



INDEPENDENT COUNTRY PROGRAMME EVALUATION BANGLADESH

2012 – 2016

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FOREWORD

The independent Evaluation Office is pleased to present the evaluation of the UNFPA eighth country programme of assistance to the Government of Bangladesh, covering the period 2012-2016.

The evaluation is an independent assessment of the relevance, the performance and the strategic positioning of UNFPA in Bangladesh. It draws lessons from past and present cooperation and provides a set of strategic and actionable recommendations to inform the next country programme cycle. This evaluation also serves as a pilot exercise for a clustered country programme evaluation of UNFPA engagement in highly vulnerable contexts. As part of this broader study, the Bangladesh country programme evaluation discusses how UNFPA has been able to take into account and address the specific causes of vulnerability in Bangladesh.

The evaluation found that UNFPA supported interventions were well targeted and designed so as to address the needs of vulnerable groups, while further attention needs to be paid to specific groups such as women and girls at risk of gender based violence, undocumented refugees or those most at risk for sexually transmitted diseases. Adolescents and youth feature prominently among the beneficiaries of UNFPA supported interventions, in alignment with the national objective to realize a demographic dividend. UNFPA has contributed to an improved quality and accessibility of maternal health and family planning services, although the demand is hampered by insufficient knowledge on the part of potential beneficiaries about these services, the existence of socio-cultural barriers and crowded or underdeveloped facilities. In the area of population and development, UNFPA has contributed to the strengthening of national capacities to collect and analyse population data and has promoted the use by the Bangladesh Bureau of Statistics of up-to-date data collection and validation techniques. In the field of gender equality, UNFPA has contributed towards the reduction of gender-based violence and of child marriage in targeted districts and municipalities.

As far as emergency preparedness and the capacity to respond to crises are concerned, UNFPA has achieved some significant results. Of particular note, the UNFPA emergency preparedness and contingency plan adequately considers major hazards and potential emergency situations. In addition, UNFPA has contributed to an improved access to and use of reproductive health and family planning services by Rohingya refugees living in camps. Addressing the needs of the undocumented refugees living outside of the camps and who represent the vast majority of refugees remains, however, an area for improvement.

In view of its next country programme for Bangladesh, UNFPA should focus on prioritizing and targeting women and girls most vulnerable to abuse of their rights, who are at high risk of morbidity, mortality and psychological hardship. Particular attention should be paid to those not fully accessing the health and education systems.

With regard to emergency preparedness and the response to crises, UNFPA should take a more active role in the United Nations joint assessments and response, and ensure that preparedness and response are reproductive health and gender sensitive. UNFPA should also work toward stronger communication and coordination with the Government and the other United Nations agencies as well as other stakeholders supporting disaster and emergency affected populations such as documented and undocumented refugees.

I hope that this evaluation will be helpful in demonstrating the contribution of UNFPA to the development results of Bangladesh, and that it provides useful lessons for consideration in the preparation of the ninth country programme.

Andrea Cook

Director, Evaluation Office

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www.unfpa.org/evaluation

Annex 1 Bangladesh eighth country programme evaluation terms of reference

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Annex 6 Overview of Budget versus Expenditure 2012-2015

Annex 7 Evaluation matrix

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ABBREVIATIONS AND ACRONYMS

AFHS	Adolescent Friendly Health Corners
ANC	Antenatal Care
APRO	Asia and the Pacific Regional Office (UNFPA)
APWR	Advancement and Promotion of Women’s Rights
ASRH	Adolescent Sexual Reproductive Health
AWP	Annual Work Plans
BAPPD	Bangladesh Association of Parliamentarians on Population and Development
BBS	Bangladesh Bureau of Statistics
BCC	Behaviour Change Communication
BDHS	Bangladesh Demographic and Health Survey
BEF	Bangladesh Employers’ Federation
BGMEA	Bangladesh Garments Manufacturers and Exporters Association
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
BWHC	Bangladesh Women’s Health Centre
CAR	Contraceptive Acceptance Rate
CBE	Clinical Breast Exams
CCA	Common Country Assessment
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CERF	Central Emergency Response Funds
ChaNGE	Changing gender equality Norms of Garment Employees
CHA	Community Health Assistants
CHV	Community Health Volunteers
CIDA	Canadian International Development Agency
CIN	Cervical Intraepithelial Neoplasia
COAR	Country Office Annual Report
CP	Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document

CPR	Contraceptive Prevalence Rate
CRHCC	Comprehensive Reproductive Health Care Centres
CRHW	Community Reproductive Health Workers
CSBA	Community Skilled Birth Attendant
CSO	Civil Society Organization
CSG	Community Support Groups
CSW	Commission on the Status of Women
CWFD	Concerned Women for Family Development
DDM	Department for Disaster Management
DER	Disaster Emergency Response
DFATD	Department of Foreign Affairs, Trade and Development (CIDA)
DFID	Department for International Development
DGHS	Directorate General of Health Services
DGFP	Directorate General of Family Planning
DGFP -MNCAH	Directorate General of Family Planning Maternal Child and Adolescent Health
DH	District Hospital
DIS	Demographic Impact Study
DMCH	Dhaka Medical College and Hospital
DNS	Department of Nursing Services
DPS	Department of Population Sciences, Dhaka University
DRLS	Directorate of Land Record and Survey
DRRO	Disaster Relief and Response Office
DWA	Department of Women Affairs
DWA APWR	Dept Women’s Rights -Advancement and Promoting Women’s Rights
ECNEC	Executive Committee of National Economic Council
EMOC	Emergency Maternal Obstetric Care
EmONC	Emergency Obstetric and Newborn Care
EORHR	Economic Opportunities and Sexual & Reproductive Health and Rights
ERD	Economic Relations Division (of the Ministry of Finance)
ERG	Evaluation Reference Group
ESCAP	United Nations Economic and Social Commission for Asia and the Pacific
EU	European Union
EVA	Especially Vulnerable Population
FACE	Funding Authorisation and Certificate of Expenditure

FGD	Focus Group Discussion
FIGO	International Federation of Gynaecology and Obstetrics
FP	Family Planning
FPAB	Family Planning Association Bangladesh
FWA	Family Welfare Assistant
FWC	Family Welfare Centres
FWV	Family Welfare Volunteer
FY	Fiscal Year
GBV	Gender Based Violence
GDP	Gross Domestic Product
GE	Gender Equality
GED	General Economics Division
GEMS	Gender Equity Movement in Schools
GIS	Geographical Information Systems
GoB	Government of Bangladesh
GRB	Gender Responsive Budget
HA	Health Assistant
HACT	Harmonized Approach to Cash Transfer
HCTT	Humanitarian Country Task Team
HDI	Human Development Index
HNP	Health Nutrition and Population
HPNSDP	Health Population and Nutrition Sector Development Plan
IASC	Inter-Agency Standing Committee
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
ICT	Information and Communications Technology
ICT4RH	Information and Communications Technology For Reproductive Health
IDU	Injecting Drug User
IOM	International Organization for Migration
IPCAT	Implementing Partner Capacity Assessment Tool
IPPF	International Planned Parenthood Federation
JICA	Japan International Cooperation Agency
JPO	Junior Professional Officer
JP-VAW	Joint Project - Violence Against Women
KAP	Knowledge, Attitudes and Practice
KAPs	Key Affected Populations

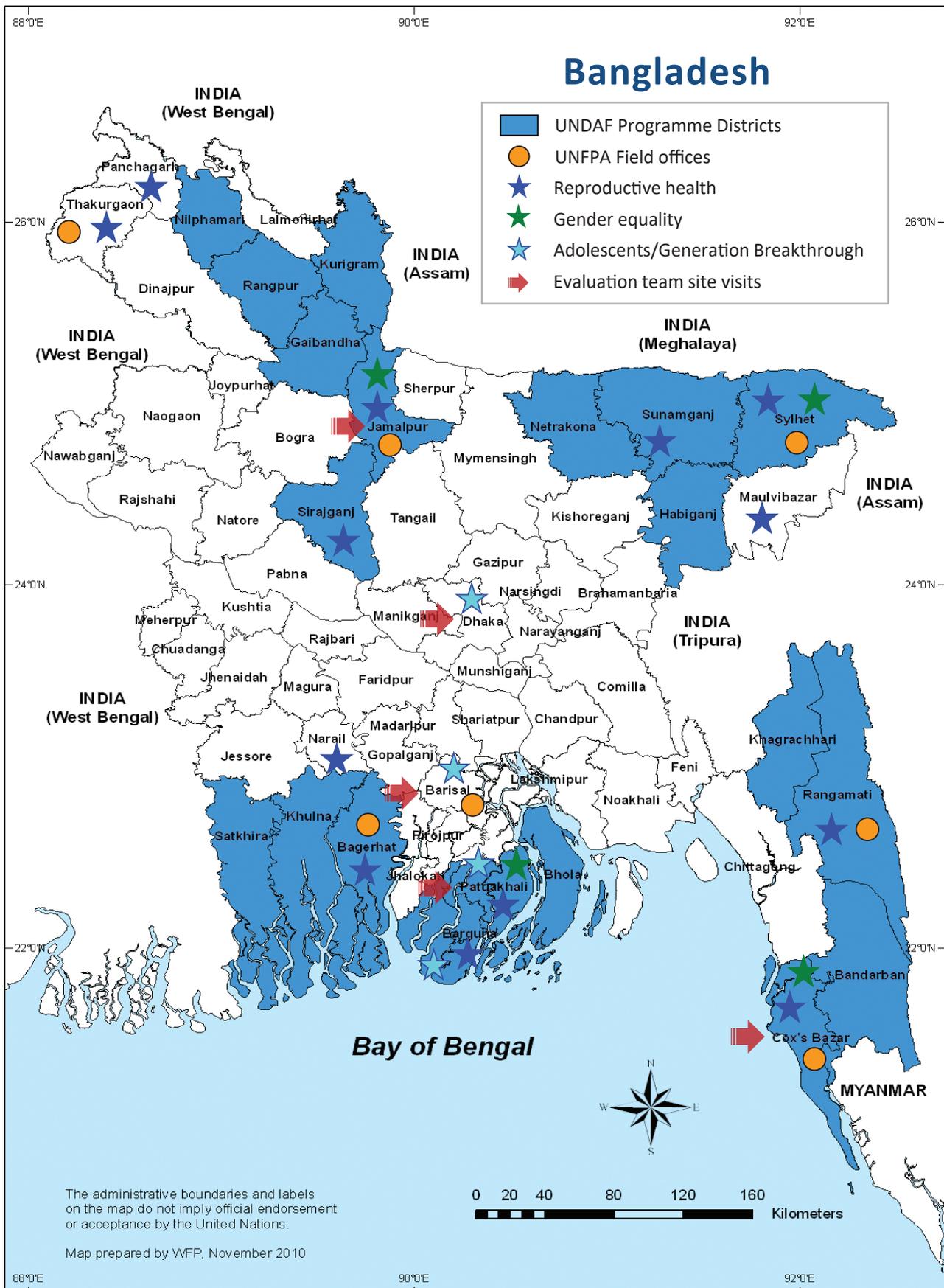
LAPM	Long Acting and Permanent Methods
LCG-WAGE	Local Consultative Group – Women’s Advancement and Gender Equality
LEEP	Loop Electrosurgical Excision Procedure
LGD	Local Government Division
LLP	Local-Level Planning
MARA	Most At-Risk Adolescents
MARP	Most At Risk Population
MARYP	Most At Risk Young Population
MCWC	Maternal and Child Welfare Centre
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MH	Maternal Health
MICS	Multiple Indicator Cluster Survey
MIS	Management Information System
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Rate
MNH	Maternal Newborn Health
MNHI	Maternal Neonatal Health Initiative
MoE	Ministry of Education
MoHA	Ministry of Home Affairs
MoHFW	Ministry of Health and Family Welfare
MoLE	Ministry of Labour and Employment
MOWCA	Ministry of Women and Children’s Affairs
MPDR	Maternal and Perinatal Death Review
MR	Menstrual Regulation
MSF	Médecins Sans Frontières
MSM	Male Having Sex with Male
MSP-VAW	Multi-Sectoral Project on Violence Against Women
MTBF	Medium Term Budgetary Framework
NAPWA	National Action Plan for Women Advancement
NEX	Nationally Executed
NNPC	Nari Nirjaton Protirodh Committee
NPA	National Programme of Action
NSV	Non-Scalpel Vasectomy
NGO	Non Government Organisations (although we might have decided against this one)
OCC	One-stop Crisis Centre

OECD-DAC	Organization for Economic Cooperation and Development – Development Assistance Committee
OFA	Operating Funds Accounts
OMP	Office Management Plans
P&D	Population and Development
PCA	Project management, Communications and Advocacy
PEP	Post Exposure Prophylaxis for HIV
PEWR	Protection and Enforcement of Women’s Rights
PLHIV	People Living with HIV
PNC	Post Natal Care
PPH	Post-Partum Haemorrhaging
PPP	Public Private Partnership
PPR	Population, Planning and Research
PRSP	Poverty Reduction Strategy Paper
PWID	People Who Inject Drugs
QA	Quality Assurance
RBM	Results Based Management
RC	Resident Coordinator
RCGP	Recurrent Capital Gender and Poverty (model)
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RMG	Ready Made Garment
RRF	Results and Resources Framework
RTMI	Research Training and Management International
SAARC	South Asian Association for Regional Cooperation
SBA	Skilled Birth Attendant
SDG	Sustainable Development Goals
SEID	Socio Economic Infrastructure Division
SI	Sub-Inspector
SME	Small and Medium Entrepreneurs
SOP	Standard Operating Procedure
SP	Superintendent of Police
SPCPD	Strengthening Parliament’s Capacity in integrating Population issues into Development
SPG	Social Protection Groups
SPR	Standard Progress Report
SPRINT	Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations

SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
SVRS	Sample Vital Registration Survey
SWAP	Sector Wide Approach
TA	Technical Assistance
TBA	Traditional Birth Attendants
TFR	Total Fertility Rate
ToT	Training of Trainers
TPP	Technical Project Proposal
UHC	Upizala Health Centre
UH& FWC	Upazila Health and Family Welfare Centre
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNECLAC	United Nations Economic Commission for Latin America and the Caribbean
UNHCR	United Nations High Commissioner for Refugees
UNITGAY	UN Interagency Theme Group for Adolescents and Youth
UNSD	United Nations Statistical Division
UPHCP	Urban Primary Health Care Project
UPHCSDP	Urban Health Care Services Delivery Project
VAW	Violence Against Women
VGd	Vulnerable Group Development
VIA	Visual Inspection using Acetic acid
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WFHD	Woman Friendly Hospital Initiative
WHD	Women’s Help Desk
WSC	Women Support Centre

Figure 1 Programme sites visited by the evaluation team, October 2015

MAP OF BANGLADESH SHOWING GEOGRAPHICAL COVERAGE BY UNFPA



KEY FACTS: BANGLADESH

KEY FACTS AND FIGURES

SOURCE

COUNTRY

Geographical Location

The People's Republic of Bangladesh is located in South Asia, with the Bay of Bengal to the south and bordered by India to the west, north and east, and Myanmar (Burma) to the southeast. It is separated from Nepal and Bhutan by a narrow corridor of land in West Bengal. Bangladesh is the world's eighth most populous country. The land is characterized by fertile alluvial plains surrounding the Padma (Ganges), Meghna and Jamuna rivers and the Sundarbans, a mangrove forest shared with India.

Surface area

147,570 square km; most parts of Bangladesh are less than 12m above sea level

Oxford School Atlas,
Oxford University Press, 2006.

POPULATION

Population (inhabitants)

160.4 million (mid 2015)

2015 World Population Data Sheet

Urban population

23%

2015 World Population Data Sheet

Population growth rate

1.22%

World Bank, 2013

GOVERNMENT

Type of government

Parliamentary Democracy

Government of the People's
Republic of Bangladesh - Legislative
and Parliamentary Division, 2015

Seats held by women in national parliament

350 members of which 50 memberships are reserved for women

Government of the People's
Republic of Bangladesh - Legislative
and Parliamentary Division, 2015

ECONOMY

GDP per capita (PPP US\$)

1,314

Bangladesh Planning Commission,
2014

GDP growth rate

6%

World Bank, 2013

Main Industries

Bangladesh's ready-made garment industry is the second largest in the world. Other key sectors include pharmaceuticals, shipbuilding, ceramics, leather goods and electronics.

KEY FACTS AND FIGURES

SOURCE

SOCIAL INDICATORS

Human Development Index Rank	142 nd position among 187 countries	UNDP (2013)
Under-employment	35%	Labour Force Survey 2010, Bangladesh Bureau of Statistics (BBS)
Life expectancy at birth	71 years	2015 World Population Data Sheet
Under-5 mortality (per 1000 live births)	46	Bangladesh Demographic and Health Survey (BDHS), 2014. Key indicators.
Maternal mortality (deaths of women per 100,000 live births)	170 (UN estimate) 194 (GoB estimate)	2015 World Population Data Sheet (UN); Bangladesh Maternal Mortality Survey (BMMS) 2011.
Health expenditure (% of GDP)	3.7 %	Bangladesh: WHO statistical profile
Births attended by skilled health personnel, percentage	31% / 42%	Bangladesh: WHO statistical profile, BDHS 2014
Adolescent fertility rate (births per 1000 women aged 15-19)	113	Bangladesh Demographic and Health Survey, 2014. Key indicators.
Condom use to overall contraceptive use among currently married women 15-49 years old, percentage	6.4 %	Bangladesh Demographic and Health Survey, 2014. Key indicators
Contraceptive prevalence rate	62.4 %	Bangladesh Demographic and Health Survey, 2014. Key indicators
Unmet need for family planning (% of women in a relationship unable to access contraceptives)	12 %	Bangladesh Demographic and Health Survey, 2014. Key indicators
People living with HIV, 15-49 years old, percentage	<0.1 %	2015 World Population Data Sheet
Adult literacy (% aged 15 and above)	60 %	World Bank website
Total net enrolment ratio in primary education, both sexes	97.3 %	APSC, DPE 2013; Millennium Development Goals Bangladesh Progress Report 2013; GED, Planning Commission, GOB, Aug 2014

KEY FACTS AND FIGURES

SOURCE

BANGLADESH MILLENNIUM DEVELOPMENT GOALS (MDGS): PROGRESS BY GOAL

<p>1. Eradicate extreme poverty and hunger.</p> <p>Goal: 29%</p>	<p>Proportion of population below \$1 (PPP) per day, reduced from 70.2% in 1992 to 43.3% in 2010</p>	<p>World Bank, 2013 – Goal expected to be accomplished.</p>
<p>2. Achieve universal primary education.</p> <p>Goal: 100%</p>	<p>Proportion of pupils starting grade 1 who reach grade 5, increased from 43% in 1990-91 to 96.4% in 2013.</p>	<p>MICS 2013; MDG Bangladesh Progress Report 2013; GED, Planning Commission, GOB, Aug 2014</p>
<p>3. Promote gender equality and empower women.</p> <p>Goal: 1.0</p>	<p>Gender Parity Index = Girls/ Boys; increased from 0.83 in 1990-91 to 1.0 in 2015.</p>	<p>MDG Bangladesh Progress Report 2013</p>
<p>4. Reduce child mortality.</p> <p>Goal: 48</p>	<p>Under-5 mortality rate (per 1,000 live births) reduced from 146 in 1990-91 to 46 in 2014.</p>	<p>Bangladesh Demographic and Health Survey, 2014</p>
<p>5. Improve maternal health.</p> <p>Goal: 144</p>	<p>Maternal mortality ratio (per 100,000 live births) decreased from 574 in 1990-91 to 170 in 2015</p>	<p>World Population Data Sheet, 2015</p>
<p>6. Combat HIV/AIDS, malaria and other diseases.</p> <p>Goal: Halting</p>	<p>Condom use rate at last high-risk sex, increased from 6.3% in 1990-91 to 43.33 in 2015; Prevalence of malaria per 100,000 population decreased from 776.9 in 2008 to 202 in 2013.</p>	<p>NASP 2013 and MIS NMCP 2013); Millennium Development Goals Bangladesh Progress Report 2013</p>
<p>7. Ensure environmental sustainability.</p> <p>Goals: Tree density = 20% Improved sanitation= 60%</p>	<p>Tree density increased from 9% in 1990-91 to 13.2% in 2013 Improved sanitation increased from 39% in 1990-91 to 55.9% in 2013.</p>	<p>DoF 2013. and MICS 2013; Millennium Development Goals Bangladesh Progress Report 2013</p>
<p>8. Develop a global partnership for development.</p> <p>Goal: None specified</p>	<p>Net ODA received by Bangladesh (million US\$) increased from \$1,732 to \$2,811.</p>	<p>ERD 2013; Millennium Development Goals Bangladesh Progress Report 2013</p>

EXECUTIVE SUMMARY

CONTEXT

This report presents the results of the final evaluation of the UNFPA eighth country programme of cooperation with the Government of Bangladesh, covering the period 2012 to 2016.

The People's Republic of Bangladesh has a population of 160 million and is the most densely populated among countries with populations exceeding 10 million. It is progressively transitioning from a low-income to a middle-income country. Bangladesh is host to over 200,000 refugees and asylum seekers from Myanmar. According to the World Risk Index, it is the fifth highest disaster risk country in the world and second in Asia.

The UNFPA eighth country programme in Bangladesh had an initial total budget of (USD) \$70 million and covered three core programme areas: (a) reproductive health and rights (allocated with \$46 million); (b) population and development (\$9 million); and (c) gender equality (\$13 million). An amount of \$2 million was allocated to programme coordination and assistance.

OBJECTIVES AND SCOPE OF THE EVALUATION

The objectives of the evaluation were:

- (1) To provide an independent assessment of the relevance and performance of the UNFPA eighth country programme to the UNFPA country office in Bangladesh, national programme stakeholders, the UNFPA Asia and the Pacific Regional Office (Bangkok), UNFPA headquarters and a broader audience
- (2) To provide a specific analysis of how UNFPA took into account and addressed those factors that leave Bangladesh vulnerable to disasters and emergencies in Bangladesh
- (3) 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

- (4) 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 programme cycle.

The evaluation covered all activities planned and/or implemented during the period 2012 to 2016, including soft aid activities.

METHODOLOGY

The evaluation was structured around two categories of evaluation criteria: (i) the criteria of relevance, effectiveness, efficiency and sustainability for the assessment of UNFPA interventions in all programme areas; (ii) the criteria of coordination and added value for the analysis of the strategic positioning of UNFPA in Bangladesh.

The data-collection tools used by the evaluation team comprised: (i) a detailed review of the documentation available regarding the country programme, as well as relevant national public policies and strategic documents; (ii) semi-structured interviews with 124 key informants; (iii) 12 focus groups discussions, which included beneficiaries of UNFPA supported interventions.

Besides Dhaka, the evaluation made four site visits, respectively in Barisal, Cox's Bazar, Jamalpur and Patuakhali. The selection of the site visits was based on a purposive sampling, meant to illustrate the portfolio of interventions supported by UNFPA in Bangladesh. In Cox's Bazar, the evaluation team was able to visit the Kutuapalong refugee camp, where two focus groups were held, respectively with women receiving family planning information and with participants to the adolescent corner activities.

Throughout the evaluation process, the evaluation team systematically triangulated its data and information sources, as well as its data collection tools. The use of the evaluation matrix was key for the formulation of evidence-based findings; it outlined the assumptions to be assessed and the corresponding indicators for each evaluation question.

Methodological constraints and limitations faced by the evaluation team included: (i) insufficient information provided by annual work plans with regard to country programme interventions (in particular those relating to “soft aid” activities such as advocacy and policy dialogue); (ii) limited availability of monitoring data (especially at the results level); (iii) the limited sample size of sites visited and final beneficiaries consulted, with regard to the broad scope of the eighth country programme and the diversity of interventions, stakeholders and beneficiaries. Mitigating measures taken by the evaluation team included: (i) an extended review of documentation (including, in particular, the analysis of data stemming from the country office standard progress reports and annual reports); (ii) a purposive sampling of site visits and key informants with a view to ensuring the consultation of the main stakeholders while allowing for the expression of a wide range of opinions.

MAIN FINDINGS

The country programme interventions were well aligned with UNFPA global policies and strategies as well as with UNDAF priorities and national policies and strategies. They rightly targeted some of the most vulnerable groups in low performing districts, slums and refugee camps. However, specific target groups, such as women and girls vulnerable to gender based violence, undocumented refugees, those not accessing family planning services and those most at risk for sexually transmitted diseases, required more strategic planning to strengthen capacity to reach them.

In the area of reproductive health and rights, UNFPA-supported interventions contributed to improved quality and accessibility of services for maternal health and family planning. It did this through local level planning, training and deployment of midwives and skilled birth attendants, ensuring a secure supply and choice of modern contraceptives and the expansion of reproductive health services for adolescents and youth. **Demand for these services is, however, challenged by insufficient awareness among target groups, crowded or underdeveloped facilities, shortages of staff and socio-cultural barriers.** The sustainability of results is also threatened by

over-reliance of most interventions on external resources and the absence of exit strategies.

In the area of population and development, UNFPA has contributed to the strengthening of national capacities to collect and analyse population data. It has also promoted the use by the Bangladesh Bureau of Statistics of up-to-date data collection and validation techniques. UNFPA supported the production of traditional census reports as well as of secondary analysis of 2011 census data. UNFPA also contributed to the integration of population and gender equality concerns into national and sectorial plans and policies. However, follow up to UNFPA supported interventions, especially trainings, has been insufficient.

In the field of gender equality, UNFPA-supported interventions have contributed toward reducing the vulnerability of marginalized and disadvantaged women and girls. The interventions are aimed at eliminating gender-based violence and child marriage in targeted districts and municipalities. Advocacy against child marriage is gaining momentum and the response to gender based violence has improved, although insufficient emphasis has been placed on sustaining the services to support women survivors. Sustainability of results is limited by the lack of a comprehensive gender equality strategy.

UNFPA has not achieved timely disbursement of funds during the eighth country programme. This is mainly due to the fact that technical proposals took a year to be approved and there were subsequent delays in implementation. Serious human resources shortages in the country office affected the achievement of several planned interventions. However, actions have been effectively taken by the country office to increase staffing capacity and to accelerate the implementation of interventions.

UNFPA has contributed effectively to good coordination and complementarity among the UN country team. UNFPA has particularly contributed to strengthening advocacy against child marriage with other UN agencies and development actors. UNFPA corporate strengths are well identified, however its interventions are perceived as being spread too thinly to produce strong results.

In terms of disaster and emergency preparedness, the UNFPA 2011 Emergency and Preparedness and Contingency Plan and its update in 2014 reflect the UNFPA global strategy and adequately consider major hazards and potential emergency situations. In terms of response to crisis, UNFPA achieved **significant results with regard to the access to and use of reproductive health and family planning services by Rohingya refugees** living in the Nayapara and Kutupalong camps. However, the wide majority of (undocumented) Rohingya refugees, living outside of the camps, do not benefit from these services. The capacity of UNFPA to respond to crisis is also hampered by the limited geographic coverage of the Minimum Initial Service Package (MISP) training.

MAIN CONCLUSIONS

The UNFPA eighth country programme was adapted to national priorities in terms of reproductive health and rights, population and development and gender equality. UNFPA effectively targeted vulnerable and marginalized groups such as slum dwellers, indigenous peoples, sex workers, and encamped refugees in targeted districts. UNFPA has effectively programmed more resources to reach adolescents and youth vulnerable to child marriage, gender based violence, and unplanned pregnancies. However, the planning did not extend adequate attention to the homeless, undocumented migrants, school dropouts, fishing populations, and those with high-risk sexual practices and those susceptible to sexually transmitted diseases, LGBT (lesbian, gay, bi-sexual and transgender) persons, women with disabilities and those in difficult circumstances.

As per the national emphasis on the growing adolescent and youth population, the need to realize the demographic dividend, and the UNFPA corporate focus on adolescents, UNFPA has substantially increased support to interventions on behalf of adolescents and youth. It did this by creating a unit to oversee the Generation Breakthrough project which effectively incorporates sexual and reproductive health and gender equality objectives. However, advocacy for increased focus on adolescent sexual and reproductive health is not strong enough to address traditional sensitivities and ensure adequate resources and attention to information and services for unmarried and married adolescents.

The gender equality programmatic area was designed based on the UNFPA mandate and built upon strong global expertise. **It is well aligned with the UNDAF as well as with national needs.** There have been gains in strengthening national and local level planning and procedures. **However, it is unclear in programme planning and documentation how UNFPA adds value to the national gender equality agenda,** and where the UNFPA role lies in relation to that of other actors, such as government ministries. With the exception of support for the gender equity movement in schools (GEMS), interventions do not appear to be strongly connected with each other at the strategic level or well integrated and mainstreamed with reproductive health and disaster and emergency management.

UNFPA has targeted some of the key groups influencing awareness-raising and advocacy on women's and reproductive health and rights. These groups have a demonstrated influence on women's abilities to protect their rights, including making decisions on family planning and the age of marriage, upholding women's rights to equality and to safe pregnancy and delivery, and protecting themselves from gender based violence and reproductive health diseases in times of emergencies and disasters. However, UNFPA has not targeted enough resources to working with men and boys, with husbands who exert strong influence on women's reproductive health choices and who may subject women to violence and with community leaders who have strong influence over the decisions of parents. There is insufficient sustained advocacy by UNFPA at high levels to promote faster gains while supporting reproductive rights.

Given the high vulnerability of Bangladesh to disasters and emergencies, UNFPA was initially slow in the eighth country programme to take action on the Minimum Initial Service Package (MISP). Training on the MISP has been limited so far, and the MISP does not fully cover gender issues in emergency. The newest response plans for UNFPA and the Interagency Standing Committee have incorporated MISP, gender based violence, and reproductive health concerns. Coordination has been mainly positive with the Government and NGOs providing assistance, however, relations are not strong enough with the Department of Disaster Management. UNFPA assistance to

Rohingya refugees has resulted in significant gains in reproductive health for this population. However, services have been hampered by uneven coordination with other UN agencies supporting the refugees.

MAIN RECOMMENDATIONS

In view of the Sustainable Development Goals (2016-2030) highlighting vulnerable populations, **UNFPA should focus more strategically** when planning the ninth country programme **on prioritizing and targeting** morbidity and mortality in **women and girls**, on those vulnerable to having their rights abused, on those in psychological hardship, and on those not fully accessing the health and education systems. It should also identify how to reach these groups.

UNFPA should continue to enhance its significant adolescents and youth focus. It could do this by considering the creation of a distinct unit with a strong technical interface with other areas. This unit could then coordinate and give more dedicated support to bolster the inputs, outputs and outcomes in the health system and in communities. This, in turn, would attract and reach greater numbers of

adolescents and youth using reproductive health and gender equality information and services.

In view of contributing to the Sustainable Development Goals, especially SDG 5: Achieve gender equality and empower women and girls, **UNFPA should strengthen the country programme gender equality strategy** and the profile of the gender equality programmatic area and press for greater clarity in the division of roles among partners.

UNFPA should assess the most appropriate means of reaching key influencing groups and prioritize advocacy and communications interventions according to those which will have the most impact.

UNFPA should take a more active role in the UN joint assessments and response, make relevant contributions, and ensure that preparedness and response are reproductive health and gender sensitive. It should also include appropriate interventions in times of emergencies to prevent gender based violence. UNFPA should work toward stronger communications and coordination with government and UN agencies as well as other stakeholders supporting disaster- and emergency-affected populations, such as documented and undocumented refugees.

1 INTRODUCTION

1.1 PURPOSE AND OBJECTIVES OF THE COUNTRY PROGRAMME EVALUATION

In accordance with the UNFPA 2013 evaluation policy¹ and the UNFPA biennial evaluation plan 2014 to 15,² the UNFPA evaluation office is conducting the final evaluation of the UNFPA eighth country programme of assistance to the Government of Bangladesh (2012-2016).

The main audience and primary users of the evaluation are the UNFPA Bangladesh country office (CO), the UNFPA Asia and Pacific regional office (APRO) and UNFPA headquarter divisions, who may use it as an objective basis for decision-making. The evaluation will also benefit secondary users such as the government partners, the civil society, as well as other development partners, such as other UN agencies in Bangladesh, through dissemination of its results.

The specific objectives of the evaluation are:

- Provide an independent assessment of the relevance and performance of the UNFPA eighth country programme to the UNFPA country office in Bangladesh, national programme stakeholders, UNFPA Asia and the Pacific regional office (Bangkok), UNFPA headquarters and a broader audience

- Provide a specific analysis on how the UNFPA country office took into account and addressed the factors that leave Bangladesh vulnerable to disasters and emergencies
- 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's development results
- 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 programme cycle.

1.2 SCOPE OF THE EVALUATION

The evaluation will cover all interventions planned or implemented by UNFPA in Bangladesh for the period 2012 to 2016, under both the development programme of assistance, in its four programmatic areas: (a) reproductive health and rights, (b) gender equality, (c) population and development and (d) adolescents and youth, as well as the cross-cutting humanitarian programme.

¹ DP/FPA/2013/5

² DP/FPA/2014/2

2 METHODOLOGY

2.1 EVALUATION PROCESS

The phases of the evaluation are as follows.

- **Preparatory:** finalisation of TOR; team formation; scoping mission; evaluation reference group formation
- **Design:** desk review; data-collection strategy for the in-country phase; preparation of a design report
- **Field:** data collection and analysis in Bangladesh (3 weeks); debriefing of the preliminary findings to the CO
- **Synthesis:** preparation of a draft report; review process; in-country stakeholder workshop; final evaluation report
- **Follow-Up:** distribute report; management response to the evaluation recommendations; report published on the UNFPA website; report made available to UNFPA Executive Board by the time of approving a new country programme document

During the **preparatory phase**, a scoping mission to Bangladesh (11-15 September 2015) was undertaken by the co-team leaders. Details of the evaluation terms of reference and work plan were agreed with the country office. An evaluation reference group (ERG) was formed, composed of representatives from partner organizations, the Ministry of Finance (Economic Relations Division), the Ministry of Health and Family Welfare (Directorate of Health Services and Directorate of Family Planning), Ministry of Women's and Children's Affairs (Department of Women's Affairs), the Bangladesh Bureau of Statistics, UNWOMEN, and WHO.

During the **design phase**, a design report was written based on a document review, containing the purpose and scope of the evaluation, the context and background of the country programme, a reconstruction of the intervention logic of the

programme, a stakeholder matrix, the structure of the evaluation matrix containing key evaluation questions, and a detailed data collection plan, including proposed site visits. In the design report, proposed methodology was described as well as data collection and analysis strategies for each programmatic area.

The **field phase** took place from 12 to 29 October 2015 in Bangladesh. A debriefing of preliminary results was conducted for country office staff in Dhaka on Thursday, 29 October 2015.

During the **synthesis phase**, a draft evaluation report was prepared, followed by a review process in December. The draft final evaluation report was completed in January 2015. This draft final report formed the basis for an **in-country stakeholder workshop**, which took place in Dhaka, on 3 March 2016. The workshop was attended by the country office as well as all the key programme stakeholders. The **final report** was drafted shortly after the workshop, taking into account comments made by the participants.

In the **follow-up phase**, the dissemination of the final evaluation report and the discussion of the findings, conclusions and recommendations are important to allow stakeholders to take into account evaluation findings in future programming.

Throughout the evaluation process, the ERG provided oversight to the evaluation, providing guidance for the evaluation team on key informants and data sources and reviewing the design report and the draft and final evaluation reports.

The quality of the final evaluation report is assessed on the basis of the evaluation quality assessment grid of the UNFPA evaluation office. A management response to the evaluation recommendations was prepared before the evaluation was posted on the UNFPA website and the report delivered to the UNFPA Executive Board.

2.2 EVALUATION QUESTIONS

The evaluation is structured around the following evaluation criteria:

- four out of the five standard OECD-DAC criteria: relevance, effectiveness, efficiency and sustainability³
- two criteria specific to UNFPA, with a view to assessing the strategic positioning of UNFPA within the Bangladesh UNCT: coordination and added value

Based on these evaluation criteria, the evaluation team proposes the following evaluation questions, which will guide its data collection and analysis work throughout the evaluation process.

- EQ1** To what extent is the Bangladesh eighth country programme (2012-2016): (a) adapted to the needs of the population, in particular the needs of the vulnerable groups, (b) aligned with government's priorities and (c) aligned with UNFPA policies and strategies?
- EQ2** To what extent has UNFPA contributed to sustainably improving access to and demand for high-quality sexual and reproductive health and HIV services, especially for the most vulnerable groups?
- EQ3** To what extent have the interventions supported by UNFPA in the field of population and development (P&D) supported government and non-government stakeholders 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?
- EQ4** To what extent have the interventions supported by UNFPA in the field of gender equality (GE) contributed toward reducing the social and institutional vulnerabilities of women and girls, including the marginalized and disadvantaged, with special focus on the elimination of sexual and gender based violence?

- EQ5** To what extent has the UNFPA Bangladesh country office made good use of its human, financial and technical resources to pursue the achievement of the outputs and outcomes defined in the country programme?
- EQ6** To what extent has the UNFPA Bangladesh country office contributed to the smooth functioning and consolidation of UNCT coordination mechanisms?
- EQ7** To what extent has UNFPA made good use of its comparative strengths to add value to the development results of Bangladesh?
- EQ8** To what extent did the UNFPA eighth country programme in Bangladesh take into account the country's vulnerability to disasters and emergencies, both at the planning and the implementation stages?
- EQ9** To what extent was (or is) UNFPA, along with its partners, able (or likely) to respond to crises during the period of the eighth country programme (2012- 2016)?

The correspondence between evaluation questions and evaluation criteria is illustrated in Table 1.

The evaluation questions have been translated into information needs, presented in the evaluation matrix (Annex 7). The evaluation matrix links evaluation questions with corresponding assumptions to be tested, indicators, sources of information and methods and tools for the data collection.

³ The OECD-DAC evaluation criterion, the impact, is not considered in UNFPA country programme evaluations, due to the nature of the interventions of the Fund, which can only be assessed in terms of contribution and not attribution.

Table 1 Coverage of evaluation criteria by evaluation questions

	Relevance	Effectiveness	Efficiency	Sustainability	Coordination	Added value
EQ1	X					
EQ2		X		X		
EQ3		X		X		
EQ4		X		X		
EQ5			X			
EQ6					X	
EQ7						X
EQ8	X					
EQ9		X				

2.3 METHODS AND TOOLS USED FOR DATA COLLECTION AND ANALYSIS

The evaluation methodology is based primarily on standards and guidance described in *How to Design and Conduct a Country Programme Evaluation at UNFPA* throughout the phases of the evaluation. Some suggested and prescribed tools, such as the evaluation matrix, were adapted for the country programme context. The team utilized the following methods for data collection: study of documentation, key informant interviews, focus group discussions (FGDs), and site visits. Triangulation was ensured throughout the evaluation process by cross-checking sources of information and data collection tools. Cross-cutting issues such as vulnerable groups, adolescents and youth and gender equality were addressed in data collection through the evaluation questions, indicators in the evaluation matrix and targeted questions formulated in the interview guides. No primary quantitative data was collected during the evaluation and data from secondary sources has largely been gender specific or gender disaggregated.

The evaluation team conducted a thorough study of the available documentation. For the purpose of the evaluation, the UNFPA country office in Dhaka provided access to documentation, including country programme documents, annual work plans (AWP), standard progress reports (SPR), country office

annual reports (COARs), office management plans, Atlas data on budgeted interventions and actual expenditure, activity reports, joint programme proposals, evaluations, review and audit reports, relevant surveys and needs-assessments studies, monitoring reports, as well as agreements signed with the partners of the respective programmes. In addition, the evaluation team collected and analysed training materials and booklets, brochures and websites designed for dissemination purposes, as well as working documents provided by individual project programmatic areas such as strategy papers. The team also reviewed international and national development statistics, national policy and planning documents and international legal instruments to which the Bangladesh government is a signatory, such as the ICPD and the CEDAW. Additional documentation and information was found on the internet as required.

The evaluation team conducted key informant interviews and held several focus group discussions. Selection of stakeholders for key informant interviews and focus group discussions (FGDs) aimed to cover a wide variety of stakeholders including beneficiaries, NGOs, public institutions, private sector representatives, as well as other UN agencies (see Annexe 5: Stakeholder matrix). The diversity of backgrounds, regions and levels of involvement with UNFPA projects were considered in selecting the interviewees (see Table 2: Interviews

and focus group discussions). Prior to the launch of the in-country data collection phase, the evaluation team prepared interview guides that consisted of appropriate types for each programmatic area, e.g. for programme staff, other UN and partners and for the focus group discussions. The guides included questions related to implementation modalities; the progress achieved throughout the programming period; the perceived challenges and implications for sustainability and factors affecting ownership. Interviews with beneficiaries were adapted in accordance with their own interests as well as levels of education (see Annexe 8: Interview guides). The team carefully structured the focus group discussions to obtain the maximum input from participants during the group interviews.

The evaluation team interviewed 124 key informants and conducted 12 focus group discussions. All interviewees were assured by the evaluation team of the confidentiality of their responses. The interviews were mainly conducted in informal settings, as discussions of gender based violence and sexual and reproductive health issues would have required personal trust. Interviews were mostly face-to-face, with some additional phone interview meetings held, due to a tight time schedule and budget for travelling. Interview logbooks were maintained by the evaluation team for the purposes of documenting and facilitating cross-analysis of data. The team closely adhered to the *UN Evaluation Group Code of Conduct and Ethical Guidelines for Evaluations (2008)*.

The evaluation team carried out site visits. The selection of sites outside of Dhaka was based on purposive sampling, which means selection based on the knowledge of a population or groups, their characteristics, and the purpose of the study. The chosen locations were illustrative of the UNFPA portfolio in Bangladesh, with two sites for reproductive health and rights, including adolescents and youth, and three sites for gender equality and humanitarian and emergency management. The sites were representative of the targeted populations and the planned interventions and demonstrated a range of challenges and successes at this point in the programme implementation. For the population and development programmatic area, data was largely collected through visits to key partners in Dhaka. (Please see Figure 1 for location of evaluation team site visits.)

Members of the team visited Barisal, Patuakhali and Cox's Bazar districts to interview staff from key reproductive health (RH) implementing partners, including district and local health service providers. The gender equality expert visited Jamalpur and Cox's Bazar districts to interview stakeholders assisting victims of gender based violence, such as the police, women's assistance centres and the one-stop crisis centres (OCCs). The three members of the team visiting Barisal and Patuakhali asked gender equality-related questions. Key informant interviews and focus group discussions were also held with relevant stakeholders in Dhaka. (Please see Annexe 4 for a detailed list of persons consulted.)

