiaries of the project?
- Do you think the channels of dialogue with other partners and beneficiaries are sufficient? In what ways could they be improved?
- Do you work with other UN agencies and/or can you say how well the activities are coordinated, overlapping?
- Are there gaps in the gender and gender based violence (GBV) needs which would not have been identified by the UN system, collectively?

4. **Objective: Sustainability, ownership and capacity building within the framework of the particular project/programme**

Possible questions:

- What are the particular gains your institution has provided from this project?
- What do you think about the sustainability of the project?
- What are the main factors affecting sustainability?
- Are the capacities in place among stakeholders to be able to carry out the activities/project without support from UNFPA?.

5. **Objective: Effectiveness of the approaches/activities/projects**

Possible questions:

- What are the indications that the approach is working or making progress toward goals established for 8th CP?
- What are the main strengths and weaknesses of this programme? In what ways could the weaknesses be addressed?

6. **Objective: Efficiency of use of UNFPA resources (partners, staff, money, global experience)**

Possible questions:

- Did your work receive the needed support from UNFPA in terms of advice, staff inputs, money or technical assistance, what were the strengths and weaknesses?
- Did you receive any other donor support in connection with the UNFPA work? Did UNFPA promote greater connections and resources from the government or national actors?

7. **Objective: Perceived difficulties / challenges for the smooth implementation of the programme/project (including the impacts of changing development context, changing national priorities, institutional structures, etc.)**

Possible questions:

- Have you experienced any particular difficulties/obstacles in project implementation?
- Have they been resolved effectively? What were the main factors leading to their resolution?
- Have your activities been affected by recent changes in legal/administrative context?

8. **Objective: The value of UNFPA work to national development**

Possible questions:

- How big of a difference is UNFPA making in gender equality in Bangladesh, what contributes to its effect, what detracts?
- Can UNFPA input be improved or strengthened?
- What are the strengths and weaknesses of UNFPA
- How can you compare UNFPA with other major international funding organizations?

9. **Objective: Interviewee recommendations**

UNFPA Bangladesh – Gender Component
Key Informant Interview Guide for Donors

KINGDOM of Netherlands

Opening

I am part of a four-person independent evaluation team for the UNFPA's 8th Country Programme of Assistance to the Government of **Bangladesh** (2012-2016) to help UNFPA plan the next country programme, it is an independent evaluation, to understand how well UNFPA has positioned itself with the communities and national partners to add value to the country development results and to draw key lessons from past and current cooperation, as well as to provide clear options for the future. We will be talking to many stakeholders including beneficiaries and visiting Jamalpur and Cox's Bazaar.

Core interview

1. Objective: Relevance of the programme / project objectives for government priorities, targeted groups, etc.

Possible questions:

- How long have you been involved in this programme / project?
- How did you decide to undertake this work, what were the indications that it would be effective and would reach the target population?
- What do you think about the pursued objectives / target groups?

2. Objective:Cooperation, coordination and relations with UNFPA and implementing partners (from public, private sector, NGOs)

Possible questions:

- Can you describe your relations with UNFPA? What is the extent of support, guidance, assistance provided by the agency?
- How would you describe your relations with other implementing partners?
- How would you describe your relations with the beneficiaries of the project?
- Do you think the channels of dialogue with stakeholders are sufficient? In what ways could they be improved?
- Do you work with other UN agencies and/or can you say how well the activities are coordinated, overlapping?

3. Objective: Sustainability of the particular project/programme

Possible questions:

- What do you think about the sustainability of the project?
- What are the main factors affecting sustainability?
- Are the capacities in place among stakeholders to be able to carry out the activities/project without support from UNFPA?

4. Objective: Perceived difficulties / challenges for the smooth implementation of the programme/project (including the impacts of changing development context, changing national priorities, institutional structures, etc.)

Possible questions:

- Have you experienced any particular difficulties/obstacles in project implementation?

- Have they been resolved effectively? What were the main factors leading to their resolution?
- Have your activities been affected by recent changes in legal/administrative context?