Table 2 *Bangladesh Eighth Country Programme Evaluation Key Informant Interviews and Focus Group Discussions (figures in parenthesis are number of persons present)*

	Reproductive Health (and Humanitarian)	Gender Equality	Population & Development	Adolescents and Youth	Management
Key Informants (number of interviewees)					
UNFPA staff	Country Office Dhaka and District Office staff	Country Office	Country Office (3)	Country Office	Country Office -Representative Deputy Representative
Ministries and Lead Government Agencies	<p>Ministry of Health, DGHS Dhaka - Midwifery (4 – BNC, DNS, BMS, OGSB) Obstetric Fistula (2 – DMCH, BWHC/PFTRR) Cervical/Breast (1 –IP -BSMMU) MISP (1 -Disaster Management Department) MNHI (DGHS, DGFP-MNCAH) DGFP – (2) Focal persons; and 1 advocacy partner (NHSFP) Urban – CRHCC activities – Local Government Division Patuakhali – District Health Centre, MCWC, UHC, UHFWC,Community Clinic Barisal – Medical College Fistula Corner, Nursing Institute, Family Planning Cox’s Bazar – One Stop Crisis; Women Support Centre Kutupalong Refugee Camp, Cox’s Bazar District</p>	<p>Ministry of Women and Children Affairs (MoWCA); Department of Women Affairs (DWA) of MoWCA Ministry of Home Affairs (MOHA); (Deputy Commissioner (DC) Jamalpur; Police Supar, Cox’s Bazar District</p>	<p>Parliament Secretariat(3) Planning Commission SEID (3) GED (1) Bangladesh Bureau of Statistics Census (3) GIS (3)</p>	<p>Ministry of Education District Education Office, Barisal District Directorate of Secondary and Higher Education (DSHE), Ministry of Education (MoE) Department of Women Affairs (DWA) District Women’s Affairs Office – Barisal</p>	<p>Ministry of Finance – Economic Division</p>
Other Implementing partners	<p>Research Training and Management International (RTMI), CARE Bangladesh EngenderHealth</p>	<p>Plan International Cox’s Bazar Medical College Hospital (OCC) Kutupalong Refugee camp, Cox’s Bazar District</p>	<p>Department of Population Sciences of Dhaka University (1) Population Council (1)</p>	<p>Plan International Bangladesh Dhaka and Barisal District CWFDP, Dhaka and Barisal District</p>	
UN; Others	<p>MNHI – UNICEF WHO Humanitarian consultant UNHCR –Cox’s Bazar Humanitarian Advisor Resident Coordinator’s Office Family Planning Association of Bangladesh (FPAB)</p>	<p>UNHCR, Cox’s Bazar</p>	<p>UNDP</p>	<p>UN Youth Advisory Panel</p>	<p>Resident Coordinator, Joint Programmes: WHO, UNDP,UNICEF;</p>
Donors	<p>USAID – (Family Planning)</p>	<p>UNDP</p>	<p>Delegation of the European Union in Bangladesh</p>	<p>Embassy of the Kingdom of the Netherlands (EKN)</p>	

	Reproductive Health (and Humanitarian)	Gender Equality	Population & Development	Adolescents and Youth	Management
Focus Groups - 7 for RH, 2 for Humanitarian, 2 for Gender equality , 1 for P&D, and 3 for Adolescents and Youth					
Government and Implementing partner	Midwifery students (25) – first and second batch students Barisal Nursing College Faculty (10) received ToT for 6 month certification, Barisal Nursing College Nurse-Midwives, (8) 6 month certificate, Barisal Medical College Hospital CSBAs, (12) 6month certificate, Cox’s Bazar Nursing College		District Development Committee	Adolescent Corner participants (12) Nari Maitree Clinic, Dhaka	
Community Beneficiaries	Slum Dwellers (15) - Dhaka: Women attending clinic for ANC and Family Planning (1) Kutuplaong Refugee Camp, Cox’s Bazar District: (10) Women receiving family planning information	Social Protection Group (SPG); Survivors of GBV, Women Support Centre (WSC)		Youth club participants (8) Patuakhalidistrict Adolescent Corner participants (10), Kutupalong Refugee Camp, Cox’s Bazar District	

2.4 LIMITATIONS AND CONSTRAINTS

The most serious limitations and risks facing the evaluation are noted below, as are the evaluators’ responses.

- **Limitations of annual work plans as tracking tools.** The annual work plans (AWPs) form the basis for documenting programme interventions, but are difficult to use to track and consolidate certain types of evidence: annual work plans may not list the “soft interventions” such as advocacy, policy dialogue, national consultations, and institutional mediation, for example. To mitigate this constraint, and to supplement the annual work plans, the team referred to the country office annual reports (COARs), the office management plans (OMPs), the standard progress reports (SPRs) and the Atlas spreadsheets. (This is a typical problem in UNFPA evaluations and it needs to be addressed for future evaluations.)
- **Data collection is limited on final beneficiaries due to time constraints.** The implementation sites are widely spread and there are large numbers of potential key informants and interviewees.

(A total of three weeks was allocated for the in-country data collection). These constraints were mitigated by use of secondary data (reports, publications, national plans, regional strategy plans, brochures distributed, web-sites, etc.). Other ways of collecting secondary data were through key informant interviews (with groups directly involved in the projects and interventions), purposive sampling (samples selected after a comprehensive review of the documents to select the right target groups), and focus group discussions to gain a range of opinions.

- **Data collection on programmes is limited.** There is a broad scope of interventions over the timescale of the eighth country programme, along with a diverse number of stakeholders and beneficiaries. Interviews were conducted with as full a range of these partners as possible and secondary data collected through documentation.
- **Language constraints.** In order to facilitate communications among English and Bangla speakers, translation was provided.

3 CONTEXT OF THE UNFPA EIGHTH COUNTRY PROGRAMME FOR BANGLADESH

3.1 POLITICAL, ECONOMIC AND SOCIAL CONTEXT

The People's Republic of Bangladesh has 160 million inhabitants and is the most densely populated among countries with populations exceeding 10 million.⁴ It is divided into 8 major regions (divisions) and 64 districts, which are composed of 'thanas' or self-contained administrative units (460 plus 36 'thanas' in 4 city corporations). Since its independence in 1971, Bangladesh has made significant achievements in human and social development, including progress in universal primary education, food production and health. It rose from 146 in 2011 to 142 in 2014 on the Human Development Index (HDI).⁵ Bangladesh has achieved many of the goals of the ICPD Programme of Action and the Millennium Development Goals (MDGs).⁶ However, there remain significant differences in development indicators among the districts.

The leadership of Bangladesh envisions progress from a low-income to a middle-income status. Between 2004 and 2014, the GDP averaged a growth rate of 6 per cent. The per-capita income is US\$ 1,314. The economy is increasingly led by export-oriented industrialization: the garment and textile industries are the second largest in the world. The country has also recently nearly achieved self-sufficiency on food production. However, food insecurity affects millions and malnutrition is a persistent problem, especially for women and children: stunting among children under 5 has declined from 51% in 2004 to 36 per cent in 2014, still ranking among the highest rates globally.⁷ The health system suffers from insufficient allocation of resources and institutional limitations, with high percentages of out-of-pocket

payments (64 per cent) required from citizens for health services.⁸

Bangladesh has experienced disrupting political challenges, which have resulted in periodic general strikes (hartals), in the last several years; one in January 2015 lasted for three months. Bangladesh is a founding member of South Asian Association for Regional Cooperation (SAARC), is a member of the Developing Eight Countries, Bay of Bengal Initiative for Multi-Sectoral Technical and Economic Cooperation (BIMSTEC) and contributes one of the largest peacekeeping forces to the UN. Bangladesh is host to over 200,000 refugees and asylum seekers from Myanmar and a similar number from Pakistan.⁹

3.2 SITUATION WITH REGARD TO DISASTER VULNERABILITY

According to the World Risk Index, out of 172 countries, Bangladesh is the fifth highest disaster risk country in the world and second in Asia.¹⁰ Bangladesh has experienced 219 natural disasters between 1980 and 2008 causing \$16 billion in damages.¹¹ Cyclones and floods pose the greatest risk nationally while the northern and eastern regions are susceptible to earthquakes. The southeast is particularly vulnerable to cyclones, floods, droughts, and earthquakes. The country is also vulnerable to other natural and human-made hazards such as river-bank erosion, tornadoes, tsunamis, ground-water pollution, fire, and building-collapse causing enormous loss of lives, both human and animal, as well as damage to standing crops, infrastructure and economic resources.¹² Women and girls in the disaster-prone areas, especially of poor and marginal households, are more vulnerable to the

⁴ Bangladesh ranks as #8 on the official population clock, 2 October, 2015, www.worldometers.info

⁵ UNDP Human Development Report, 2013, and 2014

⁶ 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.

⁷ Bangladesh Demographic and Health Survey 2014, page 42.

⁸ Bangladesh Health System Review, Health Systems in Transition, Asia Pacific Observatory on Health Systems and Policies, WHO, 2015, executive summary.

⁹ UNHCR website

¹⁰ World Risk Index, in the 2013 World Risk Report. In the *Fragile State Index 2015* (The Fund for Peace) with a Fragile State Index of 91.8, Bangladesh ranked 32 out of 178 countries.

¹¹ UNDP website

¹² Bangladesh Disaster Profile, Asian Disaster Preparedness Center, 2007.

impacts of disasters.^{13,14} Bangladesh formalized a *National Plan for Disaster Management (2010-2015)* and a *National Disaster Management Act* in 2012.¹⁵ Following the enactment, the government created the Department for Disaster Management (DDM).¹⁶

Bangladesh has advanced in the Global Climate Risk Index, moving from 5th in 2011, to 13th in 2014. However, the risks are extremely high due to the very low elevation of most of the country and exposure to climate-related hazards, which may increase in frequency and intensity as global warming continues.¹⁷ It is projected that climate change will affect almost all the fundamental determinants and indicators of health-care services.¹⁸ The impact of climate change has added a new dimension to the relational analysis from a gender equality perspective. Despite challenges, women continue to be the major contributors in disaster-resilience and adaptation to climate variability.

3.3 SITUATION WITH REGARD TO REPRODUCTIVE HEALTH AND RIGHTS

Bangladesh is on target to become one of only nine low-to-middle income countries to reduce the maternal mortality ratio (MMR) by nearly 75 per cent and is close to meeting the MDG 5.¹⁹ Maternal mortality declined from 322 in 2001, to 194 in 2010, and to 170 in 2015²⁰, mainly due to increased access to health services and decreases in fertility. Preventable causes of maternal mortality such as haemorrhage and eclampsia account for the largest proportion of maternal deaths, with obstructed labour and abortion being other key causes.²¹

Following a decade-long plateau in fertility during the 1990s at around 3.3 births per woman, the total fertility rate (TFR) has declined further and remains at 2.3 births per woman since the 2011 Bangladesh Demographic and Health Survey (BDHS).²² The urban fertility rate is 2.0 compared to the rural fertility rate of 2.4.²³ Overall, the total demand²⁴ for family planning is approximately 75 per cent and the unmet need is approximately 12 per cent.²⁵ The contraceptive prevalence rate (CPR) has risen from 7.7 per cent in 1975 to 62 per cent in 2014. Fifty-four per cent of married women use modern methods and only 8 per cent use a long-acting or permanent method. However, 30 per cent of contraceptive users stop using a method within 12 months; discontinuation rates are much higher for short-term, modern methods than for longer-term methods²⁶. The Government of Bangladesh has developed a *National Strategy for Improving Uptake in Long Acting and Permanent Methods* (LAPM) in the Family Planning Programme (2011-2016).²⁷

Approximately 79 per cent of women giving birth received antenatal care (ANC) at least once and a sharp increase was indicated in antenatal care services from medically-trained providers. Although still low, the proportion of births delivered at health facilities has been increasing rapidly, from 12 per cent in 2004 to 37 per cent, while 62 per cent are delivered at home. Four in ten births (42 per cent) were attended by trained personnel (e.g. doctor, nurse or midwife, family welfare visitor, or community skilled birth attendant). While clean delivery is practiced in 88 per cent of home births, only 6 per cent of all newborns receive all five essential care practices.

¹³ *Coping with Floods: The Experience of Rural Women in Bangladesh*, Nasreen, Mahbuba, 1995. unpublished PhD dissertation, Massey University, New Zealand.

¹⁴ *Women and Girls Vulnerable or Resilient?* Nasreen, Mahbuba, 2012. Institute of Disaster Management and Vulnerability Studies, University of Dhaka, Dhaka-1000.

¹⁵ Disaster Management and Relief Division, in coordination with the National Disaster Management Council (NDMC) and an Inter-ministerial Disaster Management Coordination Committee (IMDMCC)

¹⁶ <http://www.ddm.gov.bd/%20>

¹⁷ Global Climate Risk Index 2015, German Watch

¹⁸ *Gender, Climate Change and Health*, World Health Organization, 2009

¹⁹ Maternal mortality in Bangladesh: a Countdown to 2015 case study, Shams E Arifeen et al, *The Lancet*, 28 June, 2014

²⁰ UN Estimate is 170 as per an alternative means of calculation: "Trends in Maternal Mortality: 1990-2013, Estimate by WHO, UNFPA, The World Bank and the United Nations Population Division", 2014

²¹ Bangladesh Maternal Mortality Survey, 2010

²² Bangladesh Demographic and Health Survey (BDHS), 2014, page 20

²³ *Ibid.* page 22

²⁴ "Total demand for family planning: the sum of unmet need plus total contraceptive use", BDHS, 2014, page 26

²⁵ Unmet need: the sum of unmet need for spacing plus unmet need for limiting, BDHS, 2014, page 26

²⁶ Discontinuation rates have improved from 36% in 2011 to 30% in 2014, BDHS 2014, page 18

²⁷ Bangladesh Demographic and Health Survey 2014, page 26

A sharp rise in cesarean sections has occurred from 19.1 per cent to 23 per cent of births in 2012-2013,²⁸ particularly among institutional deliveries.²⁹ Only 36 per cent of mothers and their babies received postnatal care from a medically-trained provider within 42 days after delivery.³⁰ Early and closely-spaced pregnancies and shortages of skilled birth attendants have contributed to the high incidence of obstetric fistula with an estimated 71,000 suffering from the effects.³¹

The annual incidence of cervical cancer in Bangladesh stands at 12,000; constituting 19.3 per cent of all female cancers, while breast cancer constitutes approximately 23.9 per cent.³² Cervical cancer deaths reached over 6,500 per year while breast cancer deaths were estimate at over 7,000 per year.³³ Although cervical and breast cancer screening programmes were initiated in 2005 and 2007 respectively, awareness of screening was very poor and treatment often came too late or referrals were not followed up.³⁴

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, due to low reporting, the number potentially could be as high as 977,000.³⁵ Although HIV prevalence in the general population in Bangladesh is low, at 0.1 per cent, reported new infections have increased by a factor of about 1.5 within the last five years alone.³⁶ 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.³⁷

3.4 SITUATION WITH REGARD TO ADOLESCENTS AND YOUTH

Young people constitute about one third of the population of Bangladesh. The National Youth Policy (updated 2003) determines that citizens aged 18 to 35 years are treated as youth.³⁸ Rates of child marriage are high with 34.3 per cent of women aged from 15 to 49 at the time of the survey, married between the ages of 15 and 19. While the legal age for marriage of girls is 18, 23.8 per cent of girls were married before the age of 15.³⁹ The demand for family planning among married 15 to 19 year olds is 68 per cent while 17 per cent of these face unmet needs.⁴⁰ Unmarried youths are not eligible to receive government-supported reproductive health services, although there are some alternative service providers.

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 show that 31 per cent of adolescents in Bangladesh age 15 to 19 have begun childbearing; about one in four teenagers has given birth. As expected, the proportion of women age 15 to 19 who have begun childbearing rises rapidly with age, from 9 per cent among women age 15, to 58 per cent among women aged 19. Early childbearing among teenagers is more common in rural than in urban areas (32 per cent versus 27 per cent, respectively). Bangladesh ranks second in the world in numbers of women aged 20 to 24 who had given birth by the age of 18.⁴¹ The Government, together with support from UNFPA and UNICEF, drafted a *National Plan of Action* in

²⁸ Multiple Indicator Cluster Survey, UNICEF, 2012-2013

²⁹ Bangladesh Demographic and Health Survey 2014

³⁰ Bangladesh Demographic and Health Survey, 2014, page 20 (data collected between 2011 and 2014)

³¹ Situation Analysis of Obstetric Fistula in Bangladesh, EngenderHealth Bangladesh Country Office; Study 2003 supported by UNFPA identified 71,000 cases, with cases being added each year, this number is likely to be higher now according to roundtable, "Obstetric Fistula in Bangladesh: Looking into the future", May 11, 2013, organized by USAID, EngenderHealth and Fistula Care

³² WHO Globocan, 2012

³³ World Health Rankings, www.worldlifeexpectancy.com, data from WHO 2014

³⁴ Ibid.

³⁵ UNICEF data and Global Fund to Fight AIDS, Tuberculosis and Malaria. Standard Concept Note: Bangladesh. Dhaka, March 2014.

³⁶ Ibid.

³⁷ National AIDS/STD Programme. *Third National Strategic Plan for HIV and AIDS Response 2011-2017 (Revised)*. Dhaka, April 2014.

³⁸ "While there are no universally accepted definitions of adolescence and youth, the United Nations understands adolescents to include persons aged 10-19 years and youth as those between 15- 24 years for statistical purposes without prejudice to other definitions by Member States." Report of the Advisory Committee for the International Youth Year (A/36/215 annex) <https://www.unfpa.org/webdav/site/global/shared/factsheets/One%20pager%20on%20youth%20demographics%20GF.pdf>

³⁹ Bangladesh Multiple Indicator Cluster Survey, 2012-2013, Bangladesh Bureau of Statistics and UNICEF http://www.unicef.org/bangladesh/MICS_Final_21062015_

⁴⁰ Bangladesh Demographic and Health Survey, 2014, page 22

⁴¹ UNFPA, Adolescent Pregnancy, 2013, page 15

2015 to prevent child marriage. The prevalence of gender based violence (GBV) is also higher amongst married adolescents than older married women. The dropout rate for girls is 50 per cent by grade five.⁴² Government programmes have spiked increase in girls' enrolment, but nevertheless, the net attendance ratio for secondary school (2008-2012) is 47 per cent for girls and 43 per cent for boys.⁴³

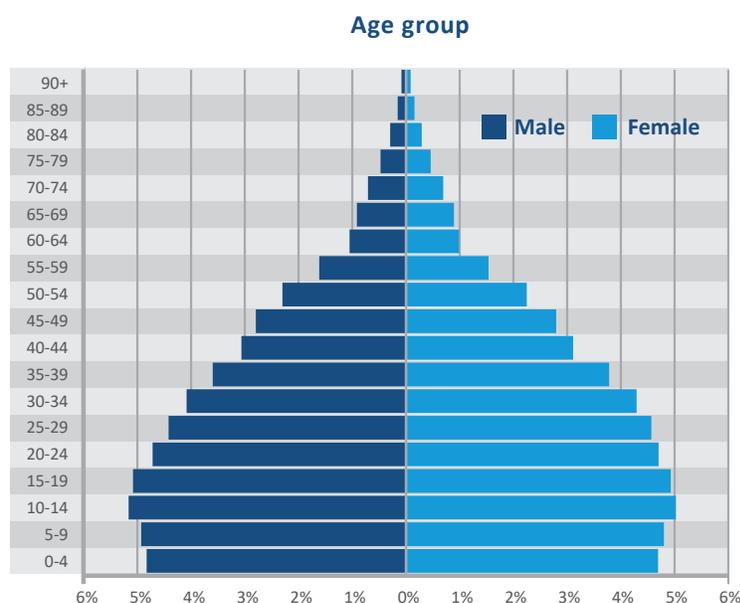
Progress has been made to promote reproductive health education, awareness and regulation, indicating national interest in investing in adolescents and youth. The National Education Policy (2010) and National Children Policy (2011) have provisions covering reproductive health education for secondary school students and adolescents. There is a *National Adolescent Reproductive Health Strategy (2006)*, and an *Adolescent Health Strategy* is being developed while the *National Youth Policy (2003)* is being revised. The Ministry of Education has approved a gender equity movement in schools (GEMS). The Ministry of Women and Children Affairs (MoWCA) supports adolescent clubs which are meant for school drop outs and where awareness is raised

and gender equality is promoted. Recently, the UN has established a Youth Advisory Panel composed of qualified youth to provide input to UN planning.

3.5 SITUATION WITH REGARD TO POPULATION AND DEVELOPMENT

Major changes have occurred in the last four decades regarding population and development in Bangladesh. Successful population programmes in the past have contributed to reduction of fertility and an increase in contraceptive prevalence. Despite these efforts, the population is projected to reach 218.4 million in 2051 under the medium fertility scenario.⁴⁴ Global climate change, which could produce a rise in sea level, is likely to reduce Bangladesh landmass by 20 per cent and cause massive movements of people from the coastal belts: internal migration will dramatically increase in the years to come. Bangladesh needs to be well prepared to manage these challenges; the country will have 60 to 80 million people more than it has today, on significantly less land mass, with far more elderly to take care of, and more than half of the population living in urban areas.

Figure 2 Population Demographics of Bangladesh⁴⁵



⁴² World Bank data, www.worldbank.org/ida/profile-gender.html

⁴³ UNICEF website; data sources: UNESCO

⁴⁴ The Impact of Demographic Transition on Socio-Economic Development in Bangladesh: Future Prospects and Implications for Public Policy. UNFPA (with financial assistance from EU), 2015, pg102.

⁴⁵ United Nations, Department of Economic and Social Affairs. Estimates, 2015.

The implications of this increase will have serious bearings on development in the form of increased poverty, poor health, food insecurity, unemployment, stagnant economic growth, crime and social unrest. It will also increase demand for reproductive health and family planning services, and affect the environment with freshwater depletion, climate change, bio-diversity loss, depletion of fisheries and coastal resources, and degradation of agricultural lands. Bangladesh is currently crossing through a demographic window of change particularly on a dependency ratio. The proportion of children under 15 years is below 30 per cent of the total population and the proportion of people 65 years and older is still below 15 per cent of the total population. This is possibly the best time for realizing demographic dividends, with a low level of combined child and elderly dependency.

Many Bangladesh citizens work outwith their home country: the number of migrants leaving Bangladesh averaged 250,000 a year between 2001 and 2005. This figure rose to almost 400,000 in 2006, and doubled to 832,600 in 2007. It dropped by almost 50 per cent in 2009, due to the global economic downturn. Remittances from Bangladeshi migrants were about \$10.72 billion in 2009. The remittances are equivalent to more than 10 per cent of gross domestic product (GDP).

Population movement within the country has also increased over the years. Estimates of rural-urban migration, which used to be 11.7 per 1000 population in 2000, increased to 24.5 in 2010. In 2010, the rural-urban migration rate for 1000 population of women was 27.4 per cent, while that of men was 21.6.⁴⁶ The urban in-migration rate of men is relatively higher than that of women in 2000 but in 2010 the urban in-migration rate of women was more than that of men, which might be due to job opportunities for women in the garments industry.

The urban population in Bangladesh is now estimated to be 30 per cent of the total population, i.e. 48 million people; up from 24 per cent in 2000. According to the demographic impact study,

37 per cent of the Dhaka city population lives in the slums. It is estimated that by 2020, 40 to 60 per cent of urban dwellers might be living in slums or on the street. The change in the composition of the urban population in future will result in increases in urban slums, increased crime rates in urban areas, overloaded transport systems, lack of adequate basic social services for the urban poor (health and education), environmental health hazards, such as water and air pollution in urban areas and the reduction of agriculture production. *The Bangladesh Urban Health Survey* of 2013 indicates contrasting disparity between slum and non-slum population, for example the total fertility rates (TFR) for slum dwellers is 2.5, compared to 1.9 for non-slum areas.

3.6 SITUATION WITH REGARD TO GENDER EQUALITY

Gender equality has been improving in Bangladesh. However, despite some progress in the Human Development Index, the status of women still remains low. Bangladesh ranked 115 out of 149 countries surveyed on the Gender Inequality Index.⁴⁷ Men outnumber women in Bangladesh and rights of women are still unequal in health, education, employment and political freedom. Female family members are less likely to receive modern medical care and the health situation is generally worse for urban women. Female literacy remains low and female attendance in secondary school is only 47 per cent (2008-2012). Women workers may suffer harassment and low wages. The ready-made garment industry in Bangladesh, the largest earner of foreign currency, provides employment to 4.2 million, about 80 per cent of whom are women.⁴⁸

The Constitution of Bangladesh affirms equal rights for women. Bangladesh has ratified the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW) in 1984. It has since issued guidelines for addressing sexual harassment, as well as promoting gender parity in school enrolment and setting quotas for women's representation in Parliament. The National Council for Women and Children Development is chaired by the Honorable

⁴⁶ Gender Statistics of Bangladesh 2012, BBS. page 16

⁴⁷ UNDP Human Development and Gender Inequality Indexes, 2014

⁴⁸ ILO, "Improving Working Conditions in the Ready Made Garment Industry: Progress and Achievements," accessed at http://www.ilo.org/dhaka/Whatwedo/Projects/WCMS_240343/lang--en/index.htm

Prime Minister. A gender responsive budgeting has been developed as well as a women development policy and its national action plan was developed in 2013.

Gender based violence (GBV) against women both in the private (domestic) and public spheres (work places) has become a widespread issue across Bangladesh, reflected in daily newspapers. The major types of violence against women are: physical violence, psychological violence, sexual harassment, trafficking, kidnapping, acid attack, wife battering, murder and rape. According to a survey on *Violence Against Women (VAW)*,⁴⁹ 60 per cent of women in Bangladesh suffer from some type of violence and almost half suffer from domestic violence: 87 per cent of married women have experienced some form of violence by their spouse. Just over half (51.5 per cent) of the women 20 to 24 years of age had experienced violence in the last 12 months before the survey.⁵⁰ A situational analysis showed 76 per cent of the female students studying at a tertiary level faced sexual harassment at least once on the campus.⁵¹

The Government has taken a number of legal steps against domestic violence, including the *Suppression of Violence against Women and Children Act 2000*, the *National Human Rights Act, 2009* and the *Domestic Violence Act* in 2010. The legal process to counter gender based violence is complex, due to procedural gaps. There is also a dearth of information on the state interventions towards preventing and responding to violence. The Ministry of Women and Children Affairs (MoWCA) has formulated a *National Action Plan to Prevent Violence Against Women and Children (2013-2015)*.

3.7 SITUATION WITH REGARD TO DEVELOPMENT ASSISTANCE

Bangladesh has received foreign aid since its independence in 1971. In 2014, it ranked eighth on the list of countries receiving the most foreign assistance. The top donors to the country are the International Development Association (IDA), Asian Development Bank (ADB), Japan, USA, UK

and the United Nations. Between 2013 and 2014, 73.22 per cent of aid was committed through multilateral partners, while the remainder came from bilateral partners. It is estimated that almost half of development expenditure is financed through external assistance: hence, if there is reduction in external assistance, development programmes such as agriculture, rural development, flood control, industry, power, transport, communication, education, health and family welfare, and infrastructural sectors, will suffer.

Grant aid contributes to about 43 per cent of total aid received by Bangladesh. External assistance increased from \$0.66 billion in 1971 to 1980 to \$1.63 billion in 2001 to 2010. In the 1970s, owing to the famine and low production capacity in the country, 32 per cent of assistance came in the form of food. In the 1990s, with increasing agricultural productivity, food aid declined and commodity aid dried up completely in 2005. In 2014, project aid attributed to 98.98 per cent of total aid.⁵²

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 for this include:

- delays due to donors' complicated disbursement procedures
- problems in tender processes and delays in consent by development partners
- delays in employment of consultants
- delays in starting the projects
- lack of coordination among the co-financers
- absence of practical work plans
- complexities in land acquisition and revision of technical project plans (TPP).⁵³

There has been significantly more efficient disbursement of external assistance in social sectors in recent years. As a result some indicators have shown remarkable improvement, including: poverty, fertility, life expectancy, school enrolment for girls and child immunization. This suggests that foreign aid plays a critical role in Bangladesh with

⁴⁹ Bangladesh Bureau of Statistics (BBS), 2011. Violence against Women (VAW) Survey Report

⁵⁰ Ibid.

⁵¹ Situational Analysis of Sexual Harassment at Tertiary Level Education Institutes in and around Dhaka, 2013, UN Human Development Report.

⁵² Bangladesh Statistical Yearbook 2012

⁵³ Changing Foreign Assistance Scenario in Bangladesh, Keystone Quarterly Review 2014

regard to infrastructural project development in targeted sectors, while improvement in health and social indicators are most likely a result of concentrated efforts by the government and NGOs. The private sector, NGOs and donors, in addition to the government contributions, support the national health sector. In 2007, 9 per cent of health expenditures were managed by NGOs.⁵⁴

The Economic Relations Division (ERD) of the Ministry of Finance is the overall coordinating agency for the UN agencies. The UN country team consists of representatives from 23 UN agencies. With regard to the humanitarian response to assist refugees, approximately 32,000 refugees (or asylum seekers) from Myanmar live in camps, assisted by the Government, with UNHCR and other agencies. UNFPA supports reproductive health services and the prevention of gender based violence in the camps. Approximately 200,000 reside in host communities and the government is addressing their reproductive health coverage with support from the International Organization for Migration (IOM) and other agencies.⁵⁵

3.8 THE UNFPA EIGHTH COUNTRY PROGRAMME FOR BANGLADESH

3.8.1 Lessons learned from previous country programme cycles

The UNFPA Bangladesh seventh country programme evaluation (February 2011) offers valuable lessons, which were considered in the planning of the eighth country programme.⁵⁶ The following is a **summary of conclusions, recommendations and lessons**, which are also reflected in the country programme document of July 2011. The evaluation of the seventh country programme concluded that the programme had contributed to developing national capacity for community-based skilled care and community involvement in countering gender based violence. It also found limited synergy among programmatic areas, a lack of clear linkages between policy advocacy and programmatic interventions, and too many projects for the resources available.

Cooperation good practices in the seventh country programme include: formation of local coalitions to promote women's rights, putting women's support centres (WSC) into operation for survivors of violence, leveraging support through participation in pooled funds for the health and population sectors, and developing national capacity for skilled birth attendants and treatment services for obstetric fistula. Demand for the services was promoted through financing for maternal health vouchers and local-level planning. Advocacy efforts influenced national commitment to the Global Strategy for Women's and Children's Health and strategies were put in place to strengthen midwifery services and adolescent sexual and reproductive health.

The seventh country programme evaluation identified lessons for future programming.⁵⁷ In regard to **programme design and integration**, it was cautioned that too much emphasis on projects and separate interventions that focused on specific groups or geographic areas could fail to include neighbouring issues and thus be incomplete in their concepts. A balanced approach is important between systems-building (e.g. health systems) and immediate assistance (e.g. response to gender based violence). Sustainability is built upon strong linkages with the Government of Bangladesh and other assistance providers. To ensure a dynamic, integrated programme strategy that avoids mere repetition of historical interventions, updated situation analyses and needs-assessments are critical. Training, research, and studies should lead to programme or policy decisions, or they may not add value to their project. Design and planning of pilot projects should ensure, before commencing, that they are carried out with a view to added value for national policy makers, and are introduced at a propitious time to feed into national deliberations.

In terms of **quality assurance and monitoring**, a well-thought-out results and resources framework, as well as common programme strategies, are vital to a clear direction for the country programme and for ongoing monitoring. A functional quality assurance system, combined with relevant programming and monitoring, is essential to achieving high quality,

⁵⁴ Bangladesh Health System Review, Health Systems in Transition, Asia Pacific Observatory on Health Systems and Policies, WHO, 2015, executive summary.

⁵⁵ UNHCR data indicated that 232,986 Rohingya refugees reside in Bangladesh, 200,000 outside the camps (UNHCR website)

⁵⁶ According to the 7th Country Programme Evaluation, a Mid-Term review was conducted for the 7th Country Programme but too late in the programme to effectively steer it.

⁵⁷ Evaluation Of The 7th Country Programme UNFPA Bangladesh, Final Report, "Lessons Learned", pages 67-70

and needs to be built into each intervention with responsibility assigned among staff. Strong coordination helps to avoid the programmatic areas from functioning in isolation.

In terms of **reaching the most vulnerable people**, to avoid a “hit or miss” approach, an effective communication strategy should be based on the most effective method for each target group (e.g. individuals, communities, most at risk populations). And then it is important to identify the partners most suited to taking responsibility for communication. Productive cooperation between the public and private sectors needs quality assurance and regulation to maintain a consistent and effective performance in reaching the poorest groups. Potentially very successful means to reach households, such as home visits, need to be evaluated. It is important to broaden the range of partner NGOs and civil society organizations (CSO) in order to enrich the advice provided by UNFPA with regard to national policy and strategy design.

The seventh country programme 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
- (e) increasing the involvement of civil society in the programme.

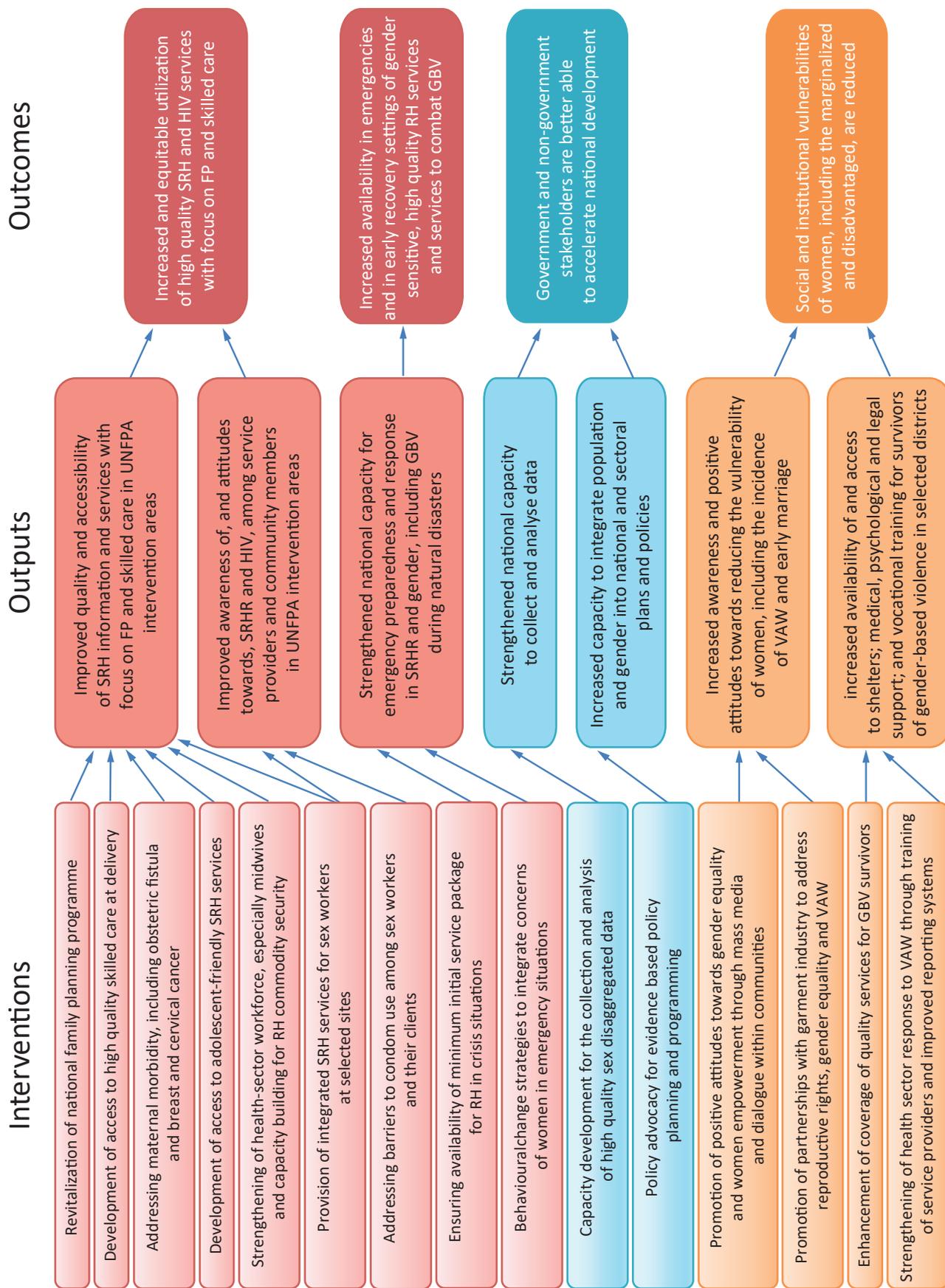
3.8.2 Intervention logic of the eighth country programme

The eighth 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 on the UNDAF, the country programme document (July 2011), the annual work plans (AWPs), the standard progress reports (SPRs), and atlas project data. The rationale behind the country programme can be described in terms of its **intervention logic** as illustrated in the **logical diagramme of effects** (see Figure 3). Generally, the interventions undertaken by the country office could be typed as a) capacity building; b) research and information support leading to knowledge management; c) advocacy and, d) facilitating service delivery.

The programme outputs undertaken between 2012 and 2016 are meant to contribute to the UNDAF outcomes of **Pillar Three**: Social services for human development; **Pillar Five**: Climate change, environment, disaster risk reduction and response; **Pillar Six**: Pro-poor urban development and **Pillar Seven**: Gender equality and women’s advancement.

According to the programme documents, the interventions are relevant with a view to contributing to the outcomes and results, but they do not clarify how interventions that are meant to benefit vulnerable groups are integrated under a comprehensive strategy. Across the programmes, there have been some disparity in time between the creation of plans and the delivery of inputs, which has caused delays in implementation. Examples of these delays are: waiting to receive government approval for Technical Project Proposals (TPP); breaks in continuity of interventions due to disruptions and hartals; staffing shortages and reorganization in the country office particularly during 2012 and 2013; a human resources realignment into 2015; and funding cuts of UNFPA core funds in 2013-2015.

Figure 3 Logical Diagramme of Effects



3.8.3 The financial structure of the country programme

The initial proposed commitment of UNFPA as per the final country programme document (July 2011) is \$70 million: \$40 million from regular resources and \$30 million through co-financing modalities and/or other, including regular resources. This amount was to be divided among core programme areas: reproductive health (RH) \$46 m (\$26 m from regular resources); population and development (P&D) \$9 m (\$5 m from regular resources); gender equality (GE) \$13 m (\$7 from regular resources); and programme coordination and assistance \$2 m from regular resources. The main donors are the European Union (EU), DFATD (former CIDA), the Netherlands (Embassy of the Kingdom of the Netherlands), the MDG Fund, DFID (UK Aid), Switzerland and Sweden.

Changes that transpired regarding the eighth country programme budget, included the reduction in the contribution from DFID in 2012 for the Maternal Neonatal Health Initiative (MNHI) project from an expected \$12.7 million to \$5.22 million. The UNFPA core funds differed from initial commitments, whereas \$40 million was expected, the total amount provided and committed was approximately \$35.8 million.⁵⁸ Due to decreases in core budgets and variations in fund raising, the actual amounts allocated by October 2015 were

reproductive health (RH) \$35.437 million (including humanitarian), population and development (P&D) \$11.67 million, gender equality (GE) \$7.048 million, and \$5.098 million for the adolescents and youth, Generation Breakthrough, and \$7.5 million dedicated to project management, communications and advocacy (PCA).⁵⁹

As of October 2015, resource mobilization figures (2015 and 2016 commitments are not finalized) amounted to \$67.757 million while expenditures amounted to \$40.797 million (please see detail chart of budgetary allocations and disbursements in the annexes.)

As per the overview and expenditure chart, the budget has exceeded the expenditures in each year of the project. In 2012 there were partial funds for the MNHI from DFID/EU, while \$12.87 million was expected, the actual amount released was \$5.22 million. The remaining was the Canadian International Development Agency (CIDA) funds and CIDA continues to fund the MNHI. Figure 7 shows the annual budgets and expenditures for the eighth country programme thus far (2012 to 2015) from regular and other resources. Figure 4 provides a comparison between programmatic area budgets from 2012 to 2015, while Figure 5 shows the budgetary allocations among the programmatic areas for 2015.

Figure 4 Comparison Between Country Programmatic Areas 2012-2015 Budgets in US\$ Millions

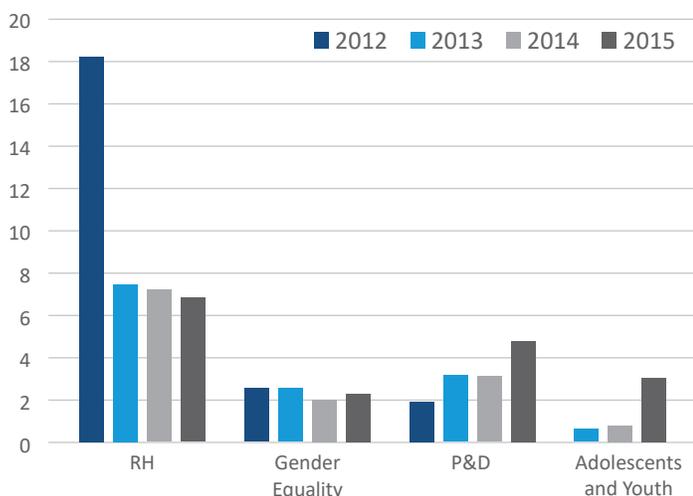
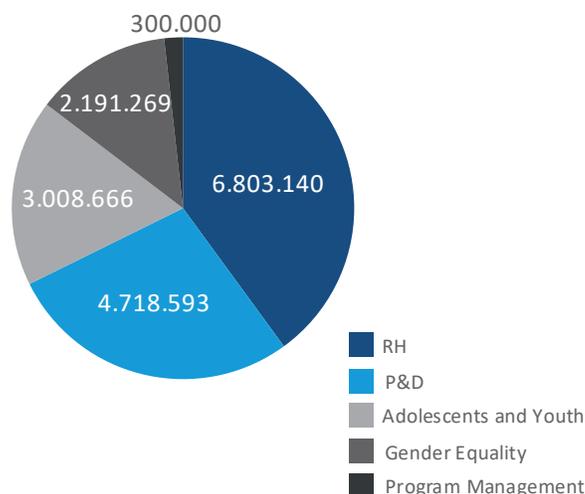


Figure 5 2015 Budget Allocations Among Programmatic Areas in US\$



⁵⁸ "Resource Mobilization for eighth country programme (core and non-core)" chart provided by the CO, September, 2015

⁵⁹ Ibid.

4 FINDINGS (RESPONSES TO EVALUATION QUESTIONS)

4.1 RELEVANCE

EQ1

To what extent is the Bangladesh eighth country programme (2012-2016): a) adapted to the needs of the population, in particular the needs of vulnerable groups, b) aligned with the Government's priorities and, c) aligned with UNFPA policies and strategies?

SUMMARY

UNFPA continued a number of partnerships and interventions from the seventh country programme: expanding focus through projects on maternal and neonatal health, producing skilled birth attendants to meet national priorities, and integrating gender equality and reproductive health for adolescents and youth. Ongoing assessments and research formed a strong basis for strengthening advocacy and policy, increasing cross-cutting links with gender equality issues and improving knowledge regarding access to and demand for services.

UNFPA targeted some of the most vulnerable people in low-performing districts, slums and refugee camps and women and girls vulnerable to gender based violence and abused rights. However, to reach undocumented refugees, those not accessing family planning services and those most at risk of sexually transmitted diseases, more strategic planning was required to strengthen capacity.

The eighth country programme objectives are consistent with priorities set by the UNDAF in five of seven intervention areas; UNDAF is tracking six indicators relevant to UNFPA priorities. The country programme

also complements the strategic direction set out in the UNFPA Strategic Plans (2008-2013 and 2014-2017), reflecting the International Conference on Population and Development goals and principles. Capacity development interventions are adapted to jointly-determined needs, based on consultations with partners, and include many examples of South-South cooperation. Gender equality mainstreaming is gathering strength compared to the seventh country programme and substantially more resources have been targeted to adolescents and youth.

All programmatic areas were strongly aligned with national and sectorial policies and MDG goals, and the objectives and strategies of the country programme were planned with national partners. Local-level planning aimed to incorporate maternal health, family planning, gender equality, and disaster and emergency preparedness and response. The bulk of interventions have been implemented with the Government and community partners and through national systems.

4.1.1 Adaptation of the country programme to the evolving needs of the population, in particular those of vulnerable and special groups

UNFPA continued a number of partnerships and interventions from the seventh country programme expanding focus through projects on maternal and neonatal health and producing skilled birth attendants to meet national priorities and integrating gender equality and reproductive health for adolescents and youth.

The eighth country programme (CP) design was based on the seventh country programme evaluation, the eighth country programme situation

analysis, and the United Nations Development Assistance Framework (UNDAF), 2012 to 2016. The Millennium Development Goals (MDG) progress report and the government strategic priorities, as expressed in its perspective plan, 2010 to 2021, and the draft Sixth Five-Year Plan, helped to establish the priorities of the UNDAF. National dialogue was held with stakeholders including government officials, civil society experts, the private sector and development partners. UNFPA implementing partners (IPs) have attested to strong collaboration on planning in all programmatic areas with both new and traditional partners.⁶⁰ The programme was supported against a backdrop of funding crunches and human resources shortages that occurred as the seventh country programme was ending and the eighth country programme was beginning.