5. Objective: The value of UNFPA work to national development

Possible questions:

- How big of a difference is UNFPA making in gender equality and reducing GBV and child marriage in Bangladesh, what contributes to its effect, what detracts?
- Can UNFPA input be improved or strengthened?
- What are the strengths and weaknesses of UNFPA
- How can you compare UNFPA with other major international funding organizations you worked with?

6. Objective: Interviewee recommendations

UNFPA Bangladesh– Gender Component
Focus Group Interview Guide for Beneficiaries

Opening

I am part of a four-person independent evaluation team for the UNFPA's 8th Country Programme of Assistance to the Government of Bangladesh (2012-2016) to help UNFPA plan the next country programme, it is an independent evaluation, to understand how well UNFPA has positioned itself with the communities and national partners to add value to the country development results and to draw key lessons from past and current cooperation, as well as to provide clear options for the future. We will be talking to many stakeholders including beneficiaries and visiting Jamalpur and Cox's Bazaar.

Core interview

1. Objective: Relevance of the programme / project objectives for targeted groups,

Possible questions:

- How and how long have you been involved in this programme / project?
- How were you reached to take part in this programme /project?
- What do you think about the activities undertaken?

2. Objective:Relations with UNFPA and implementing partners (from public, private sector, NGOs)

Possible questions:

- Can you describe your relations with UNFPA? What is the extent of support, guidance, assistance provided by the agency?
- What do you think about the communication channels with UNFPA and other partners (if relevant)

3. Objective: Importance of the service provided

Possible questions:

- How would you describe the gains provided by this programme?
- Can you talk about the concrete impacts of these gains in your life? What kind of impacts?
- Do you face any difficulties / obstacles in benefiting from these gains? In what ways can they be improved

4. Objective: The value of UNFPA work

Possible questions:

- What do you think about the role of UNFPA in this project? What are its strengths and weaknesses?

5. **Objective: Interviewee recommendations**

UNFPA Bangladesh – Population and Development (PD)
Key Informant Interview Guide for Implementers of the Programme

Bangladesh Bureau of Statistics (Census and GIS units), Department of Population Science of Dhaka University, Bangladesh Parliament Secretariat, General Economic Division of the Planning Commission, Socio-economic Infrastructure Division of Planning Commission, Population Council, District Development Committee, BIDS or other relevant research organization, UNDP and relevant network of CSOs and NGOs

Use General Introduction - Purpose of the evaluation

I am (we are) part of a four person team to evaluate the 8th Country Programme of Assistance to the Government of Bangladesh (2011-2015) to help UNFPA plan the next country programme. It is an independent evaluation and this is a confidential interview to understand how well UNFPA has positioned itself with the communities and national partners to add value to the country development results and to draw key lessons from past and current cooperation and provide clear options for the future. We will be talking to many stakeholders including beneficiaries and visiting programmes in Dhaka, Patuakhali, Barisal, and Cox's Bazar.

Core interview: objectives of the interview guide transformed into questions

Objective: Relevance

1. How did you decide to undertake the project/programme? Was there a need assessment? Did the project target the most vulnerable population?
2. How do you think the project/programme objective address the needs of the population (in particular the needs of vulnerable groups)? What was the extent of consultation with the targeted population? Was the gender sensitivity issues taken into consideration? How?
3. Who was consulted regarding the design of the project/programme? What other actors/stakeholders were involved in project design?
4. Do you think the project's activity/work support the government's priorities and work within the national structures that are in place? Which are those priorities? How? How well does it work within private structures?
5. Do you think the Country Program is aligned with policies and strategies of UNFPA (2012-2016)? Which policies and strategy? How? (for UNFPA)
6. To what extent is the UNFPA country programme aligned with the United Nations Development Assistance Framework (UNDAF) for 2012-2016?
7. To what extent was the UNFPA country office able to respond to changes in the national development context? What are those contexts? How?