The UNDAF includes a geographical focus as well as a group focus, in recognition of the increasing inequalities in the country. It targets 20 underperforming districts and 30 cities and towns based on MDG parameters. The UNFPA programme largely follows this targeting strategy and contributes to the UNDAF outcomes.⁶¹ It is recognized that UNFPA geographical targeting is limited, relative to the needs in Bangladesh in 64 districts and interventions, particularly in reproductive health (RH) and gender equality (GE), focus on a small number of districts and thus a limited proportion of the most vulnerable. However, interventions, such as advocacy and policy-making efforts, population and development data collection, support for contraceptive supply, and improving quality of service for midwifery were targeted for country-wide outcomes.⁶²

In the reproductive health (RH) programmatic area, the final country programme document (July 2011) indicated that UNFPA applies a coordinated, rights-based, supply and demand approach to reproductive health.⁶³ Mention was made supporting the Prime Minister's commitment to the United Nations Secretary-General's Global

Strategy for Women's and Children's Health, which focused on the following objectives, to be reached by the end of 2015: (a) doubling the percentage of skilled birth attendance, (b) reducing the rate of adolescent pregnancies and (c) halving the unmet need for family planning.

The seventh country programme evaluation (CPE) recommended limiting the primary focus to the reduction of fertility, while the eighth country programme situation analysis recommended addressing maternal morbidity and mortality and the stagnant contraceptive prevalence rate (CPR), as well as the high risk of sexually transmitted diseases (STD) and weak adolescent reproductive health. The intervention areas for reproductive health were generally carried forward from the seventh country programme with some revision in targeting and expansion in the areas of maternal and neonatal care and provision of skilled birth attendants. The focus on adolescents and youth was expanded through information and education in health centres, communities and schools.

In some cases, planned interventions targeted groups accessible through projects where funding was already available and where partnerships had already been successful. Focus was placed on high profile attention to reaching MDG 5 in Bangladesh (Maternal deaths due to pregnancy and delivery – 5,200 per year in addition to other negative health consequences.⁶⁴) and in fulfilling high-level development promises. While these practicalities are understandably important, focus did not extend adequate reach to some very vulnerable people such as those who do not have access to health services, for example: “floating” populations in the shoals and islands (chars), the homeless or migratory, those engaging in high-risk sexual behaviour, and those who are most vulnerable to disasters and emergencies.⁶⁵

Strategic emphasis was not prioritized, relative to the extent of some reproductive health issues demonstrated through studies and research, as

⁶⁰ Key informant interviews, October 2015

⁶¹ UNFPA Final country programme document for Bangladesh, 2012-2016, page 3

⁶² Key informant interviews, October 2015

⁶³ UNFPA Final Country Programme Document for Bangladesh, July 2011

⁶⁴ M. Koblinsky et al. “Maternal Morbidity and Disability and Their Consequences: Neglected Agenda in Maternal Health,” in *Journal of Health, Population and Nutrition*: 30(2). June 2012, pp. 124-130

⁶⁵ Key informant interviews, October 2015

discussed in the background section.⁶⁶ For example, data regarding numbers of women affected by cervical cancer and breast cancer (combined deaths greater than 13,000/year), as well as increasing numbers of people with sexually transmitted diseases, did not receive greater strategic emphasis in the eighth country programme. Data regarding the expected population growth and its impacts, including greater out-migration of fathers for work and inability of infrastructure to cope with the larger numbers, in addition to the stagnating CPR and poor acceptance of long-acting contraceptive methods, should have resulted in stronger strategic focus on community-level family planning issues. The country programme continued to place emphasis on finalizing and disseminating a national strategy for obstetric fistula (affecting more than 71,000) and strengthening service delivery and rehabilitation.

For **maternal health**, the Maternal Neonatal Health Initiative (MNHI) was expanded from 4 to 11 districts from July 2011 and continued for the eighth country programme, although funding was not increased. Justification of the project expansion is based on replicating quality achievements. Districts were selected based on eight selection criteria in both UNDAF and non-UNDAF districts. Lessons learned were incorporated into the eighth country programme plan.⁶⁷ An *Emergency Obstetric Newborn Care* (EmONC) survey helped to further identify access and demand issues related to ante- (ANC) and postnatal care (PNC) and skilled birth attendance. The MNHI project comprised the bulk of the maternal health interventions. UNFPA expanded training to increase the number of certified and registered midwives in response to the Prime Minister's commitment to place three thousand registered midwives by the end of 2015. UNFPA had

identified some key risks in the institutionalization of the midwifery programme, which were further explored in a formative evaluation of the six-month nurse-midwife certification training and interventions were planned to counter these risks.⁶⁸

The MNHI has been evaluated following the seventh country programme, through a project completion review.⁶⁹ The review attested to an impressive amount of work in four years (in four districts), including the development of local-level plans, parallel supply-and-demand initiatives and accountability mechanisms, and the inclusion of some neglected populations. The report cautioned that the noted changes were not yet institutionalized or sustainable and, importantly, delivery of greater quality and quantity services needed to be demonstrated through an improved monitoring and evaluation (M&E) strategy.⁷⁰ An end-line survey, summarized in 2013, demonstrated improvements in antenatal, facility-based delivery, postnatal care, and community awareness in the four target districts. A significant increase was noted in use of contraceptives seven months after the last pregnancy up from 26.3 per cent to 49.3 per cent.⁷¹

The MNHI project's rationale for reaching the most marginalized through a district-wide approach is based on evidence that the poor are more likely to use public, rather than private sector health services. Further, strengthening health system accountability and quality MNH services was seen to be a means to improve the system's ability to reach the poor.⁷² The project had also targeted tea workers and an indigenous group: the Rangamati hill district, home to many remote and hard to reach populations, was added to the project in 2012. Since more than 60 per cent of births still occurred at home and only 42 per cent were attended by trained personnel

⁶⁶ Situation Analysis of Obstetric Fistula in Bangladesh, EngenderHealth Bangladesh Country Office; Study 2003 supported by UNFPA identified 71,000 cases, with cases being added each year, this number is likely to be higher now according to roundtable, "Obstetric Fistula in Bangladesh: Looking Into the Future", May 11, 2013, organized by USAID, EngenderHealth and Fistula Care; WHO Globocan, 2012; World Health Rankings, www.worldlifeexpectancy.com, data from WHO 2014; UNICEF data and Global Fund to Fight AIDS, Tuberculosis and Malaria. *Standard Concept Note: Bangladesh*. Dhaka, March 2014; National AIDS/STD Programme. *Third National Strategic Plan for HIV and AIDS Response 2011-2017 (Revised)*. Dhaka, April 2014; Bangladesh Demographic and Health Survey, 2014

⁶⁷ Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction Expansion for six new districts, UN Joint Proposal, submitted to CIDA, March 2011

⁶⁸ "Certificate in Midwifery Education Program Bangladesh (Government of Bangladesh & Partners) Formative Evaluation Report" June 2014 Prepared by: Penny Haora RM MPH PhD, and Nurjahan Begum MSc

⁶⁹ 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

⁷⁰ 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

⁷¹ MNHI Endline Survey Summary, HDRC, 2013.

⁷² Initial Monitoring Mission, Joint Government of Bangladesh – United Nations Maternal and Neonatal Health Initiative (MNHI) Project Number: A-035190, July 2015, Agriteam Canada Consulting Ltd

(e.g. doctor, nurse or midwife, family welfare visitor, or community skilled birth attendant),⁷³ creating demand for facility-based midwifery-led deliveries was a major challenge. The focus on increasing the number of midwives was promoted by the Prime Minister in 2010 with her pledge to increase the numbers of skilled birth attendants by ten thousand and by at least a further three thousand at the end of 2015.

Historical interventions to address cervical and breast cancers and obstetric fistulae continued, but lacked strategic innovations in their designs to address persistent issues in reaching affected women. Increasing evidence was available that cervical and breast cancers are possibly causing more maternal deaths than those related to complications of pregnancy and delivery, and that large numbers of women were still to be treated for obstetric fistulae: this was a flagship intervention of UNFPA assistance in Bangladesh. The Urban Health Project incorporated interventions on maternal health, family planning and adolescents and youth in the Dhaka slums and surrounding areas.

With regard to **family planning**, the emphasis was placed on securing both supply and demand but focus appeared to be more strongly placed on supply while data indicated that demand and usage of contraceptives was plateauing since 2011. UNFPA took action to identify causes through studies on reproductive health commodity security (RHCS) and long-acting, permanent methods (LAPM). It also pressed for post-partum contraception and LAPM. In view of increasing evidence that people living with HIV and AIDS were on the rise and that many cases were still undetected, UNFPA emphasis on HIV remained focused on disseminating information on STDs through the adolescents and youth focus, with limited attention on sex workers and others most at risk.

The introduction of the Generation Breakthrough (GB) project infused a stronger integration between gender equality and reproductive health, targeting the demographically significant **adolescents and youth** group. Generation Breakthrough focused on adolescents aged 10 to 19, with the aim of grooming them into responsible, non-violent, healthy and happy adults, as future (sexual) partners, fathers,

mothers and care-givers, with gender equitable attitudes and practices. Generation Breakthrough targets both boys and girls and includes information on child marriage and gender based violence. Boys were also targeted through a “coaching boys into men” intervention.

The Generation Breakthrough project has three implementing partners: the Ministry of Women and Children Affairs (MoWCA), Ministry of Education (MoE), and Plan International Bangladesh (who, in turn, partners with Concerned Women for Family Development (CWFD), and BBC Media Action). Through effective sexual and reproductive health and rights and gender based violence prevention information, awareness, skills and adequate adolescent-friendly services, the project aims to contribute to the reduction of gender based violence, unwanted pregnancies, unsafe abortions, maternal mortality and the spread of HIV and other sexually transmitted infections among adolescents in the target areas of Bangladesh.

The Generation Breakthrough project included development of a gender equity movement in schools (GEMS) module and also addresses sexual and reproductive health in schools and community-based clubs. The GEMS module was supplemented with a focus on adolescent reproductive health in the health care system, a helpline, media campaigns and radio programmes, as well as activities and interactive games. Other interventions designed on behalf of adolescent reproductive health included development of adolescent corners in health centres to disseminate information and to provide services in dedicated spaces.

Humanitarian assistance continued from the seventh country programme for Rohingya **refugees** in two camps in Cox’s Bazar district to address the protracted emergency with increased emphasis on adolescents and youth. UNFPA response to assist refugees and undocumented migrants living outside of the camps was not part of the programme design. UNHCR estimated that in addition to the 32,000 living in the camps, over 200,000 lived in host communities.⁷⁴ A camp of undocumented refugees was located in close proximity to one of the UNFPA-supported camps, assisted by IOM and Médecins Sans Frontières (MSF). Given how disaster-prone

⁷³ Bangladesh Demographic and Health Survey, 2014, page 20 (data collected between 2011 and 2014)

⁷⁴ UNHCR 2015 data indicated that 232,986 Rohingya refugees reside in Bangladesh, 200,000 outside the camps (UNHCR website)

Bangladesh is, UNFPA promoted preparedness training on the Minimum Initial Services Package (MISP) and stockpiled UNFPA initial contributions in the form of safe-delivery kits. However, more focus on defining UNFPA role in disasters and emergencies was warranted in the design of the programme, as effective emergency assistance would be dependent on assessment of needs and reaching the most vulnerable with appropriate interventions.

The population and development (P&D) programmatic area appropriately emphasized the use of gender and poverty disaggregated data. The evaluation of the seventh country programme recommended improving linkages between high-level policy dialogues and the development of institutional capacity.⁷⁵ To strengthen these linkages, UNFPA and the General Economic Division (GED) of the planning commission undertook integrated research on population and gender equality issues to incorporate findings in dialogue with national planners and to promote inclusion of programmatic interventions in the national plans.⁷⁶

The eighth country programme situation analysis recommended that, given UNFPA comparative advantages, population and development should continue with its core mandate: “use of population data and information for policies and programmes”. In other words, the focus should be reinforced in three approaches: (a) research, (b) evidence-based policy advocacy and (c) data for development.⁷⁷

As per recommendation of the seventh country programme evaluation, the population and development programmatic area continued with minor adjustment. It focused on higher-level institutional capacity development and the thematic analysis of data and policy planning that addressed vulnerable and special groups in the country. It also focused on increased analysis of data and mainly centred on population dynamics, reproductive health and gender equality issues. Population and development placed emphasis on analysis of data, publication and dissemination of information through its partners. It also effectively

highlighted the use of the demographic “window of opportunity” to address the importance of investing in the development needs of adolescents and youth and take into account the demographic transition to a younger and much larger population in the future.

In the **gender equality (GE) programmatic area**, the seventh country programme evaluation recommended development of a comprehensive concept with all requirements and gaps identified and UNFPA role defined among that of other stakeholders.⁷⁸ The eighth country programme situation analysis emphasized the large dropout rate of girls from high school, the need to prepare more women to join the formal earning economy, and the slightly improving, but still weak, political involvement of women. Social vulnerabilities of women and girls, including vulnerability to gender based violence and child marriage, were also stressed. It also identified major challenges that included: institutional gaps in mainstreaming gender equality, lack of substantial data to trace progress, gaps in the legal framework, and insufficient partnerships with civil society and the private sector.⁷⁹

The joint programme, “Violence Against Women” (JP-VAW), managed by UNFPA and ERD with multiple partners, which has been running from 2008 and has been incorporated into the eighth country programme, set the stage and made progress in terms of addressing issues related to policies and the implementation of laws and conventions. It worked with the legal system to adopt and implement policies to prevent violence against women and to protect victims. It also worked towards enhancing government capacities, improving information communication and providing support to NGOs and civil society. Activities were aimed at promoting social and behavioural changes to reduce violence against women and they included awareness raising, sensitization, promoting networks and developing capacities of both gatekeepers and stakeholders.⁸⁰

In the final eighth country programme document (July 2011) the gender equality component

⁷⁵ Evaluation of the 7th country programme of UNFPA Bangladesh, Dhaka, January 2011

⁷⁶ Consolidated Standard Progress Report 2013, page 17

⁷⁷ Situation Analysis for the Formulation of the UNFPA Eighth Country Programme (2012-2016); UNFPA, Bangladesh, Dhaka, November 2010

⁷⁸ Evaluation Of The 7th Country Programme UNFPA Bangladesh, Final Report, January 2011

⁷⁹ Situation Analysis for the Formulation of the UNFPA Eighth Country Programme (2012-2016); UNFPA, Bangladesh, Dhaka, November 2010

⁸⁰ Final Evaluation, Joint Programme to Address Violence Against Women in Bangladesh, MDG Fund, July 2014

continued to focus on changing deep-rooted gender equality norms and attitudes that promote gender inequality. Interventions centred on strengthening the protective systems at community-level and targeted its information and communication toward men and boys, police, and garment industry management. UNFPA planned advocacy interventions to prevent violence and to protect women against violence. It targeted those who provide services to help survivors, such as shelters, legal assistance, and health services.

A number of assessments underpinned the approach, including the Bangladesh Bureau of Statistics, “*Violence against Women (VAW) Survey Report*” (2011). However, annually updated data regarding the prevalence of gender based violence and child marriage was needed during the eighth country programme to track progress. The preliminary findings of the UNFPA-sponsored “*Men’s Attitudes and Practices Regarding Gender and Violence Against Women in Bangladesh*” were available in 2011. The recommendations stressed targeting males for gender equality education, developing policies and programmes for changing male attitudes, as well as strengthening legal frameworks for prosecution and implementing laws against sexual violence within marriage. These were taken into consideration while designing the the eighth country programme.⁸¹

Gender equality interventions targeted four districts and two cities and included local-level planning (LLP), as per agreement with implementing partners. The design of the “*Advancement and Promoting Women’s Rights*” (APWR) project, implemented by the Department of Women Affairs (DWA), a subdivision of the Ministry of Women and Children Affairs (MoWCA), was based on stakeholders’ consultations in selected districts. The *Protection and Enforcement of Women Rights* (PEWR) implemented by the police and the Ministry of Home Affairs (MoHA) built upon needs-assessments, evaluations and data on VAW-prone districts.⁸² In order to identify organizational strengths and challenges for integrating gender

equality into the police systems and operations, a participatory gender audit was undertaken in Police HQ, the Superintendent of Police (SP) offices of four project districts, police stations and at selected districts where women help desks (WHD) were established. The gender audit process established a baseline to track the subsequent progress toward gender mainstreaming within the organization, but it was also a tool for action planning.⁸³ National- and local-level planning consultations were held with relevant stakeholders, and a rapid assessment undertaken on gender based violence (GBV) and child marriage in the selected four districts and areas under the Dhaka Metropolitan Police (DMP).⁸⁴

Prior to the implementation of the project, “*Economic Opportunities and Sexual & Reproductive Health and Rights – a Pathway to Empowering Girls and Women in Bangladesh*”, (EORHR) implemented in partnership with Bangladesh Women Chamber of Commerce and Industry (BWCCI), a mapping and baseline survey was conducted among 330 potential women entrepreneurs, developing rapport among different stakeholders, including ministries. Three inception workshops were conducted at central level and several workshops were held at district level.⁸⁵ Similarly, research was conducted prior to the formulation of the ChaNGE project (*Changing Gender Equality Norms of Garment Employees*), which was implemented along with Bangladesh Garments Manufacturers and Exporters Association (BGMEA).

The beneficiaries were selected to address relevant key issues in the large scope of the gender inequality problem in Bangladesh and to support the continued efforts of the Multi-Sectoral Project on Violence against Women (MSP-VAW), which was implemented by MoWCA in 2000 with the assistance of the Government of Denmark. Partnerships with MoWCA and MoHA projects targeted the marginalized and disadvantaged women through the creation of an enabling/women friendly environment in the workplace and community and by working with community gatekeepers.

⁸¹ “Men’s Attitudes and Practices Regarding Gender and Violence Against Women in Bangladesh” preliminary findings, Ruchira Tabassum Naved, PhD; Hamidul Huque; Subrina Farah; Muhammad Mizanur Rahman Shuvra; November 2011, supported by iccdr, UNFPA, Partners for Prevention and The Change Project

⁸² Key Informant interviews, October 2015

⁸³ ‘Situation Analysis Report on Gender Based Violence in Bangladesh’, UNFPA, 2015

⁸⁴ Standard Progress Report, 2013 (502 for both MoHA and MoWCA as both the projects were designed to achieve similar objectives

⁸⁵ As per the SPR 2013 (July-December, 2013) MoWCA and BWCCI organized these workshops individually.

The primary beneficiaries of collaboration between BWCCI and UNFPA-Bangladesh were marginalized⁸⁶ women who wished to start businesses in selected districts. The secondary beneficiaries included their families, particularly men (husbands and fathers), and communities as well as BWCCI members (women entrepreneurs) in selected districts.⁸⁷ About 80 per cent of workers in garment factories are women, many of whom are economically and socially disadvantaged, and their reproductive health and rights are often neglected. They are also vulnerable to gender based violence in the workplace. Gender equality issues and rights of the working women (as well as men) is a multispectral issue and is overseen by the Ministry of Labour and Employment (MoLE) which examines the relevance of sub-sectoral development projects to address women and gender equality issues.⁸⁸

4.1.2 Consistency between the programmatic areas and the priorities put forward in the UNDAF and in UNFPA strategic plans

The eighth country programme objectives are consistent with priorities set by the UNDAF in five of seven intervention areas. The UNDAF is tracking six indicators relevant to UNFPA priorities. As a “red” country,⁸⁹ UNFPA Bangladesh focused on advocacy, capacity development, knowledge management and strengthening service delivery.

The UNFPA eighth country programme was fully integrated into the process of developing and implementing the UNDAF (2012-2016). This process started in 2010 with a comprehensive assessment of the status of the MDGs, replacing the need for a UN Common Country Assessment (CCA). The UNDAF implementation began in 2012, under a common operational plan developed by the UN country team (UNCT). This replaced the country programme action plans (CPAPs) of the four ExComm agencies (WFP, UNDP, UNICEF and UNFPA), and also integrated the programmes of specialized and non-resident agencies.⁹⁰ Management of UNDAF results

was handled through a comprehensive framework that was built on an online database. UNFPA eighth country programme was therefore consistent with priorities put forward in the UNDAF and contributed to the ICPD perspective inherent in the relevant UNDAF plans.

The ICPD goals were reflected in the country programme and its interventions, including reduction of infant and maternal mortality, and access to reproductive and sexual health services, including family planning. Three of the MDGs are directly related to reproductive health and strongly reflect key ICPD issues: reducing child mortality, reducing maternal mortality, and combating HIV and AIDS, malaria and other diseases.

Bangladesh is the major testing field for the corporate UNFPA Strategic Plan, and is considered a “red” country (one where the needs are greatest and there is a low-to-medium ability to finance), where the modes of engagement consist in advocacy, capacity development, knowledge management and service delivery.⁹¹ An emphasis was given to advocacy and policy dialogue in order to shift national laws and policies. Examples of the development of policies and procedures included: supporting the training of skilled birthing attendants; a costed, national action plan, run through local level planning, to scale up maternal and new-born health services in the MNHI districts; development of a *National Reproductive Health Commodity Security (RHCS)* strategy; promotion of a law against child marriage and applying the Domestic Violence Law of 2010.

Service delivery was paired with capacity development so that the government could assume direct responsibility for areas such as: development of the EmONC, family planning services, cervical and breast cancer screening, provision of medicines and supplies, and response to gender based violence. Capacity development interventions were determined with implementing partners through consultations for the eighth country programme situation analysis in alignment with the goals of

⁸⁶ Women in landless households with below poverty line

⁸⁷ 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

⁸⁸ 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.

⁸⁹ According to the classification of countries in colour quadrants in the UNFPA Strategic Plan (2014-2017)

⁹⁰ UN Country Team in Bangladesh website

⁹¹ UNFPA Strategic Plan 2014-2017, page 13, “Modes of Engagement by Setting”

the UNDAF and government policies and strategies. They included technical advice, training, education, research, provision of equipment, and repairs to facilities.

In terms of **reproductive health and rights**, the extended UNFPA Strategic Plan (2008-2013), which was in effect in the planning stages, prioritized maternal health, followed by family planning. The UNFPA Strategic Plan (2014-2017) placed emphasis on a weighting of indicators: 20 per cent each for reduction of the adolescent fertility rate, reduction of the maternal mortality ratio, proportion of demand for modern contraception satisfied, and proportion of births attended by skilled birth attendants for the poorest quintile of the population. Gender inequality index indicators were weighted at 15 per cent and HIV prevalence in 15 to 24 year-olds given 5 per cent. Discussions with key informants indicated that the operational concept of maternal health tended to focus 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 morbidities and mortality, such as obstetric fistula (OF) or cervical and breast cancer (CBC).⁹² The eighth country programme placed emphasis on a facility-based delivery, which served 38 per cent of the population.

UNFPA leads the global campaign to end obstetric fistula and is the main assistance actor working on obstetric fistula in Bangladesh. The MDG5 supports the complete prevention of obstetric fistulae. The global obstetric fistula campaign has prioritized increased access to obstetric fistula treatment by upgrading health facilities and training health personnel.⁹³ UNFPA Bangladesh planned for finalizing and disseminating a national strategy for obstetric fistulae in the eighth country programme.

The eighth country programme recognized the need to promote access to screening and treatment of cervical and breast cancer. It still grouped these cancers together, but did not highlight the fact that cervical cancer can be an infectious disease as well as a reproductive health concern and that screening and treatment for each cancer requires

its own complex focus. The grouping-together of cervical and breast cancer discussions and data may not have been instrumental in drawing attention to the individual issues, since there were different causal factors, screening procedures and treatment regimes. (They were not treated together in donor countries, for example). What was relevant to one type of cancer was not always relevant to the other. One may have been emphasized to the detriment of the other.⁹⁴ Advances have been made and utilized in the screening and treatment of cervical cancer. However, an evidence-based approach to the screening and treatment of breast cancer in Bangladesh is lacking.

The **population and development** programmatic area is in line with the UNDAF priorities, the MDGs and the National Development Plans (e.g. the *Sixth Five-Year Plan*, and the *Seventh Five-Year Plan* under development). The population and development programmatic area contributed to the development and implementation of national policies, as well as plans and programmes related to population dynamics. An example of this is the “Window of Opportunity”, which is about youth development and the changing age structure of Bangladesh. The objective of the *Sixth and Seventh Five-Year Plans* is to reap this demographic dividend. The population and development programmatic area helped to monitor progress of the *Five-Year Plan* by providing reliable data on population disaggregated by residence, age-sex, marital status and occupation. It prescribed appropriate policy measures for poverty elevation, enhancing employment opportunity for youth and improving the quality of life for people.

Under the eighth country programme, **gender equality (GE) interventions** were designed to contribute to UNDAF Outcome 7.2: “Reducing the social and institutional vulnerabilities of women and girls, including the marginalized and disadvantaged, with special focus on the elimination of SGBV.” In line with this, the gender equality programmatic area intended to pursue two objectives: (a) integrating gender equality and the human rights of women and adolescent girls into relevant national and sectorial laws, policies, strategies, and plans, including women’s empowerment, and

⁹² Key Informant interviews, October 2015.

⁹³ UNFPA website

⁹⁴ Key Informant interviews, October 2015.

raising awareness on gender equality issues and (b) prevention and protection from, and response to, gender based violence improved at the national level and in programme districts. This objective is cross-cutting. It is included in two projects with the Planning Commission under the population and development programmatic area.

The promotion of gender equality is another central principle of UNFPA work. It is both a key programmatic area for UNFPA and a cross-cutting approach that influences all interventions. *UNFPA Strategic Plan, 2008-2013*, sets out Goal 3: “Gender equality advanced and women and adolescent girls empowered to exercise their human rights, particularly their reproductive rights, and live free of discrimination and violence.” Because of UNFPA comparative advantage and strategic niche, based on agreements with other UN organizations mandated for gender equality, focus was on two substantive dimensions of gender equality: (a) promoting reproductive rights and (b) addressing sexual and gender-based violence in the context of sexual and reproductive health, including emergency and conflict situations. There is also an outcome dedicated to gender equality in the *UNFPA Strategic Plan, 2014-2017*.

The seventh country programme evaluation noted that in terms of **mainstreaming gender equality, the agenda** lacked a comprehensive concept or master plan to be effectively mainstreamed among UNFPA staff and partners. The eighth country programme has more effectively integrated gender equality concepts. Gender equality and women’s empowerment are intrinsic parts of the reproductive health programmatic area. Women’s reproductive health rights, including the right to determine the number of children they will have, and birth spacing, are especially important. The population and development programmatic area is highly integrated with gender equality issues and mainstreaming gender equality concerns in data collection. Gender equality and women’s empowerment are mainstreamed in the gender equality programmatic area, although focus has been more concentrated on prevention of and response to child marriage and gender based violence, than on the full spectrum of gender equality issues. Intervention areas are effectively

divided among UN Women and other UN agencies. The UNFPA gender equality marker worksheet was used in the design of the country programme and during the formulation of the interventions in the annual work plans.

UNFPA has targeted significant resources to adolescents and youth (AY). This focus is demonstrated in the study “*The Power of 18 Billion – Adolescents, Youth and the Transformation of the Future*”, 2014. The two UNFPA strategic plans spanning the country programme included separate outcomes for adolescents:

- (2008-extended to 2013) Outcome 2: “Young people’s rights and multi-sectoral needs incorporated into public policies, poverty reduction plans and expenditure frameworks, capitalizing on the demographic dividend.”
- (2014-2017) Outcome 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 services.”

A number of studies in the past decade supported by UNFPA in Bangladesh have emphasized the vulnerability of youth in reproductive health and the high risk in child marriage and early child bearing. The project “Generation Breakthrough” received a strong focus of resources for adolescents and youth. It is funded by the Embassy of the Kingdom of the Netherlands and is implemented through three implementing partners (IPs); MoWCA, MoE and Plan International Bangladesh. It is targeted to a limited geographic area, but crosses gender equality and reproductive health in strengthening adolescent spaces in schools and clubs in communities. The project supports a counseling service for adolescents through a helpline which promotes referrals to clinics run by other assistance agencies.

UNFPA developed an adolescent and youth unit in 2014 to support Generation Breakthrough. It is also responsible for supporting the child marriage-related work of the country office and the communications and advocacy programmatic area. This has a special focus on adolescents and

youth issues and works through partnership with a widely-read Bangla newspaper, *Prothom Alo*. The adolescents and youth unit supports the Directorate General of Family Planning (DGFP) by providing technical advice to develop guidelines on minimum standards and standard operating procedures (SOPs) for adolescent-friendly health (AFH) corners available in the government health systems. UNFPA has provided financial support through the reproductive health programmatic funding to establish ten adolescent-friendly health corners in the Maternal Child Welfare Centres (MCWC) and union family welfare centres (FWC) in five districts.

Adolescents and youth issues have been mainstreamed and cross-fertilized through collaboration between the programmatic areas. Examples of this include: gender equality on the Generation Breakthrough project, child marriage with both gender equality and population and development, and the youth development subcommittee, which was established in the parliament with support from the UNFPA Parliament Project under population and development. The interface with reproductive health includes supporting development of an adolescent health strategy.

UNFPA has sought to mainstream South-South cooperation in its interventions. The following examples (see Annexe 9 for more details) were supported with UNFPA funds and/or technical support, during the eighth country programme and were mainstreamed across programmatic areas and cross-cutting management.⁹⁵ Although there was a large number of experiences, there were few examples documented of the effects of the cooperation and how those effects have benefited the target groups in Bangladesh. Further, follow-up on many of the experiences in terms of capacity building seemed to be weak.

The youth forum experiences in 2012 and 2013, an example of good practice, have been followed up with discussion on how to apply this regional experience to the national level in Bangladesh. At the high-level, inter-ministerial conference on *Evidence for Action: South-South Collaboration for ICPD beyond 2012*, regional events in Asia strengthened youth capacity by presenting evidence on rights-based programming for vulnerable groups

(youths and adolescents, especially girls). Trained youth contributed to the development of the action plan based on the ASRH strategy, which was disseminated to the stakeholders in December 2013. This same group of youth was also engaged in youth consultation for finalising the SAARC Youth Charter. The experiences strengthened UNFPA support for youth leadership. UNFPA provided consultative support to three youth-led networks: PLHIV (People living with HIV), a sex workers network and STI networks (NGOs working for prevention of sexually transmitted infection especially among the youth and adolescents). Through a series of consultative meetings, members of these networks were educated on the connection between HIV and sexual and reproductive health issues so that they could contribute to creating a demand for integrated HIV and SRH services.

4.1.3 Consistency between the country programme and government policies, strategies and guidelines, both at central and decentralized levels

All programmatic areas are strongly aligned with national and sectorial policies and MDG goals, and the objectives and strategies of the country programme were planned with national partners.

The Government of Bangladesh (GoB) has been implementing the *Sixth Five-Year Plan*, which was developed in due consideration of the *ICPD Plan of Action*, the *Beijing Platform for Action* and the MDGs. The plan was designed to meet the challenges in reproductive health, reproductive rights, youth development, and gender equality in development efforts. Implementing partners attest to close collaboration on planning with UNFPA on the eighth country programme, however, planning was affected by political disruptions.

Country programme objectives are consistent with the main national policies of the Government of Bangladesh in the field of **reproductive health and rights**, as well as the *Strategic Plan for Health Population and Nutrition Sector Development Plan (HPNSDP) 2011-2016* and the MDG 5. Planning processes are underway for a Reproductive Health Commodity Security Strategy.

⁹⁵ Country Office Annual Reports, 2013 and 2014

The Government of Bangladesh has promoted reproductive health education, awareness and regulation, indicating a 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 equity movement in schools (GEMS), to be implemented in targeted areas for Generation Breakthrough. It has not been approved for further implementation yet. A national plan of action on eliminating child marriage has been drafted. The bulk of funding for reproductive health and rights was channeled through the Ministry of Health and Family Welfare, Director of Health Services and Family Planning (DGHS and DGFP) and are nationally executed. The MNHI project funds were incorporated into DGHS and DGFP managed funding in 2013.

The objective of the **population and development** (P&D) programmatic area is to enable the government and non-government stakeholders to accelerate national development, with a focus on achieving the Millennium Development Goals and pro-poor growth. The programmatic area contributed with data related to population dynamics required for designing a country's development policies, plans and programme. In doing so, it provided major support to strengthen the national capacity to collect and analyze population data. It also increased the capacity of the implementing agencies to integrate population and gender equality concerns into national and sectoral policies, as well as plans like the National Development Plans and the sectoral plans. The population and development programmatic area has supported the government in conducting the national census and, because of this experience, the government requested UNFPA to monitor progress of MDGs in the country.⁹⁶ The Bangladesh Association of Parliamentarians on Population and Development (BAPPD) has been formed under the leadership of Honorable Speaker of the Bangladesh

Parliament. The BAPPD identified major policy issues, which are also UNFPA mandated issues, and formed subcommittees to advocate for them.

The **gender equality** programmatic area is strategically aligned with the MDG goal 3 (to promote gender equality and empower women). The Government of Bangladesh has acceded to the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW). Preventing gender based violence is one of the major focuses of CEDAW and UNFPA is contributing to support the Government's compliance with the requirements. Notwithstanding the achievements made so far, there are reservations on CEDAW articles, which undermine the principles of equality. UNFPA contributes through the eighth country programme and through the Local Consultative Group – Women's Advancement and Gender Equality (LCG-WAGE), to advocate with the government to proceed with withdrawal of reservations as per its commitment in earlier CEDAW reports. UNFPA is a traditional partner supporting the *Multi-Sectoral Project on Violence against Women (MSP-VAW)* implemented by MoWCA and 11 other ministries.⁹⁷ The *Domestic Violence Law of 2010* is also pertinent to addressing gender based violence (GBV).

The interventions of the gender equality programmatic area also contribute to achieving the goals set in the national plan of action (NPA) of the *National Women Advancement Policy, 2011* and the *Sixth Five-Year Plan's* strategic direction related to gender equality, women's empowerment and advancement.⁹⁸ However, ensuring gender sensitivity in disaster and emergency management was a priority of the NPA, which was not fully considered in the gender equality interventions of UNFPA eighth country programme, except providing a minimum initial service package (MISP) training through the DWA's *Advancement and Promoting Women's Rights* project. That being said, initiatives have been taken to address gender based violence in emergency situations in 2016.

⁹⁶ 2014 UNFPA Annual report

⁹⁷ The MSP-VAW project contributed to establish: a National Centre on Gender Based Violence (NCGVD); One Stop Crisis Centers (OCC in 8 districts) and One Stop Crisis Cell (40 in districts hospitals and 20 in Upazila Health complex since 2013-2015); National Forensic DNA Profiling Laboratory (NFDP at DMCH); Divisional DNA Screening Laboratory (DDSL in 7 Medical college hospitals); National Trauma Counselling Centre (NTCC at DWA head office); Rehabilitation Programme for GBV survivors; National Database on violence against women and children; National Helpline Centre

⁹⁸ Annual Progress Report 2014, UNFPA Gender Equality Unit, January, 2015

4.2 EFFECTIVENESS AND SUSTAINABILITY IN THE REPRODUCTIVE HEALTH AND RIGHTS PROGRAMMATIC AREA

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?

SUMMARY

The quality of services for maternal health and family planning has improved through the following measures: local level planning, training and the deployment of midwives and skilled birth attendants, increasing the availability of round-the-clock emergency obstetric and newborn care, ensuring supplies and choice of modern contraceptives, establishing a centre of excellence which treats obstetric fistula, providing a see-and-treat cervical cancer service, breast cancer screening, and expanding sexual and reproductive health services for adolescents and youth.

Accessibility has improved through capacity inputs to train health service staff and to stock and renovate some facilities. However, accessing services and higher levels of care in districts is challenging due to distances and lack of transport. Demand for higher quality services is challenged by low awareness of health consequences and reproductive health services on offer, crowded or underdeveloped facilities, shortages of staff and socio-cultural barriers to seeking treatment.

Development of adolescent corners in health services is thus far limited, but has increased access. Adolescent spaces in schools are not yet functioning. However, preparations have set the stage for effective implementation.

Adolescent clubs in communities have had minimal success in attracting those who have left school. Advocacy interventions are not strong enough with parents and influential community members to reduce socio-cultural barriers for promoting access to adolescent reproductive health information and services.

UNFPA has sought sustainability through joint-planning and resource-sharing. Training and using national capacities for local level planning has also aided sustainability as well as strengthening midwifery and adolescent sexual and reproductive health awareness, among other measures. National adoption of policies, strategies, standards and guidelines for reproductive health as well as monitoring and data collection systems indicates national commitment. Most interventions rely on external sources of funding, and hand-over strategies have not been fully elaborated in the face of limited funds.

4.2.1 Profile of the reproductive health and rights programmatic area

Four main types of interventions are implemented under the eighth country programme in reproductive health and rights (RHR).

Maternal health: The focus is on “skilled care for delivery” in collaboration with the Directorate of Health Services (DGHS) and the Ministry of Health and Family Welfare, through:

- training of skilled birth attendants, particularly registered and certified midwives and their deployment and retention, regulation and association
- capacity building for 24/7 emergency obstetric and newborn care (EmONC) through the maternal and neonatal health initiative (MNHI) jointly implemented with UNICEF and WHO
- development of a dedicated obstetric fistula surgical team and the building of a centre of excellence
- screening for cervical cancer with a “see and treat approach” and breast cancer screening.

Family planning: The focus is on “revitalizing the national family planning programme” in collaboration with the Directorate General of Family Planning (DGFP) and the Ministry of Health and Family Welfare (MoHFW), through:

- policy advocacy to provide access to adolescents (including unmarried), removal of barriers to the use of long-acting permanent methods (LAPM), increased funding and support for family planning (FP)
- strengthening service delivery for post-partum family planning, family planning counselling, and adolescent sexual reproductive health innovations
- capacity building for health service providers and local-level planning
- national campaigns and community mobilization, integrating family planning messages with child marriage and maternal, neonatal health
- use of ICT funds for data acquisition and analysis, automated messaging for clients (ICT4H)

Adolescent sexual and reproductive health (ASRH): The focus is on “ensuring access to service and information on reproductive health and rights for the adolescent group”, in collaboration with DGFP, through:

- establishment of adolescent-friendly health service (AFHS) corners at union-level and their operating procedures, capacity development for service providers on ASRH
- supporting provision of information and counselling on reproductive health and gender equality through the Generation Breakthrough project, including implementing the gender equity movement in schools (GEMS) module, linkages to adolescent-friendly health services, engaging boys through “coaching boys into men”, and a helpline and interactive website
- advocating to eliminate the practice of child marriage through interactions with parliamentarians and supporting the development of a national framework, as well as communications on family planning.

Reproductive health services in two refugee camps: The focus is on “ensuring services in Nayapara and Kutupalong refugee areas”, in collaboration with Research Training and Management International (RTMI), through:

- providing safe delivery in in-patient departments, ensuring antenatal and postnatal care and referrals for EmONC services
- addressing family planning needs, prevention and treatment of gender-based violence and promoting awareness among adolescents on reproductive health
- capacity building of service providers on reproductive health, family planning, safe delivery and newborn care and ASRH
- advocacy for reproductive health through education and raising awareness.

The effectiveness of the reproductive health services in refugee camps and emergency preparedness and response are discussed in EQs eight and nine.

Cross-service intervention areas are **urban health** through collaboration with the *Urban Primary Health Care Services Delivery Project* (UPHCSDP) Local Government Division (LGD),⁹⁹ (in 10 corporations and 4 municipalities, and partnership areas through 11 local NGOs), **HIV and AIDs** links with sexual and reproductive health, and **emergency preparedness and response** through the minimum initial services package (MISP) as well as overall quality assurance and demand-creation.

The budget for the reproductive health programmatic area is \$46 million of which \$2 million is dedicated to programme support and coordination. The majority of the funds are parallel funds with a small portion of the funds contributing to the *Health Population and Nutrition Sector Development Plan* (HPNSDP) pool funds (\$3 million). The majority of interventions are nationally executed (NEX) through implementing partners (IPs). The DGHS allocation is \$22 million and DGFP is \$16 million; the Local Government Division portion is \$3 million and RTMI is \$1 million. The major donors are European Union, Canada, Netherlands, Switzerland and UNFPA HQ-managed thematic trust funds.

⁹⁹ Annual Work Plans with Local Government Division, 2013, 2014 and 2015

Table 3 *Deployment of Skilled Birth Attendants (CPD output indicator 1.2)*¹⁰⁰

Indicator	Baseline (2012)	2014 Achievement	Progress Mid-2015	Remarks
Output 1.2: % of district hospitals (DH) and upazila health complexes (UHC) with at least 1 certified midwife (CM) performing deliveries	<p>634 certified midwives re-posted as senior staff nurses.</p> <p>Percentage of the MNHI district facilities with CMs is unknown</p> <p>Target: 3,000 by end 2015</p>	<p>989 certified midwives working as senior staff nurses in maternity units -</p> <p>DH:91% MCWC: 73% Refugee camps: 100%</p>	<p>1289 100 percent of DH in MNHI districts have at least 1 certified midwife</p> <p>77 percent of UHC in MNHI districts have at least 1 certified midwife</p>	<p>600 certified midwives will be deployed as midwives in October 2015</p> <p>The first class of registered midwives will graduate in December of 2015 and 600 will be posted in 2015</p>

The implementation of reproductive health interventions was affected by several factors, such as delays in obtaining approval of the technical project proposal (TPP). Externally, many changes of management and focal persons in the Ministry of Health and Family Welfare, as well as persistent shortages of human resources at the facility level, slowed progress in the implementation of UNFPA-supported interventions. Inter- and Intra-ministerial coordination (DGHS and DGFP) was not smooth at times.

Implementation has been facilitated by regular coordination meetings between the Government of Bangladesh's implementing partners, allowing smooth operation during 2014 to 2015. The Government's strong commitment to establish a midwifery cadre and the development of a national committee to oversee midwifery has provided additional support.¹⁰¹

4.2.2 Quality and accessibility of sexual and reproductive health information and services

The quality of services for maternal health and family planning has improved through local-level planning, training and the deployment of midwives and skilled birth attendants, increasing availability of 24/7 EmONC, ensuring supplies and choice of modern contraceptives, establishing a centre of excellence for treating obstetric fistula, establishing a “see-and-treat” approach for cervical cancer, and expanding sexual and reproductive health services for adolescents and youth.

In regard to **training of skilled birth attendants**, UNFPA partners with the Directorate of Nursing Services (DNS), the Bangladesh Nursing and Midwifery Council (BNMC) and WHO as well as with the DGHS, which channels funding. There is no institute that is completely dedicated to midwifery in Bangladesh although the Government has established a national midwifery committee.

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 recognized for at least ten 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.¹⁰² The Prime Minister's stated goal of deploying 3,000 registered midwives by the end of 2015 was not quite reached, but significant progress has been made toward increasing access to higher quality services.

UNFPA has supported training for three categories of birthing attendants: 1) three-year diploma; 2) six-month certificate for nurse-midwives and 3) community skilled birth attendants (CSBA) six-month training. (UNFPA has also supported midwifery training for nursing faculties.) The three categories are differentiated as follows:

¹⁰⁰ Compiled by the UNFPA Country Office Reproductive Health Unit, 2015

¹⁰¹ Powerpoint presentation by the Reproductive Health Unit to the 8th Country Programme Evaluation Scoping Mission, September 2015

¹⁰² The Prime Minister of Bangladesh, 2010

1. **Three-year diploma of midwifery:** This is a three-year midwifery education programme, meeting International Confederation of Midwives (ICM) standards for qualified girls who have been selected from high school graduating classes. It focuses on midwifery skills and results, upon graduation, in a registration and a posting as a midwife.
2. **Six-month post-basic certificate:** Nurse-midwives (Bangladesh nomenclature) graduate from a (three-year) nursing programme with some focus on midwifery, but mainly on general nursing. They receive a six-month training to bolster their midwifery skills to meet the ICM standards and then receive a certificate.
3. **CSBA training:** The CSBA candidates are selected from among family welfare assistants (FWA), community health volunteers (CHV) (nominated by the community), female health assistants, and some traditional birth attendants (TBA) (many of whom have one- to one-and-a-half years of education and training and usually in-depth experience in community-based health services). They receive six months of basic training on safe delivery.

Contextual issues identified early in the country programme by UNFPA included a lack of a legislative framework and dedicated midwifery posts, the severe shortage of nurses and lack of supporting staff to help midwives carry out their duties, weak capacity of the nursing colleges and institutes to host the Diploma in Midwifery, students from all over the country, and major bottlenecks in the development and availability of faculties (lecturers and clinical instructors).¹⁰³

Despite the continuing challenges, there were **significant accomplishments** (already achieved) through integrated and coordinated efforts and advocacy on the part of UNFPA and partners. These include:

- Creation of **3,000 posts for registered midwives**, starting from fiscal year 2014 to 2015 with 600 posts each year until the end of fiscal year 2018 to 2019. There will be four midwives per each 417 upazila health complexes (1668 midwives)

and one midwife per each of 1332 union sub-centres (1332 midwives).

- The **Nursing & Midwifery Act** is under revision with the MoHFW. In addition, the **Strategic Directions** for Midwifery have been endorsed.
- Finalization of the **job description for midwives** and also recruitment and retention rules
- Orientation of other health service cadres, such as the civil surgeons and medical officers, on the new roles and responsibilities for the midwives.
- Recruitment of 4,200 private nurses for government service, who will qualify to receive the six-month, post-basic certificate training (described above).
- *The International Day of the Midwives 2014* was observed and UNFPA supported a workshop on *Dissemination of State of World Midwifery 2014*.

Training started expeditiously once the eighth country programme was approved by the Government. The **three-year Diploma of Midwifery programme** started in December 2012 with 525 students in 20 educational sites. Another batch started in December 2013 in an extended number of 27 educational facilities. These two batches are expected to produce a total of 1,487 midwives by the end of 2016. It has now expanded in 2015 with a third intake of 800 students into 31 institutes/colleges.

Students at Barisal Nursing College, from the first and second batches, reflect understanding that they will be placed in pre-established positions. They agree that the quality of teaching is of a very high standard. However, too much time is spent in the classroom and the syllabus is too heavy and should constitute a Bachelor of Science (four year degree). The practical at the Barisal Medical College Hospital does not offer enough exposure to duties in the labour ward or with newborns and they may be deferred to regular nursing duties to service overcrowding. The living conditions at the college are very unsuitable for them, there are seven girls in a room meant for two, it is not sanitary and also a security risk as they have to go outside their rooms to study.¹⁰⁴

¹⁰³ Compiled Standard Progress Report, Reproductive Health, 2014.

¹⁰⁴ Focus Group Discussion with first and second batch 3 year Midwifery Students, Barisal Nursing College, October 2015

To help realize the Prime Minister's commitment, the first graduating batch of 600 were placed at the end of 2015, after taking the licensing examination for registration¹⁰⁵. Clinical-level nurses provided mentorship to support the new graduates. Key informants expressed concerns regarding institutional conditions that may affect **sustainability of the deployment and services** of the graduates. These include guarantee of adequate housing and personal security so that they can stay where they are posted. Support is still inadequate at the central level for the development of midwifery as a profession. While there is a working group to prepare orientation for deployed midwives and managers at district level, there is no central, high-level working group that can focus on strategies to prepare institutions to make the best use of the midwifery expertise.¹⁰⁶

The Government has been implementing a **six-month, post-basic Certificate of Midwifery (CM) programme**, with the support of WHO and UNFPA, for selected nurses who are already in service. The development of a standardized curriculum, syllabus, lesson plans, and assessment tools was undertaken in 2010 and updated in 2013. The training commenced in pilot areas in September 2010.¹⁰⁷ The course resumed under the eighth country programme in early 2013 in ten educational sites. As of mid-2015, a total of 1,289 students have been trained as certified midwives and deployed.

Although in some health facilities the roles of the certified midwives have changed little as a result of certification,¹⁰⁸ this may vary based on support received from the institution management. The certified midwife graduates serving in Barisal Medical College Hospital attested to increases in their capacity to effectively refer complicated cases, either to surgery for C-section generally, and newborns to the paediatric department or the 24/7 EmONC, in cases of premature or newborn

distress. They feel more revered by doctors and take greater roles in decisions.¹⁰⁹ However, support is still inadequate from supervising nurses and other health staff for the new roles of the nurse-midwives after they have completed the six-month certification.

UNFPA also supports **training for community skilled birth attendants (CSBAs)** who generally assist with home births. Trainees from Rangamati district participating in CSBA training at the Cox's Bazar Nursing School, indicated satisfaction with the course, although it was delivered in a different dialect. They are strengthening their skills to qualify for better positions and are highly motivated to continue to support local women, many of whom live in very remote areas, some only accessible by boat and foot.¹¹⁰ During the two phases of the MNHI project, the six-month CSBA training in districts, for both government staff and private participants, benefited 392 students, including 255 private CSBAs.

Both the six-month post-basic Certificate in Midwifery programme and CSBA training were initially regarded by the government as short-term solutions to the skilled birthing attendant deficit.¹¹¹ However, since home deliveries constitute the majority of births, the role of the CSBA is significant. Many are well trained and are able to perform safe deliveries including catheterization, and have the skills to detect possible obstetric complications at an early stage of labour. However, in general, the role and the scope of work of CSBAs were found to be uncertain, with no clear consensus on their job description or clarity of their role. The main barriers were low job satisfaction, lack of supportive work environment, lack of supportive policies and low acceptability in the community, which led to the CSBAs being demoralized and resulted in low productivity.¹¹²

¹⁰⁵ Placement details from this initial batch of midwives, was unavailable at the time of publication of this report

¹⁰⁶ Key informant interviews, October 2015

¹⁰⁷ "Certificate in Midwifery Education Program Bangladesh (Government of Bangladesh & Partners) Formative Evaluation Report" June 2014 Prepared by: Penny Haora RM MPH PhD, and Nurjahan Begum MSc

¹⁰⁸ Key Informant Interviews, October 2015

¹⁰⁹ Focus Group Discussion, 6 month certificate nurse-midwives, Barisal Medical College Hospital, October 2015

¹¹⁰ Focus Group Discussion, CSBA trainees, Cox's Bazaar Nursing School, October 2015

¹¹¹ Certificate in Midwifery Education Program Bangladesh (Government of Bangladesh & Partners) Formative Evaluation Report" June 2014 Prepared by: Penny Haora RM MPH PhD, and Nurjahan Begum MSc

¹¹² Community Based Skilled Birth Attendants Programme in Bangladesh; Intervention Toward Improving Maternal Health, Sabera Turkmani and Fatima Gohar, Journal of Asian Midwives (Jam) Volume 1, Issue 2, January 2015

Table 4 Output Indicators: Improved Quality of Emergency Obstetric Care¹¹³

Indicators	Baseline (2012)	2014 Achievement	Progress
Output 1.1 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	DH: 70% MCWC: 50% UHC: 0% CRHCC: 60% Target: 100%	DH: 100% MCWC:100% UHC: 50% CRHCC:100%	DH: 100% MCWC:100% UHC: 50% CRHCC:100%
2.1 % of women aged 15-49 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)	NA No Target established	46.7%	46.7%

Faculty development continued as planned in 2013 and 2014. Twenty teachers from nursing institutes attended a master trainers course for midwifery education in March with technical support and capacity development to the BNMC. UNFPA supported two training of trainers (ToTs) at the end of 2013, one for each curriculum, the Certificate and the Diploma in Midwifery. From these, 20 highly skilled midwifery teachers were identified, to be trainers of trainers for the Diploma in Midwifery curriculum in the future. The **ToT graduates** at Barisal Nursing College, who had participated in ToTs in 2013 and 2014, were very satisfied with the training and the results of the training, although this was not evaluated by UNFPA post-training. The course was interpreted from English, which was a liability, but they learned new techniques for antenatal care, which are now included in the syllabus, as well as new training methods and lesson plans.¹¹⁴ However, teaching staff at Dhaka Nursing College are over-stretched to service both nursing and midwifery educational needs, which is unsustainable.¹¹⁵

UNFPA gave technical assistance and **supported capacity development of the BNMC** to improve midwifery educational sites and equipment in order to develop their skills labs, libraries and computer labs. Site visits to the Dhaka and Barisal Nursing Colleges

indicated that some equipment was still lacking, such as pelvic models and newer versions of full-body gynecological models (life-sized mannequins), which would provide essential practice.¹¹⁶

The Maternal and Neonatal Health Initiative (MNHI) has undertaken **capacity building for 24/7 emergency obstetric and neonatal centres** and has made substantial progress in increasing quality and access to emergency obstetric and newborn care (EmONC) in the targeted districts, particularly in district hospitals, mother-child welfare centres and urban comprehensive reproductive health care centres (CRHCC). The progress in upazila health centres has been significant at 50 per cent compared to a baseline of zero. The MNHI programming has relied on an evidence base, through completion of two major surveys: 1) a baseline for new districts & midterm for old districts¹¹⁷ and 2) EmONC needs-assessment for 24 priority MNH/UNDAF districts in 2012-2013. A **reproductive, maternal and newborn health (RMNH) workforce assessment** in 2014 indicated gaps in maternal neonatal health human resources.¹¹⁸ Other evidence includes those produced by from *The Maternal Perinatal Death Review and Health Management Information System* (HMIS) data collected by the DGHS and DGFP.

¹¹³ Compiled by the UNFPA Country Office Reproductive Health Unit, 2015

¹¹⁴ Focus Group Discussion, ToT graduate nursing teachers at Barisal Medical College Hospital, October 2015

¹¹⁵ Key Informant Interviews, October 2015

¹¹⁶ Site visit and Key informant interviews, October 2015

¹¹⁷ Baseline Survey on Maternal and Neonatal Health Initiatives in Bangladesh, Ministry of Health and Family Welfare, Human Development Research Centre, November 2013

¹¹⁸ RMNH Workforce Assessment, Human Resources Management Unit, Ministry of Health and Family Welfare, 4+ High Burden Country Initiative, March 2014.

There was no mid-term review of MNHI in the eighth country programme. However, a monitoring mission report in 2015 indicated quality gains through outputs from **local-level planning** by bringing together the resources of DGHS and DGFP. Other achievements included adding human resources (local hire of ten support staff and four nurses for every doctor) at union as well as district and upazila levels based upon a rational assessment of need. This allowed health managers to open bottlenecks to better service provision, maintain cleanliness and, as an unintended result, show that locally-engaged staff are more accountable. Other capacity development input such as MNH short courses, equipping and renovating facilities and putting in place emergency transport, have been appropriate for capacity needs, but follow up on training was not systematic.¹¹⁹

Caesarian section rates are a key indicator of MNH quality and development of gender sensitive services and have remained stable between 5 per cent and 15 per cent in most MNHI districts. This is progress when compared with rising rates in the country. In receiving services (among time-tracked admissions) in EmONC facilities, the number of clients who had to wait more than 30 minutes fell from 20 per cent to 11 per cent.¹²⁰ Other gender equality efforts were limited to the Women Friendly Health Initiative and ensuring that there was at least one women representative in community support groups (CSGs).¹²¹

With the majority of births occurring outside of health facilities, access to the EmONC is critical, in cases of complications that cannot be addressed by the home-based birth attendants. Good use is made of **community volunteers**, currently around 5,220 people serve as members of community support groups and 2,600 community health volunteers (CHVs) work across 580 community clinics in 4 MNHI intervention districts. Positive results include women developing birthing plans in some districts. However, the functioning of the community health volunteers is likely to be dependent on project funding. While data collected by community health volunteers should be used to prioritize support

to the marginalized, it remains a challenge to demonstrate whether they can actually respond to local issues of marginalization and connect the very poor with government health services. The MNHI project seeks specific innovations to improve maternal and neonatal health in hard-to-reach areas, but no strategies have produced notable results.¹²²

Patuakhali is a newly-added district to the MNHI in the eighth country programme. There, shortages of health service staff and substandard facilities have led to underuse of union facilities and a lack of confidence in finding skilled birth attendants. Local women who decided to use a facility-based delivery, by-passed the union, which then created crowding at the upazila and district facilities. Numbers of births occurring in the union facilities is still very low and home deliveries are higher than the national average.¹²³

UNFPA has provided support to renovate facilities and stock them with medicines and equipment and is working with local government to create demand.¹²⁴ The family welfare assistants and local political leaders provide information regarding the benefits of facility delivery, but there are only three awareness campaigns a year. Key informants thought that more frequent campaigns were needed. Every quarter there is a meeting with fifty mothers at union-level to discuss the challenges for them. It is unclear whether all options for advocacy are used, such as coordination/collaboration with the Bangladesh Red Crescent Society. The major obstacles to accessing emergency care and avoiding prolonged labour, are the poor road conditions and limited transport options. Staff at the health facilities are supposed to advise women regarding transportation: the women can use an ambulance which is free but the ambulances are not always sufficient in number, and the women have to pay for other transport.¹²⁵

Interventions to **develop a dedicated obstetric fistula surgical team and to build a centre of excellence** were supported by UNFPA in collaboration with the DGHS. The interventions included ways to strengthen **advocacy and policy dialogue** on obstetric fistula

¹¹⁹ 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

¹²⁰ Ibid.

¹²¹ Ibid.

¹²² Ibid. pages 28 and 29

¹²³ Site visits and key informant interviews, October 2015

¹²⁴ Key informant interviews and site visits, October 2015

¹²⁵ Key Informant Interviews, October 2015

as well as service delivery and rehabilitation. This would involve dissemination and roll out of a national fistula strategy, basic and refresher training for medical personnel and CFAs, support for a fistula rehabilitation centre, procurement of drugs, furniture and basic equipment for centres, and drugs and supplies for medical colleges and district hospitals. The development of a centre of excellence at Dhaka Medical College for surgical treatment of obstetric fistula (OF) was continued in the eighth country programme. It opened on 9 June 2014 in the presence of the Honourable State Minister of Health and Family Welfare, indicating the high level of regard for UNFPA support and for attention to this debilitating issue for women. The action plan for a national fistula strategy was also endorsed in 2014.

There are basically three levels of care: prevention, case-ID and surgery, and rehabilitation. Prevention is the most important, in order to avoid women losing their marriages and becoming destitute. Case-ID and surgery require decentralization of the services, which is a long term goal. The increase in demand for antenatal care (ANC) has helped to reduce new cases of fistula, but prevention is still not adequate. New cases are more common from careless surgeries.¹²⁶ The **fistula treatment and recovery model** includes a “fistula corner”, composed of surgery, pre-op and post-op spaces/rooms. A rehabilitation centre near the hospital supports women as they undergo surgery and houses them during their recovery, providing livelihood training and support.

In 2013 and 2014, 555 fistula repairs were conducted during the eighth country programme and as of November 2014 the cumulative figure was 3,576 since 2004.¹²⁷ This comprises a very small proportion of the estimated 71,000 women who still require surgery with many more not yet identified. Many women hide their condition and are reluctant to come forward for the surgery and not enough outreach is conducted by health workers to identify them. Many are poor or destitute and require financial and logistical assistance to attend the obstetric fistula centres.¹²⁸

During the eighth country programme, UNFPA continued to support development of obstetric fistula care service delivery in ten targeted medical colleges, in district hospitals and in private facilities through training of surgeons and nurses in clinical management of fistula cases. The MoHFW and DGHS are scaling up the fistula corners, with the goal of establishing them in each district. For example, in Patuakhali district, surgeons are gaining experience with fistula surgery and the hospital plans to devote three to four beds to a fistula corner. The rehabilitation centre is thought to be critical because strong psychosocial support is needed to guide women through the process and the surgeons and nurses are often too busy to offer needed counselling.¹²⁹

Over 250 surgeons have been trained in fistula repair, many with UNFPA support. The investment in training is hampered by surgeons who are sometimes unwilling to utilize their training. Some lose interest in fistula surgery because it requires two to three hours for the simple cases and more for the complicated (compared to a half hour for a C-section). The training for the more complicated surgery targets senior surgeons who are expected to share their expertise in the districts, but many prefer not to travel as they have other surgeries. Key informants agree that the government does not have enough technical support, including from UNFPA, to promote a more rapid expansion of quality services. Surgeons could be recruited for three months to focus on the surgery, although the retention of the surgeons might be better if they are taught in the workplace and perform the fistula surgeries on the job. Follow-up is lacking on whether surgeons are using their skills and what the barriers are.¹³⁰

A national fistula campaign has been designed but it has not yet been approved and funded. The “*International Day to End Obstetric Fistula*” has been observed each year both nationally and at district level to build awareness and advocacy. UNFPA provided support to organize a campaign using print and electronic media. According to key informants,

¹²⁶ Key Informant Interviews, October 2015

¹²⁷ UNFPA Annual Report, 2014

¹²⁸ Key Informant Interviews, October 2015

¹²⁹ Key Informant Interviews, October 2015

¹³⁰ Key Informant Interview, October 2015

media campaigns and community based rallies are successful in raising awareness. They promote prevention by establishing the importance of anti-and postnatal care, catheterization during prolonged labour, and facility-based delivery. The campaigns also reach illiterate people. Following the campaigns, the numbers of women who were identified with obstetric fistula rose, as did requests for surgery in Barisal. However, targeting adolescents with preventive messages will require more effort.¹³¹

Dhaka has the only **operational fistula rehabilitation centre**. It is managed by Bangladesh Women's Health Centre (BWHC) and the numbers who have completed the rehabilitation programme by staying a month in the centre total only 416 compared to 555 surgeries. As women recover, they receive livelihood training and are provided with supporting materials such as a cow, sewing machine, or vegetable seeds. Women often prefer to leave immediately after surgery particularly those from more remote areas and the very poor. Some patients cannot be followed up very easily once they return home. The possibility of connecting recovering women to government livelihood strategies and programmes is being investigated by BWHC and UNFPA.¹³²

A key sustainable feature of the rehabilitation centre is the basic training for recovering women to work as community fistula advocates, which is voluntary. For a small monetary incentive, they organize awareness groups, refer women for surgery in coordination with the local health service and accompany them to Dhaka. There are 161 community advocates who are performing these tasks, the most recent batch receiving mobile phones for better communication in the community as well as to inform service centres.¹³³

UNFPA has provided support for **screening for cervical cancer with a "see and treat" approach and breast cancer screening** in Bangladesh since 2008 through the DGHS and Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka. UNFPA support has promoted progress on loop electrosurgical excision procedure (LEEP) which is a well-accepted, feasible and useful option for management of high-grade

cervical intraepithelial neoplasia (CIN) in Bangladesh. It has reduced the number of visits to the clinic and patients failing to receive treatment.¹³⁴

Capacity building for cervical and breast cancer services included: reviewing curriculums and ToTs; training for medical personnel and family welfare volunteers; refresher training and colposcopy basic and advanced training; orientations for service providers; community level orientation and procurement of medical equipment for screening. UNFPA provides acetic acid for cervical cancer testing and Sweden has provided 50 colposcopes. The detection for breast cancer is still only palpation and encouragement of self-examination. In terms of **policy and advocacy**, UNFPA has supported development of the '*National Guidelines for Cervical and Breast Cancer Screening in Bangladesh*', and an approved curriculum for training with basic guidance to address cervical and breast cancer screening, but there is no national strategy to reduce incidence and prevalence.¹³⁵ As mentioned in the relevance section, an evidence-based approach to screening and treatment of breast cancer in the context of Bangladesh is lacking. Research does not show a clear benefit of physical breast exams done by a health professional or self-examination, and these methods have not been found to decrease risk of dying from breast cancer. The most effective method of detection is the mammogram.¹³⁶

Cancer screening is done at union level and in mobile clinics run with staff from the upazila level. In 2013 and 2014, UNFPA supported capacity development for doctors and health service providers on basic visual inspection using acetic acid (VIA) and clinical breast exam (CBE) screening and colposcopy skills. It also bolstered acetic acid supply nationwide at VIA & CBE Centres. The BSMMU had trained 85-90 medical staff in the upazila health complexes, only half of the original number planned in 2013. UNFPA suffered core budget cuts and the government then supported additional training. Issues identified by UNFPA in progress reports in 2013 and 2014 still pertain and include insufficient attention and coordination between DGHS, BSMMU and UNFPA, weak referral systems, not enough inclusion of grass-root level actors to promote

¹³¹ Key Informant Interviews, October 2015

¹³² Key Informant Interviews, October 2015

¹³³ Key Informant Interviews, October 2015

¹³⁴ "Screening for and management of high-grade cervical intraepithelial neoplasia in Bangladesh: A cross-sectional study comparing two protocols", Ashrafun Nessa, Mohammad Harun Ur Rashid, Noor E-Ferdous and Afroza Chowdhury, *J. Obstet. Gynaecol. Res.* Vol. 39, No. 2: 564-571, February 2013

¹³⁵ Key Informant Interviews, October 2015

¹³⁶ American Cancer Society website <http://www.cancer.org/cancer/breastcancer/moreinformation/breastcancerearlydetection/breast-cancer-early-detection-acs-recs>

organized screening, and inadequate motivation, supervision and commitment of supervisors at all levels of the health service delivery system.¹³⁷

A baseline survey on *Knowledge, Attitudes and Practice (KAP) of Cervical and Breast Cancer in Bangladesh* was published by UNFPA in 2014. The study confirmed poor awareness of screening for both cancers, and lower for breast cancer (women in the households (5%); men in the households (4%) and women using service centres (14%), than cervical cancer (women in the households (8%); men in the households (8%) and women using service centres (31%) The study indicated underutilization of the screening facilities and confirmed the need to design communication strategies to accelerate the rates of acceptance of the screening services by women of ages 20 to 65 years. No nationwide awareness campaign has taken place, although evidence exists that television coverage would effectively promote awareness of causes and how to obtain screening.¹³⁸

UNFPA-supported interventions have succeeded in significantly broadening the reach of screening services in the 13 target districts; 70 VIA & CBE service centres were established from 2012 to 2014.¹³⁹ The DGHS and BSMMU are promoting ‘one-stop services’, along with referral of difficult cases of maternal and child colposcopy clinics to reduce failure of treatment in remote rural areas.¹⁴⁰

Numerous localized screening campaigns have been conducted with UNFPA support, and some have resulted in good turnouts for screening. However, the capacity to serve the numbers is still limited. For example, a one or two day “camp” with mobile units, may screen 1,000 to 1,600 women. This tasks the capacity, since there is a complex procedure involved including registration, examination and acetic acid testing.¹⁴¹ Further, the grouping-together of both cancers may offer a measure of efficiency in mass screenings but referral and treatment require differing approaches and are largely handled separately in many countries.¹⁴²

Indicators show that the incidence and prevalence of cervical cancer and breast cancer has declined in Bangladesh, although not significantly.¹⁴³ Evidence from BSMMU data obtained from satellite screening indicates that in some screening sites, as many as 50 per cent of women requiring colposcopy do not proceed to the clinic, and 60 per cent of those who have cancer do not present for treatment.¹⁴⁴ A major barrier to reducing cervical and breast cancers is the high levels of distrust of the health system among the remote populations. Factors identified in the 2014 knowledge, attitudes and practices study included the inability to afford treatment and medicines, unacceptable standards and services in health centres, and socio-cultural problems due to lack of education, fear of shame, and non-cooperation from husbands.¹⁴⁵

Table 5 2014 Cervical Cancer Screening and Clinical Breast Exam Results¹⁴⁶

UNFPA supported screening in 2014 for CBC in district hospitals and upazila health complexes		
	Total number of screened	Total number of positive cases
VIA tests performed	195,067	10,214 (5.2%)
CBE tests performed	195,464	2,057 (1.06%)

¹³⁷ 2013 and 2014 Compiled Standard Progress Report, UNFPA and Key Informant interviews, October 2015

¹³⁸ “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.

¹³⁹ Report on Cervical and Breast Cancer Screening Programme, SRH Information and Services through DGHS, January to December 2014, Department of Obstetrics and Gynecology, BSMMU

¹⁴⁰ 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.

¹⁴¹ Key informant interview, October 2015

¹⁴² Key informant interviews, October 2015

¹⁴³ Bangladesh National Health Survey 2014; WHO Globocan 2012

¹⁴⁴ Data collected by BSMMU, 2014.

¹⁴⁵ “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.

¹⁴⁶ Data collected by BSMMU, 2014.

Table 6 Revitalizing the National Family Planning Programme (CPD RHR Output 1 indicator)

Country Programme	Baseline (2012)	2014 Achievement	Progress until Mid-2015	Remarks
Output 1.3 % of public service delivery points (DH, MCWC, UHC, UH&FWC) providing at least three modern family planning methods, including one long-term or permanent method, at a given point in time	70% Target - 90%	Overall 90%, DH-81%, MCWC-100%, UHC-82% and UH&FWC-99%	Overall 90%, DH-81%, MCWC-100%, UHC-82% and UH&FWC-99%	<i>Figure included from UNFPA programme districts</i>

The tracking of suspected or detected cases is a key issue. Record-keeping has improved, with findings and management recorded on the same patient registration card. However, women may be hard to contact if they change their phone numbers and/or there is insufficient follow-up by community based health workers.¹⁴⁷ The cervical and breast cancer screening programme is using DHIS-2 for data analysis but data collection in the community level is still weak in order to establish a patient tracking system and to maintain a database of women who are over 30 years of age.¹⁴⁸

In terms of **revitalizing the national family planning programme**, the eighth country programme output indicator target (Output 1.3) has been reached, relative to the average percentages of facilities (90%) offering at least three modern methods, but the percentages vary among facilities in the districts where UNFPA is working. A further achievement is the avoidance of stock outs of contraceptives in targeted districts during the eighth country programme.

Contraceptive availability and choice is improving in targeted areas (see chart above). However acceptance and usage remain challenges and the contraceptive prevalence rate seems to be plateauing at about 62 per cent.¹⁴⁹ Some reasons cited include low usage of modern methods,¹⁵⁰ particularly long-acting and permanent (LAPM) and high discontinuation rates for short term methods.

While 17 per cent of married women do not have access to family planning overall, approximately 25 per cent of married women do not have access to the **desired services** for family planning, a substantial need.¹⁵¹ Abortion is widespread at about 1.2 million a year. UNFPA participates with other stakeholders in seeking approval for provision of implants as a method for post-partum family planning from the National Family Planning Technical Committee and this may be acceptable to more women.

At the **advocacy and policy** level, UNFPA has conducted strategic research for the *National Reproductive Health Commodity Security (RHCS) Strategy* and is working with partners toward its finalization and roll out.¹⁵² Family planning interventions were developed in **district plans (LLP)** in Cox’s Bazar, Sylhet, and the MNHI districts. In 2014, UNFPA supported development of a six-year, costed implementation plan (CIP) which will help policy makers strategize actions to achieve FP 2020 goals. Bangladesh’s participation in FP 2020 has encouraged government investment toward faster progress on the total fertility rates (TFR) and contraceptive prevalence rate (CPR) and the country is now widely regarded as a “family planning country”. Nevertheless, a large percentage of women remain out of the loop of contraceptive acceptance and usage particularly for LAPM where a large difference can be made. Furthermore, the contraceptive prevalence rate may not reflect the discontinuation rate and thus its figures are deceptive regarding planned pregnancies.¹⁵³

¹⁴⁷ Data collected by BSMMU, 2014.

¹⁴⁸ Report on Cervical and Breast Cancer Screening Programme, SRH Information and Services through DGHS, January to December 2014, Department of Obstetrics and Gynecology, BSMMU

¹⁴⁹ Bangladesh Demographic and Health Survey, 2014, page 20 (data collected between 2011 and 2014)

¹⁵⁰ 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.

¹⁵¹ UNFPA Annual Report Bangladesh, December 2014, page 16

¹⁵² 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.

¹⁵³ Key Informant interviews, October 2015

Key informants point out that there is **insufficient sustained advocacy** by UNFPA at high levels to promote faster gains on the contraceptive prevalence rate and total fertility rates, while supporting reproductive rights especially for women to choose the number of children they will have and when. UNFPA is considered a leader in family planning and, in working with DGFP and the national health system, has influence over the largest share of contraceptives in the country, as well as the main supply points for LAPM. UNFPA has not capitalized enough on the strong evidence that contraceptive use is directly related to reduction of the maternal mortality ratio (MMR) and may be preventive of reproductive morbidities such as obstetric fistula and cervical cancer.¹⁵⁴ UNFPA has also not effectively used the impact of demographic data, for example, in influencing parliamentarians, an action thought to be very powerful in changing the public sector.¹⁵⁵

The need for an **all-points campaign** for family planning seems critical in view of the burgeoning population growth. A more careful scrutiny of interventions is required at all levels to discern whether they are effective. There is not enough interaction at the division level of governance where important influence lies. (There are eight divisions or regions in Bangladesh which govern the districts under their jurisdiction.) Furthermore, health workers in communities and unions do not have sufficient management skills to categorize their clientele and find out who will use LAPM and who has discontinued modern methods and to respond effectively to these issues. UNFPA is not yet working with private pharmacies, but they can serve as an effective family planning instrument: collaboration with USAID, a key donor providing support for the private sector through social marketing, has only recently been established.¹⁵⁶

UNFPA has provided substantial support to **awareness campaigns** helping to organize a national family planning campaign in 2014 in twelve low-performing upazilas of four districts and two

city corporations in Sylhet and Chittagong divisions. In addition, support was provided for country-wide observance of World Population Day. At upazila and union levels, campaigns to promote demand for family planning services (and other maternal health services) resulted in response from communities according to health system staff but there were no before-and-after surveys or evidence of impact. Where populations are exposed to strong family planning information through health services and leaders, such as in the refugee camps, women may be able to better exercise their rights to choice.¹⁵⁷

The main cause of non-acceptance of modern methods, LAPM and discontinuation of family planning methods in Cox's Bazar district is unawareness. Women usually take on the burden of family planning and men generally want more children: some women are not given a choice by their husbands. There is generally not enough outreach to the men. Religious beliefs strongly influence the decisions. Imams receive family planning information in their training but tend to provide only general guidance, for example, advising three year birth spacing.¹⁵⁸

Fertility rates in city corporation slum areas have fallen to lower (2.0) than the national average (2.2) according to the Bangladesh urban health survey of 2013.¹⁵⁹ Between 2003 and 2006, and 2010 to 2013, the total fertility rate declined by 0.5 births per woman in slum areas. UNFPA, with the local government division in working with implementing partners in Dhaka, through the Urban Health project, has insured availability of short- and long-acting methods in target facilities and has undertaken couple registration.¹⁶⁰ Focus group discussion with attendees at a mother-child health (MCH) clinic in the Dhaka slums indicate preferences for short-acting methods and use of birth spacing.¹⁶¹ Fertility rates are higher than average among refugees in UNFPA-supported camps in Cox's Bazar district. Focus group discussions indicate acceptance of birth spacing and increasing husband agreement with use of reversible LAPM but the IUD is not well accepted.¹⁶²

¹⁵⁴ BMMS of 2010, BDHS, 2014

¹⁵⁵ Key informant interviews, October 2015

¹⁵⁶ Key informant interviews, October 2015

¹⁵⁷ Key informant interviews, October 2015

¹⁵⁸ Key Informant interviews, Cox's Bazaar, October 2015

¹⁵⁹ Bangladesh Urban Health Survey, 2013, published 2015, the CPR is highest in the slums (70%) among urban areas; the private sector is the greatest provider of contraceptives for the urban slums, 7 out of 10 use the private sector source, page 39

¹⁶⁰ Key Informant interviews, October 2015

¹⁶¹ Focus Group - Women and MCH staff Dhaka Slum, October 2015

¹⁶² Focus Group Discussion, Kutupalong Refugee camp, October 2015

The demand for family planning varies widely in terms of **coverage of the most vulnerable populations**. In Patuakhali district, there is only a 20 per cent acceptance of modern methods in remote unions. Condom use may be the choice of the very poor but is very low nationwide (4%). People may not be registered with the government and unknown to the clinic. In Patuakhali, floating populations (e.g. fishing families) have very low participation in government services. In urban unions such as Cox's Bazar, where many couples are registered, the demand for family planning is much higher. However, the gap in information to adolescents and youth before their marriages may result in early and/or unplanned pregnancy. Adolescents and youth growing up in the Dhaka slums are more likely to have been exposed to family planning through community campaigns. However, new migrants to the slums may lack this information. Since there are daily in-migrations to the Dhaka slums, awareness-raising needs to be continuous.¹⁶³

The **2014 Bangladesh Health Facility Survey** supported by the government and USAID covers family planning (FP).¹⁶⁴ While there were positive findings compared to several years ago, there remain numerous weaknesses in the availability of family planning services.¹⁶⁵ District hospitals have one of the lower percentages of contraceptive availability and some may not offer long acting permanent methods (LAPM), while other facilities may lack the basic equipment and materials. Monitoring missions by UNFPA family planning staff report some similar findings in target districts. UNFPA has upgraded a number of facilities and stocked them with contraceptives and equipment.¹⁶⁶ Orientation workshops were conducted for district, union and upazila stakeholders on the maternal health and family planning services that would be provided in the upgraded upazila health and family welfare centres.¹⁶⁷

UNFPA with DGFP also supports a wide range of training. UNFPA provided technical assistance to

DGFP for the strengthening of **quality assurance** systems across the country. A key initiative is the capacity building of front line health workers for prevention of post-partum haemorrhage (PPH) by introducing and procuring misoprostol and a planned study on the quality of two drugs to increase uterine tone and contractions (Misoprostol tablets and Oxytocin injections) will be implemented shortly. Partnership experience with EngenderHealth for training of service providers for post-partum family planning in MNHI districts was considered successful. When UNFPA started assistance to post-partum family planning, for example, in Thakurgaon District Hospital, there was no use of post-partum IUD (PPIUD). In just six months, the ratio of mothers who opted for PPIUD increased to 25 per cent from zero per cent, during 2014.¹⁶⁸

Key informants at district and union level mention that supervising staff benefited from a number of training sessions on family planning; however, they do not always effectively use the training. Furthermore, the health service staff does not always fulfil its responsibilities to promote family planning. Family planning supervisors are responsible for monitoring the records of the family welfare assistants and volunteers and the community skilled birth attendants in regard to their home visits, but they are not devoting sufficient attention to the problems with contraception in the communities.¹⁶⁹

To meet the commitment to the UN Secretary-General's *Global Strategy for Women's and Children's Health* and MDG 5, CARE Bangladesh has been implementing the **ICT4RH (Information, communication and technology for reproductive health)** project funded by UNFPA. This project has been created to strengthen quality maternal health and family planning services and stimulate the demand for these services. Specifically, the project was designed to improve the capacity of front line maternal health and family planning service providers to effectively use the data and information and increase their access to in-service training.

¹⁶³ Key informant interviews, October 2015, Patuakhali

¹⁶⁴ 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, April 2015

¹⁶⁵ Ibid. pages 36 to 44.

¹⁶⁶ Site visits and key informant interviews, October 2015

¹⁶⁷ Ibid.

¹⁶⁸ UNFPA Annual Report Bangladesh, December 2014, page 16

¹⁶⁹ Key informant interviews, October 2015

The inputs of the ICT4RH in selected districts included procurement of ICT equipment, family planning monitoring and evaluation through district-level meetings with upazila committees, IUD follow-up, and the family planning clinical supervision team-quality assurance team (FPCST-QAT) bi-annual meeting. In 2014, e-learning modules were developed on topics such as personal computer use, reproductive health, family planning, maternal health, danger signs of pregnancy and frontline health workers as effective communicators. Training of trainers (ToT) was conducted with 37 union and upazila supervisors on the Skool (Intel) software healthcare platform followed by an additional six batches of training in December 2014.

A district with a higher maternal mortality rate and lower contraceptive prevalence rate than national averages, Jamalpur, was selected as a pilot district and a knowledge, attitudes and practices (KOP) study was conducted with health workers in three upazilas in 2014, with training continuing in 2015. By providing a laptop to each of the family welfare assistants, front line family planning workers can remain updated and send their reports directly to their supervisors. They will also have copies of their job descriptions. The system allows for a commitment of increased visits by the health staff and encourages the pregnant women to undertake four antenatal care visits. It will conclude in mid-2016.

The ICT4RH project was designed to introduce a data acquisition and analysis package but this was found to be incompatible with the package used by the Ministry of Health and Family Welfare, thus agreement was reached to use District Health Information System 2 (DHIS2) instead and to align ICT4RH with the DGFP Management Information Systems (MIS) Operational Plan. If replicated nationally, it is hoped that efficiency of the management information system will be increased.

In terms of **strengthening connections between HIV and reproductive health and rights**, and in view of the low prevalence rate in Bangladesh (<1%), the

country programme took a preventive approach to addressing HIV and AIDS. It focused on providing support toward integrated sexual and reproductive health services, including voluntary counselling and testing for, and the management of, sexually transmitted infections for sex workers at selected sites. However, the country programme places a strong cautionary note that prevalence rates are much higher among groups that are most at risk and a concentrated epidemic with low rates of condom use could have far-reaching implications.¹⁷⁰

The national prevalence estimate masks higher HIV prevalence in specific geographical locations: for instance, among people who inject drugs (PWID) estimated national prevalence is 1.1 per cent, but among male people who inject drugs in Dhaka it is 5.3 per cent.¹⁷¹ The reproductive health needs of key populations including people who inject drugs (PWID), sex workers (SW), men who have sex with men (MSM) and transgender (Hijra) 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. There is a general dearth of recent data regarding the incidence of STDs and hidden cases of people living with HIV and people diagnosed with AIDS. As outmigration of men for work increases, the new cases of HIV and other STDs are likely to increase.¹⁷²

Further, the connection between gender based violence and STDs is largely unexplored. Studies show higher unmet need among sex workers, as well as high levels of violence against key affected populations (KAPs) including sex workers, men who have sex with men and transgender people. Violence affects negotiation power over condom use. Sexual violence increases the risk of contracting or transmitting HIV and other STIs.¹⁷³

In the **policy and advocacy** domain, UNFPA supported a national communications guideline on the links between HIV and reproductive health

¹⁷⁰ Final Country Programme Document, UNFPA 8th Country Programme, July 2011

¹⁷¹ UNICEF data and Global Fund to Fight AIDS, Tuberculosis and Malaria. *Standard Concept Note: Bangladesh*. Dhaka, March 2014

¹⁷² Ibid.

¹⁷³ UNFPA Bangladesh Annual Report, 2014

and rights, targeting self-help group members from people living with HIV (PLHIV), STI and sex workers networkers as well as staff of the ministry of health and family welfare. Accordingly, the ministry has introduced HIV-related services (counselling and commodity supply) at STI outdoor facilities at district-based hospitals as well as selected maternal health clinics. UNFPA also advocated with national AIDS and STD programme officials on the mainstreaming of HIV through inter-ministerial coordination and collaboration for these marginalized adolescents and young people. A strategic plan on most at risk adolescents (MARA), most at risk young population (MARYP) and especially vulnerable population (EVA) was developed in collaboration with UNICEF.¹⁷⁴

Whether these actions have resulted in concrete outcomes for the at-risk groups is unclear in UNFPA or government reporting. UNFPA has sought regional advice regarding assessment of country office inputs. According to key informants, UNFPA missed opportunities to participate in more detection work through supporting testing and surveillance and doing research such as a survey on STDs. Opportunities were missed to further explore the connection between gender based violence and STDs.¹⁷⁵

4.2.3 Awareness of and demand for reproductive health and family planning services among adolescents and youth

Development and promoting usage of adolescent corners in health centres, adolescent spaces in schools and adolescent clubs in communities is still underway.

UNFPA and implementing partners have made progress in **promoting adolescent awareness of and demand for sexual and reproductive health information** and services but indicators are still substantially below target in most areas of operation. A key reason is delay in approval of the gender equity movement in schools (GEMS) module by the Ministry of Education for the Generation Breakthrough project which will be implemented in 300 schools, 50 madrassas and 150 adolescent clubs. This project is partnered by the Ministry of Education, Ministry of Women and Children Affairs and Plan International Bangladesh. The targeted interventions, however, are effectively working toward providing models and lessons for covering the gap in reproductive health and rights services for unmarried adolescents.¹⁷⁶ Nevertheless, many key informants say that not enough resources are targeted for adolescents and youth in terms of prevention of child marriage and adolescent pregnancy, and promotion of their reproductive health rights.¹⁷⁷

Table 7 Promoting Adolescent Awareness of Reproductive Health Services¹⁷⁸

Country Programme	Baseline (2012)	2014 Achievement	Progress until Mid-2015	Remarks
Output 1.4: % of health facilities (DH, MCWC, UHC) with adolescent health corners that offer services to young people, including the unmarried in the programme areas.	30% Target: 70%	Overall: 11%, DH-18%, MCWC- 50%, UHC-3% RTMI Camps: 100%	Overall: 11%, DH-18%, MCWC- 50%, UHC-3% RTMI Camps: 100%	<i>Figure included from UNFPA Programme Districts</i>
Output 2.2: % of adolescents who have comprehensive knowledge of adolescent RHR and HIV issues, including the legal age of marriage, the risk of early pregnancy, family planning methods and HIV prevention.	NA Target not set	F=13% M=14%	F=13% M=14%	
UNFPA contribution to UNDAF Indicator: Adolescent birth rate per 1,000	127 (2007) Target: 80	113 (2014)		

¹⁷⁴ Ibid.

¹⁷⁵ Key Informant interviews, October 2015

¹⁷⁶ Standard Progress Reports, 2013 and 2014 and Key Informant interviews, October 2015

¹⁷⁷ Key Informant interviews, October 2015

¹⁷⁸ UNFPA Reproductive Health Unit data, collected at district level

At the **advocacy and policy** level, progress has been made highlighting national interest in investing in adolescents and youth. *The National Adolescent Reproductive Health Strategy* (2006) is being updated in 2016 and UNFPA is part of a working group to develop an adolescent health strategy (2016-2026). The Ministry of Education has approved the gender equity movement in schools (GEMS), and a national plan of action on eliminating child marriage has been drafted. The UNFPA-supported GEMS module is aligned with international standards to address gender equality issues and provide accurate information to young people. However, there are still traditional sensitivities regarding its usage.¹⁷⁹ UNFPA support for the *National Family Planning Campaign* in 2014, aimed to create demand for modern contraceptives among young couples (ages 15 to 24), improved awareness on reproductive health and rights issues among the unmarried adolescents and created awareness of the consequences of child marriage.¹⁸⁰

The UNFPA Youth Forum on reproductive health was very active in Bangladesh and regionally to raise awareness among policy makers. One of the biggest achievements of UNFPA in 2014 was its leading role in the establishment of the Youth Advisory Panel (UN-YAP), which replaced the Youth Forum, as a major national platform managed by the youth, to advocate for increased investments in adolescents and youth, especially the marginalized. Thirty members of this newly formed entity were successfully recruited. In 2015, UNFPA continued to support the UN-YAP with its contribution to the development of the National Youth Policy in Bangladesh with the Ministry of Youth and Sports, which is currently in draft.¹⁸¹

In 2014, UNFPA Bangladesh established partnership with major national newspapers (in both English and Bangla papers) to advocate for the prevention of child marriage and making reproductive health and rights services available to young people, among others. UNFPA led a UN joint-advocacy campaign over the *2014 World Population Day* through the UN Inter-Agency Theme Group on Youth. An example of its work was publishing a supplement

that was distributed in a major newspaper. As part of its advocacy efforts, UNFPA also assisted the government to develop the national action plan to facilitate access for adolescents and youth to information and services on reproductive health and rights and HIV.¹⁸²

Information and referrals have been strengthened through a Generation Breakthrough supported helpline. The district commissioner opened the helpline in Barisal. It has been operating for over 8 months and is heavily used as the young people have many questions. The people answering the questions are expert psychologists. The helpline in Dhaka is also very popular and already overloaded. There is one month of data available on the calls.