Objective: Effectiveness

8. To what extent have the planned outputs contributed to achieving the outcomes (illustrations of positive, negative or unintended effects, or quantitative and qualitative evidence) (numbers being reached, products produced/purchased and the extent of impact, evidence of usage of knowledge, etc.)?
9. To what extent are the technical approaches and capacity development strategies relevant and effective in achieving the outputs and outcomes?
10. What is the effectiveness of the IPs in contributing to the outputs and outcomes? Are they well aligned and efficient to contribute to the outcomes?
11. What were the barriers/challenges and how were they being addressed?

Objective: Efficiency

12. Did your work receive the needed support from UNFPA in terms of advice, staff inputs, money or technical assistance? What were the strengths and weaknesses of that

support?

13. To what extent were programme resources spent?
14. Did you receive any other donor support in connection with the UNFPA work? Did UNFPA promote greater connections and resources from the government or national actors?
15. What is the efficiency of having so many partners? Are they appropriately and adequately contributing to the CP outcomes? (ask UNFPA)

Objective: Sustainability

16. Are the capacities in place among stakeholders to be able to carry out the activities/project without support from UNFPA?
17. Are financial resources available?
18. To what extent are the results of UNFPA supported activities likely to last after termination of the project/programme?
19. Is there an exit strategy? (for UNFPA)

Objective: Coordination

20. Do you work with other UN agencies and/or can you say how well the activities are coordinated, overlapping?
21. Are there gaps in the population needs which would not have been identified by the UN system, collectively?
22. To what extent did UNFPA contribute to coordination mechanisms in the UN system in Bangladesh?

Objective: Complementarity

23. To what extent did UNFPA contribute to complementarity (i.e. avoiding overlap and duplication of activities / seeking synergies) among UN agencies in Bangladesh?

Annex 9 Examples of South-South Cooperation

Cooperation	Participant/s	Organizer	Location and Dates	Source of Information
2012				
South-South Collaboration for ICPD beyond 2012	Youth Forum	Jointly organized by the People's Republic of Bangladesh and PPD	November 2012, Dhaka, Bangladesh	COAR 2012
"*Building Youth Leadership: Asia-Regional Training for Youth Advocates".* This provided the participants with knowledge of the ICPD and MDG review process and assessed how their commitments have been implemented at the country level.	Two UNFPA Youth Forum members and one youth	UNFPA Regional Office	Bangkok, Thailand in June 2012	COAR 2012
Bali Global Youth Forum A conference with support from CO, the government and CO -affiliated youth groups. It comprised young people from various backgrounds and had a gender equality balance. The group engaged in World Population Day, ICPD validation group work, Youth Conference 2012 etc.	A group of Youths (5 persons including two UNFPA Youth Forum for RH members) and a Government Official	Global Youth Forum	Bali, Indonesia	COAR 2012
Asia Pacific Regional Conference on Midwifery	Three government officials (Bangladesh Nursing Council, Directorate of Nursing Services and Bangladesh	International Confederation of Midwives (ICM)	Hanoi, Vietnam, 24-26 July 2012	COAR 2012

Cooperation	Participant/s	Organizer	Location and Dates	Source of Information
	Midwifery Association), one journalist and UNFPA JPO (Midwifery)			
Annual Midwifery Programme Mid-Year Review and Technical Capacity Building workshop	UNFPA JPO (Midwifery)	International Confederation of Midwives (ICM)	Addis Ababa, Ethiopia, 17-21 September 2012	COAR 2012
20th FIGO World Congress of Gynecology and Obstetrics	Three GOB under MOHFW officials and UNFPA JPO (Midwifery)	International Federation of Gynecology and Obstetrics (FIGO)	Rome, Italy, 7-12th October 2012	COAR 2012
Exchange of views between officials of Bangladesh and officials of the Philippines on the integration of P&D in national and sectoral development planning processes.	Planning Commission officials	UNFPA with assistance from the Philippines CO	Philippines CO	COAR 2012
Census Data Capturing, Processing and Analysis. Through this visit, BBS discovered how to how to develop a sustainable system for census operation.	22 BBS officials	Jointly organized by UNFPA Bangladesh and BPS - Statistics Indonesia	Indonesia 6 to 12 November 2012	COAR 2012
An exchange of experience between MPs. Meetings with relevant standing committee members to share policies, strategies, plans/programmes related to P&D issues, along with visits to different government and NGOs offices			Three study tours to Thailand, Philippines and Republic of Korea.	COAR 2012
A sharing of VAW programme activities with regional facilitation team. This includes P4P, ICDC based in Bangkok - Inter-agency planning and knowledge sharing meeting on preventing and responding to violence	UNFPA staff	Regional Office - APRO	Bangkok, December 2012	COAR 2012