In terms of **health facilities accredited as adolescent-friendly**, dedicated trained health services staff are assigned full or part time to the adolescent friendly health services (AFHS) corners which may be stocked with musical instruments and games in addition to behavior change communication (BCC) materials. However, in the smaller clinics, the space may allow only one room which provides privacy to receive adolescents who choose to seek services. For centres which offer group information and education sessions, adolescents are requested to attend a certain number of days over the space of a month to several months. Attendance of boys is generally lower than girls, except in the refugee camps, which have also achieved a strong level of trained health staff and youth attendance at the centres.

Focus group discussions with adolescent girls using adolescent corners, indicate appreciation for information which they generally do not get anywhere else, on sexually transmitted diseases, menstruation, the reproductive system, changes during puberty, and issues with early marriage. They reflect back the messages in regard to choices that they will make about their own lives in avoiding child marriage and early childbirth, using birth spacing, and exercising their rights to choose the number of children they will have. Information they receive includes where to report gender based violence and some on contraceptives.¹⁸³

¹⁷⁹ UNFPA Bangladesh Annual Report, 2014

¹⁸⁰ UNFPA Bangladesh Annual Report 2014

¹⁸¹ UNFPA Bangladesh Annual Report, 2014

¹⁸² The UNFPA Bangladesh Annual Report 2014

¹⁸³ Focus Group Discussions, October 2015, adolescent corners attendees in Dhaka and Kutupalong refugee camp

With regard to **schools in Generation Breakthrough target areas**, an adolescent space where adolescents can interact, is planned in each of the 350 targeted schools and madrasas. Although the GEMS has not yet been operational, the functioning spaces will optimistically reach 350 in 2016. A number of outputs have set the stage for successful outcomes. These include the training of designated teachers (two per school), who will be supportive of the spaces, and the preparation of BCC materials including a hundred episodes of a radio programme, as well as board games, computer games, and question boxes.

The country programme supported advocacy interventions for key influencer groups included the directorate of secondary and higher education, school management, teachers, parents, and community leaders. Training for both public and madrasa teachers produced positive attitude changes on the part of teachers who received high-quality inputs regarding sensitive reproductive health and rights information not included in teaching curriculums. Guidance was provided on relating reproductive health and rights information to students. Further, the information on the rights of women and prevention of child marriage was appropriately disseminated. Nevertheless, there is still some lack of acceptance of the vocabulary (e.g. sexual).¹⁸⁴

Challenges to achieving results in reduction of child marriage and early pregnancy, promoting choice in family planning, and prevention of gender based violence, include the strong parental influence on decisions regarding early marriage and choices of spouses. It is perceived that there is not enough involvement of parents in the Generation Breakthrough interventions to gain their feedback. Furthermore, greater advocacy is needed with the school management committees, composed of locally influential persons and elected counsellors at union level who may dominate forums where parents are present. A number of options are possible, such as having “parents’ days” (adolescent fairs with audio visuals, where parents would be present), and regular parents’ workshops which may help to reduce the tensions between parents and their children.¹⁸⁵

With regard to **functioning adolescent clubs that are and providing reproductive health and rights and gender equality information to targeted areas for Generation Breakthrough (GB)**: the Department of Women Affairs (DWA) under the Ministry of Women and Children Affairs (MoWCA) supports youth clubs meant to host out-of-school adolescents and where “gender promoters” raise awareness. The DWA has also formed social protection groups (SPG) to prevent child marriage and gender based violence in two unions in each upazila. (More than 50 per cent of women aged 20 to 24 in Bangladesh are married before the age of 18 and 18 per cent are married before the age of 15.¹⁸⁶ More married than unmarried girls drop out of school.¹⁸⁷ The goal is to develop 150 clubs in two districts, Barguna and Patuakhali, which are managed by the DWA. Approximately 60-70 per cent are functioning to various degrees, but only about 10 per cent of attendees are out-of-school adolescents. It is unclear why more out-of-school adolescents do not use the clubs, aside from not having enough attraction for adolescents and difficulty in access for girls who marry early and have babies.¹⁸⁸

A focus group discussion among randomly selected youth using a club, indicated that none were out-of-school and they attended to learn more about reproductive health and rights. Having access to the computer was the most important reason for boys to attend. They suggested that there should be more creative ways to involve the parents and also to give the messages through folk-singing, theatre etc. Another activity, which may serve to draw in the male youth, might be a sports activity before the information session.¹⁸⁹

4.2.4 Existence of mechanisms to ensure national ownership of activities and sustainability of effects

UNFPA has sought sustainability through joint-planning and resource-sharing. Training and using national capacities for local-level planning has also aided sustainability as has strengthening midwifery and adolescent sexual and reproductive health awareness, among other measures.

¹⁸⁴ Key informant interviews, Barisal and Patuakhali, October 2015

¹⁸⁵ Key informant interviews, October 2015

¹⁸⁶ Multiple Indicator Cluster (MICS) Survey, 2012-2013, UNICEF Child Marriage Fact Sheet

¹⁸⁷ Bangladesh Bureau of Statistics, Bangladesh Institute of Developmental Studies and UNICEF, *Child Equity Atlas: Pockets of Social Deprivation in Bangladesh*, 2013, page 51

¹⁸⁸ Key Informant Interview, October 2015

¹⁸⁹ Focus Group discussion with Adolescent Club attendees in Mirajagonje, Patuakhali District

The eighth country programme document (July 2011) does not elaborate on mechanisms to ensure national ownership. However, capacity development is a key theme in the eighth country programme and has been manifested through joint-planning, resource-sharing, training and the development of monitoring and data collection systems run by the government. National ownership of policies, standards, and guidelines developed with support of UNFPA through consultative processes are clear indications of government commitment.

UNFPA has designed the reproductive health and rights interventions in close partnership with national actors and based them on transferrable concepts, models, studies and good practices that will facilitate replication country-wide. These include the design of the midwifery programme, including development of professional standards, and placement strategies, the obstetric fistula treatment model and the use of “see and treat” for cervical cancer. Capacity inputs for important influencers, such as Imams and other community leaders, have paid off in greater advocacy from them supporting good practices in maternal health and family planning.

Local-level planning, which factored in maternal health and family planning, has been heralded. It included 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 planning wing. It also increased the awareness and appreciation between the Government of Bangladesh and NGOs of their respective added values. The MNHI also supported community volunteers who had the potential to effectively inspire community responsibility for successful pregnancies and delivery. The changes, however, are dependent on external support and their sustainability and replicability is not yet ensured.¹⁹⁰

Inputs for adolescent and youth sexual and reproductive health and development of the GEMS with integrated reproductive health and rights and

gender equality outputs are complementary to the Government’s scholarship for girls, which has been a good investment. UNFPA efforts with implementing partners through the Generation Breakthrough project have been praised, in terms of facilitating and cultivating national interest at the community level in investing in adolescents and youth. The Ministry of Education’s generally positive response, despite slow approval processes, brings a possible alleviation to the sensitivity and reluctance of some government officials in addressing reproductive health and rights and gender based violence issues in programmes.¹⁹¹

The numbers of young people and women of reproductive age will continue to increase for only about the next 15 years, before the momentum swings toward an ageing population. With regard to the development of adolescents and youth, therefore, it is urgent to take full advantage of this “window of opportunity” in order to realize this demographic dividend. In all, the country’s performance in equipping youth with the skills for adulthood will have a major bearing on sustainable development, as well as on influencing important demographic outcomes. This includes the potential for realizing this demographic dividend and limiting the size of the population.¹⁹²

An overriding concern regarding many interventions is that they are juxtaposed on a system, particularly the health system, which struggles to institutionalize them. The local-level planning through MNHI has brought together DGHS and DGFP into one district plan. The plans are reviewed by both directorates in one forum and this is seen to be progress toward the integration long-suggested by assistance providers. However, the traditional vertical split persists, with MCWCs and district hospitals in very close proximity, both receiving MNHI support to provide EmONC. Thus the duplication and overlaps also persist.¹⁹³ Some key informants felt that the traditional donor separation of funds between the two directorates perpetuates the division and perhaps causes dilution of ownership.¹⁹⁴

¹⁹⁰ Initial Monitoring Mission, Joint Government of Bangladesh – United Nations Maternal and Neonatal Health Initiative (MNHI) Project Number: A-035190, July 2015, Agriteam Canada Consulting Ltd

¹⁹¹ Key informant interviews, October 2015

¹⁹² UNFPA CPD Situation Analysis (9th Country Programme), September 2015, Executive Summary

¹⁹³ Initial Monitoring Mission, Joint Government of Bangladesh – United Nations Maternal and Neonatal Health Initiative (MNHI) Project Number: A-035190, July 2015, Agriteam Canada Consulting Ltd

¹⁹⁴ Key informant interviews, October 2015

Lacking concrete hand-over or exit strategies, UNFPA effectively intimates that its support will be forthcoming, which is by no means guaranteed. An overall risk to sustainability is that successful interventions will be interrupted or discontinued due to lack of or reduced funding. Fewer core resources may limit UNFPA interventions, and partner ministries should be ready to assume greater planning and budgetary responsibility for interventions previously supported by UNFPA. Furthermore, as Bangladesh progresses to a middle-income country, the role of UNFPA would be primarily at the policy and advocacy level. There has, as yet, been no time frame agreed for this change in UNFPA role, nor can it be established that this change would be a positive one.

Concerns over sustainability do not only involve UNFPA, but rather the UN system in Bangladesh. The creation of the UNDAF has served as a point of reference for individual agency programmes and their development. The evaluation of the UNDAF 2012 to 2016 reiterated the link between national capacity development and the sustainability of the UN work in Bangladesh. It also noted that the lack of long-term plans and resources and staff selection and retention were factors that affected the capacity development of implementing partners on the core programming approaches. The evaluation of the UNDAF points out that work needs to be done on capacity development and programme sustainability, especially because Bangladesh is expected to become more developmentally self-reliant due to its new status as a low-to-middle-income country.¹⁹⁵

4.3 EFFECTIVENESS AND SUSTAINABILITY IN THE POPULATION AND DEVELOPMENT PROGRAMMATIC AREA

EQ3

To what extent have the interventions supported by UNFPA in the field of population and development contributed to the integration of evidence-based analysis on population dynamics in national policies at national and local levels?

SUMMARY

UNFPA has contributed to the generation of evidence and knowledge management by strengthening national capacity to produce traditional census reports, carrying out secondary analysis of 2011 census data, making census data available online, establishing a geo-database for small-area mapping, and strengthening the quality of the sample-vital registration system. UNFPA has contributed to strengthening research and policy analysis to fill data gaps. Training has inspired some institutional changes, but follow-up has not been consistent.

UNFPA, through its partnership with the parliamentary secretariat, formed the Bangladesh Association of Parliamentarian on Population and Development and equipped its members to speak on population and gender equality concerns. Its members have identified three key policy issues and formed parliamentary sub-committees for advocacy. UNFPA has effectively supported the Planning Commission to hold policy dialogues on critical population and development issues and to build capacity of planning and other line ministries to improve understanding on population development linkages. UNFPA acts as an effective resource to support well-

trained professionals. However, interventions rely on the availability of UNFPA resources, and sustainability depends on external conditions, institutional capacity of the stakeholders, and support for follow-up actions.

4.3.1 Profile of the population and development programmatic area

In the population and development (P&D) programmatic area, UNFPA supported interventions were mainly aimed at: (a) the generation of evidence and knowledge management and (b) policy advocacy. Population and development interventions were conducted with six implementing partners (IPs), all of whom received support for **capacity development**.

With regard to the **generation of evidence and knowledge management**, UNFPA in collaboration with the Bangladesh Bureau of Statistics (BBS), supported inputs to enhance the capacity of BBS. The aim was to improve data collection quality, data analysis and use of census data in planning for sustainable development. In collaboration with the Department of Population Sciences of Dhaka University, UNFPA contributed to research and policy analysis on population and development to fill data gaps. The population sciences department also provides training on population and development issues and is producing population science graduates.

For **policy advocacy**, UNFPA collaborates with the Bangladesh Parliament Secretariat (BPS) and the Ministry of Planning. The aim is to strengthen the capacity of these bodies to strategically formulate and monitor implementation of policies and legislations. It focuses on adaptation of critical policy measures in health, employment, education and human rights. Collaboration with the general economics division (GED) of the planning commission is intended to increase capacity of GED to integrate population and gender equality concerns including reproductive health and rights (RHR), and adolescent and youth development. It will incorporate emerging issues into national plans and policies.

Table 8 Budget and Expenditure of Population and Development Programmatic area (in US\$)

Year	Budget	Expenditure
2012	1,762,856.00	54,040.19
2013	2,831,872.00	834,527.39
2014	2,661,147.00	2,218,622.59
2015	4,414,945.00	1,993,893.64

Multiple funds; expenditure of 2015 is up to quarter 3.

UNFPA collaborates with the Socio Economic Infrastructure Division (SEID) of the Planning Commission with the aim to mainstream population, development and gender concerns into sectoral plans. UNFPA collaboration with the Population Council is aimed at enhancing national capacity for integrating demographic concerns and post-2015 development agenda into development planning of the Government. Interventions in collaboration with the Population Council support preparation of policy briefs for dissemination through seminars at different levels.

Several **external factors** contributed to delays of population and development interventions. These included delays in the approval process of the technical project proposal (TPP), political unrest during 2013 and 2014, and frequent changes of project staff. The approval process for the technical project proposal is multi-tiered. The partner agency prepares the technical project proposal and sends it to their ministry for approval. After review, it is sent to the planning commission which submits it to the planning ministry or the Executive Committee of National Economic Council (ECNEC) meeting for approval. It is usually approved at ECNEC. The line ministry or the planning commission manages most of the process. For the population and development interventions, almost one year was lost for the implementation of the project start-up due to the delays in approval of the technical project proposal.

Most of the projects also faced frequent changes of project directors (PD) (for example, in one project, there had been seven changes of project directors). The staffing changes slow down policy advocacy and overall implementation of the project activities.

Further, there may be last-minute decisions for implementing an activity, and the activity may not be implemented to the desired level.

In the census project, over 50 per cent of the budget remained unspent at the end of 2013, due to delays in fund-transfer from the European Union (EU) and, as a consequence, a two-year no-cost extension was granted for 2014 to 2015. A mistake in the budget was rectified and required time for approval from EU.

In terms of **internal factors influencing implementation**, the reporting is the responsibility of the implementing partners but, because of the absence of UNFPA technical staff in the project, the UNFPA country office staff generally carries out this activity for the implementing partners. Further, UNFPA revises its priorities annually, and these may not always match the activities approved in the technical project proposal, which is a static document. This makes it difficult to carry out an activity if there is an emerging need, as there is limited flexibility in the technical project proposal.

4.3.2 Contribution to the strengthening of national capacity to collect and analyze population data

There is evidence that Bangladesh Bureau of Statistics has mastered the use of up-to-date data collection and validation techniques. Small-area maps and on-line data are available for wider use by researchers and planners. The national census was successfully carried out and resulted in 135 census-traditional reports.

Table 9 Output 1 indicator - Strengthened National Capacity to Collect and Analyze Population Data (CPD – P&D Output 1 indicator)¹⁹⁶

Country Programme Indicators	Baseline (2012)	Target	Progress until Mid-2015	Remarks
Population data, disaggregated by sex, age, economic status and location, are available through the census and other surveys	60	137	135	<i>135 reports include: Preliminary Report (1); Post Enumeration Check (PEC) Report (1); Analytical Report-Volume I (1), Union Statistics -Volume II (1); Urban Area Report -Volume III (1); Socio-economic and Demographic Report -Volume IV (1); Administrative Report -Volume V (1); Zila Series- district report (64) and Community Series (64).</i> <i>An additional 14 monographs and one population projection will be produced by BBS using external consultants within the project period</i>
Regularly updated nationally representative data on gender-based violence and harmful practices are available.	0	2	2	<i>VAW Survey 2015 (in process), and VAW Survey 2011 (published in 2013)</i>

The population and development interventions have contributed to strengthening the national capacity to collect and analyse population data. For example, through the fifth, sixth and seventh country programmes, UNFPA has provided support to BBS to prepare digital geographical information systems (GIS) maps. With the newly acquired capacity, the unit is creating geo-databases to generate a small-area digital atlas¹⁹⁷ using global positioning system (GPS)¹⁹⁸ and validated by landmarks such as education and health institutions. It has also successfully introduced an online data entry system for a sample vital registration system (SVRS) and a central SVRS data analysis lab. These accomplishments indicate that BBS has mastered use of up-to-date data collection and validation techniques. Thematic maps are produced by the GIS unit and are fruitfully used by other departments and units within BBS and 10 to 12 organizations outside BBS.¹⁹⁹ This work requires sophisticated equipment and digital hardware, which are provided by UNFPA, including machines to

capture data from coded data sheets to computerized databases. More sophisticated equipment is coming to the world market and can be used to shorten the time between data collection and data use.²⁰⁰

Many **training events** related to data collection and analysis took place with UNFPA support. The majority of the participants were BBS staff, but there were also participants from the planning commission, Directorate of Land Record and Survey (DRLS), and representatives from other ministries such as local government, rural development and cooperative. The content of the training included GIS map editing and updating, and issues such as gender disaggregated data, the sample vital registration system (SVRS), and use of software to update maps. Two workshops on Integration of Statistics & Geo-Spatial Information were held.²⁰¹ The majority of participants of the trainings conducted by BBS with UNFPA support were field-level enumerators and supervisors.²⁰²

¹⁹⁶ Source: Key Informant Interviews with P&D IPs and UNFPA Consolidated Annual Progress Reports

¹⁹⁷ Smallest unit of enumeration area named as mauza in rural area and mahulla in the urban areas.

¹⁹⁸ Geographical Positioning System

¹⁹⁹ Technical Assistance Project Proposal (TPP of 2012), Part B, GIS Unit of BBS

²⁰⁰ Key Informant Interviews, October 2015

²⁰¹ Participants were from BBS, Survey of Bangladesh (SOB), Bangladesh Space Research & Remote Sensing Organization (SPARRSO), Dhaka University (DU), External Resource Division (ERD) and Implementation Monitoring and Evaluation Division (IMED) of the Planning Commission, and Local Government Engineering Department (LGED) under the Ministry of Local Government, Rural Development & Cooperatives. Monitoring and Evaluation Division (IMED) of the Planning Commission, and Local Government Engineering Department (LGED) under the Ministry of Local Government, Rural Development & Cooperatives.

²⁰² Quarterly reporting on training and workshop activities, GIS Unit, BBS

Through the training and capacity development, BBS management staff were motivated to shift the perception of the agency away from the concept of data generation towards data analysis and policy development. The orientation, however, covered very few management staff and the duration of the course was for only a few days. The report-writing training was of short duration and covered only 26 BBS staff. The training has not created sustainable change, as most of the reports and monographs are still produced by BBS with external support.

UNFPA supported the *Population and Housing Census 2011* project which has been going on for six years (2010-2015). A two-year no-cost extension was implemented for in-depth secondary analysis of census data. The extension also allowed for the development of 14 monographs, population projection, as well as conducting capacity building training on basic statistics, gender, ICT and internet browsing etc. It further gave the opportunity to strengthen online data dissemination systems and procure a four-colour printing press machine to improve in-house printing capacity of BBS so that information can be printed and disseminated quickly.

Another example of strengthened national capacity is the increased availability of regularly updated population data disaggregated by sex, age, economic status and location.²⁰³ These data are made available through the BBS website and statistical year book. Most key informants are optimistic that quality of the updated data will be improved further with full functioning of all the planned BBS offices across the country.²⁰⁴

A major breakthrough occurred in late 2015 when the Bangladesh Bureau of Statistics launched a web-based platform that allows students and researchers to quickly access housing and census data and generate desired graphs and tables. With UNFPA support, the *2011 Population and Housing Census*

generated the district and upazila level data and the draft reports are also uploaded to the BBS website. Availability of demographic data by age and sex, location and poverty has thus increased among the data users for researchers and planning purposes. In 2014 UNFPA initiated a partnership with UNECLAC²⁰⁵ to support the BBS with online dissemination of census micro data.²⁰⁶ This initiative will facilitate online data users in respect to mapping socio-economic and demographic inequalities. The partnership with UNECLAC was successful in helping BBS to install and upload the system and thereby made the 2011 census micro data available to online users. It is now the largest in the world online census data set shared with outside world in REDATAM system and can be accessed through the BBS webpage.

In order to make more issue-specific research-based papers available, the BBS plans to produce 14 monographs within the project period. A UNFPA consultant will prepare four of these monographs and Bangladeshi experts will prepare the others.²⁰⁷ These monographs will cover issues such as education, adolescents and youth, the aging population, migration, urbanization, and housing, etc.²⁰⁸ Although none of these monographs will be written in-house at BBS, indicating some technical limitations of BBS, the 135 traditional census reports have been produced using BBS's in-house capacity without external support.²⁰⁹

In terms of regularly updated, **nationally representative data on gender-based violence** and harmful practices, UNFPA continued to support BBS capacity development in analyzing and using disaggregated data on gender based violence. By the end of 2014, BBS developed a plan and budget to undertake the next round of the national *Violence Against Women (VAW) Survey (2015)*. The survey has been completed and the report is expected in the near future. (The previous VAW survey in 2011 was also supported by UNFPA and published in 2013).

²⁰³ Sample vital registration system (SVRS) is used by BBS by collecting data from 23 district offices on annual basis. These demographic data are available disaggregated by sex, age, economic status and locations. BBS is in the process of increasing number of district offices to 71.

²⁰⁴ Key Informant Interview with GIS Unit, BBS.

²⁰⁵ United Nations Economic Commission for Latin America and the Caribbean (UNECLAC)

²⁰⁶ Microdata is a statistical term for individual response data in surveys and censuses. Usually these are machine readable data

²⁰⁷ Four of the monographs will be prepared by researchers from Bangladesh Institute of Development Studies (BIDS), Institute of Statistical Research and Training (ISRT), Department of Population of Dhaka University (DPS/DU), and Statistics Department of Rajshahi University.

²⁰⁸ The monographs focus 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.

²⁰⁹ Key Informant interviews, October 2015

The following are key aspects of population and development during the eighth country programme for strengthening of national capacity to collect and analyse population data:

- BBS conducted a credible census in 2011 with UNFPA technical support. For the first time in Bangladesh, the census included information on emerging issues like gender, migration, maternal mortality, slum population, disabled population, tribal population, etc. The United Nations Statistics Division (UNSD) recognized the Census as a ‘show case’ census, while the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) recognized it as a ‘best practice’ in this region.
- Data generated from the census provides the basis for socio-economic development planning and policy formulation at national and sub-national levels. In the past, in-depth analysis of secondary census data on selected issues was limited and, in many cases, the analysis was conducted long after the census had been completed, thus producing outdated results. Under its eighth country programme, UNFPA supported BBS to improve the quality in the production, analysis and strategic use of census and other survey data in development planning. BBS, with technical assistance from four public academic and research institutions, produced

14 thematic population monographs using mainly the 2011 census, past censuses and other relevant surveys, data and reports. To improve analysis and contents of monographs, UNFPA country office fostered technical assistance and engaged two of its Asia and the Pacific regional population and development advisors.

- The BBS website provides access to metadata for different sets of statistics. For sharing the 2011 census micro data online, BBS introduced REDATAM software with UNFPA technical assistance. This allows students and researchers to quickly access housing and census data and generates desired graphs, tables etc.

4.3.3 Contribution to the strengthening of national capacity to integrate population and gender equality concerns into national and sectorial plans and policies

UNFPA has supported the production of the demographic impact study (DIS) as a background paper for the Seventh Five-Year Plan, reflecting population and gender equality concerns, although no other relevant policy development and change initiatives have taken place. UNFPA has contributed to the institutional development of GED, SEID and BBS by training their staff and has also contributed to producing research papers on several emerging issues on population and development.

Table 10 *Output 2 Indicator - Increased Capacity to Integrate Population and Gender Concerns into National and Sectoral Policies and Plans*²¹⁰

Country Programme Indicators	Baseline (2012)	Target	Progress until Mid-2015	Remarks
At least three national and sectoral plans reflected population and gender concerns.	0	0	1	The Seventh Five Year Plan is finalized. It reflects population and gender concerns.
Number of research papers that contain policy implications and recommendations on emerging issues, such as demographic dividend.	0	7	38	These are policy papers/ brief =19, monographs = 16, research paper = 1, Studies = 2).

²¹⁰ Key Informant Interviews, October 2015

UNFPA supports the Planning Commission of Bangladesh (especially GED, SEID, and BBS) to better integrate and **mainstream population and development linkages and gender equality concerns** into national development plans and sector policies. The Bangladesh Association of Parliamentarians on Population and Development (BAPPD), the Population Council and the Department of Population Sciences of Dhaka University (DPS/DU) also supports this work. This section discusses the policy and research outputs, followed by discussion of the training and education interventions.

During the eighth country programme, the population and development programmatic area through the implementing partners (Planning Commission and Bangladesh Parliament Secretariat) produced a number of policy briefs and organized policy dialogues to inform policy development in line with the ICPD and the *International Legal Framework on Women's Rights*.²¹¹ The national *Seventh Five-Year Plan* has already been finalized and endorsed by the Cabinet. This plan has already included population issues pursued by UNFPA based on the *Demographic Impact Study*. GED and SEID are planning to undertake sectoral planning in collaboration with respective ministries. It is expected that the sectoral plans will also include many of the recommendations that emerged through these policy dialogues.

The SEID and GED are responsible for creating annual development plans for 35 ministries. The GED is mandated to develop the 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 the UNFPA mandate, is to ensure integration of population and gender equality concerns in the development

project proposals. All the projects developed by these two divisions follow the project proforma, requiring that information is evidence-based, gender-sensitive, and that it incorporates population and development linkages. With UNFPA support, SEID produced a handbook on gender equality and population issues, and undertook three policy dialogues, for which three policy papers were prepared with recommendations on creating a women-friendly working environment, and on harnessing women's labour potential.²¹²

UNFPA supported the General Economics Division (GED) of the Planning Commission by undertaking a demographic impact study (DIS) under the BBS project, by a team of renowned experts.²¹³ The Planning Commission as a background paper uses the study for the Seventh Five-Year Plan (2016-2021).²¹⁴ The demographic impact study revealed that Bangladesh is currently transiting a demographic window of change particularly with regard to the dependency ratio. The proportion of children under 15 years of age is below 30 per cent of the total population and the proportion of people 65 years of age and older is still below 15 per cent of the total population. This is possibly the best time for realizing a demographic dividend, with a low level of combined child and adult dependency.²¹⁵

The GED organized the production of eight policy papers and policy dialogues. These are important research papers on emerging issues and their relevance to national planning.²¹⁶ Two monographs of the planned three have already been printed (300 copies) and disseminated to the ministries. They contain policy implications and recommendations on emerging issues, such as the demographic dividend. Two of the research papers will be on the *"ICPD Bangladesh Country Report"*, and the *"Systematic Review of Sexual and Reproductive Health of Young Population and the Sector of*

²¹¹ Information provided by PD department of UNFPA CO.

²¹² Key Informant Interview with SEID of the Bangladesh Planning Commission.

²¹³ The Impact of the Demographic Transition on Socioeconomic Development in Bangladesh: Future Prospects and Implications for Public Policy, May 2015, UNFPA, Dhaka

²¹⁴ The DIS report reviews demographic trends in Bangladesh, assesses the impact of these trends on socioeconomic development, and highlights the policy implications of the linkages between population dynamics and socio-economic development for policy and planning over the coming decades. The report describes the results of a series of population projections, and based on these projections and the lessons learned from recent population-development interactions concludes with a series of policy recommendations that may be incorporated into the Seventh Five-Year Plan as well as future five-year plans and sector-based strategies.

²¹⁵ A country with both increasing numbers of young people and declining fertility has the potential to boost economic productivity. It has growing numbers of people in the workforce relative to the number of dependents

²¹⁶ 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 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).

Investment to Harness the Demographic Dividend". These papers will be developed by the Department of Economics of Dhaka University, and will be ready before the end of the eighth country programme.

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, the BAPPD organized various policy dialogues by the parliamentarians including on reproductive health and rights, adolescents and youth, and child marriage. The project also conducted a gap analysis on maternal health related policies and services in the country, and produced a policy brief for the parliamentarians. Three sub-committees were 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 amendments on the *Dowry Prohibition Act, 1980* along with the *Early Marriage Restraint Act 1929*. They will also review the current youth policy and make evidence-based amendments and organize consultation meetings with standing committees on education, health and family welfare and finance.²¹⁷

The Population Council and one international consultant supported preparation of nine policy briefs and nine fact sheets. Two of these have been disseminated. The papers cover reproductive health needs in relation to the health system (family planning, midwifery, urban health, and maternal morbidity) and sustainable development issues (demographic dividend, climate change and migration with gender focus, gender based violence and socio-economic impact, and health-care financing).

The Department of Population Studies of Dhaka University (DPS/DU) is playing the role of centre of excellence in creating population and development professionals and conducting primary research on population and demography. During the eighth country programme, the DPS/DU has conducted

research on the "aging population" with a sample of 6,200 senior citizens. Twelve issues related to aging population are to be analyzed. The data has been collected and the report will be available soon. A study on causes and consequences of child marriage is also underway with training of enumerators and supervisors for data collection.²¹⁸ The department will soon issue for the first time a document with seven chapters entitled "*State of Bangladesh Population*" based on data collected particularly from BDHS.²¹⁹

The DPS/DU offers a two-year (four semesters) professional post-graduate degree programme, called *Master of Population Sciences* (MPS). There are 65 students in the course. A certificate course entitled "*Diploma in Population Sciences*" is also offered once every year, with maximum of 25 students. UNFPA has supported this department since it was created and now it has been institutionalized within Dhaka University, a trend towards sustainability. Students who will become professionals in the population sciences will play important roles in the future of demographic data collection and its usage. The department also introduced a Bachelor's degree programme, with 25 students.²²⁰

A five-day workshop with trainers from Dhaka University was arranged by SEID for the management staff officials from the planning division, and staff engaged in planning from other ministries. According to some testimonies, there were positive changes in staff understanding regarding gender equality and population issues, and lessons have been applied in the work environment.²²¹ Altogether 280 management staff have been trained.²²² During 2016, training goals will fall short by one batch, due to a funding shortfall, which occurred in the exchange of currency of strong local currency against the US dollar.

The GED is also conducting training on gender equality and population issues for the planning commission staff (planning wing) and stakeholders from other ministries and agencies with relevant

²¹⁷ Power Point presentation on SPCPR – Parliamentarian Action at Country Level, made by Additional Secretary (HR) of BPS and PD, SPCPD.

²¹⁸ The study focus on districts with very high and very low prevalence of child marriage (top and bottom 5%) total of 25 districts selected

²¹⁹ Key Informant Interview, October 2015

²²⁰ Brochure on "Diploma in Population Sciences, 2011" Department of Population Sciences, University of Dhaka.

²²¹ Key informant interviews, October 2015

²²² 20 participants in each batch, 12 batches

projects.²²³ A clear outcome according to participants was the ability to discuss the issues regarding the demographic dividend in various forums. Because of the training, the development and technical project pro-forma has been modified to include mandatory sections on gender equality and children's rights; it also lists beneficiaries of the proposed projects. The modified pro-forma has added value to the proposal-writing process.²²⁴

The training events arranged by the two divisions (SEID and GED) of the planning commission, however, are of similar duration and have similar content. The training arranged by GED is provided by "experts from Bangladesh", while those arranged by SEID are provided by DPS of Dhaka University. While a needs-assessment has been conducted upon which to base training events, it is not clear to what degree the training curriculum is tailored to the needs or merely replicated. Follow-up of these training programmes vis-a-vis needs-assessment and applicability to the workplace is not done systematically by UNFPA and partners. It is possible that the two training events could be merged to increase efficiency and it may be advantageous to use a centre of excellence to take up this activity.

The following are key aspects of population and development during the eighth country programme for strengthening national capacity to integrate population and gender equality concerns into national and sectorial plans and policies:

- The parliament project facilitated the formation of Bangladesh Association of Parliamentarians on Population and Development (BAPPD) with 19 MPs under the leadership of the Honourable Speaker of Bangladesh Parliament. The BAPPD identified three policy issues, which are also UNFPA mandated issues, and formed three sub-committees to advocate these issues with relevant parliamentarian standing committees. As a result, standing committees on the Ministry of Education, Ministry of Women and Children Affairs and Ministry of Information included child marriage issues as a regular point of agenda in their monthly meetings.

- Under two projects (GED and SEID) with the planning commission more than a dozen national-level policy dialogues were conducted. Keynote papers were presented by national experts at these policy dialogues, in which senior-level government officials participated, including representatives from development partners and civil society. These dialogues enriched the understanding of government planning officials on population and development issues and generated momentum among the planning cadres.

4.3.4 Existence of mechanisms to ensure national ownership of activities and sustainability of effects

UNFPA has advocated with the Government for increases in human resources development for population and development using the demographic dividend but many interventions rely on external assistance.

The UNFPA population and development programmatic area has successfully advocated with the Government with regard to the development of the national *Five-Year Plan*. The *Sixth Five-Year Plan* was developed with due consideration of ICPD objectives to meet the challenges in reproductive health and rights, youth development, and gender equality. This advocacy work has continued with the implementing partners particularly in the planning commission to propose greater human resources in the *Seventh Five-Year Plan*, reflecting the demographic dividend and growing numbers of people in the workforce. The *Seventh Five-Year Plan* is also made considering the ICPD, MDG and sustainable development goal (SDG) objectives. The population and development programmatic area partner, BBS, provided reliable data on population and gender based violence used in the national plans.²²⁵ The post ICPD situation and introduction of the sustainable development goals has created opportunity for the UNFPA population and development programme to expand its data for development (D4D) activities still further.

²²³ These trainings were for 5 days (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

²²⁴ Key informant interview, October 2015

²²⁵ 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.

While UNFPA implementing partners have shown examples of leadership, ownership and capacity achievements as described above, presently there is reliance on UNFPA and other external sources for funds and support. However, there are notable sustainable gains, such as procurement of the new BBS press which will decrease costs of printing substantially. The 135 traditional census reports are produced using BBS's in-house capacity and this reporting can be carried out without UNFPA support. Similarly the BBS has learned how to make other datasets available online using REDATAM with minimal support.²²⁶ The GIS unit of BBS established with UNFPA support is currently functioning with almost no support from UNFPA. The Department of Population Sciences of Dhaka University is now offering Bachelor's and Master's degrees in Population Sciences which are now institutionalized within the University.

As part of the Bangladesh Association of Parliamentarians on Population and Development (BAPP&D), some members of the parliament have proactively mobilized themselves under the leadership of the Honourable 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 have shown their willingness to amend the *Dowry Prohibition Act, 1980* and the *Early Marriage Restraint Act 1929*. They are also willing to review the current youth policy and channel more resources into education, health and family welfare.²²⁷

The BBS currently relies upon external consultants to conduct secondary analysis of available data and statistics to produce policy briefs and papers. Furthermore, the GED also uses external expertise to prepare reports such as the "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 capability, could be another option to take the lead in promoting ICPD objectives.

In view of the probable emerging status of Bangladesh as a low-to-middle income country, UNFPA support will be more limited in the future. At present, however, it is clear that the government earmarking of funds is vital to the sustainability of the gains made thus far in the interventions currently supported by UNFPA. These gains have been made incrementally over the years of partnership, but the partners have not developed an exit strategy. An exit strategy is necessary to identify structured steps for national sources to assume the eventual funding. A joint study may be useful to aid this process.

²²⁶ REDATAM is an acronym for REtrieval of DATA for small Areas by Microcomputer, a software. Data can come from any combination of census, survey or other sources. A database can be processed in association with external databases in common formats such as dBase

²²⁷ Key informant interview, October 2015

4.4 EFFECTIVENESS AND SUSTAINABILITY IN THE GENDER EQUALITY PROGRAMMATIC AREA

EQ4

To what extent have the interventions supported by UNFPA in the field of gender equality (GE) contributed towards reducing the social and institutional vulnerabilities of women and girls, including the marginalized and disadvantaged, with special focus on the elimination of gender based violence?

SUMMARY

UNFPA-supported interventions have contributed toward reducing vulnerabilities of marginalized and disadvantaged women and girls by aiming to eliminate gender-based violence and child marriage in targeted districts and municipalities. Advocacy against child marriage is gaining momentum. UNFPA has contributed to improved response to gender based violence, however, not enough emphasis has been given to sustaining the services to support women survivors.

UNFPA, along with implementing partners, have built capacity of management staff and service providers to prevent and address gender based violence and child marriage. These included police, garment workers, women entrepreneurs, women survivors as well as religious leaders and adolescents. Progress has been made to establish partnerships with police and private enterprises and to promote attitudes and behaviours supportive of women's rights. UNFPA has contributed to the engagement of men and boys through forming social protection and youth groups, but further efforts are required.

A number of outputs helped to strengthen national systems, including development of standard operating procedures and inclusion of gender based violence in laws and data bases. Sustainability is limited by lack of a strong gender equality strategy and mainstreaming among UNFPA, partners and other stakeholders.

4.4.1 Profile of the gender equality programmatic area

Four project areas which are related to the eighth country programme outputs are budgeted under the gender equality (GE) programmatic area. Gender equality interventions generally take place in four districts and Dhaka City Corporation. Additionally, many interventions are targeted for national outcomes such as through **policy and advocacy** interventions and **knowledge management**. UNFPA has supported local-level planning to promote national ownership and **capacity development** for planning and budgeting and monitoring at the local level.

- **Advancement and promoting women's rights** is implemented by the Ministry of Women and Children Affairs (MoWCA and district level Department of Women Affairs – DWA) and aims to reduce social and institutional vulnerabilities of women by increasing the availability of and access to shelters, medical, psychological and legal support, and vocational training for survivors of gender based violence in Sylhet, Cox's Bazar, Jamalpur, Pathuakhali, and Dhaka. Interventions include:
 - strengthening capacity of DWA staff on gender based violence and child marriage issues
 - enhancing capacity of women support centres (WSC)
 - conducting local level planning (LLP) to strengthen bottom-up planning
 - social mobilization to challenge stereotypical mindsets and harmful practices

- facilitating multi-sectoral coordination and partnership in order to integrate the support and services for survivors of gender based violence and child marriage
 - engaging men and boys to change their behaviour towards women and girls.
- **Protection and enforcement of women rights**, implemented with the Ministry of Home Affairs (MoHA) aims to involve the police force on enforcement of the laws related to and protection of survivors of gender based violence. Interventions include:
 - establishing women-friendly police stations with “women’s help desks” (WHD) in the selected 15 thanas and police stations
 - developing a standard operating procedure (SOP) for police to provide gender equality sensitive management of survivors of gender based violence and child marriage
 - building capacity of MoHA and police personnel to enhance knowledge on gender equality and related issues
 - coordinating with the government, civil society, and NGOs to provide a wide range of support to survivors
 - developing outreach programs for the police sector in order to create stronger ties with the community and establish themselves as a refuge for survivors of gender based violence and child marriage.
 - **ChaNGE/Changing gender Norms of Garments Employees** implemented with Bangladesh Garments Manufacturers and Exporter’s Association (BGMEA) focuses on prevention of gender based violence in the workplace. Interventions include:
 - capacity development of garment factory workers, mid-level managers, doctors, nurses, and owners on reproductive health and rights and gender based violence prevention
 - establishing a violence against women (VAW) cell in BGMEA, to implement the high court directives on anti-sexual harassment in workplace
 - developing standard operational procedures (SOP) for the VAW cell
 - capacity development of doctors and nurses of the garment factories on RHR and gender based violence case management
 - conducting regular gender equality audit of the garment factories to assess the gender equality congenial environment in the selected factories
- **Economic opportunities and sexual & reproductive health and rights/EORHR** (Empowerment of women through business/RHR/gender package) is implemented by the Bangladesh Women Chamber of Commerce and Industry (BWCCI) to improve the entrepreneurial and technical knowledge and skills of women, which will allow them to start their own businesses. Interventions include:
 - providing tailored entrepreneurial training, business counseling, provision of market and banking information and access
 - providing training on accessing reproductive health information and services and gender equality issues
 - establishing support systems in the communities such as: developing a community role-model on women entrepreneurship, establishing a hotline that will answer women’s questions about business and reproductive health and rights , and advocating with bank officials and policy makers.
 - advocacy through the established women entrepreneurs about reproductive health and rights and gender equality
 - incorporating reproductive health and rights and gender equality related topics into the training modules of the existing service package of BWCCI.

The Generation Breakthrough project, implemented with the DWA of MoWCA, Directorate of Secondary and Higher Education (DSHE) under the Ministry of Education (MoE) and Plan International Bangladesh, has its own budgetary heading but interfaces with gender equality and reproductive health and rights through the gender equity movement in schools (GEMS) module and the interactive games and radio programme. The project aims to address gender based violence, gender equality and adolescent reproductive health and rights and their linkages through introducing educational and skills development programmes

in schools, clubs and sporting programmes as well as through public awareness campaigns. (The progress on Generation Breakthrough is discussed in the reproductive health and rights section of the report.)

The **budget for the gender equality programmatic area** in the eighth country programme included the “Joint Programme to Address Violence Against Women in Bangladesh” (JP VAW) managed by UNFPA, and the Economic Relations Division of the Ministry of Finance, which started in 2008, and continued implementation in 2012 and 2013. The project was funded by the Government of Spain. The budget and expenditures are reflected in the gender equality budget through the partnerships with Ministries of Women and Children Affairs and expended \$3.2m against a budget of \$4.7m.

UNFPA funds (using revised budget figures in 2015) to support the eighth country programme outputs totaled approximately \$5.9 million for interventions implemented through the MoWCA, the MoHA, BWCCI and BGMEA from 2013 through to 2015. The total budget for gender equality through 2016 is approximately \$7.048 million. The funds are mainly from core resources and nationally executed. The gender equality budget was originally expected to be \$13m (\$7m from regular resources) at the onset of the country programme.

The gender equality funding (2013, 2014 and 2015 – with budget revision in 2015) was divided among the four projects as follows:

- Advancement and Promoting Women’s Rights (MoWCA): \$1.467 million
- Protection and Enforcement of Women Rights (Ministry of Home Affairs): \$1.256 million
- ChaNGE/Changing Gender Norms of Garments Employees (BGMEA): \$175,593 (this project started in 2014)
- Economic opportunities and Sexual & Reproductive Health and Rights (BWCCI): \$314,586

Funds for Generation Breakthrough were approximately \$5.098 million from the Embassy of the Kingdom of the Netherlands. The funds are

budgeted among the implementing partners (2013, 2014 and 2015) as follows: Plan International (\$2.7 million); MoWCA (\$758,435) and MoE (\$1.15 million) with \$456,500 reserved for adolescent and youth management.

The **implementation of gender equality interventions** was affected by several factors such as delays in obtaining approval of the technical project proposal (TPP) which also affected the other programmatic areas. Thus, the implementation of three projects falling under the eighth country programme outputs did not start until 2013, while the BGMEA project did not start until end of 2014. The Generation Breakthrough project implementation has been delayed by the need for official approval by the MoE for the gender equity movement in schools materials, termed the GEMS module.

Among the challenges, implementing partners did not have all of the required capacity to undertake the interventions. Some of the partners were new to UNFPA. Partnerships with MoWCA have been ongoing for many years, however, local level planning was a relatively new undertaking for the DWA. Partnership with the Ministry of Education is relatively new as were many of the ground-breaking approaches developed for the gender equity movement in schools (GEMS). The partnership with the BGMEA was carried over (and redesigned), but the partnership with BWCCI was new. Implementation was slowed due to human resources shortages and frequent transfers or changes among government staff. Implementation was facilitated by regular coordination meetings with the government and private sector implementing partners.

4.4.2 Awareness and knowledge of and positive attitudes towards reducing the vulnerability of women

Awareness and knowledge of gender based violence have been increased but the causes and consequences of child marriage remain insufficiently addressed.