Cooperation	Participant/s	Organizer	Location and Dates	Source of Information
against women				
2013				
Mission to conduct surgery and treatment of obstetric fistula patients as well as to train (East Timor) hospital staff on fistula surgery	Prof. Sayeba Akhter and Dr. Fahmida Zabin	Country Office	Dili, Timor Leste from 11-19 November 2013	COAR 2013
Strengthening the analytical skill in Population Planning for official of Ministry of Planning and UNFPA. These provided opportunities for the senior officials on how other countries addressing the population issues and development needs.	12 government planning officials	UNFPA with assistance from the Vietnam CO	Vietnam 2013	COAR 2013
Orienting project staff. AFPP&D also supported development of the 2013-2016 Advocacy plan for BAPP&D. Finalize TOR for BAPP&D.			support from AFPP&D through APRO	COAR 2013
UN- Global Geospatial Information Management (UNGGIM)	3 BBS high officials and one UNFPA staff		Cambridge, UK	COAR 2013
A week-long XXVII International Population Conference	Joint Chief and Project Director, GED	International Union of the Scientific Study of Population (IUSSP).	Korea on 26-31 August 2013	COAR 2013
M&E and Formative Research Workshops for "Generation Breakthrough" in and "UNV/UNFPA capacity building workshop with support from P4P for National and International UN Volunteers in Bangladesh"	Country Office, regional office and partners	Country Office	Dhaka, Bangladesh, 17-21 June 2013 and from 10-16 October 2013.	COAR 2013
2014				
The State of the World's Midwifery Report (2014) was launched at the International Confederation of Midwives (ICM) Conference in early June 2014. This session presented	MOHFW	Conference sponsored by the International	2014 held in Colombo, Sri Lanka	UNFPA Annual Report 2014

Cooperation	Participant/s	Organizer	Location and Dates	Source of Information
the key findings of the 2014 report, followed by country perspectives from four countries of the South Asian region that participated in the development of the report: Bangladesh, India, Nepal and Pakistan.		Federation of Gynecology and Obstetrics (FIGO), the South Asia Federation of Obstetrics and Gynecology (SAFOG), and the Sri Lankan College of Obstetrician and Gynecologists, (SLCOG)		

Cooperation	Participant/s	Organizer	Location and Dates	Source of Information
"Integrated Geospatial and Statistical Information". Received international exposure on Integrated Geospatial and Statistical Information	6 officials of BBS		Beijing, China during 9-12 June 2014 and at UN HQ, New York, USA during 4-8 August 2014	SPR 2014 up to March 2015
Census Data Capturing and Geo-Database Creation	15 BBS officials from Census Wing and SID	Indonesian National Statistical Office		SPR 2014 up to March 2015
Asia/Pacific Regional Conference 2014 at Thailand	Assistant Chief of GED	Help Age International and UNFPA	Thailand (1-4 Sep 2014)	SPR 2014 up to March 2015
Training of Economic Policy Research Institute	Deputy Chief of GED		Thailand 6-17 Oct 2014	SPR 2014 up to March 2015
Study visit to enhance the level of knowledge and understanding of Parliamentarians on P&D related issues	4 MPs, 4 Parliament Secretariat officials and one staff	Eastern Asia University of Thailand	27 Nov-3Dec 2012	SPCDP SPR Jul-Dec 2012
Collaboration with UNECLAC to disseminate Census micro data by installing REDATAM application in the BBS website	Two experts from UNECLAC conducted two separate missions to Bangladesh	Bangladesh Bureau of Statistics (BBS)	January – December 2015	PPR Component

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