Table 11 Gender Equality Output 1 Indicator - Increased awareness toward reducing vulnerability of women²²⁸

Country Programme output indicators	Baseline	Target - end of 2016	Achievement End 2014
'% of men aged 15-60 and females aged 15-49 in selected areas who are aware of the negative effects of violence against women'	NA	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'	32% (BDHS, 2011 - data only among women)	Male: 5% Female: 1%	Male :2% Female: 1%

UNFPA interventions with implementing partners (IPs) are contributing toward changing attitudes of society, promoting a greater understanding of women's rights, and working toward the prevention of child marriage and gender based violence (GBV). UNFPA is contributing to progress in achieving gender equality in Bangladesh through addressing social norms and supporting the ability of women and girls to make decisions about their lives and for society to confirm their value.²²⁹

Although the eighth country programme supports interventions to **counter child marriage**, the results and resources framework does not contain specific outputs or indicators relative to child marriage. Gender based violence is frequently spoken of together with child marriage, however the causal factors and the stakeholders involved may vary. The cross-cutting impact of child marriage is reflected across UNFPA programmatic areas in its interventions to reduce adolescent birthrates. The same can be said of the Bangladesh Association of Parliamentarians on Population and Development (BAPPD), which has organized policy dialogues on reproductive health and rights, adolescents and youth, and child marriage. The BAPPD has also formed sub-committees to carry forward the advocacy work related to prevention of child marriage. Key activities proposed by the sub-committees are to make necessary amendments on the *Dowry Prohibition Act, 1980*, along with the *Early Marriage Restraint*

Act 1929, and review the current youth policy and make evidence based amendments.²³⁰ A study on causes and consequences of child marriage in 25 districts is also underway by the Dhaka University Department of Population Studies. (See population and development section above.)

The Government of Bangladesh announced its commitment to ending child marriage (by 2041) at the *London Girl Summit* in 2014. The legal ages are currently set at 21 for men and 18 for women in the *Child Marriage Restraint Act of 1929*.²³¹ The interventions to prevent child marriages in the community need to have a strong basis in adjudication and law enforcement, or the impact of projects and programmes may be limited due to the complicity of local officials. Bangladesh's high vulnerability to natural disasters also puts girls at more risk for child marriage as their families are pushed into poverty or greater poverty by disasters and emergencies.²³² The punishment for dowry is very lenient and dowries may be difficult to track and verify.²³³

In terms of **policy and advocacy**, UNFPA has incorporated advocacy to eliminate child marriage across programmatic areas and in the Generation Breakthrough project. UNFPA led the multi-agency working group on "*Theory of Change*" to eliminate child marriage, advocated with the MoWCA to support a national programme on child marriage,

²²⁸ Annual Progress Report 2014 on 8th Country Programme, Output No 4; Output No. 5, UNFPA Gender Equality Unit, January 2015

²²⁹ 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.

²³⁰ Power Point presentation on SPCPR – Parliamentarian Action at Country Level, made by Additional Secretary (HR) of BPS and PD, SPCPD

²³¹ Speech at the London Girl Summit in 2014 by Prime Minister Sheikh Hasina

²³² Bangladesh: Girls damaged by child marriage, Human Rights Watch, June 9, 2015

²³³ Key informant interviews, October 2015

and has been supporting the development of a costed action plan with UNICEF. UNFPA has also provided significant inputs to drafting of the *Child Marriage Restraint Act of 2014*.²³⁴ UNFPA has supported the Ministry of Foreign Affairs before the *Girl Summit in London* in 2014 to draft its commitments. UNFPA, together with UNICEF, led advocacy and consultative efforts to engage a large number of development partners and NGOs and to forge a common platform raising concerns about lowering the legal age for marriage. Strong pressures from local interest groups to allow exceptions to the age limitations seem to be diminishing.^{235,236} Further, UNFPA advocated with traditional partners including the parliamentarians to include child marriage prevention in meetings with their constituencies and advocated to increase the minimum number of years of education from 5 to 12 years. (See further discussion in the coordination section.)

Work with adolescents and youth that deals with prevention of adolescent pregnancy and child marriage has the potential to be extended to cover unmarried youth through reproductive health and rights and Generation Breakthrough interventions. All of UNFPA interventions are reaching a small proportion of girls vulnerable to child marriage in Bangladesh, thus their replication by the Government is a key factor in affecting the national indicators. It is unclear to what degree successful approaches among agencies working on child marriage issues have been shared and their replication promoted.

The gender equality programmatic area has supported interventions regarding child marriage with the Ministry of Women and Children Affairs (MoWCA) and the district Department of Women Affairs (DWA), and the Ministry of Home Affairs (MoHA) with the thana police departments. Information dissemination regarding prevention of child marriage and its detrimental effects are

widely incorporated among gender equality and other programmatic area interventions. A number of mechanisms have been employed to raise community awareness and respond to individual cases, although they do not appear to be completely systematic, coordinated or mapped as to coverage and outcomes²³⁷:

- Eighty-nine social protection groups (SPG) were formed.²³⁸ In Jamalpur, the active involvement of the union parishad chairman made significant contributions towards preventing child marriage and gender based violence through holding regular meetings of the social protection groups. The upazila women affairs officer also calls monthly meeting of social protection group (members of which are mostly men), which is more frequent than the planned quarterly meetings²³⁹
- NGOs, CBOs, youth groups, clubs and women's associations in the network were activated (or created) and given advice. They focused on gender based violence and child-marriage prevention
- Thirteen community networks were established in the selected districts: Sylhet (4), Jamalpur (3), Cox's Bazar (3), Patuakhali (3).²⁴⁰ Network members refer victims to GO/NGO facilities whenever required
- Religious leaders were approached, 3,000 of which were trained
- Twenty community dialogues were conducted in 35 upazilas and a total of 1186 community people sensitized to the negative consequence of gender based violence and child marriage
- The Nari Nirjaton Protirodh Committee (NNPC), a government structure, was active at the union level, informing its members of actions on child marriage and gender based violence.

²³⁴ Annual Progress Report 2014 on 8th Country Programme, Output No 4; Output No. 5, UNFPA Gender Equality Unit, January 2015

²³⁵ Marriage age to remain 18, The Daily Star, Dhaka, Monday October 19, 2015

²³⁶ UNFPA 2014 Annual Report Bangladesh, December 2014

²³⁷ Annual Progress Report 2014 on 8th Country Programme, Output No 4; Output No. 5, UNFPA Gender Equality Unit, January 2015

²³⁸ The role of the Social Protection Groups relative to UNFPA interventions is not clear but the formation of these groups seems dependent on the implementing partners and project objectives rather than as a sustainable mechanism managed by the MoWCA or MoHA. For example, the Midterm Performance Evaluation of the Protecting Human Rights (PHR) Project, Enforcement of laws and provisions of legal and other services in cases of domestic violence, early marriage, dowry, and related women's rights abuses" USAID Bangladesh, June 2014 – page 14 – 15, the PHR has facilitated formation of Social Protection Groups in each project union to help reduce domestic violence and prevent child marriage, each SPG has 15-20 local representatives headed by the UP chair (supported by Plan International).

²³⁹ Key informant interviews and site visit, October 2015

²⁴⁰ In Jamalpur, Sylhet and Cox's bazar, 4 networks are fully functional, and remaining needs further support to improve coordination and reporting. Patuakhali networks require follow up and motivation of UWA officer.

Table 12 *Examples of Adolescent and Youth Friendly Advocacy Efforts*²⁴¹

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

Although the data is not clearly amalgamated, the social protection groups, the police and the local administration have prevented well over two hundred child marriages in the target districts.²⁴² (See “number of activities to prevent child marriage by UNFPA implementing partners” chart in the evaluation matrix in the annexes.²⁴³) In the Jamalpur district, the UNFPA interventions supported the first local initiatives to prevent child marriage and reportedly Jamalpur Sadar upazila is completely free of child marriage while it is expected that the entire district will soon be a child-marriage-free district. The keys to this success story should be clarified and good practices and lessons disseminated.

The challenges regarding the prevention of child marriage include the lack of adequate baseline data at the upazila and district level in order to measure the changes that the interventions have contributed towards.²⁴⁴ Further, it is difficult to ascertain whether marriages actually take place secretly or later and thus cannot be ultimately considered as prevented.²⁴⁵ The numbers of and

the consequences for girls who enter polygamous marriage arrangements are also not well known.²⁴⁶ Birth registers and marriage registers are considered important at upazila and district level to determine age at marriage, and those in charge of checking evidence need to be further sensitized. UNFPA has supported a number of upazila-level workshops to sensitize religious leaders, marriage registrars and community leaders but the coverage is unclear.²⁴⁷

UNFPA interventions contributed to **enhancing the capacity of DWA of MoWCA** in preventing gender based violence and child marriage. The social protection groups (SPGs) have been provided with orientation on preventing gender based violence and child marriage, as well as its causes and consequences and these have led to the positive outputs as described above.

The DWA supported **local-level planning (LLP) on gender based violence, child marriage** and relevant issues and 39 district and upazila level plans were produced as per the target. In all the intervention

²⁴¹ Quarterly Consolidated Report (April-June, 2015), UNFPA Gender Equality Unit

²⁴² Approximately 200 child marriages were prevented by the SPG in DWA 4 target districts. 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).

²⁴³ Compiled from Standard Progress Reports and Annual Progress reports, UNFPA Gender Equality Unit, 2014-2015

²⁴⁴ Annual Progress Report 2014 on 8th Country Programme, Output No 4; Output No. 5, UNFPA Gender Equality Unit, January 2015

²⁴⁵ Key informant interviews, 8th CPE inception mission, September 2015

²⁴⁶ Key Findings of Field Monitoring Visits, UNFPA Gender Equality Unit, January 2014 through March 2015

²⁴⁷ Key Findings of Field Monitoring Visits, UNFPA Gender Equality Unit, January 2014 through March 2015

areas, LLP exercises have been developed in a participatory manner involving relevant local and national stakeholders and the plans were submitted to the DWA and MoWCA for approval.²⁴⁸ Local level planning also supported interventions related to the health sector, such as the 'One Stop Crisis Centre' (OCC)²⁴⁹ in Sylhet and Cox's Bazar, and building capacity for operation of women support centres (WSC) in Sylhet and Cox's Bazar.

However, the DWA lacked strong orientation on local-level planning to effectively and efficiently incorporate local-level plans on gender based violence and reproductive health into DWA's own core programme plans.²⁵⁰ Frequent transfer or changes of government staff also delayed approval and implementation, as new staff were not acquainted with local-level planning. Most recommendations from the local-level planning exercises were incorporated into annual work plans as part of an awareness campaign. However, some recommended interventions could not be undertaken or completed which was a source of disappointment for local stakeholders.²⁵¹

A number of **interventions that target men and boys with information regarding gender based violence and child marriage** were undertaken. local-level planning exercises identified the involvement of the religious leaders, such as imams, as important to reduce child marriage. Sensitizing key leaders of different religions and the marriage registrars provided them with guidance. It allowed them to establish their role of not condoning or registering marriages involving underage girls. UNFPA supported interventions including an awareness campaign on gender based violence and child marriage which ran for 16 days on television and radio.²⁵² This was also an input from the *Joint Project-Violence Against Women (JP VAW)* project in 2012, and brought together activities of all the agencies and increased visibility. But more important than the actual 16 day campaign was the

process that was put forward which, if replicated and built on, could yield significant results.²⁵³

Local-level planning stakeholders as key influencers to change, also mentioned youth groups, mindsets and attitudes. However, relative to other groups, there has been limited progress in terms of involving young men. As noted above, a number of examples exist on the initiatives to form youth and school-based networks working toward results. Seven school-based student/youth networks, with 30 students (taking 6 students from each class) in each network, have been formed in Jamalpur with encouragement from the thana police. Five networks have both boys and girls and two are solely boys' networks. They are mainly engaged in class monitoring for child marriage prevention and collecting baseline data for each class (e.g. number of students, numbers already married, plans to reduce child marriage, etc.). Data collection was completed by June 2015 and in January 2016 they will reassess their efforts along with the police to share the progress they have made. (See "number of activities to prevent child marriage by UNFPA implementing partners" chart in the evaluation matrix in the annexes.²⁵⁴)

The challenges to planning interventions targeting men and boys is the lack of baseline data on male awareness to indicate the scope of the problems and to set realistic targets. The local-level planning stakeholder workshops indicated that engaging men and boys was not the typical way of thinking of prevention, and that DWA staff had difficulty facilitating community dialogue on masculinity and gender in conservative communities.²⁵⁵ What is lacking is systematic recording and reporting on the part of all partners on the levels to which men and boys engage to prevent gender based violence or child marriage and for outcomes from interventions to include them. **Behaviour change communications** were not systematically developed to target men and boys.

²⁴⁸ Annual Progress Report 2014 on 8th Country Programme, Output No 4; Output No. 5, UNFPA Gender Equality Unit, January 2015

²⁴⁹ The One Stop Crisis Centers (OCC) are to provide all required services for a woman who is victim of violence in one place, including health care, police assistance, DNA testing, social services, legal service, legal assistance, psychological counseling and shelter service. The OCC was a joint initiative of the Government of Bangladesh and the Danish Government with the MoWCA and several other ministries with pilots from 2000 to 2008 and a second phase starting in 2008 and now located in 8 Divisions and one city Dhaka. Annual Progress Report 2014 on 8th CP, UNFPA Gender Equality Unit, Output 4, January, 2015

²⁵⁰ Key Informant interview, October 2015

²⁵¹ Key informant interviews, October 2015

²⁵² Standard Progress Report1, Gender Equality and Women's Empowerment, (implementing partners DWA and BWCCI), Reporting period February, 2014

²⁵³ Final Evaluation, Joint Programme to Address Violence Against Women in Bangladesh, MDG Fund, July 2014, page 22

²⁵⁴ Compiled from Standard Progress Reports and Annual Progress reports, UNFPA Gender Equality Unit, 2014-2015

²⁵⁵ Key Findings of Field Monitoring Visits, UNFPA Gender Equality Unit, January 2014 through March 2015

Table 13 Gender Equality Output 2: Functional facilities providing support to GBV survivors²⁵⁶

Facilities for GBV survivors	Baseline (2012)	2014	2016 (target)
Functional facilities in selected areas providing services for GBV survivors	02	07	11
Number of health facilities that provide screening and referrals services for survivors of GBV	3 (DH: 31% and UHC 20% as per the DWA baseline)	District Hospital: 31% Upazila Health Centre: 20%	DH: 35% UHC: 25%
% of women with adequate knowledge on where to report GBV	Rural: 60% Urban: 40%	Rural: 60% Urban: 40%	Rural: 65% Urban: 45%

Overall, the **challenges include weak coordination** between the APWR and PEWR projects which have essentially aimed to achieve similar outputs. Project implementation and steering committee meetings have been conducted independently, which represents a lost opportunity to share good practices and lessons.²⁵⁷ There are good examples of coordination, such as a case study in Jamalpur of coordinating human resources with events; however, not all coordination activities are well documented. While the strength of coordination is not the same in all districts, there has been significant progress through UNFPA and implementing partners' efforts to develop formal mechanisms for coordination.²⁵⁸

4.4.3 Access to and use of facilities and services for survivors of gender based violence

Access to facilities set up to assist survivors of gender based violence has increased, but quality and quantity is lacking for some services and lapses in funding have affected some of the continuity. Referral systems do not function well.

UNFPA, along with its implementing partners have made progress in tackling a very difficult and sensitive issue in Bangladesh centering on how to encourage reporting of gender based violence to avoid impunity for the perpetrators of the violence and how to best assist the victims so that they can recover to live fulfilling lives.

In terms of **advocacy and policy**, the *Joint Programme - Violence Against Women (JP-VAW)*

from 2008 to 2012 tackled issues related to violence against women policies, the implementation of laws and conventions. The programme trained judges and prosecutors to enhance their understanding of issues related to violence against women to facilitate legal processes for the victims of violence. The *CEDAW Benchbook* and the *CEDAW Booklet*, an accessible Bangla version of CEDAW, were created for judges, the police and other related stakeholders to facilitate access and understanding, and application and use.²⁵⁹ The JP-VAW supported extensive awareness-raising for media and the public. UNFPA has supported capacity development of the Bangladesh Bureau of Statistics (BBS) for analyzing and using disaggregated data on gender-based violence and conducting the national *Violence Against Women (VAW) Survey 2011*, published in 2013. The BBS has completed a second round of the survey in 2015 and the report is expected in the near future.

The JP-VAW contributed at national level towards increased awareness and tools to address violence against women in the workplace. Among others, the Bangladesh Employers' Federation (BEF) has developed a gender quality policy which incorporated issues of violence against women/sexual harassment at the workplace that will be applicable for private sectors employers. UNFPA has advocated to incorporate gender based violence and reproductive health issues into the *Bangladesh Labour Rule* (draft) and *Labour Inspector Checklist* and this was accomplished during the eighth country programme.

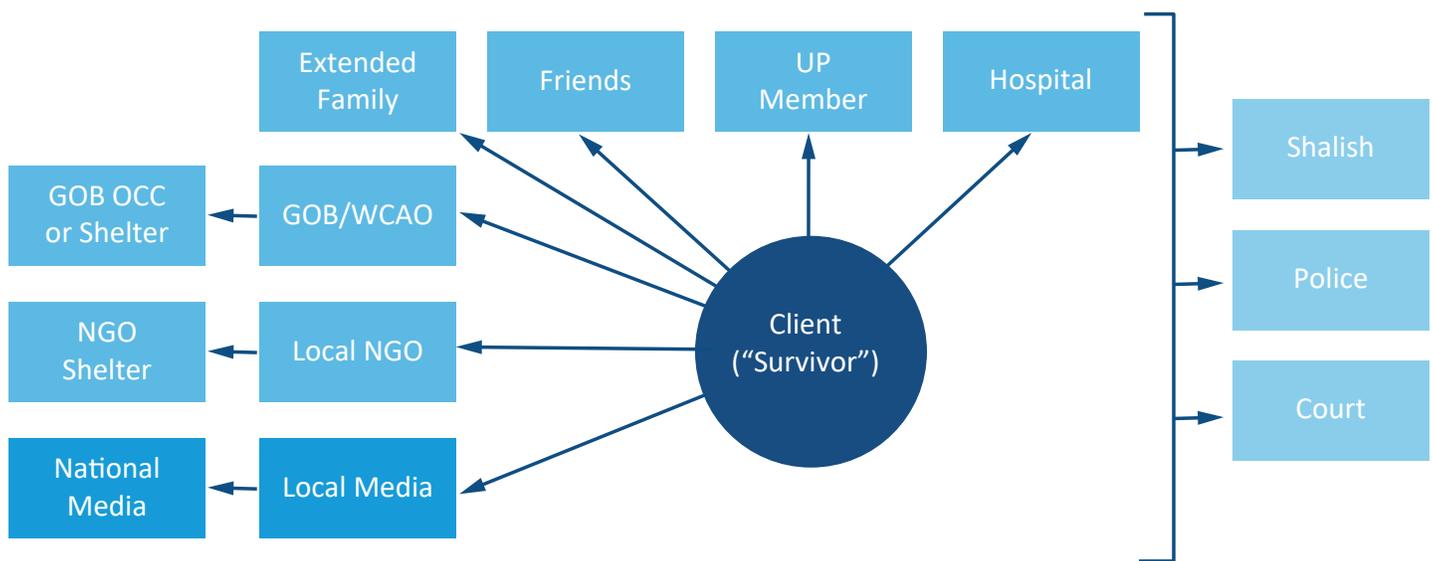
²⁵⁶ Annual Progress Report 2014 on 8th Country Programme, UNFPA Gender Equality Unit, Output No 4, Output No. 5, January 2015

²⁵⁷ 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

²⁵⁸ Site visits to Jamalpur and Cox's Bazar.

²⁵⁹ Final Evaluation, Joint Programme to Address Violence Against Women in Bangladesh, MDG Fund, July 2014

Figure 6 Depiction of Support Services for Survivors of Gender Based Violence²⁶⁰



In regard to **advocacy on the CEDAW** and working with the Government of Bangladesh toward removing its reservations, the country office through the local consultative group – Women’s Advancement and Gender Equality (LCG-WAGE) provided feedback in the *CEDAW Alternative Report*, the *CEDAW Shadow Report*, and was representative to Commission on the Status of Women (CSW) annual meeting. The group flagged issues in the forum and shared a UNFPA position paper with the government delegation for CSW. UN Women leads this process and UNFPA is closely working with UN Women: for example, UNFPA prepared a report on violence against women for the UN confidential report on the CEDAW.

Generally, women who have experienced violence may seek help from their family or friends or a local community leader. If they are injured they may seek help from a clinic or hospital. If they do not want to return to the place of violence they may access the one-stop crisis centre, or an NGO shelter. If they choose to prosecute the perpetrator, they may use the local *shalish*, or go through the police and judicial system. However, women rarely come to police stations to lodge complaints, mainly because the majority of officers are men and violence against

women and gender based violence is not high on the list of priorities for police work.²⁶¹

In the eighth country programme, UNFPA interventions to provide services for the gender based violence survivors and to hold perpetrators accountable, included the Ministry of Home Affairs/thana police intervention **Protection and Enforcement of Women’s Rights (PEWR)**, which was carried out at two levels:

1. Within the selected geographical districts of operation at police stations
2. At the national level through police training institutes and coordination through the Ministry of Home Affairs (MoHA) Secretariat. UNFPA provided technical assistance to MoHA utilizing the hierarchy within the Bangladesh Police Force from the national to the district and thana levels.

UNFPA provided support to the MoHA in the creation of a specialized unit (women help desk) within each selected thana which is tasked with handling gender based violence-related law enforcement issues, and which has trained personnel (with at least gender parity among officers within the unit).

²⁶⁰ Graphic adapted from Midterm Performance Evaluation of the Protecting Human Rights (PHR) Project, Enforcement of laws and provisions of legal and other services in cases of domestic violence, early marriage, dowry, and related women’s rights abuses” USAID Bangladesh, June 2014, page 13

²⁶¹ Annual Progress Report 2014 on 8th Country Programme, UNFPA Gender Equality Unit, Output No 4, Output No. 5, January 2015; Very low usage of police by GBV survivors is confirmed in the Midterm Performance Evaluation of the Protecting Human Rights (PHR) Project, Enforcement of laws and provisions of legal and other services in cases of domestic violence, early marriage, dowry, and related women’s rights abuses” USAID Bangladesh, June 2014, page 14.

It has terms of reference, and a fully operationalized standard operating procedure (SOP) for offering comprehensive support to gender based violence survivors and facilitating prosecution of the offenders.

Under the leadership of the Superintendent of Police, the police force worked closely with one-stop crisis centres (OCCs), the upazila Department of Women Affairs (DWA) and upazila health complexes (UHCs) which were also supported by UNFPA interventions. Within upazilas, the officer-in-charge was responsible for implementation and project monitoring at the thana level. In order to identify organizational strengths and challenges to integrating gender equality in the police systems and operations, a participatory gender audit had been undertaken in police HQ, the offices of the Superintendent of Police in the four project districts, and police stations at selected thanas where women help desks are located.

Since there was already a central MIS system to record criminal data, UNFPA has supported inclusion of qualitative data on gender based violence in the existing MIS. The selected pilot thanas under UNFPA support have been linked directly with the Office of the Superintendent of Police (SP) through the internet for reporting the recorded cases and immediate data storage. A “gender based violence monitoring cell” at the MoHA national office has also been established. The networks that support the response to gender based violence and child marriage, including community members and students, are effectively informing police through text messages.²⁶²

The project aimed to help reduce fear and change attitudes of communities towards the police force. Women tend to feel more comfortable sharing sensitive information on gender based violence with another woman. However, there were few women police officers at sub-inspector (SI) level who managed the women help desk (WHD) and thus female constables (a lesser rank) tended to manage the WHD. Sub-inspectors are needed as per government policy, in order to file a case, keep records for monitoring, and investigate a case

with full freedom. UNFPA lobbied with the MoHA and police headquarters to place more women of appropriate rank at the women’s help desks.

Significant positive changes have been observed through the PEWR. These include:

- Support of high ranking police officials for the functioning of the women’s help desks through assignment of female or male sub-inspectors or female constables
- Increased motivation (HQ, district and sub-district level police personnel) gained through capacity development and coordination to prevent gender based violence and child marriage
- A more trustworthy relationship created between community and police through police outreach: for example, village-level ‘women ambassadors’ have been formed to prevent gender based violence and child marriage in Jamalpur
- Women survivors in Jamalpur²⁶³ and Cox’s Bazar reported satisfaction in police handling of their cases
- A gradual increase in the number of women reporting to women’s help desks²⁶⁴
- A positive influence on preventing gender based violence through police interest and presence
- Incorporation of gender based violence data in the police criminal data management system

A major **challenge** to increasing police capacity to enforce laws supporting women’s rights was developing the awareness of the police regarding the use of the *Domestic Violence Act of 2010* as many had no previous experience in confronting gender based violence (or child marriage). The need for greater understanding of the law was met by incorporating a session in the police training under the project and involving the superintendent of police in the workshops, as well as senior resource people as trainers.

²⁶² Key Informant Interview, October 2015

²⁶³ 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.

²⁶⁴ Key informant interviews, October 2015

Table 14 Services Provided to the Gender Based Violence Survivors by Women’s Support Centres (January, 2015,²⁶⁵ and April-June, 2015)²⁶⁶

Services provided by WSC	Cox’s 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 (2 nd 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

Coordinated and back and forth referral was planned from 15 women help desks (WHD), which have been established in all the selected districts as per the guidelines set down by the Ministry of Home Affairs, who are recording, reporting and investigating gender based violence and domestic violence cases. However, women reporting to the women’s help desks have not been linked with the women’s support centres or one-stop crisis centres but they may be referred by police to the civil surgeon or a safe house. Where some women help desks exist such as in Jamalpur, there is no women’s support centre, thus a gender based violence survivor can only file a case at the police

thana, but they may need shelter at least for a limited time.²⁶⁷ In Cox’s Bazar a referral mechanism between the one-stop crisis centres and the womens’ support centres has been established in late 2015.

Women face strong cultural aversions to visiting a police station. There is a risk that gender based violence survivors at women’s help desks receive limited support in terms of systematic referrals to legal counsel or shelter and that women do not confide in male officers. Community outreach needs to be continuous to encourage trust in the police support system.

Table 15 Services Provided to the Gender Based Violence Survivors by Cox’s Bazar Women’s Support Centres (July 2015-September 2015)²⁶⁸

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)	68 ²⁶⁹
Cases resolved through arbitration	29
Food support	77 (New 19+19 children; old 18+21 children)
Psychological support	32 (within shelter 19 & outside 13)
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

²⁶⁵ Annual Progress Report 2014 on 8th CP, UNFPA Gender Equality Unit, Output 4, January, 2015

²⁶⁶ Consolidated Quarterly Report (April-June, 2015), UNFPA

²⁶⁷ Key Informant interviews, October 2015

²⁶⁸ Progress Report of WSC Cox’s Bazar (from July to September, 2015)

²⁶⁹ Within WSC19 and outside 10 and 2 years as well as imprisonment for 1 perpetrator

A number of other capacity challenges were addressed through monitoring and were effectively documented by the gender equality unit. These included the need for fund management orientation, report writing, and monitoring training at the police station. A continuing issue was strengthening the motivation and accountability of the police to support survivors and, given the high turnover, the annual training was not adequate to change staff mind sets. The technical project proposal was ultimately revised to include more activities.²⁷⁰

Interventions supported by UNFPA in partnership with the MoWCA/DWA include the **strengthening of the women's support centres (WSC)**, which reflect a commitment from the government and are continued from support provided under the seventh country programme. The JP-VAW (2008-2012) evaluation noted that linkage made to legal counselling was a 'best practice' but psychological counselling and health care should have been prioritized. A new standard operating procedure for MoWCA shelters was developed.²⁷¹ The data presented in the tables above indicate the usage of services provided by two women support centres over a limited time period. The women support centre in Cox's Bazar has produced strong results. From 2008 till September 2015 a total of 1,025 women received legal support (444 within the shelter and 581 outside the shelter); 882 were given shelter (women 444 and children 438). With legal support from the women support centre, 48 women filed court cases of which 35 were resolved. A total of 767 cases were resolved through the shalish (village court).²⁷²

The eighth country programme output was **strengthening existing facilities: e.g. medical, psychological and legal support and training for income generating activities (IGA) for GBV survivors in programme areas and capacity building for staff**. There are two women support centres in Cox's Bazar,

and Sylhet. Under the seventh country programme (CP), as per the agreement with the government, the DWA/MoWCA agreed to take over support for the women support centres and to develop a plan for two years of support from government revenue for women support centres in Cox's Bazar, Patuakhali and Jamalpur.²⁷³ However, the transfer of funds from MoWCA to the Department of Women's Affairs was delayed, causing lapse of assistance in 2012 to the women support centre in Cox's Bazar. This resulted in sudden discontinuation of services to clients who had been sheltered there. Funding issues continue to plague the women support centre, which is struggling to support the gender based violence survivors.²⁷⁴ The lapses in activities and funding has resulted in tremendous pressure on the women support centre management and the gender based violence survivors.

The women support centres typically aim to provide the following services: food support, psychological support, medical support, legal support, vocational training, and non-formal education for women and their children. Security for women has also been ensured through appointing security guards. The women support centres report on all activities undertaken at upazila and union levels, regarding registration and case follow-up. Success stories of gender based violence survivors have been regularly published in newspapers.²⁷⁵ Gender based violence survivors outside women support centre can access a 24/7 helpline support and some cases have been resolved through arbitration.²⁷⁶ The project has also supported the Dhaka women support centre (through government funds) to incorporate a child corner.

All gender based violence survivors receive skills training in, for example, handicrafts. However, some see this to be too restricted, as the products have limited markets and may not be sustainable. The gender based violence survivors in women support

²⁷⁰ Key Findings of Field Monitoring Visits, UNFPA Gender Equality Unit, January 2014 through March 2015

²⁷¹ Final Evaluation, Joint Programme to Address Violence Against Women in Bangladesh, MDG Fund, July 2014, pages 40-44

²⁷² UNFPA Office, Cox's Bazar, October 2015

²⁷³ Annual Progress Report 2014 on 8th Country Programme, Gender Equality Unit, Output No. 4, UNFPA BCO, January 2015.

²⁷⁴ There was a dislocation of 16 women GVB survivors who were also forced to leave the NGO operated shelter (supported by UNFPA prior to the present intervention). Those who had places to go returned and the rest were kept in different human rights 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 under the 8th CP. The reason for the budget cut was not known by the WSC management. As a result WSC of Cox's Bazar 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 through DWA for an increase in the fund release, (Key Informants' Interview, WSC, Cox's Bazar, October 2015).

²⁷⁵ Progress Report of WSC Cox's Bazar (from July to September, 2015 in Bangla), UNFPA (Implementing Partner, DWA)

²⁷⁶ Consolidated Quarterly Report (April-June, 2015), UNFPA

centres reported that they do not get regular health checkups or health support, which could be due to shortages of health staff.²⁷⁷ Furthermore, limited psychosocial support is provided to gender based violence survivors, sometimes spread between the one-stop crisis centres and the women support centres. This is clearly inadequate since some gender based violence survivors, especially adolescents who are victims of rape or attempted rape, require continuous psychosocial support and also may lack the means to access the legal or arbitration systems.²⁷⁸

Most of the gender based violence survivors wish to be reintegrated into their families through a third-party engagement in conflict-resolution supported by the women support centre, which they may not be able to access otherwise. The legal advisor acts for resolution according to the wishes of the women. Legal support is complex, as most cases are solved through arbitration or through a *shalish* (village court) and rarely in court. Conflict-resolution is a practical solution as most gender based violence survivors have very limited options to survive on their own. The women support centres generally call on panel lawyers on a contract basis when required.²⁷⁹ However, the degree to which follow-up and monitoring of resolved cases is carried out is unclear.

The gender based violence survivors are informed about the women support centres through community-awareness campaigns and are able to access its services. However, the capacity of a women support centre is limited and a gender based violence survivor can stay only for six months. In cases of delay in arbitration, there is no mechanism in place to provide support apart from the helpline. Shortages of staff in both the Department of Women's Affairs and the women support centres limits scope for keeping track of individual women for more than six months. The number of districts with functional referral mechanisms established by the Department of Women's Affairs officials among women support centres, health facilities and police-based women help desks has largely not improved. There is no plan for increasing the services.

The ChaNGE (**Changing Gender Norms of Garments Employees**) initiative was implemented by Bangladesh Garments Manufacturers and Exporter's Association (BGMEA) and focuses on prevention of gender based violence in the workplace. 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 per cent and men 20 per cent).

The project was intended to strengthen the knowledge and awareness of workers, mid-level managers and owners, but it was difficult to get adequate time and attention from the workers, as factories follow the assembly-line system of work. However, the commitment of the owners made it possible to access workers. The strong rapport between UNFPA and BMGEA senior management has made a huge difference in achieving the project result, giving space for UNFPA to highlight gender based violence and reproductive health and rights issues.

There are a number of challenges in effective communication of the gender based violence prevention and response messages. While training was ongoing for both male and female employees at BGMEA, the module for the one-day training covers very basic issues on gender, gender based violence and reproductive health and rights.²⁸⁰ Other data collection requests from the BGMEA were also delayed, such as a baseline on the percentage of workers (M/F) and officials who received training or participated in the workshops on gender based violence and reproductive health and rights related topics and improved their understanding on those issues.

Other activities have been achieved, such as the setting up of the violence against women cell in BGMEA, to implement the high court directives on anti-sexual harassment in workplace. A standard operational procedure (SOP) for the violence against women cell has been developed, and a regularized gender equality audit of the garment factories has been implemented to assess how compliant the factory environments are to gender equality.²⁸¹ Under the BGMEA, intervention-awareness sessions were conducted for workers. Targeted workers and

²⁷⁷ Key Findings of Field Monitoring Visits, UNFPA Gender Equality Unit, January 2014 through March 2015

²⁷⁸ Key informant interviews, October 2015

²⁷⁹ The WSC in Cox's Bazar is having remarkable 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 *Shalish /salish* (village court), Project Manager, WSC, Cox's Bazar

²⁸⁰ FGD with garment employees

²⁸¹ Situation Analysis on Violence Against Women in Bangladesh, 9th Country Programme Situation Analysis, UNFPA, 2015

management staff improved their understanding about gender based violence and reproductive health and rights. A majority (60 per cent) of the training recipients know the response procedures for gender based violence and reproductive health and rights. However, as it was mainly observed by the training facilitators, there was no formal pre- and post- test system to assess workers' knowledge for reporting of incidences.²⁸² Because of the late start of implementation, project interventions will continue into the first two quarters of 2016.

The ***“Economic opportunities and sexual & reproductive health and rights – a pathway to empowering girls and women in Bangladesh” (Empowerment of women through Business/RHR/ Gender package)*** is implemented by the Bangladesh Women Chamber of Commerce and Industry (BWCCI) and aims to empower women, particularly the marginalized²⁸³, with increased access to income and reproductive health and rights. The underlying principle of the project is to build the self-esteem, confidence, knowledge and skills of women, which would allow them to become economically active and to lead healthy sexual and reproductive lives. Creating male champion groups is one of the unique strategies in this project to address gender based violence and reproductive health and rights issues in families and advance women's empowerment.

To achieve these goals, the UNFPA gender equality programmatic area added specially designed reproductive health and rights and gender related topics in the existing training module developed by BWCCI for the women entrepreneurs. The training module and services of BWCCI for potential and present female entrepreneurs include tailor-made, practical business skills training, including sessions on basic economics and market knowledge, how to start a small businesses, interviewing skills, linking local production to regional, national and global markets, networking services about market and banking, business counselling, and legal literacy services. However, no discussion on women's socio-cultural vulnerabilities, reproductive health and rights or gender equality issues were included in the module and therefore UNFPA has supported modification of the module to cover these issues.

The project was meant to enhance the economic empowerment of potential women's entrepreneurship. However, women entrepreneurs did not have adequate knowledge of the ten per cent interest rate declared by Bangladesh Bank (central bank of Bangladesh) or about SME loans, among other financial issues. Moreover, bankers do not have sufficient knowledge on loan schemes for women entrepreneurs declared by Bangladesh Bank. The UNFPA-sponsored project oriented women entrepreneurs and bank officials in three districts and many banks have established a dedicated help desk for women entrepreneurs to promote women entrepreneurship. However, a significant perception gap was revealed regarding linkages between sustainable entrepreneurship, gender based violence and reproductive health and rights. This constituted a lessons learned, that more basic orientation is needed for all stakeholders in the private sector. However, the BWCCI as a private organization is seeking appropriate staff to manage the interventions as the organization would benefit from including a staff person who has experience in the social development sector. The results framework for the BWCCI has been revised in 2015 with more explicit indicators.²⁸⁴

4.4.4 Existence of mechanisms to ensure national ownership of activities and sustainability of effects

Sustainability is promoted by outputs strengthening national systems but mechanisms for replicating the outputs and handing them over are not strong enough. Partnerships with the private sector pave the way toward equality in the workplace and income opportunities. However, the gender equality strategy in the country programme is not strong enough to promote mainstreaming among the programmatic areas and through all interventions.

Since 2009, the Government started reporting on the progress of the gender equality responsive budget. The Ministry of Finance initiated the 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

²⁸² Quarterly Consolidated Report (April-June, 2015), Gender Equality Unit, UNFPA

²⁸³ Women in landless households below the poverty line

²⁸⁴ Revised Results Framework for the BWCCI interventions, 2015

percentage of allocation benefiting women and also addressing poverty. A gender responsive budgeting (GRB) was introduced, with fourteen criteria of performance on women's advancement and gender equality. This provided an essential tool for promoting gender equality. The MoWCA has issued guidelines for gender responsive planning and review, guiding government agencies on how to address gender equality in technical assistance and investment project documents.²⁸⁵

Partnerships with national stakeholders increase ownership and sustainability. For example, the women support centre (DWA) of Dhaka has been absorbed into the revenue budget; women entrepreneurs of BWCCI will remain the members of BWCCI. In the BGMEA implemented project, standard operating systems were developed for the violence against women cell, and gender based violence and reproductive health and rights issues have been incorporated into the *Bangladesh Labour Rule* (draft) and *Labour Inspector Checklist*. Development of the GEMS module under the Generation Breakthrough project has been approved by the MoE and the National Curriculum and Text Book Board, to be used at selected secondary schools and clubs and may be replicated by others. Collaborations and coordination between government agencies, other development partners, NGOs, private enterprises, media, academia and experts have been established.

Nevertheless, on the strategic level, gender equality interventions have to be based on a comprehensive strategy for achieving goals, as set out in international instruments (e.g. CEDAW). While the gender equality strategy follows the *National Women's Advancement Policy of 2011*, which focuses on CEDAW, serious reservations and gaps still exist and strong legislation on child marriage is lacking. The scope of the gender based violence and child marriage problems in Bangladesh have raised alarm on a global level. As yet, a cohesive strategy on the part of the Government with assistance stakeholders is not strongly evident.

UNFPA also lacks a cohesive gender equality strategy in the country programme. It needs a strategy that is described effectively, holistic, coordinated with other agencies and focused on efficiency and effectiveness in targeted interventions. All programmatic

area interventions should serve as effective vehicles for promoting gender equality, women's empowerment and the elimination of gender based violence and child marriage. Successful gender mainstreaming among UNFPA programmatic areas requires vigilance to ensure that all opportunities are used. More attention is required from all staff in planning, implementation and documentation with strong monitoring from the gender equality unit. Furthermore, language in UNFPA documentation could be further standardized, promoting the usage of "gender equality" rather than "gender" child marriage, which is marriage of girls below 18 rather than early marriage which is non-specific. Refining terminology should lead to more clarity on definitions and scope.

Sustainability is in question when services are sub-standard or indicate weak accountability towards women and girl clients and the subsequent possible lack of their trust in the services. The women support centres (WSC) have been supported through the seventh country programme and also through the JP-VAW into the eighth country programme, but their function is undermined by an inconsistent delivery of agreed services. MoWCA has not achieved its agreed role of assuming the financial responsibility for the WSC. This forms a lesson in sustainability: in order to achieve replicable results and a successful handover, it is necessary to have agreed and structured plans. Coordination is also weak with regard to shared responsibility for women's welfare such as gender based violence survivors and facilitating their referral to the most appropriate services. A lesson to take from this experience is to have coordination arrangements and phase-out or exit strategies clearly set out in the programme formulation stage of the project, with safeguarding measures during transitions.

Sustainability is also dependent on the ability of UNFPA and its national partners to manage services essential to changing attitudes and behaviours. These include services such as local-level planning, behaviour change communication and systematic data collection and monitoring to steer the interventions. With experience, these abilities and services will grow in strength, but currently, for coordination and monitoring, they will require dedicated, adequate human resources.

4.5 EFFICIENCY

EQ5

To what extent has the UNFPA Bangladesh country office made good use of its human, financial and technical resources to pursue the achievement of the outcomes and outputs defined in the country programme?

SUMMARY

UNFPA has not achieved timely disbursement of funds during the eighth country programme. This is due mainly to lack of approval of the technical project proposals for one year and subsequent implementation delays. General public strikes also stalled progress. Serious human resources shortages in the country office affected achievement of some planned interventions; actions have been effectively taken by the country office to increase staffing capacity and by UNFPA and implementing partners to speed up implementation.

UNFPA soft and financial resources have triggered provision of other resources from donors, government at the national and sub-national levels, and from communities and partners. Resource mobilization was exemplary to motivate private donor funds for adolescents and youth through the Generation Breakthrough project and through the Maternal Neonatal Health Initiative Joint Programme. For the gender equality programmatic area, there are considerable challenges for triggering sustainable resources to maintain the momentum of the interventions.

The country office has strengthened administrative procedures and financial accounting to track the disbursements and progress on interventions and indicators.

4.5.1 Adequate and timely allocation of resources for planned UNFPA support to beneficiaries

UNFPA has not fully disbursed funds as per annual plans throughout the eighth country programme.

According to programme documentation, the rate of disbursement averages approximately 60 per cent. As of October 2015, resource mobilization figures (2015 and 2106 commitments are not finalized) amounted to \$66,890,953 while expenditures amounted to \$41,659,148. (Please see detailed chart of budgetary allocations and disbursements in Annexe 6.) As per the overview and expenditure chart (Figure 11), the budget has exceeded the expenditures in each year of the country programme. In 2012 there were partial funds for the Maternal Neonatal Health Initiative (MNHI) from DFID/EU, while \$12.87 million was expected, the actual amount released was \$5.22 million. The remaining was DFATD (former CIDA) funds and DFATD continues to fund the MNHI.²⁸⁶ The Joint Programme – Violence Against Women (JP-VAW) project, for which UNFPA had 61 per cent of funds, was also carried over into the eighth country programme.²⁸⁷

Interventions for all programmatic areas were delayed due to the late approval by the Government of the technical project proposals (TPP) until nearly the end of the first year of the eighth country programme. For example, the General Economics Division project was not initiated until 2013: a year later than anticipated. At the end of 2012, three of the five projects under the gender equality programmatic area had not been approved. UNFPA provided assistance to the Government in preparation of the technical project proposals. At the end of 2012, only 4 out of 11 projects were operational.²⁸⁸ General nationwide strikes and disruptions also caused delays; notably one event which started on January 5, 2015 and spanned a period of three months, delaying implementation in the target districts.^{289,290}

²⁸⁶ "Analysis of Bangladesh Financial Data" email from the Deputy Representative to the NY Evaluation Office, September 4, 2015

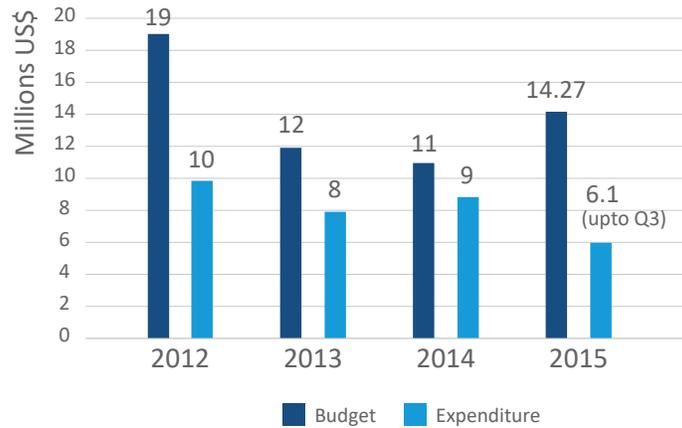
²⁸⁷ Final Evaluation, Joint Programme to Address Violence Against Women in Bangladesh, MDG Fund, July 2014, pages 14

²⁸⁸ Office Management Plan (OMP), 2012 and 2013

²⁸⁹ Key informant interviews, October 2015

²⁹⁰ Public disruptions are mentioned as affecting programme implementation however, the details are not specified in the COAR 2013

Figure 7 Overview of Budget and Expenditure 2012-2015 in US\$ Millions



In terms of **human resources**, the country office faced serious staffing shortages at the beginning of the eighth country programme as well as reorganization in the country office, particularly during 2012 and 2013. These shortages resulted in delays in all programmatic areas as discussed above (see EQs 2, 3 and 4) and particularly with regard to local-level planning for the reproductive health and gender equality inputs, which could not be started in 2012, as planned.²⁹¹ In 2012, an office re-profiling took place and a revised ‘organigram’ was developed around the eighth country programme outputs. Since 2013, UNFPA has been systematically developing a strong base of qualified staff that have the technical capacity to achieve the objectives of the country programme.²⁹² In 2013, there were 63 vacant positions and 43 recruitments.²⁹³ In 2015, the recruitment continued from a baseline of 90 per cent successful recruitment with a goal of 95 per cent.²⁹⁴

In addition, staff shortages, turnovers and transfers of government health service providers at district and upazila level also hampered the establishment of round-the-clock emergency obstetric and newborn care (EmONC).²⁹⁵ Frequent turnovers of staff among police and the DWA affected the implementation of

gender equality interventions to support survivors of gender based violence.

UNFPA staff are considered by stakeholders to be valuable contributors to the partners’ capacities.²⁹⁶ However, staff were extenuated by the staffing shortages, and lengthy recruitment process: for instance, the recruitment of key positions such as Deputy Representative, Operations Manager, and Chief of Health took 9 to 13 months. Staff were overstretched in Cox’s Bazar. This was because they had to cover vacant positions and they lacked full time reproductive health staff presence in the following areas: skilled birthing-attendant-trainers where complex, health-system-based interventions were taking place, one-stop crisis centres (OCC) and reproductive health staff for the refugee camps.²⁹⁷ Furthermore, many responsibilities of staff incorporate the “soft interventions” which may not be specifically described or budgeted in the annual work plans, yet require a great deal of staff time. Soft interventions, particularly advocating with government partners, involves continuously encouraging progress toward planned results and joint problem-solving. The positioning of UNFPA staff in partner ministries such as the Ministry of Health and Family Welfare, has promoted more timely interventions.²⁹⁸

²⁹¹ Office Management Plan, 2012

²⁹² Country Office Annual Reports, 2012 and 2014

²⁹³ Office Management Plan, 2013

²⁹⁴ 2015 Annual Planning – Bangladesh, Finalized Official Planning, May 2015

²⁹⁵ Standard Progress Report, RHR compiled report, 2014

²⁹⁶ Key Informant interviews, October 2015

²⁹⁷ Site visits and Key Informant interviews, October 2015

²⁹⁸ Key informant interviews, October 2015

UNFPA and implementing partner staff in the districts have been key to inspiring change in remote and rural areas. Examples are the revival of union and community clinics and their health system staff functions and motivations, changing attitudes toward family planning and maternal health, for example, in the refugee camps, and gathering support from teachers and community stakeholders in the school systems for Generation Breakthrough.²⁹⁹

The human resources allocated to the gender equality programmatic area are limited, relative to the enormity of the needs in Bangladesh to promote equality and to prevent gender based violence and child marriage. Gender equality unit staff in Dhaka and the districts are extenuated due to weak data collection and reporting and limited monitoring of community activities. Further, the programmatic area is faced with strong competition from other agencies for funding and obtaining the required levels of expertise and the post for programme manager has remained unfilled. Field level staff carry heavy workloads for more than one project with different implementing partners. UN volunteers are providing valuable assistance but need strong orientation on interventions to support them with confidence.

4.5.2 Leverage effect of resources provided by UNFPA

UNFPA soft and financial resources have triggered provision of other resources from donors, government at the national and sub-national levels, and from communities and partners.

UNFPA resource mobilizations plans for the eighth country programme to complement the core funds were shared with the Asia Pacific Regional Office (APRO) and UNFPA Headquarters. UNFPA has successfully mobilized US\$20 million from (former CIDA) for the MNHI programme and mobilized another US\$ 6.5 million from the Netherlands for implementing the Generation Breakthrough project. National NGOs also partnered in implementing this project. Funds were obtained from the Swiss Government to support the gender equality effort in preventing child marriage.³⁰⁰ The EU and UNFPA

strive toward similar population and development goals, and the EU supports the UNFPA and Bangladesh Bureau of Statistics (BBS) project on the census and GIS.

Successful fund raising strategies should be applied to support the gender equality programmatic area so that positive outcomes can be sustained and interventions supported with necessary human and financial resources. Examples and expertise from regional offices and headquarters should be employed to focus on bolstering the strategies and approaches and to raise the profile of gender equality in UNFPA Bangladesh.

The Government of Bangladesh is the biggest donor to its own development. The need for more domestic resource mobilization is a major recommendation from the Addis Ababa “Financing for Development” conference in 2015. Most nationally-executed projects are accompanied by government contributions. In some cases, the government contribution was not forthcoming as agreed: education sites for midwifery training, which were supposed to be funded by the government, remained unfunded and therefore did not operate in 2014. In addition, human resources capacity was limited to undertake additional interventions. The nursing faculty, including lecturers and clinical instructors, were severely understaffed.³⁰¹ However, Government revenues were used to cover gaps in training for population and development partner Bangladesh Bureau of Statistics and for DGHS BSMMU cervical and breast cancer screening, among others.

National stakeholders contributed significantly to interventions, and generated additional human and material resources, as mentioned in EQs 2, 3 and 4. Examples include:

- Local-level planning for the MNHI increased efficiency by bringing together the resources of DGHS and DGFP and increasing accountability on the part of locally engaged staff. Because of the MNHI achievements, (a) the Government replicated local-level planning in other districts using the domestic resources and (b) local-level planning is now incorporated into the next fourth health sector plan. This is highlighted as a major success attributable to UNFPA in

²⁹⁹ Site visits and Key informant interviews, October 2015

³⁰⁰ Office Management Plans, 2012, and 2013: Key Result 1

³⁰¹ Standard Progress Report, Midwifery Programme, UNFPA RHR Unit, 2014

leveraging effects of UNFPA interventions to be mainstreamed into the Government's projects and budgets.

- The development of supporting mechanisms to implement Generation Breakthrough has inspired community resources through support from teachers, community leaders and groups.
- Services for gender based violence survivors through the police and DWA efforts amassed various forms of support from youth networks, students, community leaders and women's groups.

4.5.3 Appropriateness of administrative and financial procedures as well as of implementation modalities to the execution of the country programme

The country office has strengthened administrative procedures and financial accounting to track the disbursements and progress on interventions and indicators.

There is a rigorous scrutiny of administrative and financial procedures. In 2013, an audit of nationally executed (NEX) funds was completed and uploaded in NEXAMS. An internal UNFPA audit was conducted in 2015.³⁰² Changes transpired regarding the eighth country programme (CP) budget, including the reduction in the contribution from DFID in 2012 for the MNHI project, from an expected \$12.7 million to \$5.22 million. The UNFPA core funds differed from initial commitments, whereas \$40 million was expected, the total amount provided and committed was approximately \$35.8 million. These changes affected the initial plans. UNFPA, with implementing partners, revised their annual work plans to reflect lower budgetary figures accordingly.³⁰³ The country office monitored the fund disbursement and stopped additional fund transfers until all of the old operating fund accounts (OFA) were liquidated.³⁰⁴

The procedure for transfer of funds to the implementing partners (IPs) in light of the harmonized approach to cash transfer (HACT), involves use of

funding authorization and certificate of expenditure (FACE) forms. The implementing partners use these to describe activities for which advance payment of funds are requested for the coming quarter. They are also used to report on expenditure for the past quarter.³⁰⁵

In 2013 and 2014, the country office improved the **monitoring of the country programme** by developing a monitoring framework based on the results and resources framework (RRF) and included baseline and targets for all indicators including identification of activities and milestones for qualitative indicators. The country office organized training on results based management (RBM) and monitoring and evaluation (M&E) for all staff members, as most of the staff members were new.³⁰⁶ The country office is intensively involved with UNDAF monitoring systems and has synchronized the country programme monitoring system with that of the UNDAF. The country programme outputs have been divided into several sub-outputs with process indicators in order to monitor regular progress of activities. This has been included in the country programme monitoring framework. The country programme set up systematic site visits and follow-ups with trip reports uploaded into the web portal and the recommendations compiled.³⁰⁷

The implementing partners (IPs) have included all necessary indicators in the annual work plans (AWPs) for regular monitoring. The country office has also developed a web portal for monitoring, reporting and exchanging information, which facilitates monitoring of individual projects.³⁰⁸ The UNFPA country programme (2012- 2016) has 17 output indicators to monitor and, in 2014, 16 of them were due reporting. The country office was able to report against all these 16 indicators.³⁰⁹ The "2015 Annual Planning" report has effectively assigned the programme cycle outputs to responsible team members with indicators and annual targets, as well as quarterly milestones.³¹⁰ As pointed out, however, in previous sections of the report (e.g. EQs 2 and 4), regular monitoring may be weak at the district and sub-district levels.

³⁰² Key Informant Interview, October, 2015

³⁰³ "Resource Mobilization for 8th Country Programme (core and non-core)" chart provided by the CO, September, 2015. Revised Annual Work Plans for 2013 and 2014

³⁰⁴ Office Management Plan, 2013

³⁰⁵ "Analysis of Bangladesh Financial Data" email from the Deputy Representative, to the NY Evaluation Office, September 4, 2015

³⁰⁶ Office Management Plan, 2014

³⁰⁷ Office Management Plan, 2014

³⁰⁸ Country Office Annual Reports, 2012, 2013

³⁰⁹ UNFPA Bangladesh Annual Report, 2014

³¹⁰ UNFPA 2015 Annual Planning- Bangladesh, Finalized Official Planning, May 14, 2015

An analysis of the annual work plans (AWPs) for Bangladesh indicates overlaps and duplications, unclear referencing of outcomes and outputs, and different project titles with the same code.³¹¹ The use of the codes was a decision made by the country office in line with the UNFPA policy guidance, where the codes were not ascribed to be unique for each annual work plan but for specific thematic areas within each annual work plan. This is considered to be a world-wide practice and not unique to Bangladesh.³¹² Nevertheless, the system in use makes the evaluation process, which needs to systematically follow the development and implementation of the country programme, difficult.

A rigorous process is undertaken to **select implementing partners (IPs)**. The UNFPA implementing partner capacity assessment tool (IPCAT), designed by UNFPA headquarters, has nine dimensions:

- governance and leadership
- human resources
- programme
- monitoring and evaluation
- financial management
- procurement systems
- comparative advantage
- knowledge management
- 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 a number of checklists or questions. Senior officials from respective sections of CARE were contacted for an interview and also various documents as per requirement were reviewed.³¹³

On the other hand, family planning has numerous implementing partners, some of which are traditional partners, and are difficult to coordinate. The reduction of the implementing partners (there are 17 or 18 ministries that are partners) may allow them to be monitored more effectively.³¹⁴

The quality of input by partners to support the gender equality programmatic area has varied. A key issue is that the implementing partners come from different sectors and backgrounds, some of which do not have specific or strong expertise in gender equality, including gender based violence (GBV) and child marriage. Allowing a limited number of key partners to become lead agencies may promote stronger implementation and monitoring.³¹⁵

The 2015 quarterly consolidated progress reports track total expenditures and implementation rates and they rate progress as good, moderate or poor. The reports also mention the performance of implementing partners in delivering interventions and in using funds. The reports mention lapses in programme implementation, overall, if the implementing partners had poor ratings, they achieved a better rating the next time.³¹⁶

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

- 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
- Behaviour change communication, 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 and training activities
- Support for recruitment of project personnel in accordance with the annual work plans
- Support to procure goods, supplies and equipment, research and studies, consultancies and services for the programme needs, at the request of the implementing partners in accordance with UNFPA regulations, rules, policies and procedures

³¹¹ Analysis of the Bangladesh Atlas data by the UNFPA Evaluation Office, August 2015

³¹² "Analysis of Bangladesh Financial Data" email from the Deputy Representative, to the NY Evaluation Office, September 4, 2015

³¹³ ICT4RH Implementing Partner NGO, Final Recommendations from Selection Committee, March 2013

³¹⁴ Key informant interviews, October 2015

³¹⁵ Key informant interviews, October 2015

³¹⁶ Quarterly Consolidated Progress Report, 2015

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

Collaboration and cross-fertilization between the programmatic units contribute to increasing the efficiency of UNFPA work. For example, the adolescent and youth unit works together with the:

- (a) Gender unit on the Generation Breakthrough project and on child marriage by sharing resource material, providing technical input, developing joint proposals etc.
- (b) Population, planning and research unit on child marriage, and youth development subcommittees of the Parliament Project by providing technical input and supporting the development of resource material to interventions supported by the subcommittees. In addition, the adolescent and youth unit also works with the Dhaka University on the Child Marriage Study.

- (c) Reproductive health unit by supporting the development of the adolescent health strategy, providing technical input into developing the standard operating procedures on the adolescent friendly health service (AFHS) corners, establishing the AFHS corners and the process of developing the adolescent health strategy.

The *Country Office Annual Report 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*”. The efficiency of the individual communication and advocacy events (as described above in EQs 2, 3 and 4) do not appear to be evaluated separately or as part of a cohesive strategy.³¹⁷ It was widely noted from key informants the desire to design and employ more interactive teaching and communication tools, such as videos, theatre, songs and singing, and practical experiences, for training and public awareness raising. These should be put in place in the health clinics, adolescent corners and adolescent clubs, and the police stations.³¹⁸

³¹⁷ Bangladesh National Communications Strategy for Family Planning and Reproductive Health of 2008 is referenced in the UNFPA 2014 Annual Report, June 2015, page 23.

³¹⁸ Key informant interviews, October 2015

4.6 COORDINATION WITHIN THE UNITED NATIONS COUNTRY TEAM

EQ6

To what extent has the UNFPA Bangladesh country office contributed to the functioning and consolidation of UNCT coordination mechanisms?

SUMMARY

UNFPA effectively contributes to monitoring of the UNDAF and has led coordination of Pillar 7 Women's Advancement. UNFPA leads the adolescents and youth advisory group and plays an active role in the monitoring and evaluation advisory group and the local consultative groups.

UNFPA leadership and participation in UN task-sharing has strengthened since 2014. UNFPA has sought to achieve complementarity with UN partners in reproductive health and rights and is collaborating to address pressing issues in gender equality, with respect to the mandates and capacities of other agencies. UNFPA has contributed significantly to strengthening advocacy against child marriage with other UN and development actors.

4.6.1 Contribution of the UNFPA country office to UNCT working groups and joint initiatives

UNFPA effectively contributes to monitoring of the UNDAF and has led coordination of Pillar 7: Gender Equality and Women's Advancement.

The Bangladesh UN country team (UNCT) consists of representatives from 23 UN agencies, funds and programmes and, through monthly meetings, aims

to optimize UN synergies at country-level. The UNCT is supported by the UN Resident Coordinator's Office, UNDAF Pillars, and other inter-agency thematic groups.³¹⁹ UNFPA has effectively led Pillar 7 Gender Equality and Women's Advancement for one year. UNFPA has also actively participated in the monitoring and evaluation (M&E) advisory group and in other core structures such as the UN communication & advocacy group.

The UN's cooperation with the broader development community on thematic issues (e.g. child marriage) and national planning processes (e.g. the *Seventh Five-Year Plan* under formulation) is executed through the **local consultative group (LCG)**, the plenary composed of government and heads of 60 agencies.³²⁰ The UN co-leads seven (out of 18) LCG working groups which are critical forums for executing policy decisions.³²¹ UNFPA formerly co-lead the women's advancement and gender group with the Ministry of Women and Children Affairs (MoWCA), however, UN Women, which became a resident agency in 2014, has now assumed the co-leadership position.³²² UNFPA helped to lead the Beijing +20 national review process in 2014.³²³ UNFPA is also an active member of LCG health, nutrition and population (HNP) sector group, where UNFPA advocated for increased investments in the health sector, including for adolescents and youth, especially in the context of the *Seventh Five-Year Plan*. UNFPA participated in the disaster and emergency response (DER) group, described in more detail in Section 9.1. Through the HNP, UNFPA supports the health sector wide approach (SWAP) by contributing to the "pool fund".

For common positioning, joint messaging and advocacy, the UN system uses the task team/theme group. UNFPA was instrumental in promoting and leading a UN interagency theme group for adolescents and youth (UNITGAY) and this group has effectively diversified to become a larger group including government and other stakeholders. UNFPA is the secretariat for UNITGAY which is also chaired by a UNFPA representative and is supported by the UNFPA adolescent and youth unit. The group has promoted important survey work on child marriage. UNFPA also provides input to the social

³¹⁹ Resident Coordinator Induction, Bangladesh Profile, 2014, <http://www.un-bd.org/>

³²⁰ Chaired by the Aid Effectiveness Unit (AEU) in Economic Relations Division (ERD), Ministry of Finance

³²¹ Resident Coordinator Induction, Bangladesh Profile, 2014, <http://www.un-bd.org/>

³²² <http://www.lcgbangladesh.org/>

³²³ Office Management Plan, Mid-term review 2014

protection theme group, the post-2015 task team, and the indigenous people task team, among others. UNFPA participates in the harmonized approach to cash transfers, HACT. UNFPA is in the “theme group of AIDS” in the UN system. UNAIDS is the convener of the group. As a member of this group, UNFPA works for the AIDS portfolio and is assigned to work with sex workers and supports the Government and civil society organizations with technical expertise.

UNFPA has contributed substantially in developing and monitoring the UNDAF and helps in tracking UNDAF indicators through various surveys and studies. 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
- Percentage of women aged 15 to 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
- Percentage of women/girls aged 15 to 49 in the selected areas who have experienced any forms of violence in the past 12 months

4.6.2 Contribution of the UNFPA country office to an adequate division of tasks among the UNCT

UNFPA leadership and participation in UN task-sharing has strengthened since 2014.

Overall, UNFPA participation in coordination and task-sharing was affected by human resources shortages in the early part of the eighth country programme (2012 and 2013). Since then, UNFPA has been strengthening its human resources base, by

recruiting specialized talent and supporting training for its staff. As a result, UNFPA is much more visible since 2014 in coordination groups and coordinated initiatives, and its leadership role in the UN is being more strongly defined.³²⁴ UNFPA leadership was strongly demonstrated when, as co-chair of the local consultative group (LCG) on disaster and emergency response (DER), the representative helped manage a strong response to floods in Chittagong and Cox’s Bazar in 2015.³²⁵

UNFPA contributes funding to the resident coordinator (RC) function, which receives high marks from the UN member agencies.³²⁶ UNFPA leadership is seen to be supportive of the UN “Delivering as One” as demonstrated when the UNFPA representative acted as resident coordinator in February 2015 before the current resident coordinator took up the position. UNFPA has stepped in to co-chair the humanitarian country task team (HCTT) which has a wide membership including NGOs and government.

In terms of **joint programmes**, the Maternal Neonatal Health Initiative (MNHI) is implemented by the Ministry of Health and Family Welfare, UNFPA, UNICEF and WHO. The three UN agencies are implementing a project together for the first time in Bangladesh and they have in the process enabled and improved working relationships between DGHS and DGFP in districts, unions, upazilas and community clinics.³²⁷ The benefits of the UN agencies working together were demonstrated when they were able to bring issues to a policy level, but they were less effective where coordination challenges occurred. It was noted that the individual mandates, administrative systems and the need to refer decisions for relatively minor budget changes back to headquarters, affected planned implementation and caused delays to joint implementation.³²⁸

UNFPA participates in a number of **joint initiatives** with other UN agencies. For example, UNFPA response to child marriage at the policy and advocacy level is conducted in coordination and

³²⁴ Key Informant Interviews, October 2015

³²⁵ Key Informant interview, October 2015

³²⁶ Evaluation Of The 2012-2016 UNDAF For Bangladesh, Draft Report, Prepared by Joel Beasca and Salma Akhter, UNDAF Evaluation Team, September 2015

³²⁷ 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) Agriteam Canada Consulting Ltd

³²⁸ 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

collaboration with UNICEF and other development partners. 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 in London 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 five year, costed national programme of action (NPA) to end child marriage, in response to the Prime Minister's pledge.³²⁹ The costing for this intervention will be developed with exclusive support from UNFPA.

Common advocacy messages have been developed for use by all development partners regarding the *Child Marriage Restraint Act* in response to efforts to include special caveats for allowing marriages of 16 and 17 year old girls. UNFPA, along with UNICEF, are working together with development partners and NGOs to employ the most feasible strategies to advocate for not including such an exception in the draft bill. Currently, there is no mapping of the interventions on child marriage. However, when the national programme of action is finalized, UN and other development partners plan to work together to ensure coherence.

Joint programmes and initiatives have produced measures of success, but the efforts could appear less effective if there is insufficient evidence to substantiate results. The **Joint Programme on Reduction of Violence against Women** (MDG Spain Fund), concluded in 2013, lacked sufficient data to determine UN contribution towards the results, requiring further evaluation.³³⁰ After success in the first phase at demonstrating improvements, strengthened data collection for the **MNHI** indicates midterm progress, but lacks definitive data regarding the current phase in which the project was scaled up from 4 districts to 11, with less funding.³³¹

The UNFPA role in coordination is affected by factors which weaken overall UN coordination in Bangladesh.

These include a strong climate of competition among the donor and the UN community, in regard to development directions. One reason may be the predicted diminishing of overseas development assistance for Bangladesh due to its emerging higher economic status. To outsiders, the UN does not always appear coordinated among its members. Since the UN is not playing as large a role as in the past, the need for the UN to speak with one voice takes on greater importance. UNFPA is tasked with advocating for the vulnerable groups in reproductive health and its voice is not always strong enough in the local consultative groups.³³²

Within the UN in Bangladesh, role clarification and agreement on who will do what require improvement. While agencies need to respect each other's capacities, UNFPA faces delicate issues around mandate interpretation and leadership capacity. The agencies are working to address these issues and to put forth a more united front. For example, UNFPA has relinquished the chairmanship of the local consultative group, women's advancement, and the gender equality working group to UN Women and the two agencies generally work in partnership. Both agencies clearly have strong global and country level experience in gender equality interventions.³³³

Overall, there are insufficient joint actions to address urgent issues, such as response to evidence that 87 per cent of women in Bangladesh are subjected to gender based violence.³³⁴ UNFPA has taken a definitive lead in gender equality in a number of other countries (e.g. Turkey, Armenia). In Bangladesh, however, there are nine major entities working on gender equality and there is undeniably competition. However, there are also opportunities to be explored as illustrated in discussions regarding Pillar 7. The UN organizations working on gender equality issues have renewed pledges to work together on policy priorities identified in 2014, mapping their inputs, and leveraging the comparative advantage of all agencies combined.³³⁵

³²⁹ UNFPA Bangladesh Annual Report, 2014

³³⁰ Meeting Minutes, UNDAF Pillar 7 Workplan, 22 April, 2015

³³¹ 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), Agriteam Canada Consulting Ltd

³³² Key informant interviews, October 2015

³³³ Key Informant Interviews, October 2015

³³⁴ Bangladesh Bureau of Statistics (BBS), 2011. Violence against Women (VAW) Survey Report

³³⁵ Meeting Minutes, UNDAF Pillar 7 Workplan, 22 April, 2015

4.7 ADDED VALUE OF THE UNFPA COUNTRY PROGRAMME

EQ7

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

SUMMARY

UNFPA corporate strengths are well identified and incorporated in programme design. UNFPA added value to the Government's development goals is strongly identified as are its contributions in programmatic areas. UNFPA expanded potential to reach vulnerable groups through public/private partnerships and with local stakeholders.

The UNFPA interventions are perceived as being spread too thinly. However, capacity issues have not been systematically analyzed. UNFPA marketing of its strengths is affected by competition from UN agencies in some areas. There is inadequate focus on the main areas of strength and strategic niches which may produce stronger results.

4.7.1 Identification and use by UNFPA of its comparative strengths in designing and implementing its country programme

UNFPA corporate strengths are well identified and incorporated in programme design.

One of the comparative strengths of UNFPA, at corporate level, is its ability to convene national and international stakeholders to address sensitive issues relating to family planning, reproductive health and rights, and gender equality: all areas where UNFPA

expertise is acknowledged. This expertise justifies UNFPA ability to take a leadership role in addressing issues related to its mandate.³³⁶ The UNFPA global focus on adolescents has added value for the development community. For example, the study *"The Power of 18 Billion – Adolescents, Youth and the Transformation of the Future"*, emphasizes the vulnerability of youth in sexual and reproductive health and the high risk of early marriage and child bearing.³³⁷

UNFPA support to national institutions for conducting the census is an internationally recognized strength. UNFPA has been developing its expertise in delivering the minimum initial service package (MISP) for reproductive health since 2008 and creating capacity globally, regionally and nationally.³³⁸ For family planning, UNFPA is a key player in delivery of results: it is the biggest global procurer of family planning commodities. UNFPA has a partnership role with a large proportion of international players and will therefore be contributing significantly to global family planning results.³³⁹

Globally, UNFPA has identified Bangladesh as a priority country enabling all four modes of engagement (policy advice, capacity development, knowledge management, and service delivery). A number of outcomes and results have been achieved with UNFPA support as described in EQs 2, 3 and 4 in the areas of operation and with regard to reaching the most vulnerable people.

In Bangladesh, UNFPA is highly regarded by the Government of Bangladesh's (GoB) partners and other stakeholders for its ability to bring together senior policy officials to discuss sensitive issues about which UNFPA has clear expertise. A comparative strength of UNFPA is that it works with the Government of Bangladesh based on both the country priorities as well as the ICPD agenda. In this respect, UNFPA has carved out a strong corporate recognition with the Government of Bangladesh. Government counterparts regard UNFPA as accessible. It also fully credits the government lead role in, for example, reproductive health and rights, where this may not be the case with other

³³⁶ Review of UNFPA Business Model, Deliverables 3 and 4, Comparative Advantages, Brad Herbert Associates, January 2014.

³³⁷ *"The Power of 18 Billion – Adolescents, Youth and the Transformation of the Future"*, UNFPA 2014.

³³⁸ <http://www.unfpa.org/public/global/pid/1058>.

³³⁹ 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

partners.³⁴⁰ Stakeholders regard UNFPA work with national systems to be the most sustainable route to development and important for mainstreaming gender equality.

Stakeholders mention strengths of UNFPA, particularly as its strong influence and energy in family planning, leadership in adolescent and youth reproductive health, and effective support to strengthen the midwifery programme. Ready-made garment factories may be conduits for information and advocacy regarding child marriage and gender based violence, thus UNFPA work with the private sector is critical. UNFPA collaboration for local-level planning in regard to reproductive health, gender equality, and disaster management is seen to be a means to reach the most vulnerable people.

4.7.2 Acknowledgement of these comparative strengths by other development partners, particularly other UN agencies

The UNFPA interventions are perceived as being spread too thinly to achieve strong results however capacity issues have not been systematically analyzed.

The seventh 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 equality agenda. The capacity issues in the country office are cited as reasons to limit the scope of the country programme interventions.³⁴¹ Capacity issues, however, are not elaborated upon.

The eighth country programme situation analysis also prioritizes intervention areas.³⁴² However, neither the eighth country programme assessment nor the eighth country programme document discuss in depth the potential UNFPA 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, the UNICEF mandate overlaps with that of UNFPA in areas, including maternal and adolescent health. There is evidence that the agencies address these overlaps and capacity issues through negotiated discussions rather than in a systematic manner.³⁴³

Without firm capacity 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 seventh country programme evaluation.³⁴⁴ 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, with for example, UNICEF and UN Women, and where collaboration and coordination as well as negotiation is needed to determine who will do what to avoid overlap and duplication of resources.³⁴⁵

The capacity of UNFPA to take the UN 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. A number of stakeholders maintain that UNFPA should look for strategic niches and seek evidence-based approaches toward stronger results. By covering too many intervention types, UNFPA may run the risk of diluting the Government's ownership and preventing it from scaling up the intervention. In this regard, family planning and midwifery stand out as the area of interventions 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.³⁴⁶ Another area where UNFPA can add more value is population and development, especially "data for development", the need for which is underscored in the Sustainable Development Goals.

³⁴⁰ Key Informant interviews, October 2015

³⁴¹ Evaluation Of The 7th Country Programme UNFPA Bangladesh, Final Report, "Lessons Learned", pages 67-70

³⁴² UNFPA 8th Country Programme Situation Analysis, 2011, Page 26

³⁴³ Key Informant interviews, October 2015

³⁴⁴ Key Informant interviews, October 2015

³⁴⁵ Key Informant interviews, October 2015

³⁴⁶ Key Informant interviews, October 2015

4.8 PREPAREDNESS FOR DISASTERS AND EMERGENCIES

EQ8

To what extent did the UNFPA eighth country programme in Bangladesh take into account the country's vulnerability to disasters and emergencies, both at the planning and the implementation stages?

SUMMARY

The UNFPA 2011 *Emergency Preparedness and Contingency Plan* and its update in 2014 reflect the UNFPA global strategy and consider major hazards and potential emergency situations. Integration of reproductive health and rights and gender based violence in national, UNDAF and UN Interagency Standing Committee plans, and implementation of UNFPA standard operating procedures were not fully addressed in programme design. Systematic disaster and emergency preparedness in the country office has improved and UNFPA has received funds to support needs-assessment for undocumented refugees in 2015 from the UN Central Emergency Response Fund.

Gaps in the national and the Interagency Standing Committee contingency plans and joint assessments with regard to sexual and reproductive health and gender based violence are covered in the newest update of the plans for 2016. The *Minimum Initial Services Package* training has incorporated gender based violence but it does not fully cover gender equality issues in emergencies. Addressing gender based violence in emergency situations has been incorporated into the training module for the Department of Women's Affairs and the police.

4.8.1 Consideration for the disaster proneness of Bangladesh in UNFPA programming documents

The UNFPA 2011 Emergency Preparedness and Contingency Plan and its update in 2014 reflect the UNFPA global strategy and consider major hazards and potential emergency situations.

This section discusses the relevance of the UNFPA country programme preparedness for disasters and emergencies to the context of Bangladesh's high disaster risk profile as the fifth highest disaster risk country in the world and second in Asia.³⁴⁷ Relevance is discussed in light of the UNFPA global objectives, the UN-supported Inter-Agency Standing Committee (IASC) plans, the UNDAF objectives, the national plans and instruments for disaster management, and the lessons from the seventh country programme evaluation.

The UNFPA *Global Strategic Plan (SP) 2008 to 2014* covers SP Output 5: Increased national capacity to provide sexual and reproductive health services in humanitarian settings. The strategic plan 2014 to 2017 promotes humanitarian concerns to be cross-cutting. UNFPA issued a *Humanitarian Response Strategy "Second Generation"* globally in 2012 and emphasized alignment with the Inter-Agency Standing Committee (IASC) work on a common humanitarian response monitoring framework, currently being field tested.³⁴⁸

The 2011 UNFPA *Bangladesh Emergency and Contingency Plan* is well structured according to UNFPA standards, containing the essential elements including attention to the 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.³⁴⁹ The plan covers lessons from previous responses and builds upon the IASC *Emergency Response Preparedness Plan, 2014*, using 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

³⁴⁷ World Risk Index, in the 2013 World Risk Report. In the Fragile State Index 2015 (The Fund for Peace) with a Fragile State Index of 91.8, Bangladesh ranked 32 out of 178 countries.

³⁴⁸ <https://interagencystandingcommittee.org/iasc-transformative-agenda>

³⁴⁹ UNFPA Emergency Preparedness and Contingency Plan, 2014, page 14

pre-positioning of UNFPA-supported reproductive health supplies and dignity kits.³⁵⁰

In 2012, a *National Disaster Management Act* was passed. The *National Disaster Management Policy* describes the broad national objectives and strategies while the 2010 to 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 2015. 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 reproductive health and gender equality. Plans included the distribution of emergency reproductive health kits and stockpiling of dignity kits.

The UNFPA Bangladesh seventh 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.”*³⁵¹ The MISP training was not specifically assessed in the seventh country programme. The eighth country programme situation analysis (2010) recommends continuation of MISP implementation, mainstreaming reproductive health and gender equality into disaster management and emergency response, and the pre-positioning of reproductive health commodities.³⁵²

A strong programme logic in emergency and disaster response was lacking in the design of the eighth

country programme, given the need to support the inclusion of reproductive health and gender based violence 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 the **reproductive health - humanitarian** annual work plans through the district general hospitals. Mainstreaming interventions for emergency preparedness and response was not strong in the programme plans or the implementation. The soft interventions, such as building strategic partnerships, are not clearly mentioned in the annual work plans. (Please see summary chart of SOPs and planned interventions in the evaluation matrix in Annexe 5.)

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 country office in the early years of the eighth country programme. The need for a dedicated staff member (junior professional officer, JPO) for humanitarian response and disaster management was identified in 2013, a staff member stepped in temporarily in the interim, and a dedicated staff member was finally hired in late 2015.³⁵³ 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. Programmatic prioritization has now been resumed, including resources mobilization for disasters and emergencies.³⁵⁴

Resources mobilization for disasters and emergencies: Bangladesh falls under the eligibility criteria for fast track procedures in receiving Central Emergency Response Funds (CERF) because it is considered to be particularly vulnerable to disasters. Other funds that may be available include the UNFPA Emergency Fund up to US \$50,000, APRO

³⁵⁰ UNDAF Pillar 5, Outcome Results reports, 2013, and 2014

³⁵¹ UNFPA Bangladesh 7th Country Programme Evaluation, February 2011

³⁵² UNFPA 8th Country Programme Situation Analysis, 2010

³⁵³ Country Office Annual Reports, 2013 and 2014, and Key Informant interviews, October 2015

³⁵⁴ Key informant interviews, October 2015

Regional Fund for Emergencies, Bilateral Resource Mobilization, and the UN Flash Appeal. UNFPA drew from reproductive health “humanitarian” MISP funds to support response to the 2014 floods (purchase and delivery of safe delivery kits). UNFPA has received CERF funds in October 2015 (\$225,000 for nine months) for interventions addressing the needs of undocumented refugees.

4.8.2 Attention paid to reproductive health and rights and gender equality needs of affected populations in situation of disasters and emergencies

Gaps in the national and the IASC contingency plans and joint assessments, with regard to sexual and reproductive health and gender based violence, are covered in the newest update of the plans.

Background documents served as preparation for interventions to mainstream reproductive health (RH) and gender equality (GE) needs in emergencies in the eighth country programme. The Ministry of Women and Children Affairs (MoWCA) produced a concept paper “*Mainstreaming Emergency Preparedness*”. Under the DGHS work plan, UNFPA supported a *Literature Review on Gender and Natural Disasters in Bangladesh*, published in 2012.³⁵⁵ The purpose of the review was to inform the implementation process of the *National Disaster Management Plan (2010-2015)* and the *Standing Orders for Disasters*. It was also meant to support the coordination between the Government of Bangladesh (GoB) and the UN, donors and NGOs, as well as the integration of women’s and girls’ concerns in the work of the Disaster Emergency Response (DER) sub-working group.³⁵⁶

Strong evidence in global studies which cite Bangladesh examples, indicates that women and girls are particularly vulnerable in disasters and emergencies to morbidity and mortality and to violence and abuse of their rights.³⁵⁷ For example, 90 per cent of deaths as a result of Bangladesh’s

1991 cyclone Marion were women.³⁵⁸ Due to removal of their normal mechanisms of security during disasters and emergencies, women may be placed at greater risk of violence, rape, abuse and trafficking. For example, after the 1998 flood disaster, there was an increase in the number of girls moving to Dhaka to become sex workers.³⁵⁹ Women may be expected to face increasing disasters such as large-scale and intensified floods, cyclones and droughts brought about by climate change.³⁶⁰

The concerns for reproductive health and gender sensitivity in the UNDAF, Pillar 5, (climate change, environment, disaster risk reduction and response) are reflected in the outcomes results reports (2013 and 2014), and interventions planned under the outcomes consider equality and also incorporate gender justice. However, focus on gender equality and protection of women’s rights in emergencies is not particularly evident. UNFPA has not fully mainstreamed gender equality and prevention of gender based violence into the country programme interventions. For example, the MISP training curriculum (in four districts in 2014-15) does not present a comprehensive picture of the relationship between gender equality needs and disaster, although gender based violence and response to rape are covered.

The focus of UNFPA support with the MoWCA and the (district) Departments of Women’s Affairs (DWA) was capacity building to coordinate prevention and protective services regarding gender based violence during and in the aftermath of emergencies and disasters. While gender based violence issues during emergencies have been taken up by partners at local level (e.g. the MoWCA, and the Ministry of Home Affairs - MoHA), they were not given orientation by UNFPA. Preparedness and response support at the community level for women is still not strong enough. For example, in the Kanil village of Jamalpur, women who face frequent flooding and river erosion must take their own initiatives.³⁶¹

³⁵⁵ 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.

³⁵⁶ Ibid, preface.

³⁵⁷ Unseen, unheard, Gender Based Violence in disasters, IFRC, 2015; Women, vulnerability and Humanitarian emergencies, Fionnuala Ni Aolain, 2011; Women, girls and disasters, a review for DFID, Sarah Bradshaw and Maureen Fordham, August 2013

³⁵⁸ The Anatomy of a Silent Crisis, Global Humanitarian Forum, Geneva, 2009

³⁵⁹ Our climate, our children, our responsibility, UNICEF, 2008

³⁶⁰ Gender, Climate Change and Disaster Risk Reduction and Recovery Strategy- Asia Pacific, 2015 – 2018, UN WOMEN

³⁶¹ Key informant interviews, October 2015

However, sensitization activities on MISP have been conducted for members of 280 government and NGO implementing partners through five MISP trainings (e.g. DWA officials, Disaster Management Committee (DMC), DGHS and DGFP officers and NGO personnel). Participants have agreed to incorporate gender based violence issues in district disaster management plans and address gender based violence issues in other plans they make.³⁶²

In terms of **district level preparedness**, in Barguna and Patuakhali Districts, UNFPA has effectively advocated for government and other district actors to address reproductive health and gender equality, including protection against gender based violence in their plans; the local government's district plans for 2016 will cover these topics as the previous versions did not. Contingency plans currently allocate space in the shelters, some of which are schools, for pregnant and lactating women and adolescent girls. There have been rehearsals and periodic meetings to review preparedness measures on the part of vulnerable people and responders, including hospitals and volunteers. An emergency control room has been opened in the disaster relief and response office (DRRO) which is the focal point for both districts. Requests for essential medicines and water purifying tablets to be pre-positioned are sent to the district general hospitals.³⁶³

According to some stakeholders, the response of the communities to the planned contingencies should be analysed, to ensure that dignity will be respected. In past emergencies, some cyclone shelters have become very crowded and unsanitary and people seek other options, such as shelter with relatives, where they may not be able to access medical services or other relief measures. There are challenges regarding protection of the poorest in an emergency. Most agencies have a set package of responses ready to deploy, but the packages may not be tailored in terms of specific needs. Contradictions can therefore occur, where there is an abundance of hygiene kits but inadequate water or toilets.³⁶⁴

Although UNFPA is a development agency, the correlations between disasters and development have been well vetted for many years. The typical response interventions offered by UNFPA including the MISP may need to be reviewed in terms of their added value in actual response. Furthermore, the Director General of the Department of Disaster Management (DDM), who assumed his role eight months ago, has not been fully informed regarding UNFPA response strategy and resources. Keeping this line of communication open and informing new staff regarding UNFPA capacity may help UNFPA better support the Government's response and recovery interventions.³⁶⁵

³⁶² Annual Progress Report on 8th Country Programme, UNFPA Gender Equality Unit, Output No. 5, January, 2015

³⁶³ Key informant interviews, October 2015 and Joint preparedness meeting notes, Patuakhali, May 2015

³⁶⁴ Key Informant Interviews, October 2015

³⁶⁵ Key informant interview, October 2015

4.9 CAPACITY OF RESPONSE TO CRISES

EQ9

To what extent was (or is) UNFPA, along with its partners, able (or likely) to respond to crises during the period of the eighth country programme (2012-2016)?

SUMMARY

The effectiveness of the Minimum Initial Service Package for UNFPA emergency response is difficult to ascertain with the evaluative tools presently used. Coordination in Dhaka and at district level for disaster management planning has been generally strong. High-level advocacy and follow up on contributions to response has been limited. UNFPA participates in the disaster and emergency response group, the humanitarian coordination task team, and the sexual and reproductive health programme in crisis and post-crisis situations (SPRINT). UNFPA assistance to refugees has contributed to capacity of health care providers for gender sensitive services. However, coordination has periodically lacked efficiency regarding joint decisions on services for refugees.

UNFPA support has increased the capacity of the Bangladesh Bureau of Statistics to provide demographic data to the Department of Disaster Management for planning preparedness and response.

4.9.1 Contribution to strengthening the capacity of health-care providers in emergencies and early recovery settings to provide gender sensitive reproductive health and rights and gender equality services

The effectiveness of the Minimum Initial Service Package training is difficult to ascertain and it only covers eight districts thus far.

UNFPA aimed to **increase stakeholders' knowledge in implementing the Minimum Initial Service Package (MISP)**. Various stakeholders and levels of governance 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, mainly from MNHI, targeted districts which benefited from regional ToT training in Bangkok for SPRINT (sexual and reproductive health programme in crisis and post-crisis situations) 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, Bagerhat. Eight batches of MISP training were organized in 2014 to 2015 covering eight districts. The coverage of the training is expected to be increased in the targeted priority districts in 2016.

At district level, through the DGHS in Patuakhali and Barguna districts, training was held for 27 participants in 2014, and in Sunamganj and Sirajganj districts for 45 participants organized in 2015. The MISP training in Bagerhat district is organized from 21 to 23 December 2015. Under the gender equality programmatic area, more than 200 district-level service providers, managers and police officers were trained and oriented on MISP in four districts: Cox's Bazar, Sylhet, Jamalpur and Patuakhali (Ministries of Home Affairs and Women and Children's Affairs interventions).³⁶⁶

Evaluation of the training was conducted through pre- and post-tests. Improvements in knowledge of the MISP and in regard to providing services to support reproductive health and prevent gender based violence were obvious in all workshops. However, it was noted that tests were administered in English, and some participants had difficulty understanding the questions.³⁶⁷ There is no evidence that the training was followed up at a later date to

³⁶⁶ Data provided by the Country Office, December 2015

³⁶⁷ UNFPA MISP Workshop reports, 2014, 2015

ascertain usefulness, or to what degree the ToT has resulted in replication of the workshop.

The MISP/SPRINT training curriculum was prepared with Bangladesh specifically in mind. In 2016 a formal training curriculum and workshop agenda will be submitted to the DGHS for approval. A printed Bangla version of the MISP online training manual (1500 copies) was 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. The coverage of the training falls far short of the UNDAF (2012-2016) 20 targeted priority districts and 30 cities and towns.³⁶⁸ In 2014, 49 UNFPA staff completed MISP online training and obtained a certificate. The coverage of UNFPA staff with training on gender equality and emergencies is unclear.³⁶⁹

Coordination for disasters and emergencies including emergency preparedness, response coordination, and risk reduction is executed through the Local Consultative Group (LCG) “**Disaster and Emergency Response Group (DER)**”, and the cluster mechanism. UNFPA participates in the DER and will assume co-lead in the health cluster with WHO. It also participates in the **humanitarian coordination task team (HCTT)**, a platform under the LCG DER for strengthening the collective capacity of humanitarian actors in Bangladesh. UNFPA leadership role in the health cluster is seen as an

opportunity for stronger participation by UNFPA in emergency/disaster assessment and response.³⁷⁰ UNFPA also participates in the **SPRINT** country coordination team hosted by the Department of Disaster Management, which aims to coordinate reproductive health in emergencies. This venue provides an opportunity for UNFPA to coordinate the MISP training.³⁷¹

Coordination at the district level for preparedness and response is strong in Patuakhali and Cox’s Bazar, both exceptionally prone to cyclones and storms. In both districts, membership consists of the Department of Disaster Management and other relevant government bodies, the Bangladesh Red Crescent Society, UNFPA and other UN agencies such as WFP and UNICEF, in addition to NGOs operating in the district. In Cox’s Bazar, monthly meetings take place for disaster management, and include refugee camp coordination staff, the Ministry of Health and Family Welfare, UNFPA, UNHCR, WFP, IOM, in addition to a separate forum for coordination of a health cluster.³⁷²

The UNFPA response to the 2014 floods in northern Bangladesh was hampered by lack of attention to reproductive health and protection of women’s rights in the IASC Joint Assessment.³⁷³ UNFPA notified the IASC assessment team and measures to address reproductive health and prevention of gender based violence were added to the proposed response. Later in 2014, the *Joint Emergency Response Plan* (ERP) covering earthquakes, cyclones, floods and water logging events, had not fully considered the protection mechanisms needed for women, girls and pregnant women under the health, WASH (water, sanitation and hygiene), shelter and nutrition headings. UNFPA submitted comments, including some preventive actions, as well as responses which were fully incorporated into the final plan from November 2014.^{374,375}

³⁶⁸ 8th Country Programme, Ministry of Women’s and Children’s Affairs- Concept and Design of UNFPA Support, 2012

³⁶⁹ Key Informant interviews, October 2015

³⁷⁰ Key Informant interviews, October 2015

³⁷¹ Key informant interviews, October 2015

³⁷² Site visits and Key informant interviews, October 2015

³⁷³ See details in the evaluation matrix in Annex 5

³⁷⁴ Key informant interview, October 2015

³⁷⁵ See details in the evaluation matrix in Annex 5

Table 16 Reproductive Health Output 3 Indicators, Humanitarian Assistance, Emergency Preparedness and Response³⁷⁶

Indicators	Baseline (2012)	2014 Achievement	Progress until Mid-2015	Remarks
3.1 Reproductive health and gender equality issues are incorporated into the national emergency preparedness and response plan	No target set	Yes	No	Will be incorporated during next revision
3.2 Estimated coverage of reproductive health kits/hygiene kit distributed during emergencies	No target set	3,400 Safe delivery kits distributed to 6 flood affected district and Pre-positioned 1,000 kits in 3 districts.	7,800 Clean delivery kits ordered. Expect to arrive End Aug/ Early Sept.	

Due to delays in programme approval from the Government, the annual targets for distribution of reproductive health-safe delivery kits were not achieved in 2012 and targets for 2013 and 2014 were revised.³⁷⁷ (Please see chart with detailed interventions in the evaluation matrix in Annexe 5.) UNFPA is committed to provide the reproductive health kits in times of emergencies wherever they are needed.

Humanitarian interventions on behalf of Rohingya refugees have been undertaken by UNFPA since 2008, to address a protracted emergency of documented refugees which has no durable solution to their refugee status in Bangladesh (e.g. repatriation, integration or third country resettlement). The interventions “*RH Information and Services through RTMI/Ensuring RH service delivery in Nayapura and Kutupalong refugee areas*” were undertaken to contribute to Output 1.1 and Output 1.2. The two camps (Nayapara, Teknaf and Kutupalong, Ukhia) are composed of approximately 32,000 Rohingya refugees.

The focus is on “ensuring services in Nayapara and Kutupalong refugee areas”, in collaboration with Research Training and Management International (RTMI), through:

- providing safe delivery in inpatient departments/ birthing units, ensuring antenatal and postnatal care and referrals for EmONC services
- Addressing family planning (FP) needs, prevention and treatment of gender based violence and promoting awareness for adolescents for sexual and reproductive health (SRH)
- Capacity building of service providers on reproductive health, family planning, safe delivery and newborn care and adolescent sexual and reproductive health
- Advocacy for reproductive health through education and awareness-raising.

Interventions implemented by UNFPA implementing partner, Research Training and Management International (RTMI), included training for nurse-midwives and medical assistants on safe delivery, providing orientation to community leaders, running two birthing units and ensuring comprehensive family planning services for the camp population. Interventions included reduction of gender-related barriers and gender based violence and targeting youth and adolescents as well as clinical management of rape survivors. Support was provided to community health assistants (CHAs)

³⁷⁶ Data provided by UNFPA Reproductive Health Unit, October 2015

³⁷⁷ 2012, 2013 (revised), 2014 (revised), 2015 Annual Work Plans for DGHS

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.³⁷⁸ (See intervention details in the evaluation matrix in Annexe 5.)

Interventions on behalf of refugees have contributed to **improved quality of reproductive health services** for women and adolescents and have resulted in greater prevention and response to gender based violence. Interventions on behalf of refugees have contributed to improvements in indicators for the camp populations. In 2014, approximately 95 per cent of deliveries out of a target of 100 per cent are conducted by skilled providers compared to only 10 per cent in 2008. Some women prefer to use traditional birth attendants, but this is slowly changing with advocacy and information. The contraceptive prevalence rate is 66.40 per cent, which is higher than the national average.³⁷⁹ Monthly food rationing for a new born child and adult is the same quantity and is seen to

encourage the community to have larger families which results in high birth rates. A high degree of success has been achieved in attracting adolescents and youth to the sexual and reproductive health corners through training of medical officers and counsellors and providing effectively targeted information.³⁸⁰ Attendance at the corners in 2014 totalled 1,614 girls and 2,123 boys.³⁸¹

As a good practice, the RTMI has documented lessons learned in implementing refugee assistance.³⁸² Challenges have included high turnover of staff, especially the trained nurses and paramedics from birthing units and family planning services units. This is as a result of recruitment by the international agencies working around the camps with higher salaries. There are also shortages of accommodation for full-time technical staff (doctors, nurses and midwives) within the camps and lack of a government qualified nurse-midwife. The same technical staff (doctors, nurses, paramedics, medical assistants) and general staff are required for each camp to provide services, which increases transaction costs.

Table 17 *Rohingya Refugee Response Indicators*³⁸³

Indicators	Targets (No Baseline noted)	2014 Achievement	Means of Verification
Delivery and newborn care conducted by skilled providers	100%	94.88%	<ul style="list-style-type: none"> • Record register • Monthly report • Admission form
Referrals for complicated cases	100%	100%	
Reported rape cases receiving PEP	100%	100%	
Wider acceptance and use of contraceptive methods and practices by the targeted beneficiaries leading to increased Contraceptive Acceptance Rate (CAR)	100%	66.4%	

³⁷⁸ There are two Standard Progress Reports available for RTMI, 2013 and 2014, the interventions are not set out by quantity in the Annual Work Plans, 2012, 2013, 2014, and 2015, and the progress is not matched to targets in the SPR, thus the precise intervention progress against target is not possible with these documents

³⁷⁹ Standard Progress Report, 2014

³⁸⁰ Key informant interviews, October 2015

³⁸¹ RTMI Standard Progress Report, 2014

³⁸² RTMI Lessons and Challenges in Ensuring RH Service Delivery in Rohingya Camps, 2015

³⁸³ Data provided by UNFPA Reproductive Health Unit, October 2015

A major humanitarian issue concerns mixed marriages, where a registered refugee has married a local person or an undocumented refugee. In this situation the spouse will not receive services unless in an emergency. Greater UNFPA advocacy for coverage of these spouses and their children is seen to be needed.³⁸⁴ In addition to these undocumented refugees, there are an estimated 200,000 undocumented Rohingya living in Bangladesh. Approximately 200,000 in the Cox's Bazar and Chittagong areas are assisted by IOM, ICRC and the Bangladesh Red Crescent Society. UNFPA is currently not working with **undocumented refugees**. However, using the CERF funds mentioned above, a rapid needs-assessment will be undertaken. Based on this needs-assessment, interventions will be planned for 2016.³⁸⁵

Support for the protracted refugee situation in the Rohingya refugee camps in Cox's Bazar is managed through **partnerships** jointly by the (district) Department of Disaster Management (DDM) with UNFPA and UNHCR and their implementing partners. The sharing of plans and communications have been weak at times between UNFPA and UNHCR and this has stressed the relationship, particularly in terms of decisions that need to be made efficiently to support the most vulnerable. UNHCR reduction in funding in 2013 resulted in major activities, which were previously supported by UNHCR, being shouldered by UNFPA. These activities included: ambulance maintenance and services, the provision of fuel, transportation costs to refer patients to higher-level facilities, ante- and post-natal services, and incentives for 14 community health assistants (formerly community trained birth attendants) as well as 14 community reproductive health workers (CRHW). Examples also include supporting an operating theatre closer to the camps and coordinating effectively to address gender based violence in the camps, where the roles have been split on prevention (UNHCR) and response (UNFPA).³⁸⁶

UNHCR facilitates the referrals of complicated cases to the district hospital in Cox's Bazar and also to Chittagong District Hospital, and covers transport and medicine. The Department of Disaster Management is in charge of the refugee health unit. Approximately 10 to 15 patients a month receive C-sections. Two ambulances were contributed by UNFPA but only one is functioning and is covering both camps.³⁸⁷

Coordination at the camp level is managed by RTMI and UNFPA with the refugee health unit. There was a gap in oversight in April 2015 due to the absence of UNFPA staff. Coordination could be more regular between UNHCR and UNFPA, however, UNFPA has not been consistently present over the past four to five months and the office has only one staff member to cover the whole district. This poses difficulties as RTMI cannot take a decision alone if there is a budgetary issue. For example, it is being proposed that an operating theatre (OT) be developed in the camp area to serve the camps and the undocumented refugees, so they do not have to go to Cox's Bazar where the upazila health complex has only 50 beds, it is a huge burden presently for the hospital to serve the refugee population and there is a need to discuss this idea with the local Ministry of Health and Family Welfare (MoHFW). RTMI can coordinate this operating theatre locally, but UNFPA advocacy support is needed, particularly from the Dhaka management.

In terms of district-level disaster management and preparedness, there is a camp coordinator, and very good coordination for cyclone preparedness among the MoHFW, UNFPA, WFP, IOM for undocumented refugees, and UNFPA. There is also an office of the Refugee Repatriation and Rehabilitation Commissioner of the Ministry of Disaster Management and Relief who bears overall responsibility for refugee assistance and who is active in the district. There has been good coordination through monthly meetings and all stakeholders attend. There is another forum for coordination of a health cluster.

³⁸⁴ Site visits and key informant interviews, October 2015

³⁸⁵ Key informant interviews, October 2015 and UNHCR data

³⁸⁶ Key informant interviews, October 2015

³⁸⁷ Key informant interviews, October 2015

4.9.2 Contribution to strengthening national capacities for the integration of demographic data in disaster response plans

UNFPA support has increased the capacity of the Bangladesh Bureau of Statistics to provide demographic data to the Department of Disaster Management for planning preparedness and response.

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 the *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-governmental organizations working on various aspects of disaster risk reduction and response management.

UNFPA implementing partner Bangladesh Bureau of Statistics (BBS) contributes to disaster risk reduction by supplying “base data” for preparation of the national disaster response plan. The Department of Disaster Management also relies on BBS data for the *Social Safety Net* programme, which is a means to alleviate poverty and vulnerability in Bangladesh. A basic concept is that natural disasters force many poor people into vulnerable situations and the safety net helps to reduce their risks.³⁸⁸

The Department of Disaster Management and the BBS have a collaborative relationship and participate together in meetings and workshops. After a disaster, the DDM obtains “base data” from BBS about the affected area. This data is generated at the union level by the BBS, and then is forwarded to the DDM central office in Dhaka. The information regarding the affected area includes the number of affected people and damages and loss to infrastructure, houses, crop, cattle, poultry, etc. The “base data” is sent from the upazila via e-mail expeditiously and the DDM depends on this data for planning relief and rehabilitation work.

As mentioned above, stronger communications with the Department of Disaster Management could provide opportunities for UNFPA with its population and development partners to collaborate further on disaster preparedness and response.

³⁸⁸ Social Safety Net Programme as a Means to Alleviate Poverty in Bangladesh, Ishita Ahmed, Nusrat Jahan, and Fatema Tuz-Zohora, *Developing Country Studies*, Vol 4 No 17, 2014

5 CONCLUSIONS AND RECOMMENDATIONS

5.1 STRATEGIC LEVEL

CONCLUSION 1 (C1)

Targeting of the most vulnerable

The UNFPA eighth country programme was adapted to national priorities in terms of reproductive health and rights, population and development and gender equality. UNFPA effectively targeted **vulnerable and marginalized groups** such as slum dwellers, indigenous peoples, sex workers, and encamped refugees in targeted districts. UNFPA has effectively programmed more resources to reach adolescents and youth vulnerable to child marriage, gender based violence, and unplanned pregnancies.

However, the planning did not extend adequate attention to the homeless, undocumented migrants, school dropouts, fishing populations, and those with high-risk sexual practices and those susceptible to sexually transmitted diseases, LGBT (lesbian, gay, bi-sexual and transgender) persons, women with disabilities and in difficult circumstances.

ORIGIN EQ1, EQ2, EQ3, EQ4 and EQ8

RECOMMENDATION 1 (R1)

In view of the Sustainable Development Goals (SDG) highlighting vulnerable populations, UNFPA should focus more strategically when planning the ninth country programme on prioritizing and targeting women and girls vulnerable to abuse of their rights, who are at high risk of morbidity, mortality and psychological hardship, and those not fully accessing the health and education systems, and identifying how to reach these women and girls.

PRIORITY LEVEL HIGH

ADDRESSEE COUNTRY OFFICE

OPERATIONAL IMPLICATIONS

UNFPA should:

- Place greater emphasis on women and girls who risk home births and adolescent pregnancy, who are vulnerable to gender based violence, who discontinue contraception methods, and who use high-risk sexual practices.
- Focus on women and girls who live in remote rural areas or are homeless, migrants, school dropouts or slum dwellers and those who migrate daily into slums, and design strategies to reach these women.
- Take into consideration people who do not access the national health or education systems and strategize ways to gain their trust and reach them with information and assistance.
- Consider the factors which are leading to vulnerability or exclusion in assessments.
- Ensure regular sampling of target populations to gauge progress on outcomes such as prevalence of gender based violence and child marriage and adolescent pregnancies, school drop-outs amongst girls, and discontinuation of contraceptives.

CONCLUSION 2 (C2)

Increasing focus on adolescents and youth

As per the national emphasis on the growing adolescent and youth population, the need to realize the demographic dividend, and the UNPFA corporate focus on adolescents, UNPFA has substantially increased support to interventions on behalf of **adolescents and youth**. It has created a unit to oversee the Generation Breakthrough project which effectively incorporates sexual and reproductive health and gender equality objectives. The adolescents and youth unit also plays a pivotal role contributing to efficiency through interchanges of technical expertise among the programmatic areas regarding child marriage, gender equality and adolescent sexual and reproductive health.

Advocacy efforts by UNPFA and development partners on preventing and eliminating child marriage are gaining in strength and momentum. A *Child Marriage Restraint Act of 2014* and an *Adolescent Health Strategy* are in the process of being drafted. Work thus far through Generation Breakthrough holds promise for using the education system and behaviour change communications to promote gains in attitudes and knowledge. Advocacy for increased focus on adolescent sexual and reproductive health is not strong enough to address traditional sensitivities and ensure adequate resources and attention to information and services for unmarried and married adolescents. Services and coverage are very limited in health centres and community-based adolescent clubs to attract the poor and marginal groups and those who have left school.

ORIGIN EQ1, EQ2, EQ3, EQ4, EQ5 and EQ6

RECOMMENDATION 2 (R2)

UNPFA should continue to enhance its significant adolescents and youth focus by considering creation of a distinct programmatic area with strong technical interface with other areas. Through this unit, it should coordinate and promote more dedicated advocacy to bolster the inputs, outputs and outcomes in the health

system and in communities to attract and reach greater numbers of adolescents and youth with reproductive health and gender equality information and services.

PRIORITY LEVEL HIGH

ADDRESSEE COUNTRY OFFICE

OPERATIONAL IMPLICATIONS

UNPFA should:

- Consider creating a separate adolescents and youth programmatic area which will effectively oversee and help to focus efforts of the other programmatic areas, ensuring that their efforts are cohesive in a well-developed and well-documented strategy
- Address weaknesses/strengths in coverage and content of the adolescent corners in health centres and in community clubs and go beyond to other forms of communication with vulnerable and marginal groups who do not have access to these resources
- Ensure that eliminating child marriage is promoted through all programmatic areas and efforts are well monitored and documented
- Address life skills development to enhance young people's employability to use the window of opportunity to reap the demographic dividend
- Create results indicators with strong data sources to ensure that the outcomes and results can be measured and are contributing to national level indicators on child marriage and gender equality
- Work closely with other stakeholders such as UNICEF and NGOs/CBOs to promote goals of adolescent development and sexual and reproductive health
- Document and share lessons learned through Generation Breakthrough on all phases of development of the project so that it can be replicated
- Develop exit plans and create benchmarks for eventual takeover by the Government

CONCLUSION 3 (C3)

Gender equality strategic direction

The **gender equality programmatic area** was designed based on the UNFPA mandate and built upon strong global expertise. It is well-aligned with the UNDAF as well as with national needs. There have been gains in strengthening national and local-level planning and procedures.

However, it is unclear in programme planning and documentation how UNFPA adds value to the national gender equality agenda, and where the UNFPA role lies in relation to that of other actors, such as government ministries. With the exception of support for the gender equity movement in schools (GEMS), interventions do not appear to be strongly connected with each other at the strategic level, or well integrated and mainstreamed with reproductive health and disaster and emergency management.

The lack of a strong, strategic overview has been further challenged by the uneven expertise of partners and at times, lacks clarity on fundamental concepts that underpin the project design. Gender equality concerns are not sufficiently backed up by strategically placed human and financial resources including through implementing partnerships. It is unclear exactly how the gender equality projects could be replicated and handed over to national stakeholders.

ORIGIN EQ1, EQ2, EQ3, EQ4, EQ7 and EQ8

RECOMMENDATION 3 (R3)

In view of contributing to the Sustainable Development Goals, especially SDG 5: Achieve gender equality and empower women and girls, UNFPA should strengthen the country programme gender equality strategy and the profile of the gender equality programmatic area and press for greater clarity in the division of roles among partners.

PRIORITY LEVEL HIGH

**ADDRESSEE COUNTRY OFFICE;
ASIA AND PACIFIC REGIONAL OFFICE;
HEADQUARTERS**

OPERATIONAL IMPLICATIONS

UNFPA should:

- Ensure that the gender equality strategy for the ninth country programme:
 - covers the range of gender equality support at all levels and reflects the global, regional, and national UNFPA strategies
 - reflects the inputs of other actors supporting the gender equality agenda and national plans of action in Bangladesh and ensures that UNFPA comparative value and strengths are positioned appropriately
 - mainstreams gender in all outcome areas, with the gender unit assigned a clear responsibility to ensure gender-mainstreaming
 - addresses the nexus between the health sector response to gender based violence and the response to gender based violence in humanitarian settings
 - sets strong indicators and means to collect data on a regular basis to track them
 - sets out the means by which sustainability will be attained through exit strategies with clear benchmarks for increased government resources and clear means to effect replication of successful interventions
 - heightens the profile of the UNFPA gender equality interventions and uses successful fund-raising strategies to secure financial and human resources
 - uses all possible channels of communication regarding prevention of gender based violence and child marriage including the health system and the traditional health practitioners
- Strengthen terminology and approaches that encompass the range of gender equality concerns, emphasizing gender equality as a rights-based discipline with legal and institutional standards for the elimination of abuse of women's rights of which violence is one symptom
- Increase quality of reporting and monitoring so that the interventions of the gender equality programmatic area and follow-up on monitoring are clearly described in documentation
- As per the goals of the *Seventh Five-Year Plan*, capitalize on the strengthening number of women parliamentarians

- Continues work in the pillar coordination group and the local consultative group, WAGE, to develop the joint gender equality strategy
- Draw on global and regional expertise and UNFPA experience in other countries to seek other perspectives and strategize stronger support for gender equality strategies and interventions
- Develop an office management plan that strongly supports the gender equality programmatic area with strong staffing support, including capacity development and ensuring that gender equality concerns are firmly mainstreamed
- Select implementing partners who have the capacity to achieve the strongest outcomes and determine a structured capacity development programme with benchmarking for those who require further capacity
- Establish clear targets for results at all levels of influence, including policy and legislation, leadership, strengthening adjudication, local-level planning and implementation, community awareness, and reduction of harmful traditional attitudes and behaviours

CONCLUSION 4 (C4)

Working with key influencer groups

UNFPA has targeted some of the key influencer groups for awareness raising and advocacy on women’s and reproductive health and rights, such as national and community leaders, members of parliament, local-level planners, men and boys, parents, and religious and school leaders. These groups have a demonstrated influence on women’s ability to protect their rights, including decisions regarding family planning and the age of marriage, upholding women’s rights to equality and to safe pregnancy and delivery. These groups will help women protect themselves from gender based violence and reproductive health diseases, especially in times of emergencies and disasters.

UNFPA has not targeted enough resources to working with some of these groups, especially men and boys, husbands who exert strong

influence on women’s reproductive health choices and may subject them to violence, community leaders who have strong influence over the decisions of parents, and the parents themselves and the choices they will make for their children.

There is insufficient sustained advocacy by UNFPA at high levels to promote faster gains while supporting reproductive rights. UNFPA has also not fully used the impact of demographic data, for example, in influencing parliamentarians. The levels of governance which may have powerful influence such as divisions (regions) have not been fully explored.

ORIGIN EQ2, EQ4, EQ5 and EQ6

RECOMMENDATION 4 (R4)

UNFPA should assess the most appropriate means of reaching key influencer groups and prioritize advocacy and communications interventions according to those which will have the most impact.

PRIORITY LEVEL MEDIUM

ADDRESSEE COUNTRY OFFICE

OPERATIONAL IMPLICATIONS

UNFPA should:

- Finalize the country office communications plan
- Develop joint communication plans with partners and other stakeholders
- Make better use of demographic data to influence politicians and government leaders, to promote better understanding of the issues and to appraise the appropriateness of government projects
- Include divisional leaders in advocacy and communications
- Utilize data already collected on communications, such as the KAP study on cervical and breast cancer in order to design appropriate campaigns

CONCLUSION 5 (C5)

Addressing vulnerability to disasters and emergencies

Given the high vulnerability of Bangladesh to **disasters and emergencies**, UNFPA was slow in the eighth country programme to take action on the Minimum Initial Service Package (MISP). Training on the MISP has been limited so far, and the MISP does not fully cover gender issues in emergency. The newest response plans for UNFPA and the Interagency Standing Committee have incorporated MISP, gender based violence, and reproductive health concerns. Coordination has been mainly positive with the Government and NGOs providing assistance. However, relations are not strong enough with the Department of Disaster Management. Response to recent natural disasters such as the 2014 floods and a storm surge in 2015 has not been sufficiently tailored to the needs of the affected populations, or followed up in sufficient detail.

UNFPA assistance to Rohingya refugees has resulted in significant gains in reproductive health for this population, such as increased contraceptive acceptance, higher use of skilled birth attendants, and high rates of adolescent usage of the adolescent corner services. However, services have been hampered by uneven coordination with other UN agencies supporting the refugees.

ORIGIN EQ8 and EQ9

RECOMMENDATION 5 (R5)

UNFPA should take a more active role in the UN joint assessments and response, make relevant contributions, and ensure that preparedness and response are reproductive health and gender sensitive and include appropriate interventions in times of emergencies to prevent gender based violence. UNFPA should work toward stronger communications and coordination with government and UN agencies as well as other stakeholders supporting disaster and emergency affected populations, such as documented and undocumented refugees.

PRIORITY LEVEL MEDIUM

ADDRESSEE COUNTRY OFFICE

OPERATIONAL IMPLICATIONS

UNFPA should:

- Ensure that the country office has assigned an emergency response team among staff to promote mainstreaming
- Take part in the UN joint assessment or follow it closely and be prepared to contribute according to needs-assessments
- Promote strong follow-up on contributions to response so that they are accounted for and to assess their usefulness in an emergency
- Collaborate through SPRINT to promote faster dissemination of MISP and information on ways to promote gender sensitive emergency response
- Establish stronger relations with the Department of Disaster Management to promote reproductive health and gender sensitive responses
- Streamline coordination arrangements with UNHCR for documented refugees in camps and undocumented refugees with IOM and other stakeholders
- Use good practices and lessons learned from reproductive health and gender equality efforts in the refugee camps in planning assistance to undocumented refugees
- Ensure that the MISP training materials and workshops cover all aspects of gender equality and protection of women and girls in disasters and emergencies, including protection of dignity
- Ensure that all staff have received capacity building on gender sensitivity and prevention of women's rights abuses in disasters and emergency response
- Extend area coverage for the MISP in the UNFPA-targeted districts of southern Bangladesh: Satkhira, Khulna and Bagerhat (which are prone to disasters) as well as the three hill districts.

CONCLUSION 6 (C6)

Added value and sustainability of results

UNFPA has participated actively in coordination forums, joint initiatives and programmes, and its leadership and participation in UN task sharing has strengthened since 2014. UNFPA has sought to achieve complementarity with UN partners. However, the scope and coverage of UNFPA inputs is very limited, reaching only a small proportion of districts, institutions, communities and individuals in Bangladesh.

The emerging status of Bangladesh as a low-to-middle income country means that UNFPA will limit its inputs as per the global strategic direction. Funding limitations will pose further constraints on the traditionally supplied and branded inputs that are expected from UNFPA in terms of facility upgrading and provision of equipment. UNFPA does not have specific exit plans with partners to promote **sustainability**, possibly creating unrealistic expectations that UNFPA support will be continuous.

ORIGIN EQ1, EQ2, EQ3, EQ4, EQ5, EQ6, EQ7, EQ8 and EQ9

RECOMMENDATION 6 (R6)

The UNFPA ninth country programme should plan the handover of programmes and interventions with the Government to anticipate the eventual decreases in funding and work more closely with UN and other agencies in Bangladesh, sharing resources and strategic analyses, to make stronger progress toward results.

PRIORITY LEVEL MEDIUM

ADDRESSEE COUNTRY OFFICE

OPERATIONAL IMPLICATIONS

UNFPA should:

- Work more closely with UN and other agencies in Bangladesh, sharing resources and strategic analyses. This might include, for example, WHO for midwifery, UNICEF for adolescents, USAID for family planning, EngenderHealth for obstetric fistula, and WHO for cervical and breast cancer and UNAIDs for sexually transmitted diseases, UNHCR, IOM and MSF for undocumented refugees, and UNDP and UN Women for gender equality.
- Advocate with UNICEF and donors such as the Japan International Cooperation Agency (JICA), for support from the Government to deal with the challenges in the midwifery profession; a working group would be helpful to strengthen the Department of Nursing Services in midwifery and to support a faculty position dedicated to midwifery; UNFPA also needs to secure a division focus and coordination with the Assistant Director of Nursing at the district level.
- Work with USAID to identify channels for communications through private pharmacies, improve coverage to reach vulnerable groups with contraceptives and information on preventing sexually transmitted diseases.
- Strengthen joint initiatives with UNICEF to promote proven concepts and techniques for reaching adolescents and their parents.

5.2 PROGRAMMATIC LEVEL

Reproductive health and rights

CONCLUSION 7 (C7)

Support to family planning

UNFPA has supported revitalization of the **family planning programme**, achieving high levels of consistent contraceptive availability and supporting policy to reach the FP 2020 goals through strategic research. However, contraceptive usage and high discontinuation rates remain a challenge and a large percentage of women and men remain out of the loop of family planning information and contraceptive acceptance. Men remain the key decision-makers regarding women's family planning options. All health facilities, such as district hospitals, do not offer long-acting and permanent methods or a selection of them, including long acting reversible methods, which could prove the most acceptable. The facilities are ready, which is an improvement, but reasons for discontinuation is poor supervision and lack of follow-up at the community level, which is a weakness.

UNFPA has not pushed strongly enough among partners and donors to promote coverage of families who have not been effectively reached. There is insufficient data on the type of contraception in demand, usage, discontinuation rates, and the accompanying services such as counselling and follow-up. Training received by the health system staff is not always effectively used and is not always followed up with evaluation.

ORIGIN EQ1, EQ2 and EQ7

RECOMMENDATION 7 (R7)

In view of Sustainable Development Goal 3 target: Ensure universal access to sexual and reproductive health-care services, including for family planning, UNFPA should support data collection to gather sufficient evidence for resource allocations in family planning and continue to work on strengthening health worker capacity to supervise, monitor, and follow up on contraceptive discontinuation and promote long-acting and permanent methods.

PRIORITY LEVEL HIGH

ADDRESSEE COUNTRY OFFICE

OPERATIONAL IMPLICATIONS

UNFPA should:

- Demonstrate its strength in family planning through increasing high level advocacy with parliamentarians, divisions, ministerial stakeholders, religious and community leaders, as well as donors and other UN agencies referring to demographic data to promote greater coverage of gaps in usage of information and contraceptives
- Collect data on reasons for discontinuation of long-acting and permanent (LAPM) methods and on acceptability among the selection available while advocating for methods that may be preferred
- Train health workers to efficiently categorize their clientele in terms of contraceptive acceptance and family planning and focus efforts on those who discontinue, in order to help them select another method
- If it proves successful, replicate the ICT4RH as soon as possible and ensure that follow-up with clientele and on-training utility is part of the ICT requirements for staff

- Select the appropriate approach to introducing family planning before marriage to couples that have a high probability of accepting it successfully
- Monitor contraceptive acceptance and discontinuation including couple registration and marriage registration, use of census and population data and MIS HMIS data
- Expand advocacy for provision of information to unmarried adolescents and youth and reach the influencing groups, as well as women of child bearing age who live in remote areas or are from marginal groups
- Use lessons from previous successful work in raising the contraceptive prevalence rate and contraceptive acceptance rate such as in the refugee camps among Rohingya
- Tie in closely the benefits of family planning to preventing maternal mortality and to promoting a woman's right to choose the number of children she will have and when.

CONCLUSION 8 (C8)

Addressing cervical and breast cancer

Campaigns to promote awareness on cervical and breast cancer have been successful in attracting women for screening but campaigns have not been sufficiently accompanied by appropriate and quality supporting services. Screening and follow-up suffered from ineffective supervision by the health system supervisors, poor quality of services, and an inefficient supply chain to the union level. In addition, referral systems are weak and there is not enough inclusion of grass-root-level actors to promote organized screening. Further, the grouping-together of both cancers may offer a measure of efficiency in mass screenings but referral and treatment require differing approaches.

ORIGIN EQ1 and EQ2

RECOMMENDATION 8 (R8)

In view of the Sustainable Development Goal 3 target: Reduce by one third premature mortality through prevention and treatment, UNFPA should advocate for a national strategy to address cervical cancer and breast cancer and to prioritize screening and treatment regimens specific for each type of cancer.

PRIORITY LEVEL HIGH

**ADDRESSEE COUNTRY OFFICE;
ASIA AND PACIFIC REGIONAL OFFICE**

OPERATIONAL IMPLICATIONS

UNFPA should:

- Advocate for a national strategy to address both types of cancer while specifying appropriate referrals and regimens to treat them
- Advocate for an evidence-based approach to screening and treatment of breast cancer
- Support localized campaigns in the most vulnerable areas to reach those not yet reached and facilitate access to appropriate treatment and follow-up
- Support a nationwide campaign, such as through television coverage, along with readiness of services for prevention, detection and treatment
- Coordinate with other actors working on similar issues, both nationally and regionally, drawing attention to the high incidence and prevalence and bringing in new ideas and resources
- Collect more data on the reasons why women who suffer or die from cancer did not seek screening or treatment. This may constitute a type of morbidity and mortality review such as conducted for the maternal neonatal health initiative and involving all levels of the health system.

CONCLUSION 9 (C9)

Supporting obstetric fistula treatment and recovery

Obstetric fistula repairs thus far comprise a very small proportion of the estimated 71,000 women who require surgery. Major reasons are the shortage of trained surgeons who commit to conducting the surgery on a regular basis, lack of rehabilitation centres in the districts and insufficient outreach by health workers to facilitate access to services. A National Fistula Strategy has been finalized and a *National Fistula Campaign* has been designed, but it has not yet been approved and funded.

UNFPA has supported the selection of surgeons for both the basic and specialized training, but challenges exist to retaining their services for fistula surgeries and at needed service delivery points. UNFPA technical assistance needs to be stronger to promote replication of the fistula treatment and recovery model in Dhaka in district health centres to develop surgical capacity, fistula corners and rehabilitation centres with dedicated staff for counseling and logistical support.

ORIGIN EQ1

OPERATIONAL IMPLICATIONS

UNFPA should:

- Advocate at the ministry level to fund the national fistula campaign in light of the services that can be provided when women respond for surgeries
- Work with the model rehabilitation centres to establish strong referral ties to the Government of Bangladesh livelihood strategies when recovering women return home
- Strengthen the *Community Fistula Advocate programmes*, champion them, and include other volunteers
- Strengthen technical support and monitoring by UNFPA staff, particularly at the district level
- Confer with trained surgeons or conduct a survey to determine reasons for lack of dedication to the surgery and collect recommendations for improvement
- Support fistula surgeons and technical experts on rehabilitation to visit the districts, upazilas and unions to share perspectives and motivate and support local stakeholders.

RECOMMENDATION 9 (R9)

UNFPA should advocate for greater attention to replicating the *Obstetric Fistula Treatment and Recovery Model* and promoting development of an effective surgical team nationwide, accompanied by streamlined rehabilitation centres and national awareness campaigns.

PRIORITY LEVEL MEDIUM

ADDRESSEE COUNTRY OFFICE

CONCLUSION 10 (C10)

Addressing sexually transmitted infections and diseases

The country programme focused on providing support toward integrated sexual and reproductive health services, including voluntary counselling and testing for **HIV and AIDS**, and the management of sexually transmitted infections for sex workers. UNFPA supported a *National Communications Guideline* on linkage of HIV and sexual reproductive health and also advocated with National AIDS/STD programme officials on mainstreaming of HIV through inter-ministerial coordination.

However, high HIV prevalence in specific geographical locations and among high risk populations is of concern. Many of these populations fall outside of the usual discussion on sexual and reproductive rights and health and gender, although they may be the most vulnerable to sexual and physical violence, stigma and discrimination. As out-migration of men for work increases, the incidence of STDs among them and their partners is also on the increase. UNFPA missed opportunities to participate in more detection work through supporting testing and surveillance and doing research such as a survey on STDs. Opportunities were missed to further explore the connection between gender based violence and STDs.

ORIGIN EQ1

OPERATIONAL IMPLICATIONS

UNFPA should:

- Participate in more detection work through supporting testing and surveillance
- Conduct research, such as a survey on STDs
- Collaborate with UNAIDS, UN WOMEN, WHO and UNICEF among others to explore the connection between gender based violence and STDs.

CONCLUSION 11 (C11)

Supporting the development of midwives

UNFPA has effectively supported training for **birthing attendants** as well as faculty development. There were significant accomplishments, including the creation of 3,000 posts for midwives, revision of the *Nursing & Midwifery Act* and orientation of other health service cadres on the new roles and responsibilities for the registered and certified midwives.

Support is growing for the development of midwifery-led facility-based deliveries but issues remain regarding resources for supporting midwifery faculty posts, providing midwifery students with adequate lodging, and assurances of housing and security in their new posts. All categories of skilled birthing attendants will be needed until the goals of midwifery-led facility-based services are realized.

ORIGIN EQ1 and EQ2

RECOMMENDATION 10 (R10)

In view of the Sustainable Development Goal 3 target: Ensure healthy lives, UNFPA should engage in a stronger response to the potential increase in sexually transmitted infections and diseases through testing and research.

PRIORITY LEVEL MEDIUM

ADDRESSEE COUNTRY OFFICE

RECOMMENDATION 11 (R11)

In view of the Sustainable Development Goal 3 target: Reduce the global maternal mortality ratio and end preventable deaths of newborns, UNFPA should continue to advocate for stronger support for midwifery-led facility-based deliveries and for women who are receiving training and education as midwives and skilled birthing attendants to ensure sustainability of the investment in their training and to promote good working conditions with recognition of their skills.

PRIORITY LEVEL MEDIUM

ADDRESSEE COUNTRY OFFICE

OPERATIONAL IMPLICATIONS

UNFPA should:

- Work toward a supportive environment for midwifery posts at union level where a strong need has been identified
- Advocate with health system staff to participate in the midwifery education
- Advocate with national and international agencies and other stakeholders for dedicated institutions and for a faculty for midwifery
- Continue to support the high-level midwifery working group, including other relevant UN agencies and donors to strengthen the advocacy voices
- Press for resources to provide midwifery students with adequate lodging during their studies to avoid dropouts and promote greater achievement
- Seek guarantees that midwifery graduates (registered) will have residences and security in their posting so that they will stay where they are posted.

CONCLUSION 12 (C12)

UNFPA has effectively supported the development of Emergency Obstetric and Newborn Care (EmONC) through an assessment, a costed plan and capacity development. The availability of the EmONC services has improved in targeted districts. However there are still significant gaps in both the provision of services as well as in the creation of demand and confidence in the service provision. These include the need for a comprehensive strategy which addresses capacity issues, including financial and human resources and technical support necessary to provide all women with access to the EmONC.

ORIGIN EQ1 and EQ2

RECOMMENDATION 12 (R12)

In view of the Sustainable Development Goal 3 target: Reduce the global maternal mortality ratio and end preventable deaths of newborns, UNFPA should continue to advocate for, and support the Government to, improve the access to quality EmONC services.

PRIORITY LEVEL MEDIUM

ADDRESSEE COUNTRY OFFICE

OPERATIONAL IMPLICATIONS

UNFPA should:

- Advocate and support the Government to implement a national policy for EmONC that includes timely access and a minimal service package
- Advocate for a national EmONC plan that maps a network of 24 hour services as delineated in the above EmONC policy
- Advocate for government investments to be directed toward functioning 24/7 EmONC services
- Support models at district level to demonstrate well-functioning EmONC services
- Advocate for, and provide technical support to, a national level governmental system for ongoing EmONC training, supervision, and support to facilities and providers implementing EmONC
- Support the use of midwives as the first-line provider for Basic EmONC (BEmONC) (these include assisted vaginal delivery, use of parenteral antibiotics and oxytocic drugs, resuscitation for babies, and premature/small baby care)

Population and development

CONCLUSION 13 (C13)

Increased availability and use of demographic data

UNFPA-supported interventions in **population and development** have effectively contributed to increased availability of demographic data, which are being generated using up-to-date data collection and validation techniques. UNFPA partners are making effective use of these data in sectoral and national plans, and are showing ownership in tackling population issues.

UNFPA contribution to institutional capacity to produce strong research results has promoted focus on issues regarding gender based violence, disasters and emergencies and child marriage, among others, and has made positive changes by opening up the data for use by everyone, a milestone in Bangladesh. UNFPA support has helped to produce a new generation of population and development academics.

Coordination has not always been strong enough regarding training carried out at various levels within different institutional settings.

National planners have proposed a higher budgetary allocation in the Five-Year Plan for human resource development in order to harness greater benefit from the demographic dividend. The sustainability of UNFPA-supported interventions still depends, however, on availability of UNFPA resources.

ORIGIN EQ3

RECOMMENDATION 13 (R13)

Given the importance of the capitalizing on the demographic dividend in the coming years and the need for greater availability of data on vulnerable populations as per the Sustainable Development Goals and the Seventh Five-Year Plan, UNFPA should advocate for increasing government support for capacity building in data collection and analysis and report-writing skills.

UNFPA should further strengthen its advocacy role with law makers using up-to-date demographic data to promote sexual and reproductive health and rights and gender equality, while having a specific focus on the most disadvantaged groups such as women, adolescents and youth, and those affected by disasters and emergencies.

PRIORITY LEVEL MEDIUM

ADDRESSEE COUNTRY OFFICE

OPERATIONAL IMPLICATIONS

UNFPA should:

- Strengthen collaboration with the Planning Commission in order to include the Seventh Five-Year Plan targets and mainstream SDGs targets into the national and sectoral plans, and formulate a monitoring and reporting framework
- Advocate for greater support from the Government for human and financial resources (e.g. to purchase equipment with the government budget) toward greater efficiency in national data collection efforts which could make a huge developmental difference
- Strengthen data collection capacity on morbidity and mortality (i.e. maternal, neonatal, children under 5, premature deaths from communicable and non-communicable diseases, traffic accidents, deaths from hazardous chemicals, etc.) and measure the progress toward SDG goals
- Provide technical support and training expertise, possibly through a specialized training institution to coordinate and avoid duplication, to strengthen data collection, and support training for qualified national staff to enhance their analytical skills and report-writing
- Ensure that data, analysis and reports produced by the national statistical office are easily available to users (through the internet and web based platforms)
- Identify more institutions to conduct research with research grants, such as for vaccine and medicines; health financing; recruitment, development, training and retention of health workforce; and early warning, risk reduction and management of health risks.

Gender equality

CONCLUSION 14 (C14)

Prevention of and response to gender based violence and child marriage

UNFPA with implementing partners has contributed to the capacity development of management staff and service providers to prevent and address gender based violence and child marriage in selected districts. Progress has been made to establish partnerships with police and private enterprises and to promote attitudes and behaviours supportive of women's rights.

The eighth country programme interventions have resulted in prevention of a number of child marriages and resolution of some gender based violence cases however, data and reporting are not adequate to illustrate changes in attitudes and behaviour. Behaviour change communications lack structured planning to reach men and boys. Coordination has been weak among partners and stakeholders working toward similar outcomes: there are gaps in referrals and provisions of critical services to survivors of gender based violence.

ORIGIN EQ4

RECOMMENDATION 14 (R14)

In view of contributing to Sustainable Development Goal 5: Achieve gender equality and empower women and girls, UNFPA should produce higher quality monitoring and reporting, ensure high quality data availability, perform periodic surveys on attitudes and behaviour and have a structured communication plan. It should also continue to strengthen coordination among partners and stakeholders and provide promised services and referrals for survivors of gender based violence.

PRIORITY LEVEL HIGH

ADDRESSEE COUNTRY OFFICE;
ASIA AND PACIFIC REGIONAL OFFICE;
HEADQUARTERS

OPERATIONAL IMPLICATIONS

UNFPA should:

- Increase quality of monitoring and reporting on outputs and outcomes so that the steering of the interventions can be more efficiently documented and followed
- Ensure availability of high quality data to measure progress toward outcomes and results: cross-check data on outcomes for child marriages and cases of gender based violence
- Conduct periodic mini-surveys to test knowledge, attitudes and behaviour in targeted districts
- Develop, as part of the country office communications strategy, structured plans to increase communications especially for men and boys and for people not fully accessing the health and education systems
- Work closely with partners and other stakeholders to monitor protective mechanisms that have been jointly developed and that centre on prevention and response to gender based violence, to avoid any lapses of support to vulnerable women who are depending on the support services offered. This must be done through careful budgeting: funds that are transferred or discontinued must be monitored, as must the quantity and quality of the promised services
- Continue to improve referrals and coordination among service providers
- Continue working to decrease the perception gap regarding linkages between sustainable entrepreneurship, gender based violence and reproductive health



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